Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

May 11, 2022

Administrator
Diamond Willow Of Proctor
913 Old Highway 2
Proctor, MN 55810

RE: Project Number(s) SL23609015

Dear Administrator:

On May 4, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine correction of orders found on the evaluation completed on September 17, 2021. The follow-up evaluation determined your facility had not corrected all of the state licensing orders issued pursuant to the September 17, 2021 evaluation.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state licensing orders issued pursuant to the last evaluation completed on September 17, 2021, found not corrected at the time of the May 4, 2022, follow-up evaluation and/or subject to penalty assessment are as follows:

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

The details of the violations noted at the time of this follow-up evaluation completed on May 4, 2022 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $500.00**. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

Also, at the time of this follow-up evaluation completed on May 4, 2022, we identified the following violation(s):

0110-Assisted Living Director License Required-144g.10 Subdivision 1a

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

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), by the correction order date, the licensee must document in the provider's records any action taken to comply with the correction order by the

correction order date. The commissioner may request a copy of this documentation and the assisted living facility's action to respond to the correction orders in future evaluations, upon a complaint investigation, and as otherwise needed.

IMPOSITION OF FINES:

Level 1: no fines or enforcement.

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

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

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

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

REQUESTING A HEARING

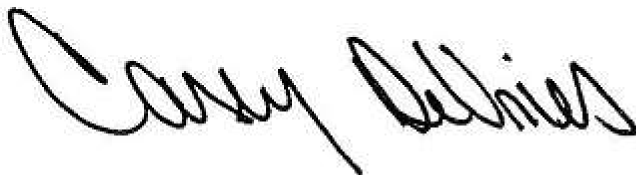
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for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

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

We urge you to review these orders carefully. If you have questions, please contact Casey DeVries at 651-201-5917.

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

Sincerely,



Casey DeVries, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-5917 Fax: 651-215-9697

PMB

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23609	A. BUILDING: ______ B. WING ______	R 05/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAMOND WILLOW OF PROCTOR	**913 OLD HIGHWAY 2 PROCTOR, MN 55810**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 000}	Initial Comments Initial comments *****ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL23609015-3 On May 4, 2022, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on September 17, 2021, and a revisit survey completed on December 9, 2021 and February 15, 2022. At the time of the survey, there were twenty-four (24) residents receiving services under the Assisted Living with Dementia Care license.	{0 000}	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Home Care Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 110 SS=F	144G.10 Subdivision 1a Assisted living director license required Each assisted living facility must employ an assisted living director licensed or permitted by	0 110		

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0 110	Continued From page 1 the Board of Executives for Long Term Services and Supports. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the licensed assisted living director (LALD) was listed as the Director of Record with the Board of Executives for Long Term Services and Supports (BELTSS). This had the potential to affect all of the licensee's residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings included: On May 4, 2022, at 3:00 p.m., clinical nurse supervisor (CNS)-C informed the surveyor that licensed assisted living director/assistant director of operations (LALD)-G ended their employment on May 3, 2022, effective immediately. CNS-C conferenced in via phone, director of operations/interim licensed assisted living director (DOP)-D. On May 4, 2022, at approximately 3:00 p.m., DOP-D stated LALD-G ended employment with licensee effective immediately on May 3, 2022. DOP-D stated LALD-G was LALD for three facilities (same ownership) when LALD-G left employment. DOP-D stated as of May 4, 2022,	0 110		

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0 110	Continued From page 2 DOP-D was the interim LALD for those three facilities in addition to two other facilities DOP-D was overseeing. DOP-D stated, "do what you have to do, it's been less than 24 hours since she [LALD-G] left without notice." DOP-D confirmed their place of residence was located approximately 159 miles from one of the five locations, with a spectrum of distances between the five facilities ranging from 23 miles to 85 miles. On May 4, 2022, at approximately 3:20 p.m., and again on May 5, 2022, at 10:31 a.m., the surveyor verified DOP-D, interim LALD, had a license effective through October 31, 2022; however, DOP-D was not listed as the director of record for the licensee or the other four facilities in BELTSS. No further information provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110		
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (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: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules,	{0 480}		

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{0 480}	Continued From page 3 chapter 4626; and This MN Requirement is not met as evidenced by: No further action is required.	{0 480}		
{0 510} SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (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 establish and maintain an effective infection control program that complied with accepted health care, medical, and nursing standards for infection control related to COVID-19. The licensee failed to ensure staff wore recommended personal protective equipment while working in the facility and failed to ensure staff screened themselves for COVID-19. The deficient practice had the potential to affect all residents, employees and visitors.	{0 510}		

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{0 510}	Continued From page 4 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). Findings include: EYE PROTECTION On May 4, 2022, at 10:58 a.m., the surveyor entered the facility and observed covid screening binders, a thermometer and disinfectant on the entry way table. On May 4, 2022, at 11:50 a.m., the surveyor observed unlicensed personnel (ULP)-A talking with ULP-Q, preparing lunch and gathering supplies in the common dining room with three (3) residents present. The surveyor observed ULP-A was not wearing protective eyewear. After ULP-A noted the surveyor's presence, ULP-A turned her back to the surveyor and placed protective eyewear on her face. The surveyor approached ULP-A, provided education on the use of protective eyewear due to high community transmission levels. ULP-A confirmed the eyewear was not in place and stated, "ok." During an interview on May 4, 2022, at 1:27 p.m., clinical nurse supervisor (CNS)-C requested clarification from the surveyor about when and where protective eyewear should be worn within the facility. The surveyor provided CNS-C educational resources and direction to CDC county tracker site for community transmission levels. The surveyor also provided education and	{0 510}		

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{0 510}		{0 510}		

Continued From page 5

resources to the facility during previous surveys, with the last survey conducted February 15, 2022.

The Minnesota Department of Health (MDH) COVID-19 PPE and Source Control Grids for Congregate Care Settings by Community Transmission Levels dated April 7, 2022, indicated with high community transmission levels, protective eyewear and medical grade masks were to be worn by staff to prevent unseen spread of COVID-19 in a facility. The guidance recommended eye protection when staff were in resident care areas. On May 4, 2022, at approximately 2:03 p.m., the surveyor and CNS-C confirmed the Centers for Disease Control and Prevention (CDC) county tracker indicated covid transmission levels were high within the county the facility is located.

STAFF SCREENING
The surveyor reviewed Covid-19 Pre-Shift Screen documents for April 1, 2022, through May 4, 2022 for employees (ULP-A and ULP-N.) The documents lacked evidence ULP-A and ULP-N had COVID-19 screened prior to working their scheduled shifts.

On May 4, 2022, at 11:50 a.m., the surveyor observed ULP-A in the Arbor Rose facility preparing lunch and gathering supplies while conversing with another ULP.

On May 4, 2022, at 1:27 p.m., the surveyor reviewed Covid-19 Pre-Shift Screen documents for ULP-A and ULP-N, which revealed ULP-A and ULP-N had not completed COVID-19 screening. ULP-A lacked COVID-19 screening on April 13, 2022, and May 1, 2022. ULP-N lacked COVID-19 screening on April 29, 2022.

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{0 510}	Continued From page 6	{0 510}		

On May 4, 2022, at approximately 2:00 p.m., clinical nurse supervisor (CNS)-B confirmed ULP-A and ULP-N had not completed COVID-19 screening and stated, "it appears so."

The Centers for Disease Control and Prevention (CDC) guidance updated February 2, 2022, indicated facilities should establish a process to identify anyone entering the facility, regardless of vaccination status, who may be positive for SARS-CoV-2, have symptoms of COVID-19 or have had close contact with someone with SARS-CoV-2. The CDC provides individual screening on arrival at the facility as an option to meet the updated guidance.
The licensee's COVID Precautions and Education policy updated March 10, 2021, did not address staff use of eye protection or staff COVID screening, however, the policy did indicate nursing would monitor the staff screening log daily.

No further information provided.

{0 780} SS=E — 144G.45 Subd. 2 (a) (1) Fire protection and physical environment — {0 780}

(a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and:

(1) for dwellings or sleeping units, as defined in the State Fire Code:
(i) provide smoke alarms in each room used for sleeping purposes;
(ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms;
(iii) provide smoke alarms on each story

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{0 780}	Continued From page 7 within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: No further action is required.	{0 780}		
{0 810} SS=E	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	{0 810}		

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{0 810}	Continued From page 8 readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: No further action is required.	{0 810}		
{02040} SS=E	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; 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: No further action is required.	{02040}		

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March 9, 2022

Administrator
Diamond Willow Of Proctor
913 Old Highway 2
Proctor, MN 55810

RE: Project Number(s) SL23609015

Dear Administrator:

On February 15, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine correction of orders found on the evaluation completed on September 17, 2021. The follow-up evaluation determined your agency had not corrected all of the state licensing orders issued pursuant to the September 17, 2021 evaluation.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state licensing orders issued pursuant to the last evaluation completed on September 17, 2021, found not corrected at the time of the February 15, 2022, follow-up evaluation and/or subject to penalty assessment are as follows:

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The details of the violations noted at the time of this follow-up evaluation completed on February 15, 2022 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $500.00**. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
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Level 1: no fines or enforcement.
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REQUESTING A HEARING

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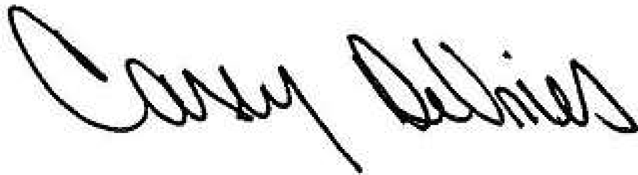
To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both.

We urge you to review these orders carefully. If you have questions, please contact Casey DeVries at 651-201-5917.

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

Sincerely,



Casey DeVries, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-5917 Fax: 651-215-9697

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{0 000}	Initial Comments Initial comments *****ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL23609015 On February 15, 2022, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on September 17, 2021 and a revisit survey completed on December 9, 2021. At the time of the survey, there were twenty-seven (27) residents receiving services under the Assisted Living with Dementia Care license. As a result of the revisit, the following orders were reissued: 0510 and 1890 The licensee is in substantial compliance with correction orders 0480, 0780, 0810, and 2040.	{0 000}	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Home Care Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	{0 480}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23609	A. BUILDING: ____ B. WING ____	R 02/15/2022

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{0 480}	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: No further action is required.	{0 480}		
{0 510} SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision.	{0 510}		

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{0 510}	Continued From page 2	{0 510}		

This MN Requirement is not met as evidenced by:
Based on observation, interview, and document review, the licensee failed to establish and maintain an effective infection control program that complied with accepted health care, medical, and nursing standards for infection control related to COVID-19. The licensee failed to ensure staff wore recommended personal protective equipment while working in the facility and failed to ensure staff screened for COVID-19. The deficient practice had the potential to affect all residents, employees and visitors.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).

Findings include:

Eye Protection

On February 15, 2022, at 10:45 a.m., the Minnesota Department of Health (MDH) surveyor entered the facility. A staff member approached and identified herself as the executive director (ED)-H. The surveyor observed ED-H wearing a medical grade mask without eye protection.

During an observation on February 15, 2022, at approximately 11:00 a.m., ED-H on four (4) occasions walked between the dining/living area and office entry area while several residents were sitting in the common areas. ED-H wore no eye protection.

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{0 510}	Continued From page 3	{0 510}		

During an interview on February 15, 2022, at 1:27 p.m., ED-H requested clarification from the surveyor about when and where protective eyewear should be worn within the facility. ED-H confirmed she had not worn protective eyewear in common areas used by residents.

On February 15, 2022, at 11:40 a.m., the surveyor observed unlicensed personnel (ULP)-I preparing lunch and gathering supplies in the common dining room with four (4) residents and a visitor present. The surveyor observed ULP-I wearing prescription glasses only. ULP-I was asked by the surveyor if protective eyewear had been provided to ULP-I for use within the facility. ULP-I stated she had protective sides that attached to her prescription glasses, but ULP-I had forgotten the eyewear attachments at home.

On February 15, 2022, at 12:08 p.m., the surveyor observed ULP-J assisting with lunch and supplies in the common dining room with four (4) residents and a visitor present. ULP-J was wearing her protective eyewear on the top of her head. As the surveyor approached, ULP-J placed the protective eyewear properly over her eyes.

The Minnesota Department of Health (MDH) COVID-19 Toolkit, Information for Long-Term Care Facilities dated March 8, 2021, indicated to prevent unseen spread of COVID-19 in a facility, staff should use eye protection (face shield or goggles) during all resident care encounters to reduce COVID-19 exposure risk to staff. The guidance recommended eye protection when staff were in resident care areas.

The Centers for Disease Control and Prevention (CDC) Interim Infection Prevention and Control

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NAME OF PROVIDER OR SUPPLIER: **DIAMOND WILLOW OF PROCTOR**

STREET ADDRESS, CITY, STATE, ZIP CODE: **913 OLD HIGHWAY 2, PROCTOR, MN 55810**

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{0 510}	Continued From page 4 Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic guidance dated September 10, 2021, indicated eye protection (i.e., goggles or a face shield that covers the front and sides of the face) should be worn during all patient care encounters. Staff Screening Employees (ULP-K and ULP-L) Covid-19 Staff Pre-Shift Screen documents for January and February, 2022, lacked evidence ULP-K and ULP-L had COVID-19 screened prior to shifts. On February 15, 2022, at 11:45 a.m., the surveyor observed ULP-L in the Arbor Rose facility at medication cart side 1 preparing medications. ULP-L was asked by the surveyor if ULP-L had COVID-19 screened prior to starting the shift. ULP-L stated, "I don't think I did". On February 15, 2022, at 11:52 a.m., the surveyor observed ULP-K in the Arbor Rose facility assisting a resident. ULP-K was asked by the surveyor if ULP-K had COVID-19 screened prior to starting the shift. ULP-K stated, "did I forget?" On February 15, 2022, at 11:57 a.m., Staff Pre-Shift Screen documents indicated ULP-L and ULP-K had not completed a COVID-19 screening. On February 15, 2022, at 12:20 p.m., clinical nurse supervisor (CNS)-B confirmed ULP-L and ULP-K had not completed COVID-19 screening. The Centers for Disease Control and Prevention (CDC) guidance updated February 2, 2022, indicated facilities should establish a process to	{0 510}		

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{0 510}	Continued From page 5 identify anyone entering the facility, regardless of vaccination status, who may be positive for SARS-CoV-2, have symptoms of COVID-19 or have had close contact with someone with SARS-CoV-2. The CDC provides individual screening on arrival at the facility as an option to meet the updated guidance. The licensee's COVID Precautions policy dated November 3, 2020, did not address staff use of eye protection or staff COVID screening.	{0 510}		
{0 780} SS=E	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated;	{0 780}		

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{0 780}	Continued From page 6 This MN Requirement is not met as evidenced by: No further action is required.	{0 780}		
{0 810} SS=E	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill.	{0 810}		

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{0 810}	Continued From page 7 This MN Requirement is not met as evidenced by: No further action is required.	{0 810}		
{01890} SS=E	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure prescription medications were labeled correctly for two of two residents (R3, R2) reviewed for insulin, when three insulin pens did not indicate the date opened. 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). Findings include: R3 On February 15, 2022, at approximately 11:24 a.m., the surveyor observed R3's insulin	{01890}		

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{01890}	Continued From page 8	{01890}		

medications stored in an unrefrigerated medication cart in the Misty Ivy building. Clinical nurse supervisor (CNS)-B identified two (2) insulin pens as R3's, one (1) Novalog flexpen 100 units (u) per milliliter (ml) and one (1) Basaglar 100u/ml. The pens were not labeled and did not indicate when they were opened or taken out of the refrigerator.

Novalog flexpen manufacturer's instruction directs to discard the unrefrigerated medication after 28 days.

