Electronically Delivered

February 8, 2022

Administrator
Diamond Willow Of Lester Park
6353 East Superior Street
Duluth, MN 55804

RE: Project Number(s) SL28545015

Dear Administrator:

On January 18, 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 October 14, 2021. The follow-up evaluation determined your agency had not corrected all of the state licensing orders issued pursuant to the October 14, 2021 evaluation.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state licensing orders issued pursuant to the last evaluation completed on October 14, 2021, found not corrected at the time of the January 18, 2022 follow-up evaluation and subject to penalty assessment are as follows:

0650-Employee Records-144g.42 Subd. 8
0900-Contract Required-144g.50 Subdivision 1
1620-Initial Reviews, Assessments, And Monitoring-144g.70 Subd. 2

The details of the violations noted at the time of this follow-up evaluation completed on January 18, 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