Basaglar manufacturer's instruction directs to discard the unrefrigerated medication after 28 days.

During an interview on February 15, 2022, at 11:27 a.m., CNS-B verified R3's insulin pens located in the unrefrigerated medication cart in the Misty Ivy building were not labeled and did not have open dates on the pens.

R2
On February 15, 2022, at approximately 11:48 a.m., the surveyor observed R2's insulin medications stored in an unrefrigerated medication cart in the Arbor Rose building. CNS-B identified one (1) insulin pen, Levamir 100 u/ml, as R2's. The pen was not labeled and did not indicate when it had been opened or taken out of the refrigerator

Levamir manufacturer's instruction directs to discard the unrefrigerated medication after 42 days.

During an interview on February 15, 2022, at 11:53 a.m., CNS-B verified R2's insulin pen located in an unrefrigerated medication cart in the

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{01890}	Continued From page 9 Arbor Rose building was not labeled and did not have an open date on the pen. Additionally, during the initial survey September 17, 2021, and on the follow up visit December 9, 2021, R2's insulin pens lacked a label indicating the open date. Licensee's Storage of Medications policy dated December 24, 2019, indicated medications shall be stored consistent with manufacturer's recommendations (refrigerated, room temperature, or frozen). Licensee's Insulin Pens policy, updated April 26, 2018, indicated when a new pen is obtained from the refrigerator, to bring the pen to room temperature and document the date opened on the body of the pen prior to administration.	{01890}		
{02040} SS=E	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; 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: No further action is required.	{02040}		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

December 27, 2021

Administrator
Diamond Willow of Proctor
913 Old Highway 2
Proctor, MN 55810

RE: Project Number(s) SL23609015-1

Dear Administrator:

On December 9, 2021, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine correction of orders found on the evaluation completed on September 17, 2021. The follow-up evaluation determined your agency had not corrected all of the state licensing orders issued pursuant to the September 17, 2021 evaluation.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state licensing orders issued pursuant to the last evaluation completed on September 17, 2021, found not corrected at the time of the December 7, 2021 follow-up evaluation and subject to penalty assessment are as follows:

The details of the violations noted at the time of this follow-up evaluation completed on December 9, 2021 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

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

0480 - 144g.41 Subd 1 (13) (i) (b) - Minimum Requirements = $500.00
0510 - 144g.41 Subd. 3 - Infection Control Program = $500.00
0680 - 144g.42 Subd. 10 - Disaster Planning And Emergency Preparedness = $500.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $1,500.00**. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

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

IMPOSITION OF FINES:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

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

REQUESTING A HEARING

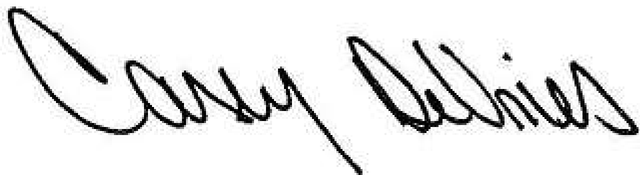
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 16, a request for a hearing must be in writing and received by the Department of Health within 15 calendar days. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

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

We urge you to review these orders carefully. If you have questions, please contact Casey DeVries at 651-201-5917.

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

Sincerely,



Casey DeVries, Supervisor
State Rapid Response Team
85 East Seventh Place, Suite 220
P.O. Box 64970
St. Paul, MN 55164-0970
Telephone: 651-201-5917 Fax: 651-281-9796

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DIAMOND WILLOW OF PROCTOR	**913 OLD HIGHWAY 2 PROCTOR, MN 55810**

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{0 480}	Continued From page 1	{0 480}		

(13) offer to provide or make available at least the following services to residents:

(i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply:

(B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and

This MN Requirement is not met as evidenced by:
Based on observation, interview, and record review, the licensee failed to comply with Minnesota Food Code, Chapter 4626. This had the potential to affect all twenty-one (21) residents residing at the facility.

This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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 additional documentation included in the Food and Beverage Establishment Inspection Reports dated December 9, 2021.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23609	A. BUILDING: ______ B. WING ______	R 12/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAMOND WILLOW OF PROCTOR	**913 OLD HIGHWAY 2 PROCTOR, MN 55810**

(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=F	144G.41 Subd. 3 Infection control program	{0 510}		

(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 document review, the licensee failed to establish and maintain an effective infection control program that complied with accepted health care, medical, and nursing standards for infection control related to COVID-19. The licensee failed to ensure staff wore recommended personal protective equipment while working in the facility and failed to ensure staff screened residents for COVID-19 daily. The deficient practice had the potential to affect all residents, employees, and visitors.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).

Findings include:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 23609	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED R 12/09/2021

NAME OF PROVIDER OR SUPPLIER: **DIAMOND WILLOW OF PROCTOR**

STREET ADDRESS, CITY, STATE, ZIP CODE: **913 OLD HIGHWAY 2 PROCTOR, MN 55810**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 510}	Continued From page 3	{0 510}		

Eye Protection

On December 7, 2021, at 10:30 a.m., the MDH surveyor entered the facility. A staff member approached and identified herself as the life enrichment coordinator (LEC)-E. The investigator observed LEC-E wearing a medical grade mask and prescription glasses without additional eye protection.

During an observation on December 7, 2021, at 1:15 p.m., LEC-E conducted an activity with three residents in the common area. LEC-E wore no eye protection.

During an interview on December 7, 2021, at 11:30 a.m., LEC-E stated that she had some goggles somewhere, but only wore them when she entered a resident room.

The Minnesota Department of Health (MDH) COVID-19 Toolkit, Information for Long-Term Care Facilities dated March 8, 2021, indicated to prevent unseen spread of COVID-19 in a facility, staff should use eye protection (face shield or goggles) during all resident care encounters to reduce COVID-19 exposure risk to staff. The guidance recommended eye protection when staff were in resident care areas.

The Centers for Disease Control and Prevention (CDC) Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic guidance dated September 10, 2021, indicated eye protection (i.e., goggles or a face shield that covers the front and sides of the face) should be worn during all patient care encounters.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23609	A. BUILDING: ____ B. WING ____	R 12/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAMOND WILLOW OF PROCTOR	**913 OLD HIGHWAY 2 PROCTOR, MN 55810**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 510}	Continued From page 4 The licensee's COVID Precautions policy dated November 3, 2020, did not address staff use of eye protection. Resident Screening Residents (R1, R4, R5, R6, R7, R8, and R9) COVID-19 Active Screening/Monitoring documents for December 2021 lacked evidence of daily COVID-19 screening. R1's COVID-19 Active Screening/Monitoring document reviewed on December 7, 2021, indicated staff did not screen R1 on December 2, 5, or 6, 2021. R4's COVID-19 Active Screening/Monitoring document reviewed on December 7, 2021, indicated staff did not screen R4 on December 2, 5, or 6, 2021. R5's COVID-19 Active Screening/Monitoring document reviewed on December 7, 2021, indicated staff did not screen R5 on December 2, 5, or 6, 2021. R6's COVID-19 Active Screening/Monitoring document reviewed on December 7, 2021, indicated staff did not screen R6 on December 2, 5, or 6, 2021. R7's COVID-19 Active Screening/Monitoring document reviewed on December 7, 2021, indicated staff did not screen R7 on December 2, 5, or 6, 2021. R8's COVID-19 Active Screening/Monitoring document reviewed on December 7, 2021, indicated staff did not screen R8 on December 2,	{0 510}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23609	A. BUILDING: ______ B. WING ______	R 12/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAMOND WILLOW OF PROCTOR	**913 OLD HIGHWAY 2 PROCTOR, MN 55810**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 510}	Continued From page 5 5, or 6, 2021. R9's COVID-19 Active Screening/Monitoring document reviewed on December 7, 2021, indicated staff did not screen R9 on December 2, 3, 4, 5, or 6, 2021. During an interview on December 7, 2021, at 3:30 p.m., director of operations (DOO)-D stated the hope was for staff to screen residents twice per day but confirmed that staff did not screen the residents once per day. The MDH COVID-19 Guidance: Long-term Care Indoor Visitation for Nursing Facilities and Assisted Living-type Settings guidance dated May 20, 2021, indicated facilities should actively screen all resident for fever and respiratory symptoms of illness at least daily and increase monitoring of ill residents to at least three times daily. The CDC Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread dated September 10, 2021, indicated facilities should actively monitor all residents upon admission and at least daily for fever and symptoms consistent with COVID-19, including an assessment of oxygen saturation via pulse oximetry. The licensee's COVID Precautions policy dated November 3, 2020, did not address resident COVID screening.	{0 510}		
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness	{0 680}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23609	A. BUILDING: ______ B. WING ______	R 12/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAMOND WILLOW OF PROCTOR	**913 OLD HIGHWAY 2 PROCTOR, MN 55810**

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{0 680}	Continued From page 6 (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop a written plan of action to facilitate the management of resident care and services in response to a natural disaster, such as storms or other emergencies, that may disrupt the licensee's ability to provide care and services. In addition, the licensee failed to develop an all-hazards emergency preparedness program and plan to include Appendix Z required elements. This had the potential to affect all twenty-one (21) residents receiving assisted living services and staff.	{0 680}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23609	A. BUILDING: ____ B. WING ____	R 12/09/2021

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{0 680}	Continued From page 7 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: On December 7, 2021, at 12:42 p.m., the licensee's emergency preparedness plan and Appendix Z were requested. On December 8, 2021, at approximately 8:10 a.m., licensee's emergency preparedness plan and Appendix Z were provided for surveyor review. The licensee lacked a complete emergency preparedness and Appendix Z plan to manage resident care and services in response to a disaster or emergency. On December 8, 2021, at 9:14 a.m., director of operations (DOO)-D confirmed the licensee lacked a complete customized emergency preparedness plan and Appendix Z which included: -a written emergency disaster plan that contained a plan for evacuation, addresses elements of sheltering in place, identified temporary relocation sites, and detailed staff assignments in the event of a disaster or an emergency; -posted an emergency disaster plan prominently; -emergency and disaster training to all staff during the initial staff orientation; and -Appendix Z required elements Licensee's 9.01 Emergency Preparedness Plan - Appendix Z Compliance Policy, dated August 1,	{0 680}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{0 680}	Continued From page 8 2021, indicated licensee's emergency preparedness plan would include all required elements of Appendix Z and include initial training of all staff on the emergency preparedness plan and annually. No further information was provided.	{0 680}		
{0 780} SS=E	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: No further action required	{0 780}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{0 810} SS=E	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: No further action required	{0 810}		

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DIAMOND WILLOW OF PROCTOR	**913 OLD HIGHWAY 2 PROCTOR, MN 55810**

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{01890}	Continued From page 10	{01890}		
{01890} SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure prescription medications were labeled correctly for one of three residents (R3) reviewed for insulin, when three insulin pens did not indicate the date opened. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). Findings include: Observation of R3's medications stored in an unrefrigerated medication cart revealed three insulin pens for R3 (Levamir 100 units (u) per milliliter (ml), Novalog flexpen 100u/ml, and Victoza 18 milligrams (mg)). The pens did not indicate when they were opened or taken out of the refrigerator . Levamir manufacturer's instruction directs to discard the unrefrigerated medication after 42 days.	{01890}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{01890}	Continued From page 11	{01890}		

Novalog flexpen manufacturer's instruction directs to discard the unrefrigerated medication after 28 days.

Victoza manufacturer's instruction directs to discard the unrefrigerated medication after 30 days.

During an interview on December 7, 2021, at 2:20 p.m., unlicensed personnel (ULP)-B verified the insulin pens (Levamir, Novalog flexpen, and Victoza) were labeled as R3's medications and did not have the date they were opened on the pen.

During an interview on December 7, 2021, at 3:00 p.m., licensed practical nurse (LPN)-G verified that the licensee's practice included documenting the date on insulin pens removed from the refrigerator and placing the pens in the medication cart.

Licensee's Storage of Medications policy dated December 24, 2019, indicated medications shall be stored consistent with manufacturer's recommendations (refrigerated, room temperature, or frozen).

Licensee's Insulin policy dated August 1, 2021, lacked information for placing the date opened on the insulin pen.

{02040} SS=E — 144G.81 Subdivision 1 Fire protection and physical environment — {02040}

An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{02040}	Continued From page 12 following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; 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: No further action required.	{02040}		

Minnesota Department of Health
Food, Pools, & Lodging Services
P.O. Box 64975
Saint Paul, MN 55164-0975
651-201-4500

Type: Follow-Up
Date: *12/09/21*
Time: 09:30:00
Report: 1006211099

Food and Beverage Establishment Inspection Report

Location:
Diamond Willow Of Proctor
913 Old Highway 2
Proctor, MN55810
St. Louis County, 69

Establishment Info:
ID #: 0038470
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 2186249771
ID #:

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

The following orders were issued during this inspection.

2-100 Supervision

2-102.12AMN

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

THE PREVIOUS CFPM NO LONGER WORKS AT THE FACILITY. HOLLY WILL BE TAKING A COURSE ON SATURDAY 12/11. SEND IN STATE APPLICATION AND FEE AFTER THE CLASS IS TAKEN TO RECEIVE THE STATE CERTIFICATE.

Comply By: 01/09/22

2-100 Supervision

2-102.12DMN

MN Rule 4626.0033D Post the certified food protection manager certificate.

ONCE THE STATE CERTIFIED FOOD PROTECTION MANAGERS CERTIFICATE IS RECEIVED POST THE CERTIFICATE IN THE FACILITY.

Comply By: 01/20/21

Surface and Equipment Sanitizers

Quaternary Ammonia: = 400 PPM at Degrees Fahrenheit
Location: QUAT SANITIZER WIPES
Violation Issued: No

Food and Beverage Establishment Inspection Report

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

COMMENTS:

INSPECTION WAS DONE AT ARBOR ROSE FACILITY. INSPECTION ACCOMPANIED BY HOLLY LAMON.

THE PREVIOUS STATE CERTIFIED FOOD PROTECTION MANAGER NO LONGER WORKS AT THE ESTABLISHMENT. HOLLY IS SCHEDULED TO TAKE THE COURSE AND EXAM THIS SATURDAY, 12/11. ONCE THE COURSE IS COMPLETED SEND IN THE STATE APPLICATION AND FEE TO RECEIVE THE STATE CERTIFICATE. POST THE STATE CERTIFICATE IN THE FACILITY ONCE RECEIVED. REMINDER THAT THE STATE CERTIFICATE NEEDS TO BE RENEWED EVERY 3 YEARS.

ESTABLISHMENT NOW HAS LIQUID EGG TO USE WHEN MAKING SCRAMBLED EGGS, EGG BAKES, ETC. DISCUSSED USING PASTEURIZED SHELL EGGS OR PASTEURIZED LIQUID EGGS WHEN REQUIRED. ESTABLISHMENT DOES HAVE REGULAR SHELL EGGS THAT ARE NOW KEPT ON THE BOTTOM RACK OF THE REFRIGERATOR. MAKE SURE ALL STAFF ARE TRAINED ON THE PROPER USE OF RAW SHELL EGGS VS. PASTEURIZED EGGS. IF FACILITY WISHES TO CONTINUE USING SHELL EGGS, RECOMMEND USING ALL PASTEURIZED SHELL EGGS TO AVOID ANY CONFUSION AMONG STAFF.

DISCUSSED WITH HOLLY TRAINING STAFF IN FOOD SAFETY SO ALL STAFF ARE DOING THINGS CORRECTLY AND CONSISTENTLY. STAFF HAVE PRINTED OFF SOME FOOD SAFETY SIGNAGE THROUGHOUT THE KITCHEN. RECOMMEND HAVING A FOOD SAFETY TRAINING BINDER THAT STAFF CAN REFERENCE IF THERE ARE EVER ANY QUESTIONS. FACT SHEETS CAN BE FOUND ON THE MDH WEBSITE, OTHERWISE CONTACT THE DEPARTMENT OF HEALTH IF YOU NEED ANY FACT SHEETS.

ALL OTHER PREVIOUS ORDERS HAVE BEEN CLEARED.

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 1006211099 of 12/09/21.

Certified Food Protection Manager:____________________

Certification Number: __________ Expires: / / __________

Inspection report reviewed with person in charge and emailed.

Signed:____________________
Sara Kleinschmidt
Manager

Signed:____________________
Inspector 1006

651-201-4500
health.foodlodging@state.mn.us

Minnesota Department of Health
Food, Pools, & Lodging Services
P.O. Box 64975
Saint Paul, MN 55164-0975
651-201-4500

Type: Follow-Up
Date: *12/09/21*
Time: 10:00:00
Report: 1006211100

Food and Beverage Establishment Inspection Report

Location:
Diamond Willow Of Proctor
913 Old Highway 2
Proctor, MN55810
St. Louis County, 69

Establishment Info:
ID #: 0038470
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 2186249771
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 previously issued on 12/09/21 have NOT been corrected.

2-100 Supervision

2-102.12AMN

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

THE PREVIOUS CFPM NO LONGER WORKS AT THE FACILITY. HOLLY WILL BE TAKING A COURSE ON SATURDAY 12/11. SEND IN STATE APPLICATION AND FEE AFTER THE CLASS IS TAKEN TO RECEIVE THE STATE CERTIFICATE.

Issued on: 12/09/21 *Comply By: 01/09/22*

2-100 Supervision

2-102.12DMN

MN Rule 4626.0033D Post the certified food protection manager certificate.

ONCE THE STATE CERTIFIED FOOD PROTECTION MANAGERS CERTIFICATE IS RECEIVED POST THE CERTIFICATE IN THE FACILITY.

Issued on: 12/09/21 *Comply By: 01/20/21*

No NEW orders were issued during this inspection.

Food and Equipment Temperatures

Process/Item: Upright Cooler
Temperature: 38 Degrees Fahrenheit - Location: MILK- STORAGE ROOM FRIDGE
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 39 Degrees Fahrenheit - Location: RASPBERRY JAM- WHIRLPOOL
Violation Issued: No

Food and Beverage Establishment Inspection Report

Process/Item: Upright Cooler
Temperature: 40 Degrees Fahrenheit - Location: MILK- WHIRLPOOL
Violation Issued: No

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

COMMENTS:

INSPECTION WAS AT THE MISTY IVY FACILITY.

INSPECTION ACCOMPANIED BY HOLLY LAMON.

ALL OTHER PREVIOUS ORDERS HAVE BEEN CORRECTED. REFER TO INSPECTION REPORT #1006211099 FOR ADDITIONAL COMMENTS.

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 1006211100 of 12/09/21.

Certified Food Protection Manager:________________________________

Certification Number: _______________ Expires: __/ /__________

Inspection report reviewed with person in charge and emailed.

Signed:________________________________

Sara Kleinschmidt
Manager

Signed:________________________________

Inspector 1006

651-201-4500
health.foodlodging@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

October 27, 2021

Administrator
Diamond Willow Of Proctor
913 Old Highway 2
Proctor, MN 55810

RE: Project Number(s) SL23609015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on September 17, 2021, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

The enclosed State Form documents the state licensing orders. The Department of Health documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Home Care 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 are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

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

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

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

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

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

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

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

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

DOCUMENTATION OF ACTION TO COMPLY

Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order. A copy of the provider's records documenting those actions may be requested for follow-up surveys. 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 client(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's clients/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.

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

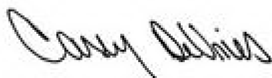
Free from Maltreatment reconsideration requests should addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

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

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

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

Sincerely,



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

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23609	A. BUILDING: ______ B. WING ______	09/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAMOND WILLOW OF PROCTOR	**913 OLD HIGHWAY 2 PROCTOR, MN 55810**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL#23609015 On, September 14, 2021 through September 17, 2021, 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 twenty-nine (29) residents receiving services under the Assisted Living with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 250 SS=F	144G.20 Subdivision 1. Conditions	0 250		

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0 250	Continued From page 1 (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04;	0 250		

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0 250	Continued From page 2	0 250		

(12) fails to timely pay any fines assessed by the commissioner;
(13) violates any local, city, or township ordinance relating to housing or assisted living services;
(14) has repeated incidents of personnel performing services beyond their competency level; or
(15) has operated beyond the scope of the assisted living facility's license category.
(b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to ensure the management officials who were in charge of the day-to-day operations; and responsible for the residents' home care services, understood all of the home care provider regulations; and the licensee failed to ensure policies and procedures were developed and/or implemented. This had the potential to affect all twenty-nine (29) residents.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).

The findings include:

During the entrance conference on September 14, 2021, at approximately 10:30 a.m., registered nurse (RN)-A confirmed she was responsible for

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0 250	Continued From page 3 and participated in the facility's day-to-day operations. RN-A stated she was familiar with the Assisted Living with Dementia licensing rules. The licensee's Application for Assisted Living License, section titled Official Verification of Owner or Authorized Agent, (page four and five of the application), identified, I certify I have read and understand the following: [a check mark was placed before each of the following]: - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45 (opens in a new window), my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17 (opens in a new window). - I have read and fully understand Minn. Stat. sect. 144G.80 (opens in a new window), 144G.81 (opens in a new window). and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22 (opens in a new window), my building(s) must comply with these sections if applicable. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G (opens in a new window). - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659 (proposed and not final) (opens in a new window). - Reporting of Maltreatment of Vulnerable Adults (opens in a new window). - Electronic Monitoring in Certain Facilities (opens in a new window). - I understand pursuant to Minn. Stat. sect. 13.04	0 250		

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0 250	Continued From page 4	0 250		

Rights of Subjects of Data (opens in a new window), the Commissioner will use information provided in this application, which may include an in-person or telephone conference, to determine if the applicant meets requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying a license. I understand that information submitted to the commissioner in this application may, ins some circumstances, be disclosed to the appropriate state, federal or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices.

- I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons (opens in a new window), all data submitted on this application shall be classified as public information upon issuance of a provisional license or license. All data submitted are considered private until MDH issues a license.

- I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G (opens in a new window), and Minnesota Rules, chapter 4659 (proposed and not final) (opens in a new window), governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of

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0 250	Continued From page 5 the existence of a management agreement or subcontract. - I have examined this application and all attachments, and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct and complete. I will notify MDH, in writing, of any changes to this information as required. - I attest to have all required policies and procedures of Minn. Stat. chapter 144G (opens in new window). and Minn. Rules chapter 4659 (proposed and not final) (opens in new window), in place upon licensure and to keep them current as applicable. Page five was electronically signed by the authorized agent - director of operations (DOO)-B on May 28, 2021. The licensee had an assisted living with dementia license issued on July 29, 2021, with an expiration date of July 31, 2022. The licensee had attested they read and understood the Assisted Living/Dementia Care licensing statues. The licensee failed to implement the following required policies and procedures: - orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; - conducting initial and ongoing resident	0 250		

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0 250	Continued From page 6	0 250		

Continued From page 6

evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a residents condition are identified, managed, and communicated to staff and other health care providers as appropriate;

- infection control practices;

- conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards;

- medication and treatment management;

- delegation of tasks by registered nurses or licensed health professionals.

Refer to licensing order at Statute 144G.41, Subd. 3. The licensee failed to establish and maintain an infection control program that complied with accepted health care, medical and nursing standards for infection control to include Covid-19 infection control, hand washing and eyewear. This had the potential to affect all twenty-nine (29) nine residents, all staff working at the facility and visitors.

Refer to licensing order at Statute 144G.42, Subd. 9. 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). The licensee failed to ensure history and symptoms screening and screening for active TB (either a two-step tuberculin skin test (TST) or blood test) were completed and documented for two of four unlicensed personnel (ULP-D and

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0 250	Continued From page 7	0 250		

ULP-E) with employee records reviewed.

Refer to licensing order at Statute 144G.63, Subd. 1. The licensee failed to ensure orientation training to assisted living licensing requirements and regulations was provided for one of six employees (RN-C) with records reviewed.

Refer to licensing order at Statute 144G.63, Subd. 2. The licensee failed to ensure unlicensed personnel received orientation to assisted living facility licensing requirements and regulations for four of four unlicensed personnel (ULP-D, ULP-E, ULP-F and ULP-G) with records reviewed.

Refer to licensing order at Statute 144G.71, Subd. 10. The licensee failed to ensure that medication management unplanned time away from home training had been provided to four of four unlicensed personnel (ULP-D, ULP-E, ULP-F and ULP-G) with records reviewed.

Refer to licensing order at Statute 144G.72, Subd. 4. The licensee failed to ensure unlicensed personnel were trained and demonstrated competency in treatments to a registered nurse for three of three unlicensed personnel (ULP-F, ULP-G and ULP-H) with records reviewed.

On September 16, 2021, at approximately 2:30 p.m., director of operations (DOO)-B confirmed the above listed policies and procedures had not been successfully implemented.

Thirty-three (33) correction orders were issued, which indicated the licensee's understanding of the Minnesota statutes were limited or not evident for compliance with sections 144G.08 to 144G.9999.

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0 250	Continued From page 8 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 250		
0 460 SS=D	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request assistance for health and safety needs 24 hours per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to provide a means for residents to request assistance for health and safety needs 24 hours a day, seven days a week for one of eighteen residents (R2) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 460		

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0 460	Continued From page 9	0 460		

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

The findings include:

R2 had diagnoses that included mild cognitive impairment (the stage between the expected cognitive decline of normal aging and the more serious decline of dementia).

During observations in the main area of house two on September 16, 2021, at approximately 9:00 a.m., licensed practical nurse (LPN)-I let R2 outside through a key coded, frosted glass access door. R2 ambulated with assistance of a four-wheel walker and remained outside alone, smoking on a front patio, until approximately 9:20 a.m., at which time a surveyor onsite approached R2 and asked if R2 was wearing a call pendant. R2 stated, "No, I don't have one." The surveyor verified no staff were present outdoors to provide supervision to R2, and R2 lacked a means to request assistance for health or safety needs.

R2's assessment dated July 19, 2021, indicated R2 required supervision.

On September 16, 2021, at approximately 9:30 a.m., LPN-I confirmed that R2 did not have a call pendant available and that the entrance/exit doors were key code locked with frosted glass, which prevented staff from providing visual supervision from indoors and that no staff were present outside providing supervision for R2, as required by R2's assessment dated July 19,

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2021. LPN-I further confirmed "not all residents have call pendants". LPN-I was asked how residents could call for assistance if the resident had no means to request assistance, LPN-I stated, "I think we can do hourly safety checks or something like that. We can hear them also."

The licensee lacked policies to include the new Assisted Living Licensure requirements that went into effect August 1, 2021.

No further information was provided.

TIME PERIOD FOR CORRECTION: Seven (7) days

0 470 SS=F — 144G.41 Subdivision 1 Minimum requirements — 0 470

(11) develop and implement a staffing plan for determining its staffing level that:
(i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility;
(ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and
(iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility;
(12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be:
(i) awake;
(ii) located in the same building, in an attached

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building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time;
(iii) capable of communicating with residents;
(iv) capable of providing or summoning the appropriate assistance; and
(v) capable of following directions;

This MN Requirement is not met as evidenced by:
Based on observation, interview and record review, the licensee failed to ensure the required staffing plan was developed and posted as required, potentially affecting all twenty-nine (29) residents in the assisted living facility, staff and any visitors of the licensee.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).

The findings include:

The licensee lacked a daily staffing schedule developed by the clinical nurse supervisor to:

- include direct-care staff work schedules for each direct-care staff member showing all work shifts, including days and hours worked;

- identify the direct-care staff member's resident assignments or work location;

- be posted after redacting direct-care staff

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0 470	Continued From page 12 member's resident assignments, at the beginning of each work shift in a central location in each building On September 14, 2021, at approximately 10:30 a.m., during entrance, no posted staff schedule was observed in the main entry area of the facility or two hallway areas of house one or house two. On September 14, 2021, at approximately 10:45 a.m., registered nurse/regional manager (RN)-A confirmed the licensee had not developed a staffing plan or posted a staffing schedule as required. The licensee lacked policies to include the new Assisted Living Licensure requirements, that went into effect August 1, 2021. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (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: (B) food must be prepared and served according	0 480		

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to the Minnesota Food Code, Minnesota Rules, chapter 4626; and

This MN Requirement is not met as evidenced by:
Based on observation, interview and record review, the licensee failed to ensure food was prepared according to the Minnesota Food Code. This had the potential to affect all twenty-nine (29) residents.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).

The findings include:

KITCHEN INSPECTION

Please refer to the additional documentation included in the "Food and Beverage Establishment Inspection Reports," dated September 14, 2021.

No further information provided.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days

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0 485	Continued From page 14	0 485		
0 485 SS=F	144G.41 Subd 1. (13) (i) (A) and (C) Minimum Requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (A) menus must be prepared at least one week in advance, and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; (C) the facility cannot require a resident to include and pay for meals in their contract; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure a menu was prepared a week in advance and provided to the residents. This had the potential to affect all twenty-nine (29) residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic	0 485		

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0 485	Continued From page 15 failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On September 14, 2021, at approximately 10:30 a.m., during entrance conference, registered nurse (RN)-A stated a dietitian developed the menus. In addition, she stated the menu for the day was posted in the common area of each home. On September 15, 2021, at approximately 6:00 a.m., the menu for the day was posted on a white board in the common area in house one. On September 15, 2021, at approximately 6:40 a.m., the menu for the day was posted on a white board in the common dining room area in house two. On September 15, 2021, at approximately 8:35 a.m., unlicensed personnel (ULP)-D confirmed that menus are posted daily on the whiteboards. The licensee lacked policies to include the new Assisted Living Licensure requirements, that went into effect August 1, 2021. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and	0 510		

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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 establish and maintain an infection control program that complied with accepted health care, medical and nursing standards for infection control to include COVID-19 infection control, hand washing and eyewear. This had the potential to affect all twenty-nine (29) residents, staff and visitors.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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:

EYE PROTECTION

On September 14, 2021, at 10:30 a.m., during the entrance conference, registered nurse (RN)-A was observed not wearing eye protection. She confirmed she was not wearing eye protection.

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On September 14, 2021, at 12:35 p.m. director of operations (DOO)-B was observed not wearing eye protection in resident care areas. The surveyor discussed the need for all employees to be wearing eye protection with DOO-B.

On September 15, 2021, at approximately 6:00 a.m., unlicensed personnel (ULP)-D was observed wearing a mask and no eye protection. At 6:11 a.m., DOO-B arrived at house one wearing a mask and no eye protection. At 6:30 a.m., ULP-G entered house one and walked into the office in the presence of other employees. ULP-G was not wearing a mask or eye protection. At 6:35 a.m., DOO-B confirmed employees were not wearing eye protection and brought several pairs of eye protection into the office for the staff to wear.

On September 15, 2021, at approximately 7:10 a.m., during observations in house two, ULP-D and ULP-E were observed going in and out of residents' rooms wearing masks and no eye protection. On September 15, 2021, at approximately 7:25 a.m., ULP-D and ULP-E were observed assisting a resident to the shower room via wheelchair with masks on and no eye protection. At approximately 7:55 a.m., RN-C confirmed staff were not wearing protective eyewear and stated, "I've reminded them multiple times."

The Minnesota Department of Health (MDH) document titled, COVID-19 Toolkit, Information for Long Term Care Facilities, dated March 8, 2021, indicated on page 8, all staff should wear a well-fitting mask and eye protection (e.g. face shield, goggles) when in resident care areas.

The MDH document titled COVID-19 Personal

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Protective Equipment (PPE) Grid for Congregate Care Settings, dated April 23, 2021, noted healthcare workers with face-to-face contact with residents should wear a medical grade well-fitting mask and eye protection.

RESIDENT MONITORING FOR COVID-19

Resident's (R3, R8, R9, R10, R11, R12, R13, R14, R15, R16, R17, R18 and R19) Covid-19 Active Screening/Monitoring sheets for September 2021 lacked evidence the residents in house one received daily COVID-19 monitoring.

R3's Covid-19 Active Screening/Monitoring sheet for September 2021 indicated the resident was only screened nine (9) out of 15 opportunities.
R8's Covid-19 Active Screening/Monitoring sheet for September 2021 indicated the resident was only screened six (6) out of 15 opportunities.
R9's Covid-19 Active Screening/Monitoring sheet for September 2021 indicated the resident was only screened 10 out of 15 opportunities.
R10's Covid-19 Active Screening/Monitoring sheet for September 2021 indicated the resident was only screened seven (7) out of 15 opportunities.
R11's Covid-19 Active Screening/Monitoring sheet for September 2021 indicated the resident was only screened eight (8) out of 15 opportunities.
R12's Covid-19 Active Screening/Monitoring sheet for September 2021 indicated the resident was only screened nine (9) out of 15 opportunities.
R13's Covid-19 Active Screening/Monitoring sheet for September 2021 indicated the resident was only screened seven (7) out of 15 opportunities.
R14's Covid-19 Active Screening/Monitoring

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sheet for September 2021 indicated the resident was only screened five (5) out of 15 opportunities.
R15's Covid-19 Active Screening/Monitoring sheet for September 2021 indicated the resident was only screened seven (7) out of 15 opportunities.
R16's Covid-19 Active Screening/Monitoring sheet for September 2021 indicated the resident was only screened six (6) out of 15 opportunities.
R17's Covid-19 Active Screening/Monitoring sheet for September 2021 indicated the resident was only screened seven (7) out of 15 opportunities.
R18's Covid-19 Active Screening/Monitoring sheet for September 2021 indicated the resident was only screened seven (7) out of 15 opportunities.
R19's Covid-19 Active Screening/Monitoring sheet for September 2021 indicated the resident was only screened eight (8) out of 15 opportunities.

The resident Covid-19 Active Screening/Monitoring sheet indicated for staff to complete two times a day, unless directed more frequently by nursing.

R3, R8, R9, R10, R11, R12, R13, R14, R15, R16, R17, R18 and R19's Covid-19 Active Screening/Monitoring sheets for September 2021 lacked evidence the residents received two times a day Covid-19 monitoring.

On September 16, 2021, at approximately 1:00 p.m., DOO-B confirmed the above residents were not monitored for Covid-19 as least daily.

RESIDENT COVID-19 MONITORING AND SCREENING

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MDH guidance titled, COVID-19 Toolkit dated March 8, 2021, indicated all residents should be actively screened for fever and respiratory symptoms at least daily. Daily pulse oximeter screening was recommended. Chart all clinical measurements and symptoms for each resident.

Policy and procedure was requested but not provided.

HAND WASHING

On September 15, 2021, at approximately 8:30 a.m., ULP-H was observed to perform Covid-19 monitoring, including checking R15's temperature, oxygen saturation, and symptoms. ULP-H cleansed both the thermometer and oxygen saturation machine with an alcohol wipe and proceeded (without washing hands) to perform Covid-19 monitor for R3. ULP-H then cleaned the equipment and proceeded (without washing hands) to perform Covid-19 monitoring for R10. ULP-H confirmed she did not wash her hands in between providing Covid-19 monitoring to residents. ULP-H stated she should have washed her hands or used hand sanitizer between providing Covid-19 monitoring to residents.

On September 15, 2021, at approximately 9:10 a.m., ULP-D was observed to provide medication administration to R2 in the resident's room. ULP-D applied new gloves, administered medication and removed gloves. ULP-D then went to R6's room (without hand washing) to assist with a brief change. ULP-D applied new gloves, assisted with a wet brief change, continued to wear the same gloves while providing dressing assistance to R6 moving throughout R6's room, moving items in closet,

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0 510	Continued From page 21 and moving items on the cupboard. ULP-D removed gloves upon exit from room and proceeded to the next room without washing hands or using hand sanitizer. ULP-D confirmed that hand washing should have been completed between tasks and residents. On September 15, 2021, at approximately 9:00 a.m., DOO-B confirmed ULPs were trained to wash their hands between providing services to residents. The licensee's Hand Washing policy last reviewed January 28, 2020, indicated proper hand washing techniques should be used to protect the spread of infection. Hand washing shall be completed before and after caring for someone who is sick. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 570 SS=C	144G.42 Subdivision 1 Display of license The original current license must be displayed at the main entrance of each assisted living facility. The facility must provide a copy of the license to any person who requests it. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to display a current license at the main entrance of two of two houses on the assisted living campus. This practice resulted in a level one violation (a violation that has no potential to cause more than	0 570		

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0 570	Continued From page 22 a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On September 14, 2021, at approximately 11:00 a.m., during tours of house one and house two, there was no original current license posted at facility entrances, hallways, dining areas, or in living areas. On September 14, 2021, at approximately 2:15 p.m., registered nurse (RN)-A and director of operations (DOO)-B confirmed the licensee lacked a posting of an original current license. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 570		
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal.	0 580		

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This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to engage in and maintain documentation of quality management activities. This had the potential to affect all twenty-nine (29) residents receiving assisted living services.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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:

On September 14, 2021, at approximately 11:00 a.m., during the entrance conference, the licensee's quality management documentation was requested for review of any quality management activity.

On September 14, 2021, at approximately 11:05 a.m., registered nurse (RN)-A confirmed there was no current documentation of quality management activity.

The licensee's quality management policy was requested but not provided.

No further information was provided.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days

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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
0 640	Continued From page 24	0 640		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to support protection and safety when the licensee neglected to post the 911 emergency number in common areas and near telephones provided by the assisted living facility. This had the potential to affect all twenty-nine (29) residents receiving assisted living services, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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:	0 640		

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DIAMOND WILLOW OF PROCTOR	**913 OLD HIGHWAY 2 PROCTOR, MN 55810**

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0 640	Continued From page 25 The licensee lacked a posting of the 911 emergency number in common areas and near telephones provided by the assisted living. On September 14, 2021, at approximately 11:00 a.m., during tour and observation, the licensee lacked any posted 911 emergency number in common areas or near telephones in the office of house one. On September 14, 2021, at approximately 11:15 a.m., during tour and observation of main living areas, two hallways and dining area, the 911 emergency number was not observed to be posted near telephones in house two. On September 14, 2021, at approximately 2:50 p.m., director of operations (DOO)-B confirmed the licensee did not post the 911 emergency number in common areas and near telephones. Emergency management policy requested, but not received. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 640		
0 660 SS=E	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity	0 660		

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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 maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC). The licensee failed to ensure history and symptoms screenings and screening for active TB (either a two-step tuberculin skin test (TST) or blood test) were completed and documented for two of four unlicensed personnel (ULP-D and ULP-E) with employee records reviewed.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).
The findings include:
ULP-D was hired March 26, 2021, to provide assisted living services for the licensee. On September 15, 2021, at approximately 9:10 a.m., ULP-D was observed administering medications to resident (R)2.

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0 660	Continued From page 27 ULP-E was hired August 9, 2021, to provide assisted living services for the licensee. On September 15, 2021, at approximately 9:25 a.m., ULP-E was observed administering medications to R1. ULP-D and ULP-E employee records lacked evidence of a completed tuberculosis (TB) history and symptoms screening and screening for active TB (either a two-step tuberculin skin test (TST) or blood test) as required. On September 16, 2021, at approximately 11:45 a.m., director of operations (DOO)/registered nurse (RN)-B confirmed ULP-D and ULP-E had not completed tuberculosis (TB) history and symptoms screening and screening for active TB (either a two-step tuberculin skin test (TST) or blood test) as required. Licensee's Infection Control policy, updated May 10, 2021, indicated the licensee would screen all employees and volunteers for tuberculosis infection and all employees would receive a two-step Mantoux upon 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	0 680		

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contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency;
(2) post an emergency disaster plan prominently;
(3) provide building emergency exit diagrams to all residents;
(4) post emergency exit diagrams on each floor; and
(5) have a written policy and procedure regarding missing tenant residents.
(b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site.
(c) The facility must meet any additional requirements adopted in rule.

This MN Requirement is not met as evidenced by:
Based on observation, interview and record review, the licensee failed to develop a written plan of action to facilitate the management of resident care and services in response to a natural disaster, such as storms or other emergencies that may disrupt the licensee's ability to provide care and services. In addition, the licensee failed to develop an all-hazards emergency preparedness program and plan to include Appendix Z required elements. This had the potential to affect all twenty-nine (29) residents receiving assisted living services and staff.

This practice resulted in a level two violation (a

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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:

On September 16, 2021, at approximately 12:30 p.m., the licensee's emergency preparedness plan and Appendix Z were requested. The licensee lacked an emergency preparedness and Appendix Z plans to manage resident care and services in response to a disaster or emergency.

During tours of house one and house two on September 14, 2021, at approximately 11:15 a.m., there was no observed signage posted or information regarding the licensee's emergency plan or emergency exit diagrams at the facility entrances, hallways, in the dining areas or in the living areas.

On September 16, 2021, at approximately 12:30 p.m., registered nurse (RN)-A and on September 16, 2021, at approximately 2:30 p.m., director of operations (DOO)-B, confirmed the licensee lacked a customized emergency preparedness plan and Appendix Z which included:
- a written emergency disaster plan that contained a plan for evacuation, addresses elements of sheltering in place, identified temporary relocation sites, and detailed staff assignments in the event of a disaster or an emergency;
-posted an emergency disaster plan prominently;
-provided building emergency exit diagrams to all

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0 680	Continued From page 30 residents; -posted emergency exit diagrams on each floor; -emergency and disaster training to all staff during the initial staff orientation; and -Appendix Z required elements A policy for emergency preparedness was requested, but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21)	0 680		
0 780 SS=E	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code,	0 780		

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except that newly introduced smoke alarms in existing buildings may be battery operated;

This MN Requirement is not met as evidenced by:
Based on observation and interview, the licensee failed to provide smoke alarms outside resident sleeping areas in house one and house two. This had the potential to directly affect all twenty-nine (29) residents, staff and visitors.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of clients 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:

On September 15, 2021, between 9:30 a.m., and 12:00 p.m., survey staff toured the facility with maintenance personnel (M)-J.

On September 15, 2021, during the tour, between 10:00 a.m., and 11:45 a.m., it was observed that smoke alarms were not installed in the hallways outside resident sleeping rooms in house one or house two.

On September 15, 2021 at apprximately 11:30 a.m., M-J confirmed that integral smoke detector door closer assemblies were provided on each resident room door and that the facility did not have additional smoke alarms or smoke detectors in the hallways.

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0 780	Continued From page 32 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 780		
0 810 SS=E	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system	0 810		

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activation is not required to initiate the evacuation drill.

This MN Requirement is not met as evidenced by:
Based on record review and staff interview, the facility failed to provide the required documentation on fire safety and evacuation plans. This has the potential to directly affect all twenty-nine (29) residents, staff and visitors.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of clients 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:

On September 15, 2021, between 9:30 a.m. and 12:00 p.m., survey staff toured the facility with maintenance personnel (M)-J. During the tour, it was observed that evacuation maps were not posted within house one or house two. M-J confirmed that evacuation maps were not posted but that they had been drafted by an outside company. At approximately 12:00 p.m., M-J provided copies of the drafted evacuation maps. M-J stated that these maps would be posted on the doors of each resident room and in the lobby once the final versions were printed. M-J stated he believed the posting could be completed within fourteen (14) days.

Director of Operations (DOO)-B provided copies

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0 810	Continued From page 34 of the fire safety and evacuation policies for review. The policies lacked identification or number of resident sleeping rooms. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (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. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care; (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 (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. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and	01060		

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designated representative;
(2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and
(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.
(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.

This MN Requirement is not met as evidenced by:
Based on observation, interview and record review, licensee failed to provide documentation that showed urgent medical reasons or imminent risk existed prior to the transfer of nine (9) residents receiving assisted living services. Two (2) residents were transferred off campus, seven (7) residents were transferred within the campus to other buildings.

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:
On September 14, 2021, at approximately 11:00 a.m., during the entrance conference, registered nurse (RN)-A was asked about the transfer and placement of nine (9) residents from four (4) houses on campus to a combined two (2) houses, house one and house two. RN-A stated

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that "It was not my decision. It was done over the weekend when I wasn't here."
On September 17, 2021, at approximately 10:30 a.m., director of operations (DOO)-B was asked about the transfer and placement of nine (9) residents from four (4) houses on campus to a combined two (2) houses. Two (2) residents relocated off campus and seven (7) residents relocated within the campus to additional buildings. DOO-B stated, "I don't know what else we could have done. When you don't have staff, what do you do?"
Licensee lacked documentation providing a reason for the relocation, and a written notice providing the required minimums:
-reason for relocation;
-contact information for the Office of Ombudsman for Long-Term Care;
-the notice under paragraph (b) must be delivered as soon as practicable to:
-the resident, legal representative, and designated representative;
-for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager;
-the Office of Ombudsman for Long-Term Care if the resident has been relocated.
On September 17, 2021, at approximately 10:30 a.m., DOO-B confirmed records documentation to show the process that occurred when two (2) residents were moved to a sister facility in Duluth on August 4, 2021, and seven (7) residents were moved from two other houses on the campus site to house one and house two.
The licensee lacked policies to include the new Assisted Living Licensure requirements, that went into effect August 1, 2021.
No further information provided.
TIME PERIOD FOR CORRECTION: Twenty-one

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01060	Continued From page 37 (21) days	01060		
01140 SS=F	144G.55 Subd. 3 Relocation plan required The facility must prepare a relocation plan to prepare for the move to the new location or service provider. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, licensee failed to prepare a relocation plan that included documentation of considerations for the care needs, psychosocial impacts of moving, and accounting of residents property prior to initiating the transfer of nine (9) residents receiving assisted living services. Two (2) residents were transferred off campus, seven (7) residents were transferred within the campus to other buildings. 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: On September 14, 2021, at approximately 11:00 a.m., during the entrance conference, registered nurse (RN)-A was asked about the transfer and placement of nine (9) residents from four (4) houses on campus to a combined two houses, house one and house two. Two (2) residents were transferred off campus, seven (7) residents were transferred within the campus to other	01140		

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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
01140	Continued From page 38 buildings. RN-A stated, "It was not my decision. It was done over the weekend when I wasn't here." On September 17, 2021, at approximately 10:30 a.m., director of operations (DOO)-B was asked about the transfer and placement of nine (9) residents from four (4) houses on campus to a combined two houses. DOO-B stated, "I don't know what else we could have done. When you don't have staff, what do you do?" On September 17, 2021, at approximately 10:30 a.m., DOO-B confirmed licensee lacked a relocation plan to address the care needs, psychosocial impacts of moving and an accounting of resident property when four (4) residents were moved to a facility in Duluth on August 4, 2021, and seven (7) residents were moved to house one and house two from two other houses on the campus site. The licensee lacked policies to include the new Assisted Living Licensure requirements, that went into effect August 1, 2021. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01140		
01170 SS=F	144G.56 Subd. 3 Notice required (a) A facility must provide at least 30 calendar days' advance written notice to the resident and the resident's legal and designated representative of a facility-initiated transfer. The notice must include: (1) the effective date of the proposed transfer; (2) the proposed transfer location; (3) a statement that the resident may refuse the proposed transfer, and may discuss any consequences of a refusal with staff of the facility; (4) the name and contact information of a person employed by the facility with whom the resident	01170		

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may discuss the notice of transfer; and
(5) contact information for the Office of Ombudsman for Long-Term Care.
(b) Notwithstanding paragraph (a), a facility may conduct a facility-initiated transfer of a resident with less than 30 days' written notice if the transfer is necessary due to:
(1) conditions that render the resident's room or private living unit uninhabitable;
(2) the resident's urgent medical needs; or
(3) a risk to the health or safety of another resident of the facility.

This MN Requirement is not met as evidenced by:
Based on observation, interview and record review, licensee failed to provide a 30-calendar day advance written notice to the resident and/or the resident's legal/designated representative prior to initiating the transfer of nine (9) residents receiving assisted living services. Two (2) residents were transferred off campus, seven (7) residents were transferred within the campus to other buildings.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).
The findings include:
On September 14, 2021, at approximately 11:00 a.m., during the entrance conference, registered nurse (RN)-A was asked about the transfer and placement of nine (9) residents from four (4) houses on campus to a combined two (2) houses, house one and house two. Two (2)

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01170	Continued From page 40 residents were transferred off campus, seven (7) residents were transferred within the campus to other buildings. RN-A stated, "It was not my decision. It was done over the weekend when I wasn't here." On September 17, 2021, at approximately 10:30 a.m., director of operations (DOO)-B was asked about the transfer and placement of nine (9) residents from four (4) houses on campus to a combined two (2) houses.. DOO-B stated, "I don't know what else we could have done. When you don't have staff, what do you do?" DOO-B then stated two (2) residents had been moved to a facility in Duluth on August 4, 2021, and seven (7) residents were moved to house one and house two from two other houses on the campus site. Licensee lacked documentation showing a 30-day written notification was provided to the resident and the resident's legal and designated representative as required that contained the following: -a facility must provide at least 30 calendar days advance written notice to the resident and the resident's legal and designated representative of a facility-initiated transfer; -the effective date of the proposed transfer; -the proposed transfer location; -a statement that the resident may refuse the proposed transfer, and may discuss any consequences of a refusal with staff of the facility; -the name and contact information of a person employed by the facility with whom the resident may discuss the notice of transfer; and -contact information for the Office of Ombudsman for Long-Term Care; -(b) not withstanding paragraph (a), a facility may conduct a facility-initiated transfer of a resident with less than 30 days written notice if the transfer is necessary due to: -conditions that render the resident's room or	01170		

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01170	Continued From page 41 private living unit uninhabitable; -the resident's urgent medical needs; or -a risk to the health or safety of another resident of the facility. On September 17, 2021, at approximately 10:30 a.m., DOO-B confirmed licensee had not provided a written notice to residents, resident legal representatives or contact information for the Office of the Ombudsman prior to the relocation of nine (9) residents. Furthermore, DOO-B stated, "This was my directive. This isn't on the RNs." The licensee lacked policies to include the new Assisted Living Licensure requirements, that went into effect August 1, 2021. Further information requested, but not provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01170		
01190 SS=F	144G.56 Subd. 5 Changes in facility operations (a) In situations where there is a curtailment, reduction, or capital improvement within a facility necessitating transfers, the facility must: (1) minimize the number of transfers it initiates to complete the project or change in operations; (2) consider individual resident needs and preferences; (3) provide reasonable accommodations for individual resident requests regarding the transfers; and (4) in advance of any notice to any residents, legal representatives, or designated representatives, provide notice to the Office of Ombudsman for Long-Term Care and, when appropriate, the Office of Ombudsman for Mental Health and Developmental Disabilities of the curtailment, reduction, or capital improvement and the corresponding needed transfers.	01190		

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01190	Continued From page 42	01190		

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This MN Requirement is not met as evidenced by:
Based on observation, interview and record review, licensee failed to provide advance notice to residents, legal representatives, designated representatives or provide notice to the Office of Ombudsman for Long Term Care prior to initiating the transfer of nine (9) residents receiving assisted living services. Two (2) residents were transferred off campus, seven (7) residents were transferred within the campus to other buildings.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).
The findings include:
On September 14, 2021, at approximately 11:00 a.m., during the entrance conference, registered nurse (RN)-A was asked about the transfer and placement of nine (9) residents from four (4) houses on campus to a combined two (2) houses, house one and house two. Two (2) residents were transferred off campus, seven (7) residents were transferred within the campus to other buildings. RN-A stated, "It was not my decision. It was done over the weekend when I wasn't here."
On September 17, 2021, at approximately 10:30 a.m., director of operations (DOO)-B was asked about the transfer and placement of nine (9) residents from four (4) houses on campus to a combined two (2) houses. DOO-B stated, "I don't know what else we could have done. When you don't have staff, what do you do?" DOO-B then

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01190	Continued From page 43 stated two (2) residents had been moved to a facility in Duluth on August 4, 2021, and seven (7) residents were moved to house one and house two from two other houses on the campus site. Licensee lacked documentation showing licensee had completed the required steps of notification in a change of operations as follows: - consideration of the needs and preferences of individual residents; - advance of any notice to residents, legal representatives, or designated representatives; -notice to the Office of Ombudsman for Long-Term Care. On September 17, 2021, at approximately 10:30 a.m., DOO-B confirmed licensee had not taken the required steps in a change to facility operations. DOO-B stated, "This was my directive. This isn't on the RNs." The licensee lacked policies to include the new Assisted Living Licensure requirements, that went into effect August 1, 2021. Further information requested, but not provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01190		
01420 SS=F	144G.62 Subd. 2 Delegation of assisted living services (b) When the registered nurse or licensed health professional delegates tasks to unlicensed personnel, that person must ensure that prior to the delegation the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each resident and is able to demonstrate the ability to competently follow the procedures and perform the tasks. If an unlicensed personnel has not regularly performed the delegated assisted living task for a period of 24 consecutive months, the unlicensed personnel	01420		

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01420	Continued From page 44	01420		

must demonstrate competency in the task to the registered nurse or appropriate licensed health professional. The registered nurse or licensed health professional must document instructions for the delegated tasks in the resident's record.

This MN Requirement is not met as evidenced by:
Based on observation, interview and record review, licensee failed to provide delegated training by a registered nurse (RN) for the use of alarms by three of three unlicensed personnel (ULP-D, ULP-E and ULP- F) with records reviewed.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).

The findings include:

ULP-D
On September 15, 2021, at approximately 8:05 a.m., R6 was observed sitting at the dining room table eating breakfast with a chirper alarm attached to R6's shirt and wheelchair. ULP-D was observed providing meal assistance and medication administration to R6.

R6's assessment dated September 16, 2021, indicated R6 was not assessed for use of an alarm.

R6's record lacked evidence the RN documented

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01420	Continued From page 45	01420		

instructions for the alarms in R6's record.

ULP-D's employee record did not contain evidence ULP-D was trained by an RN and demonstrated competency in the use of alarms.

ULP-E
On September 15, 2021, at approximately 8:05 a.m., R7 was observed sitting at the dining room table eating breakfast with a chirper alarm attached to R7's shirt and wheelchair. ULP-E was observed providing meal assistance and medication administration to R7.

R7's record lacked evidence the RN documented instructions for the alarms in the R7's record.

ULP-E's employee record did not contain evidence ULP-E was trained by an RN and demonstrated competency in the use of alarms.

On September 16, 2021, at approximately 1:30 p.m., RN-C confirmed ULP-D and ULP-E's employee record lacked evidence the employees were trained and demonstrated competency in the use of alarms. In addition, RN-C confirmed R6 and R7's record lacked written instructions pertaining to the use of alarms.

ULP-F
On September 15, 2021, at approximately 6:45 a.m., R3 was observed in bed with a bed alarm attached to R3's pajamas. There was also a sensor alarm on R3's dresser pointed at R3's bed. ULP-F was observed removing R3's bed alarm, transfering R3 into the wheelchair, and wheeling R3 to the bathroom. ULP-F provided bathing, dressing, and toileting to R3. ULP-F transferred R3 back into R3's wheelchair and applied the chair alarm. ULP-F checked the

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01420	Continued From page 46 alarm to ensure it was working. R3's assessment dated September 10, 2021, indicated ensure all alarms are on and working properly. R3's record lacked evidence the RN documented instructions for the use of the alarm in R3's record. ULP-F's employee record did not contain evidence ULP-F was trained by the RN and demonstrated competency in the use of alarms. On September 16, 2021, at approximately 1:00 p.m., director of operations (DOO)-B confirmed ULP-F's employee record lacked evidence ULP-F was trained and demonstrated competency in the use of alarms. DOO-B confirmed R3's recorded lacked written instructions pertained to alarms. A policy was requested but not provided. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01420		
01460 SS=D	144G.63 Subdivision 1 Orientation of staff and supervisors All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another	01460		

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01460	Continued From page 47 facility. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, licensee failed to ensure employees received orientation training to the assisted living licensing requirements and regulations for one of six employees (registered nurse [RN]-C) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: RN-C was hired on August 30, 2021, to provide direct care services to the licensee's residents. At approximately 6:40 a.m., RN-C was observed providing direct care services for R2, which included reviewing medications administered and the narcotic count. RN-C's employee records did not contain documentation RN-C completed orientation to the assisted living facility licensing requirements and regulations before providing assisted living services to residents. On September 16, 2021, at approximately 2:15 p.m., director of operations (DOO)-B confirmed RN-C did not complete orientation to the assisted living facility licensing requirements and regulations as required.	01460		

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01460	Continued From page 48 An orientation training policy requested, but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01460		
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human	01470		

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Services, county-managed care advocates, or other relevant advocacy services; and
(9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure.
(b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics:
(1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication;
(2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or
(3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions.

This MN Requirement is not met as evidenced by:
Based on observation, interview and record review, the licensee failed to ensure unlicensed personnel received orientation to assisted living facility licensing requirements and regulations for four of four unlicensed personnel (ULP-D, ULP-E, ULP-F and ULP-G) with records reviewed.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to

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cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).

The findings include:

ULP-D, ULP-E, ULP-F and ULP-G's records lacked evidence to indicate the employees received orientation to include the following topics:
- an overview of this chapter; and
- the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person.

ULP-D,ULP-F, and ULP-G began providing assisted living services for the licensee on August 1, 2021. The employees' records lacked the above required content.

ULP-E began providing assisted living services for the licensee on August 9, 2021. ULP-E's employee record lacked the above required content.

On September 15, 2021, at approximately 8:15 a.m., ULP-D was observed providing direct cares to R2.

On September 15, 2021, at approximately 8:30 a.m., ULP-E was observed providing direct cares to R1.

On September 15, 2021, at approximately 6:45 a.m., ULP-F was observed providing direct care to R3.

On September 15, 2021, at approximately 7:00

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01470	Continued From page 51 a.m., ULP-G was observed administering medications to R3. On September 16, 2021, at approximately 1:00 p.m., director of operations (DOO)-B confirmed ULP-D, ULP-E, ULP-F and ULP-G did not receive orientation to home care as indicated above. An orientation training policy was requested, but was not received. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01470		
01540 SS=D	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced	01540		

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01540	Continued From page 52 by: Based on observation, interview and record review, licensee failed to ensure one of one licensed employee registered nurse (RN)-C received the required amount of dementia care training in the required time frame with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: The licensee had a current assisted living with dementia care license. RN-C was hired on August 30, 2021, to provide direct care services to the licensee's residents. On September 15, 2021, at approximately 6:40 a.m., RN-C was observed providing direct care services for R2, which included reviewing medications administered and the narcotic count. RN-C's employee record did not contain evidence RN-C completed the required eight (8) hours of training on the specific dementia care topics within 80 working hours of RN-C's hire date. On September 16, 2021, at approximately 1:30 p.m., RN-C confirmed lack of completion of the above noted dementia training as required.	01540		

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01540	Continued From page 53 A dementia training policy was requested, but not received. No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days	01540		
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 medications were administered as ordered for one of eighteen residents (R2) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a	01760		

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01760	Continued From page 54 limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2's diagnoses included, but were not limited to, Type II diabetes mellitus (condition results from insufficient production of insulin causing high blood sugar) and chronic kidney disease Stage 3 (condition characterized by a gradual loss of kidney function). R2's service plan dated September 15, 2021, indicated R2 received insulin four times daily to be administered by unlicensed personnel (ULP). R2's current medication list dated September 16, 2021, included the following insulin and diabetic injection medications: - Levemir (insulin) 100u (units)/ml (milliliter) inject 30 units subcutaneously twice daily at 8:00 a.m. and 8:00 p.m. - Novolog Flexpen (insulin) 100u (units)/ml (milliliter) inject 8 units subcutaneously three times daily before/at meals. -Victoza 18 mg (milligrams) inject 1.8 mg (milligrams) subcutaneously one time a day at 8:00 a.m. On September 15, 2021, at approximately 8:45 a.m., ULP-D was observed checking R2's blood glucose and administering morning injectable insulin medications. R2's medication administration summary for August 2021 indicated R2's medication record lacked documentation of administered insulin medications for the following dates: Novolog Flexpen: 12:00 p.m. dose on August 4, 11, 14, 22, and 23, 2021. 5:00 p.m. dose on August 3, 2021. Levemir: 8:00 p.m. dose on August 3, 12, 16, and 26, 2021.	01760		

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01760	Continued From page 55 On September 16, 2021, at approximately 12:30 p.m., director of operations (DOO)-B confirmed R2's medication record lacked documentation of insulin administration for the above listed dates and stated, "We know we have some challenges right now." The licensee's policy 5.08 Medication Administration - Documentation, updated July 25, 2021, indicated that unlicensed personnel would chart in each resident's medication administration record any problems with medication administration to include refusals. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01790 SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may	01790		

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01790	Continued From page 56 delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the	01790		

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01790	Continued From page 57 doses of each returned medication. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure that medication management for unplanned time away from home training was provided to four of four unlicensed personnel (ULP-D, ULP-E, ULP-F and ULP-G) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: TRAINING ULP-D, ULP-E, ULP-F, and ULP-G's records lacked evidence to indicate the registered nurse (RN) had trained and determined competency to prepare and administer medications for residents having unplaned times away. ULP-D, ULP-F and ULP-G were hired on August 1, 2021. ULP-E was hired on August 9, 2021. On September 15, 2021, at approximately 8:15 a.m., ULP-D was observed providing medication administration to R2. On September 15, 2021, at approximately 9:00 a.m., ULP-E was observed providing medication administration to R1.	01790		

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01790	Continued From page 58 R3's August 2021, medication administration record (MAR) indicated ULP-F provided medication administration to R3 on August 29, 2021. On September 15, 2021, at approximately 7:00 a.m., ULP-G was observed providing medication administration to R3. On September 16, 2021, at approximately 1:00 p.m. director of operations (DOO)-B confirmed ULP-D, ULP-E, ULP-F, ULP-G and all other ULPs who administer medications were not trained or demonstrated competency to prepare and give medications for any of the licensee's residents unplanned times away from home. The licensee's 5.11 Medication Administration-Outings and Planned or unplanned Leaves of Absence policy revised January 9, 2017, indicated for unplanned resident time away when a pharmacist or licensed nurse is not available, the RN may delegate this task to unlicensed personnel if the RN has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments	01880		

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01880	Continued From page 59 according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure refrigerated medications were maintained at manufactured recommended temperatures by failing to monitor and document medication refrigerator temperatures located in two of two houses within facility grounds. 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: On September 15, 2021, at approximately 11:13 a.m. the medication refrigerator in house one was observed locked in the office. Licensed practical nurse (LPN)-I stated she thought the night shift checked the temperature of the medication refrigerator. LPN-I unlocked the refrigerator; which revealed no thermometer. The refrigerator contained the following medications: - two unopened boxes of Lantus (long acting) insulin pens (multiple dose pen shaped injector devices used for insulin administration) for resident R12; - two opened boxes Basaglar Kwik Pen (insulin) for R3; and -three boxes of Insulin Apart Flex Pens and three boxes of Levemir Flex Touch pens for R18.	01880		

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01880	Continued From page 60	01880		

On September 15, 2021, at approximately 1:30 p.m., director of operations (DOO)-B stated she was unable to find documentation indicating the temperature of the medication refrigerators were monitored daily.

The manufacturer's instructions for Lantus insulin pens dated July 2015 indicated before opening, store the insulin pens in the refrigerator between 36 to 46 degrees F. Do not allow the Lantus to freeze.

The manufacturer's instructions for Basaglar Kwik pens dated July 2021 indicated before opening, store the insulin pens in the refrigerator between 36 to 46 degrees F. Do not allow the Basaglar to freeze.

The manufacturer's instructions for Aspart Flex pens dated February 2015 indicated before opening, store the insulin pens in the refrigerator between 36 to 46 degrees F. Do not allow the Aspart to freeze.

The manufacturer's instructions for Levemir Flex touch dated February 2015 indicated before opening, store the insulin pens in the refrigerator between 36 to 46 degrees F. Do not allow the Levemir to freeze.

A policy pertaining to storage of medications was requested but not provided.

No further information was provided.

TIME PERIOD FOR CORRECTION: Seven (7) days

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01890	Continued From page 61	01890		
01890 SS=D	144G.71 Subd. 20 Prescription drugs	01890		

A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug.

This MN Requirement is not met as evidenced by:
Based on observation, interview, and record review, the licensee failed to ensure medications were labeled correctly for one of eighteen residents (R2) with records reviewed.

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

Findings include:

On September 15, 2021, at approximately 8:45 a.m., unlicensed personnel (ULP)-D prepared insulin pens for administration to R2.

R2's three insulin injectable pens prepared by ULP-D lacked labels that provided both the dates the medications had been opened and the expiration dates. The insulin pens prepared by ULP-D included:
- Levemir 100u (units)/ml (milliliter)
- Novolog Flexpen 100u (units)/ml (milliliter)

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01890	Continued From page 62 -Victoza 18 mg (milligrams) Manufacturer's instructions for Levemir indicated the pen should be discarded after 42 days. Manufacturer's instructions for Novolog indicated the pen should be discarded after 28 days. Manufacturer's instructions for Victoza indicated the pen should be discarded after 30 days. On September 15, 2021, at approximately 9:10 a.m., registered nurse (RN)-C confirmed all insulin pens should be dated when opened. RN-C stated, "We have those labels. I'll take care of that." An insulin pen policy was requested. A policy addressing subcutaneous insulin injections was received; the policy did not address the use of insulin pens. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	01890		
01900 SS=D	144G.71 Subd. 21 Prohibitions No prescription drug supply for one resident may be used or saved for use by anyone other than the resident. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure a prescription insulin pen supply for one resident was not being saved for use by anyone other than the resident prescribed the	01900		

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01900	Continued From page 63	01900		

insulin.

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:
On September 15, 2021, at approximately 9:10 a.m., during observation of a medication administration pass with unlicensed personnel (ULP)-D, ULP-D unlocked the medication refrigerator, which contained a gallon sized baggie, placed in the door, marked "save." The baggie contained seven (7) insulin pens, unlabeled; four Lantus pens and three Humalog pens with varying amounts of insulin remaining in pens. ULP-D stated, "I think the nurses were going to see if they could be donated."

On September 15, 2021, at approximately 9:15 a.m., registered nurse (RN)-C confirmed the presence of the marked baggie and stated, "I will take care of that." On September 15, 2021, at approximately 9:30 a.m., RN-A confirmed the licensee did not dispose of seven (7) insulin pens as required.

Licensee's policy, Disposal of Medication, updated December 24, 2019, indicated unused medications managed by the licensee would be returned to the pharmacy for credit or given to the client/client's representative when medications are no longer managed by licensee.

No further information provided.

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01900	Continued From page 64 TIME PERIOD FOR CORRECTION: Seven (7) days	01900		
01950 SS=F	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure unlicensed personnel were trained and demonstrated competency in treatments to a registered nurse (RN) for three of three unlicensed personnel (ULP-F, ULP-G and ULP-H) with records reviewed.	01950		

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01950	Continued From page 65	01950		

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:

Unlicensed personnel (ULP)-F, ULP-G and ULP-H were hired on August 1, 2021, to provide direct care services to residents.

ULP-F
On September 15, 2021, at approximately 6:45 a.m., ULP-F was observed applying R3's right leg brace.

R3's Service Recap Summary for August 2021, indicated on August 29, 2021, ULP-F applied a right arm sling and compression sleeve to R3's right arm.

ULP-F's employee record lacked evidence to indicate ULP-F was trained and demonstrated competency to an RN to apply R3's right arm sling, compression sleeve or right leg brace.

ULP-G
R3's Service Recap Summary for August 2021 indicated on August 8, 9, 21, 22, 23, 24, and 31, 2021, ULP-G applied a compression sleeve and sling to R3's right arm and the brace to R3's right leg.

ULP-G's employee record lacked evidence to indicate ULP-G was trained and demonstrated

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competency to an RN to apply R3's right arm sling, compression sleeve, or right leg brace.

ULP-H
On September 15, 2021, at approximately 7:10 a.m. ULP-H was observed to apply R3's right arm compression sleeve and right arm sling.

ULP-H's employee record lacked evidence to indicate ULP-H was trained and demonstrated competency to an RN to apply R3's right arm sling or compression sleeve.

On September 16, 2021, at approximately 1:00 p.m., director of operations (DOO)-B confirmed ULP-F, ULP-G, and ULP-H's employee records lacked evidence the employees had been trained and had demonstrated competency to the RN to apply R3's right arm sling, compression sleeve, or right leg brace.

The licensee's Development of Treatment or Therapy Management Plans policy reviewed July, 25, 2021, indicated treatment and therapies will be provided to the unlicensed personnel after they have been trained and deemed competent by the RN.

No further information provided.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days

01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments	01960		

Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the

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signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs.

This MN Requirement is not met as evidenced by:
Based on observation, interview and record review, the licensee failed to ensure treatments or therapies were administered as prescribed and if not administered, the reason why they were not provided was documented for two of two residents (R1 and R2) with blood glucose monitoring managed by the provider.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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:
R1
R1's diagnoses included, but were not limited to, Type II diabetes mellitus (a group of diseases that affect how your body uses blood sugar (glucose).

R1's assessment dated August 3, 2021, indicated R1 required assistance with services which included medication administration, monthly vitals signs, full assistance with the application and removal of anti-embolism stockings, and assistance with bathing, grooming, and dressing.

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On September 15, 2021, at approximately 8:30 a.m., unlicensed personnel (ULP)-E was observed checking R1's blood glucose.

R1's service recap summary for August 2021 indicated R1's treatment record lacked documentation of completed treatments on the following dates and times:

Blood glucose checks:

8:00 a.m. - August 13,15, 2021

12:00 p.m. - August 10, 13, 14, 15, 18, 22, 23, 2021

5:00 p.m. - August 1, 9, 16, 19, 27, 2021.

Anti-embolism stockings:

A.M. - August 10, 11, 13, 14, 15, 23, 24, 2021

P.M. - August 13, 19, 2021

R2
R2's diagnoses included, but were not limited to, Type II diabetes mellitus (a group of diseases that affect how your body uses blood sugar (glucose) and chronic kidney disease stage 3 (condition characterized by a gradual loss of kidney function).

R2's service plan dated September 15, 2021, indicated R2 required assistance with services which included medication administration, glucose monitoring, weight monitoring daily per physician, assistance with bathing, grooming, and dressing.

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01960	Continued From page 69 On September 15, 2021, at approximately 8:45 a.m., ULP-D was observed to check R2's blood glucose. R2's service recap summary for September 2021, indicated R2's treatment record lacked documentation of completed treatments for the following dates and times: Blood Glucose checks: 12:00 p.m. - September 2, 2021 4:00 p.m. - September 4, 2021 8:00 p.m. - September 4, 2021 Daily weights: September 1, 2, 3, 4, 5, 7, 9, 12, 13, 2021 On September 16, 2021, at approximately 1:30 p.m., registered nurse (RN)-C confirmed treatment documentation lacked on above noted dates and times. The licensee's policy, Development of Treatment or Therapy Management Plans, updated July 25, 2021, indicated documentation of treatments and therapies would be completed in the resident record or recorded in Residex. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		
02040 SS=E	144G.81 Subdivision 1 Fire protection and physical environment	02040		

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An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements:
(1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; 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 facility failed to include hazards identified within the kitchens and living room gas fireplaces in their hazard vulnerability assessment/analysis. This had the potential to directly affect all twenty-nine (29) residents and staff.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).

The findings include:

On September 15, 2021, between 9:30 a.m. and 12:00 p.m., survey staff toured the facility with maintenance personnel (M)-J. It was observed in house one and house two that gate style doors separated the kitchen from resident living area,

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and the style of these gates would not prevent a resident from contacting the cooking range. It was also observed in house one and house two that no protective barriers were provided around gas fireplaces in living rooms.

On September 15, 2021, at approximately 11:50 a.m., during an interview, director of operations (DOO)-B, confirmed that cooking ranges and ovens were not disconnected during times when the kitchen was not staffed and that the gate style doors would not prevent a resident from entering the kitchen when staff are not present.

Licensee document, Hazard Vulnerability Analysis, failed to identify hazards posed by the kitchen or gas fireplaces.

No further information was provided.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days

02110 SS=F — 144G.82 Subd. 3 Policies — 02110

(a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the:
(1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented;
(2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed;

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02110	Continued From page 72 (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. This MN Requirement is not met as evidenced by: Based on interview and record review, licensee failed to ensure policies and procedures required in the licensing of assisted living facilities with dementia care were developed or implemented. 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:	02110		

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The licensee failed to develop and implement policies and procedures that addressed:

-philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented;

-evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed;

-wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes;

-medication management, including an assessment of residents for the use and effects of medication, including psychotropic medications;

-staff training specific to dementia care;

-description of life enrichment programs and how activities are implemented;

-description of family support programs and efforts to keep the family engaged;

-limiting the use of public address and intercom systems for emergencies and drills only;

-transportation coordination and assistance to and from outside medication appointments; and
-safekeeping of resident's possessions.

On September 16, 2021, at approximately 12:30 p.m., director of operations (DOO)-B confirmed the licensee had not developed policies and

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02110	Continued From page 74 procedures related to dementia care. The licensee lacked policies to include the new Assisted Living Licensure requirements that went into effect August 1, 2021. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02110		
02170 SS=E	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following: (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) 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. Daily activity options based on resident evaluation may include but are not limited to: (1) occupation or chore related tasks; (2) scheduled and planned events such as entertainment or outings;	02170		

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(3) spontaneous activities for enjoyment or those that may help defuse a behavior;
(4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music;
(5) spiritual, creative, and intellectual activities;
(6) sensory stimulation activities;
(7) physical activities that enhance or maintain a resident's ability to ambulate or move; and
(8) outdoor activities.

This MN Requirement is not met as evidenced by:
Based on observation, interview and record review, licensee failed to conduct an individualized written activity evaluation that addressed all six provisions and failed to write individual activity plans for three of eighteen residents (R1, R2, R3) with records reviewed

This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a 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:
The licensee had a current assisted living with dementia care license.

R1
R1's diagnoses included, but were not limited to, diabetes Type II (condition results from insufficient production of insulin, causing high blood sugar).

R1's record lacked the development of an

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individualized activity plan and any evidence R1 was evaluated for activities according to the licensing rules of the facility to include the following:
- past and current interests

- current abilities and skills

- emotional and social needs and patterns

- physical abilities and limitations

- adaptations necessary for the resident to participate; and

- identification of activities for behavioral interventions

R2
R2's diagnoses included, but were not limited to, diabetes Type 2 (condition results from insufficient production of insulin, causing high blood sugar) and chronic kidney disease stage 3 (condition characterized by a gradual loss of kidney function).

R2's record lacked the development of an individualized activity plan and any evidence R2 was evaluated for activities according to the licensing rules of the facility to include the following:
- past and current interests

- current abilities and skills

- emotional and social needs and patterns

- physical abilities and limitations

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02170	Continued From page 77 - adaptations necessary for the resident to participate; and - identification of activities for behavioral interventions R3 R3's diagnoses included, but were not limited to, early Alzheimer's dementia and diabetes. R3's record lacked the development of an individualized activity plan and any evidence R3 was evaluated for activities according to the licensing rules of the facility to include the following: - past and current interests - current abilities and skills - emotional and social needs and patterns - physical abilities and limitations - adaptations necessary for the resident to participate; and - identification of activities for behavioral interventions On September 16, 2021, at approximately 11:30 a.m. registerd nurse (RN)-C confirmed evaluations for activities and individual activity plans had not been completed for R1, R2, or R3. RN-C stated, "We are working on it. We just have not gotten to that yet." The licensee lacked policies to include the new Assisted Living Licensure requirements, that went into effect August 1, 2021.	02170		

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02170	Continued From page 78 No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02170		
02260 SS=C	144G.90 Subd. 3 Notice of dementia training An assisted living facility with dementia care shall make available in written or electronic form, to residents and families or other persons who request it, a description of the training program and related training it provides, including the categories of employees trained, the frequency of training, and the basic topics covered. A hard copy of this notice must be provided upon request. This MN Requirement is not met as evidenced by: Based on interview and record review, licensee failed to include the frequency of dementia training into the notice of dementia training provided to residents, legal representatives and families with records reviewed. This affected all (29) residents receiving assisted living with dementia services. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On September 14, 2021, at approximately 11:00 a.m. director of operations (DOO)-B provided a	02260		

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02260	Continued From page 79 written copy of the notice of dementia training provided to residents, legal representatives and families upon request. The notice of dementia training did not include the frequency of the training provided by the licensee. On September 14, 2021, at approximately 2:50 p.m., DOO-B confirmed the notice of dementia training did not include the frequency of training. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	02260		
02310 SS=E	144G.91 Subd. 4 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 provide care and services according to acceptable health care standards, medical or nursing standards for three of eighteen residents (R5, R6, R7) who utilized alarms with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more	02310		

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DIAMOND WILLOW OF PROCTOR	**913 OLD HIGHWAY 2 PROCTOR, MN 55810**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 80	02310		

than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).
The findings include:

R5
R5's record lacked evidence the registered nurse (RN) completed an assessment/reassessment prior to the placement of a bed alarm and a motion sensor alarm.

On September 16, 2021, at approximately 8:35 a.m., unlicensed personnel (ULP)-D was observed responding to yelling coming from R5's room. A motion sensor alarm box was observed to the left of R5's bed midway across the room. R5 stated to ULP-D, "That thing goes off everytime I want to get up." ULP-D stated to R5 that the alarm was in place to prevent R5 from getting up and falling. ULP-D confirmed that R5 also has an activated bed alarm and a call pendant. Alarms sounded in R5's room at 8:35 a.m., 8:40 a.m. and 8:45 a.m. Throughout several hours of observation in house two, R5's alarms activated regularly.

R5's assessment dated September 16, 2021, did not address bed alarm, motion sensor alarm or call pendant use by R5.

On September 16, 2021, at approximately 1:30 p.m., RN-C verified that a safety assessment to address the use of alarms for R5 had not been completed. Additionally, the licensed practical nurse (LPN)-I stated, "She has those so she doesn't fall. She just got back from the hospital like a week ago or something like that because she had a broken hip."

R6

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23609	A. BUILDING: ______ B. WING ______	09/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAMOND WILLOW OF PROCTOR	**913 OLD HIGHWAY 2 PROCTOR, MN 55810**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 81	02310		

R6's record lacked evidence that the RN completed an assessment/reassessment prior to the placement of a chirper alarm.

On September 16, 2021, at approximately 9:00 a.m., LPN-I was observed assisting R6 in the dining area with wheelchair ambulation. R6 wore a chirper alarm attached to R6's shirt and wheelchair. No call pendant was observed.

R6's assessment dated September 16, 2021, did not address the use of a chirper alarm or lack of a call pendant.

R7
R7's record lacked evidence that the RN completed an assessment/reassessment prior to the placement of a chirper alarm.

On September 16, 2021, at approximately 9:00 a.m., LPN-I was observed assisting R7 in the dining area with a meal. R7 wore a chirper alarm that was attached to R7's shirt. No call pendant was observed.

R7's assessment dated September 16, 2021, did not address the use of a chirper alarm or lack of a call pendant.

On September 16, 2021, at approximately 1:30 p.m., RN-C confirmed that R5, R6 and R7's current assessments were not updated to reflect the residents' individuals needs for use of alarms or lack of call pendants. Additionally, LPN-I stated, "I think we can do hourly checks or something like that. We can hear them also." when asked by surveyor how residents that do not have call pendants request assistance from staff.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23609	A. BUILDING: ______ B. WING ______	09/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAMOND WILLOW OF PROCTOR	**913 OLD HIGHWAY 2 PROCTOR, MN 55810**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 82 The licensee lacked policies to include the new Assisted Living Licensure requirements that went into effect August 1, 2021. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02310		

DEPARTMENT OF HEALTH

Minnesota Department of Health
Minnesota Department of Health
PO Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *09/14/21*
Time: 11:00:00
Report: 8010211147

Food and Beverage Establishment Inspection Report

Location:
Diamond Willow of Proctor
915 Old Hwy 2
Proctor, MN55810
St. Louis County, 69

Establishment Info:
ID #: N000915
Risk: High
Announced Inspection: No

License Categories:

Expires on: 12/31/21

Operator:
Sara Kleinschmidt
Phone #:
ID #:

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

The following orders were issued during this inspection.

3-500B Microbial Control: hot and cold holding

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

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

THE TEMPERATURE OF TURKEY 45F, CHICKEN 42F, MILK 45F AND RICOTTA CHEESE 43F STORED IN THE KITCHEN REFRIGERATOR WAS ABOVE THE MAXIMUM COLD HOLDING TEMPERATURE OF 41F. TURKEY AND CHICKEN WERE DISCARDED, UNIT TURNED COLDER AND TEMPERATURES WILL BE MONITORED

Corrected on Site

3-800 Highly Susceptible Populations

3-801.11B ***** Priority 1 *****

MN Rule 4626.0447B Discontinue using unpasteurized eggs or egg products in the preparation of Caesar salad, hollandaise or Bearnaise sauce, mayonnaise, meringue, eggnog, ice cream, and egg-fortified beverages when serving a highly susceptible population.

DISCONTINUE USING UNPASTEURIZED EGGS WHEN MORE THAN ONE EGG IS BROKEN, COMBINE AND NOT COOKED, BAKED, USED OR SERVED IMMEDIATELY AND NOT USED FOR A SINGLE RESIDENT. REFER TO THE HIGHLY SUSCEPTIBLE POPULATION FACT SHEET THAT WAS EMAILED WITH THIS REPORT.

Comply By: 09/14/21

Food and Beverage Establishment Inspection Report

4-700 Sanitizing Equipment and Utensils

4-702.11 ***** Priority 1 *****

MN Rule 4626.0900 Sanitize utensils and food contact surfaces of equipment before use, after cleaning.

THERE WAS NO SANITIZER PRESENT OR IN USE IN THE FOOD PREPARATION AREA. A CHLORINE SPRAY BOTTLE WAS MADE TO THE PROPER CONCENTRATION TO USE FOR FOOD CONTACT SURFACES.

Corrected on Site

2-100 Supervision

2-101.11 ***** Priority 2 *****

MN Rule 4626.0025 Designate a person in charge and ensure that the person in charge is present in the establishment during all hours of operation.

DESIGNATE A PERSON IN CHARGE FOR EACH FOOD PREPARATION TIME.

Comply By: 09/14/21

2-100 Supervision

2-102.11DEFGHI ***** Priority 2 *****

MN Rule 4626.0030DEFGHI The person in charge must be able to demonstrate their knowledge to the inspector of the importance of the following food handling procedures to preventing foodborne disease: handwashing; avoiding cross contamination; avoiding hand contact with ready-to-eat foods; time and temperature requirements for safely refrigerating, hot holding, cooling, and reheating TCS food; hazards of eating raw or undercooked meat, poultry, eggs, and fish; food temperatures and cooking times required to safely cook TCS food including meat, poultry, eggs, and fish; foods identified as major food allergens and the symptoms of an allergic reaction; identification of critical control points in a food service operation and steps to be taken to ensure the points are controlled.

EACH PERSON IN CHARGE IS TO BE TRAINED BY THE CERTIFIED FOOD PROTECTION MANAGER ON FOOD SAFETY PROCEDURES LISTED ABOVE.

Comply By: 09/14/21

2-100 Supervision

2-102.11JKLMO ***** Priority 2 *****

MN Rule 4626.0030JKLMO The person in charge must be able to demonstrate their knowledge to the inspector of the food safety risks within their food operation and the relationship of the following factors to preventing foodborne disease: maintaining the food establishment and equipment in a clean condition and in good repair; procedures for cleaning and sanitizing utensils and food-contact surfaces of equipment; the importance of adequate food service equipment; responsibilities when a HACCP plan is required; proper use of toxic compounds in the establishment; and preventing contamination of the water supply from plumbing cross connections or backflow.

EACH PERSON IN CHARGE IS TO BE TRAINED BY THE CERTIFIED FOOD PROTECTION MANAGER ON FOOD SAFETY RISKS WITHIN THEIR FOOD OPERATION AS LISTED ABOVE TO PREVENT FOODBORNE ILLNESS.

Comply By: 09/14/21

4-300 Equipment Numbers and Capacities

4-302.13B ***** Priority 2 *****

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

PROVIDE TEMPERATURE TEST TAPES FOR THE HOT WATER SANITIZER DISH MACHINE. EMAIL ME THE RESULTS (PICTURE) OF THE TEMPERATURE TAPES THAT WERE GIVEN TO SARA AT THE TIME OF THE INSPECTION. deb.kosiak@state.mn.us

Comply By: 09/14/21

4-300 Equipment Numbers and Capacities

4-302.14 ***** Priority 2 *****

MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.

PROVIDE TEST STRIPS TO TEST THE CONCENTRATION OF THE SANITIZER.
CHLORINE SANITIZER CONCENTRATION IS BETWEEN 50-200 PPM.

Comply By: 09/14/21

5-200C Plumbing: Maintenance, fixture location

5-205.11AB ***** Priority 2 *****

MN Rule 4626.1110AB The handwashing sink must be accessible at all times for employee use, and must be used only for handwashing.

THERE WERE UTENSILS IN THE DESIGNATED MIDDLE HANDWASHING SINK. THE HANDSINK IS TO BE USED FOR HANDWASHING ONLY.

Comply By: 09/14/21

2-100 Supervision

2-102.12DMN

MN Rule 4626.0033D Post the certified food protection manager certificate.

POST THE CERTIFIED FOOD PROTECTION MANAGER CERTIFICATE IN THE ESTABLISHMENT.

Comply By: 09/14/21

2-100 Supervision

2-102.12FMN

MN Rule 4626.0033F The certified food protection manager must identify the hazards in the operation of the food establishment; develop or implement policies, procedures, or standards to prevent foodborne illness in the food establishment; coordinate training, supervision or direction of food preparation activities; take corrective action in the food establishment as needed to protect the health of the consumer; and, complete in-house self-inspections of the daily operations in the food establishment at a frequency that ensures food safety policies and procedures are followed.

THE CERTIFIED FOOD PROTECTION MANAGER IS TO IMPLEMENT FOOD SAFETY POLICIES AND PROCEDURES AS LISTED ABOVE.

Comply By: 09/14/21

Food and Beverage Establishment Inspection Report

2-400 Hygenic Practices

2-401.11B

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

PROVIDE BEVERAGE CONTAINERS WITH LIDS FOR FOOD SERVICE EMPLOYEES TO USE IN FOOD PREPARATION AREAS.

Comply By: 09/14/21

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

3-304.14B

MN Rule 4626.0285B Wiping cloths used for wiping counters and other equipment surfaces must be held in an approved sanitizing solution and laundered daily.

WIPING CLOTHS ARE TO BE STORED IN A SANITIZER WITH THE PROPER CONCENTRATION BETWEEN USE.

Comply By: 09/14/21

6-300 Physical Facility Numbers and Capacities

6-301.14A

MN Rule 4626.1457 Provide a sign or poster at all handwashing sinks used by food employees that notifies them to wash their hands

PROVIDE A HANDWASHING SIGN AT THE DESIGNATED MIDDLE HANDWASHING SINK.

Comply By: 09/14/21

Surface and Equipment Sanitizers

Chlorine: = 200 PPM at Degrees Fahrenheit
Location: SPRAY BOTTLE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Hot Holding
Temperature: 172 Degrees Fahrenheit - Location: SAUERKRAUT/SAUSAGE
Violation Issued: No

Process/Item: Hot Holding
Temperature: 156 Degrees Fahrenheit - Location: BEEF STEW
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 45 Degrees Fahrenheit - Location: COOKED TURKEY-WHIRLPOOL
Violation Issued: Yes

Process/Item: Upright Cooler
Temperature: 42 Degrees Fahrenheit - Location: COOKED CHICKEN-WHIRLPOOL
Violation Issued: Yes

Food and Beverage Establishment Inspection Report

Process/Item: Upright Cooler
Temperature: 45 Degrees Fahrenheit - Location: MILK-WHIRLPOOL
Violation Issued: Yes

Process/Item: Upright Cooler
Temperature: 43 Degrees Fahrenheit - Location: RICOTTA CHEESE-WHIRLPOOL
Violation Issued: Yes

Process/Item: Upright Freezer
Temperature: Degrees Fahrenheit - Location: FOODS FROZEN-WHIRLPOOL
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 40 Degrees Fahrenheit - Location: MILK-REFRIGERATOR IN OFFICE
Violation Issued: No

Process/Item: Upright Freezer
Temperature: Degrees Fahrenheit - Location: FOODS FROZEN-TOP FREEZER OF REFRIGERATOR
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	3	6	5

COMMENTS:

DISTRIBUTED AN EMPLOYEE ILLNESS LOG SHEET AND DISCUSSED THE EXCLUSION OF EMPLOYEES ILL WITH VOMITING OR DIARRHEA FROM THE FOOD ESTABLISHMENT FOR 24 HOURS AFTER SYMPTOMS ARE GONE WITH SARA AND HEATHER.

DISCUSSED LIMITING BARE HAND CONTACT WITH READY TO EAT FOODS BY USING GLOVES OR UTENSILS WITH SARA. GLOVES ARE AVAILABLE FOR STAFF TO USE.

DISCUSSED PREPARING TCS (TIME/TEMPERATURE CONTROL FOR SAFETY FOOD) FOODS ONLY FOR SAME DAY SERVICE.

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 8010211147 of 09/14/21.

Certified Food Protection Manager: Heather Longsdorf

Certification Number: FM106636 Expires: 05/24/24

Inspection report reviewed with person in charge and emailed.

Signed:
Sara Kleinschmidt
Manager

Signed:
8010

651-201-4500
health.foodlodging@state.mn.us

Report #: 8010211147

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Minnesota Department of Health
PO Box 64975
St. Paul, MN 55164-0975

No. of RF/PHI Categories Out	7	Date 09/14/21
No. of Repeat RF/PHI Categories Out	0	Time In 11:00:00
Legal Authority MN Rules Chapter 4626		Time Out

Diamond Willow of Proctor	Address	City/State	Zip Code	Telephone
	915 Old Hwy 2	Proctor, MN	55810	

License/Permit #	Permit Holder	Purpose of Inspection	Est Type	Risk Category
N000915	Sara Kleinschmidt	Full		H

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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

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

#	Compliance Status (circled)	Item	COS	R
	Supervision			
1	OUT	PIC knowledgeable; duties & oversight		
2	OUT	Certified food protection manager, duties		
	Employee Health			
3	IN	Mgmt/Staff;knowledge,responsibilities&reporting		
4	IN	Proper use of reporting, restriction & exclusion		
5	IN	Procedures for responding to vomiting & diarrheal events		
	Good Hygenic Practices			
6	OUT	Proper eating, tasting, drinking, or tobacco use		
7	IN	No discharge from eyes, nose, & mouth		
	Preventing Contamination by Hands			
8	IN	Hands clean & properly washed		
9	IN	No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed		
10	OUT	Adequate handwashing sinks supplied/accessible		
	Approved Source			
11	IN	Food obtained from approved source		
12	N/O	Food received at proper temperature		
13	IN	Food in good condition, safe, & unadulterated		
14	N/A	Required records available; shellstock tags, parasite destruction		
	Protection from Contamination			
15	IN	Food separated and protected		
16	OUT	Food contact surfaces: cleaned & sanitized	X	
17	IN	Proper disposition of returned, previously served, reconditioned, & unsafe food		
	Time/Temperature Control for Safety			
18	N/O	Proper cooking time & temperature		
19	N/A	Proper reheating procedures for hot holding		
20	N/O	Proper cooling time & temperature		
21	IN	Proper hot holding temperatures		
22	OUT	Proper cold holding temperatures		X
23	IN	Proper date marking & disposition		
24	N/A	Time as a public health control: procedures & records		
	Consumer Advisory			
25	N/A	Consumer advisory provided for raw/undercooked food		
	Highly Susceptible Populations			
26	OUT	Pasteurized foods used; prohibited foods not offered		
	Food and Color Additives and Toxic Substances			
27	N/A	Food additives: approved & properly used		
28	IN	Toxic substances properly identified, stored, & used		
	Conformance with Approved Procedures			
29	N/A	Compliance with variance/specialized process/HACCP		

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

GOOD RETAIL PRACTICES

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

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

#	Status	Item	COS	R
	Safe Food and Water			
30	IN (circled)	Pasteurized eggs used where required		
31		Water & ice obtained from an approved source		
32	N/A (circled)	Variance obtained for specialized processing methods		
	Food Temperature Control			
33		Proper cooling methods used; adequate equipment for temperature control		
34	N/O (circled)	Plant food properly cooked for hot holding		
35	N/O (circled)	Approved thawing methods used		
36		Thermometers provided & accurate		
	Food Identification			
37		Food properly labled; original container		
	Prevention of Food Contamination			
38		Insects, rodents, & animals not present		
39		Contamination prevented during food prep, storage & display		
40		Personal cleanliness		
41	X	Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		
	Proper Use of Utensils			
43		In-use utensils: properly stored		
44		Utensils, equipment & linens: properly stored, dried, & handled		
45		Single-use/single service articles: properly stored & used		
46		Gloves used properly		
	Utensil Equipment and Vending			
47		Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48	X	Warewashing facilities: installed, maintained, & used; test strips		
49		Non-food contact surfaces clean		
	Physical Facilities			
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		Physical facilities installed, maintained, & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing & plan review		

Food Recalls: ____________________

Person in Charge (Signature) — Date: 09/15/21

Inspector (Signature)

Minnesota Department of Health
Minnesota Department of Health
PO Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *09/14/21*
Time: 19:00:00
Report: 8010211148

Food and Beverage Establishment Inspection Report

Location:
Diamond Willow of Proctor
917 Old Hwy 2
Proctor, MN55810
St. Louis County, 69

Establishment Info:
ID #: N000917
Risk: High
Announced Inspection: No

License Categories:

Expires on: 12/31/21

Operator:
Sara Kleinschmidt
Phone #:
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

3-302.11A(1) ***** Priority 1 *****

MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.

CARTONS OF RAW SHELL EGGS WERE STORED ON THE SECOND TO TOP SHELF IN THE KITCHEN REFRIGERATOR. STORE RAW SHELL EGGS ON THE LOWEST SHELF SEPARATED FROM READY TO EAT FOODS. EGGS WERE MOVED TO THE LOWEST SHELF.

Corrected on Site

3-800 Highly Susceptible Populations

3-801.11B ***** Priority 1 *****

MN Rule 4626.0447B Discontinue using unpasteurized eggs or egg products in the preparation of Caesar salad, hollandaise or Bearnaise sauce, mayonnaise, meringue, eggnog, ice cream, and egg-fortified beverages when serving a highly susceptible population.

DISCONTINUE USING UNPASTEURIZED EGGS WHEN MORE THAN ONE EGG IS BROKEN, COMBINED AND NOT COOKED, BAKED, USED OR SERVED IMMEDIATELY AND NOT USED FOR A SINGLE RESIDENT. REFER TO THE HIGHLY SUSCEPTIBLE POPULATION FACT SHEET THAT WAS EMAILED WITH THIS REPORT.

Comply By: 09/14/21

4-700 Sanitizing Equipment and Utensils

4-702.11 ***** Priority 1 *****

MN Rule 4626.0900 Sanitize utensils and food contact surfaces of equipment before use, after cleaning.

THERE WAS NO SANITIZER PRESENT IN THE FOOD PREPARATION AREA.

Comply By: 09/14/21

Food and Beverage Establishment Inspection Report

2-100 Supervision

2-101.11 ***** Priority 2 *****

MN Rule 4626.0025 Designate a person in charge and ensure that the person in charge is present in the establishment during all hours of operation.

DESIGNATE A PERSON IN CHARGE FOR EACH FOOD PREPARATION TIME.

Comply By: 09/14/21

2-100 Supervision

2-102.11DEFGHI ***** Priority 2 *****

MN Rule 4626.0030DEFGHI The person in charge must be able to demonstrate their knowledge to the inspector of the importance of the following food handling procedures to preventing foodborne disease: handwashing; avoiding cross contamination; avoiding hand contact with ready-to-eat foods; time and temperature requirements for safely refrigerating, hot holding, cooling, and reheating TCS food; hazards of eating raw or undercooked meat, poultry, eggs, and fish; food temperatures and cooking times required to safely cook TCS food including meat, poultry, eggs, and fish; foods identified as major food allergens and the symptoms of an allergic reaction; identification of critical control points in a food service operation and steps to be taken to ensure the points are controlled.

EACH PERSON IN CHARGE IS TO BE TRAINED BY THE CERTIFIED FOOD PROTECTION MANAGER ON FOOD SAFETY PROCEDURES LISTED ABOVE.

Comply By: 09/14/21

2-100 Supervision

2-102.11JKLMO ***** Priority 2 *****

MN Rule 4626.0030JKLMO The person in charge must be able to demonstrate their knowledge to the inspector of the food safety risks within their food operation and the relationship of the following factors to preventing foodborne disease: maintaining the food establishment and equipment in a clean condition and in good repair; procedures for cleaning and sanitizing utensils and food-contact surfaces of equipment; the importance of adequate food service equipment; responsibilities when a HACCP plan is required; proper use of toxic compounds in the establishment; and preventing contamination of the water supply from plumbing cross connections or backflow.

EACH PERSON IN CHARGE IS TO BE TRAINED BY THE CERTIFIED FOOD PROTECTION MANAGER ON FOOD SAFETY RISKS WITHIN THEIR FOOD OPERATION AS LISTED ABOVE TO PREVENT FOODBORNE ILLNESS.

Comply By: 09/14/21

4-300 Equipment Numbers and Capacities

4-302.13B ***** Priority 2 *****

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

PROVIDE TEMPERATURE TEST TAPES FOR THE HOT WATER SANITIZER DISH MACHINE. EMAIL ME THE RESUTS (PICTURE) OF THE TEMPERATURE TAPES THAT WERE GIVEN TO SARA.

Comply By: 09/14/21

4-300 Equipment Numbers and Capacities

4-302.14 ***** Priority 2 *****

MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.

PROVIDE TEST STRIPS TO TEST THE CONCENTRATION OF THE SANITIZER.
CHLORINE SANITIZER CONCENTRATION IS BETWEEN 50-200 PPM.

Comply By: 09/14/21

6-300 Physical Facility Numbers and Capacities

6-301.12 ***** Priority 2 *****

MN Rule 4626.1445 Provide and maintain a supply of individual disposable towels, a continuous towel system, a heated-air hand drying device, or an approved ambient air temperature hand drying device at each handwashing sink or group of adjacent handwashing sinks.

THERE WERE NO PAPER TOWELS AT THE KITCHEN HANDSINK.

Comply By: 09/14/21

2-100 Supervision

2-102.12DMN

MN Rule 4626.0033D Post the certified food protection manager certificate.

POST THE CERTIFIED FOOD PROTECTION MANAGER CERTIFICATE IN THE ESTABLISHMENT.

Comply By: 09/14/21

2-100 Supervision

2-102.12FMN

MN Rule 4626.0033F The certified food protection manager must identify the hazards in the operation of the food establishment; develop or implement policies, procedures, or standards to prevent foodborne illness in the food establishment; coordinate training, supervision or direction of food preparation activities; take corrective action in the food establishment as needed to protect the health of the consumer; and, complete in-house self-inspections of the daily operations in the food establishment at a frequency that ensures food safety policies and procedures are followed.

THE CERTIFIED FOOD PROTECTION MANAGER IS TO IMPLEMENT FOOD SAFETY POLICIES AND PROCEDURES AS LISTED ABOVE.

Comply By: 09/14/21

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

3-302.12

MN Rule 4626.0240 Properly label all working containers holding food or food ingredients that are removed from orginal packages with the common name of the food. Label the food in English and any other languages used by employees who handle food.

TWO WORKING CONTAINERS WITH WHITE SUBSTANCES IN THE KITCHEN STORE ROOM WERE NOT LABELED WITH THE COMMON NAME OF THE FOOD.

Comply By: 09/14/21

Food and Beverage Establishment Inspection Report

4-600 Cleaning Equipment and Utensils

4-602.12

MN Rule 4626.0850 Clean the food contact surfaces of cooking and baking equipment and interior cavities of microwave ovens at least every 24 hours.

CLEAN AND MAINTAIN CLEAN THE INSIDE OF THE MICROWAVE.

Comply By: 09/14/21

4-600 Cleaning Equipment and Utensils

4-602.13

MN Rule 4626.0855 Clean all non-food-contact surfaces of equipment at a frequency necessary to preclude accumulation of soil residues.

CLEAN AND MAINTAIN CLEAN THE OUTSIDE OF THE KITCHEN REFRIGERATOR AND FREEZER.

Comply By: 09/14/21

Food and Equipment Temperatures

Process/Item: Upright Cooler
Temperature: 34 Degrees Fahrenheit - Location: PREPACKAGED SLICED TURKEY
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 38 Degrees Fahrenheit - Location: SLICED CHEESE
Violation Issued: No

Process/Item: Hot Holding
Temperature: 196 Degrees Fahrenheit - Location: BEEF STEW
Violation Issued: No

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

Process/Item: Upright Cooler
Temperature: 40 Degrees Fahrenheit - Location: FRIGIDAIRE-AIR TEMP STORE ROOM
Violation Issued: No

Process/Item: Upright Cooler
Temperature: Degrees Fahrenheit - Location: FOODS FROZEN-TOP FREEZER OF REFRIGERATOR IN STORE ROOM
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	3	6	5

COMMENTS:

DISTRIBUTED AN EMPLOYEE ILLNESS LOG SHEET AND DISCUSSED THE EXCLUSION OF EMPLOYEES ILL WITH VOMITING OR DIARRHEA FROM THE FOOD ESTABLISHMENT FOR 24 HOURS AFTER SYMPTOMS ARE GONE WITH SARA AND HEATHER.

Food and Beverage Establishment Inspection Report

DISCUSSED LIMITING BARE HAND CONTACT WITH READY TO EAT FOODS BY USING GLOVES OR UTENSILS WITH SARA. GLOVES ARE AVAILABLE FOR STAFF TO USE.

DISCUSSED PREPARING TCS (TIME/TEMPERATURE CONTROL FOR SAFETY FOOD) FOODS ONLY FOR SAME DAY SERVICE.

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 8010211148 of 09/14/21.

Certified Food Protection Manager: Heather Longsdorf

Certification Number: FM106636 Expires: 05/24/24

Inspection report reviewed with person in charge and emailed.

Signed:
Sara Kleinschmidt
Manager

Signed:
8010

651-201-4500
health.foodlodging@state.mn.us

Report #: 8010211148

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Minnesota Department of Health
PO Box 64975
St. Paul, MN 55164-0975

No. of RF/PHI Categories Out	6	Date	09/14/21
No. of Repeat RF/PHI Categories Out	0	Time In	19:00:00
Legal Authority MN Rules Chapter 4626		Time Out	

Establishment	Address	City/State	Zip Code	Telephone
Diamond Willow of Proctor	917 Old Hwy 2	Proctor, MN	55810	

License/Permit #	Permit Holder	Purpose of Inspection	Est Type	Risk Category
N000917	Sara Kleinschmidt	Full		H

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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

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

#	Compliance Status (circled)	Item	COS	R
	Supervision			
1	OUT	PIC knowledgeable; duties & oversight		
2	OUT	Certified food protection manager, duties		
	Employee Health			
3	IN	Mgmt/Staff;knowledge,responsibilities&reporting		
4	IN	Proper use of reporting, restriction & exclusion		
5	IN	Procedures for responding to vomiting & diarrheal events		
	Good Hygenic Practices			
6	IN	Proper eating, tasting, drinking, or tobacco use		
7	IN	No discharge from eyes, nose, & mouth		
	Preventing Contamination by Hands			
8	IN	Hands clean & properly washed		
9	IN	No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed		
10	OUT	Adequate handwashing sinks supplied/accessible		
	Approved Source			
11	IN	Food obtained from approved source		
12	N/O	Food received at proper temperature		
13	IN	Food in good condition, safe, & unadulterated		
14	N/A	Required records available; shellstock tags, parasite destruction		
	Protection from Contamination			
15	OUT	Food separated and protected	X	
16	OUT	Food contact surfaces: cleaned & sanitized		
17	IN	Proper disposition of returned, previously served, reconditioned, & unsafe food		
	Time/Temperature Control for Safety			
18	N/O	Proper cooking time & temperature		
19	N/A	Proper reheating procedures for hot holding		
20	N/O	Proper cooling time & temperature		
21	IN	Proper hot holding temperatures		
22	IN	Proper cold holding temperatures		
23	IN	Proper date marking & disposition		
24	N/A	Time as a public health control: procedures & records		
	Consumer Advisory			
25	N/A	Consumer advisory provided for raw/undercooked food		
	Highly Susceptible Populations			
26	OUT	Pasteurized foods used; prohibited foods not offered		
	Food and Color Additives and Toxic Substances			
27	N/A	Food additives: approved & properly used		
28	IN	Toxic substances properly identified, stored, & used		
	Conformance with Approved Procedures			
29	N/A	Compliance with variance/specialized process/HACCP		

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

GOOD RETAIL PRACTICES

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

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

#	Mark	Item	COS	R
	Safe Food and Water			
30	IN (circled)	Pasteurized eggs used where required		
31		Water & ice obtained from an approved source		
32	N/A (circled)	Variance obtained for specialized processing methods		
	Food Temperature Control			
33		Proper cooling methods used; adequate equipment for temperature control		
34	N/O (circled)	Plant food properly cooked for hot holding		
35	N/O (circled)	Approved thawing methods used		
36		Thermometers provided & accurate		
	Food Identification			
37	X	Food properly labled; original container		
	Prevention of Food Contamination			
38		Insects, rodents, & animals not present		
39		Contamination prevented during food prep, storage & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		
	Proper Use of Utensils			
43		In-use utensils: properly stored		
44		Utensils, equipment & linens: properly stored, dried, & handled		
45		Single-use/single service articles: properly stored & used		
46		Gloves used properly		
	Utensil Equipment and Vending			
47		Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48	X	Warewashing facilities: installed, maintained, & used; test strips		
49	X	Non-food contact surfaces clean		
	Physical Facilities			
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		Physical facilities installed, maintained, & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing & plan review		

Food Recalls: ____________________

Person in Charge (Signature) — Date: 09/15/21

Inspector (Signature)

MINNESOTA

Highly Susceptible Population

RESTRICTIONS AND LIMITATIONS TO PROTECT VULNERABLE INDIVIDUALS

Definition

A highly susceptible population means persons who are more likely than others in the general population to experience foodborne disease because they are:

- Immunocompromised
- Preschool-age children, or older adults

AND

- They obtain food at a facility that provides services such as:
  - Custodial care
  - Health care
  - Nutritional services
  - Socialization services (e.g., senior center)

Restrictions

The following practices are **not** allowed in a food establishment that serves a highly susceptible population:

- Use of bare hand contact with ready-to-eat foods.
- Use of consumer advisories in lieu of required cooking temperatures.
- Service or sale of the following food in a ready-to-eat form:
  - Raw animal food such as raw fish, raw marinated fish, raw molluscan shellfish and steak tartare.
  - Partially cooked animal food such as lightly cooked fish, rare meat, soft-cooked eggs that are made from raw eggs, and meringue.
  - Raw seed sprouts.
- Use of time as public health control for raw eggs.
- Re-service of:
  - Any food from patients or clients who are under contact precautions in medical isolation, quarantine, or protective environment isolation.
  - Packages of food from patients, clients, or other consumers to patients in protective environmental isolation.

Limitations

Food safety requirements are more stringent when serving highly susceptible populations. Effective control measures for specific food products may help reduce the risk for foodborne illness.

Juice

Prepackaged, unpasteurized juice or unpasteurized beverages containing juice cannot be served or sold in a food establishment that serves a highly susceptible population.

For juice, a highly susceptible population includes children age nine or less that receive food in a school, day care setting, or place that provides custodial care.

Eggs

Raw eggs may be used in one customer's serving at a single meal if the eggs are combined, cooked and served immediately, such as in an omelet, soufflé, or scrambled

eggs. Cook raw eggs to 145°F or above for 15 seconds.

Raw eggs may be used in baked goods that are thoroughly cooked such as a cake, muffin, or bread if the eggs are combined as an ingredient immediately before baking.

Pasteurized eggs or egg products must be substituted for raw eggs:

- In recipes when more than one egg is broken, combined, and not cooked, baked, or used immediately
- When preparing food containing uncooked or lightly cooked egg, such as:
  - Caesar salad
  - Hollandaise or Béarnaise sauce
  - Mayonnaise
  - Meringue
  - Eggnog
  - Ice cream
  - Egg-fortified beverages

HACCP

An approved Hazard Analysis Critical Control Point (HACCP) plan is required in food establishments serving highly susceptible populations when:

- Unpackaged juice is prepared on site for sale or service.
- Preparing food that includes raw unpasteurized eggs that are combined and not used immediately.

Contact your inspector for help with HACCP plan requirements for food establishments serving highly susceptible populations.

Resources

Minnesota Department of Health Food Business Safety (www.health.state.mn.us/foodbizsafety)

Minnesota Department of Health
Food, Pools, and Lodging Services
PO Box 64975
St. Paul, MN 55164-0975
651-201-4500
health.foodlodging@state.mn.us
www.health.state.mn.us

Minnesota Department of Agriculture
Food and Feed Safety Division
625 Robert Street N
St. Paul, MN 55155-2538
651-201-6027
MDA.FFSD.Info@state.mn.us
www.mda.state.mn.us

JANUARY 2019

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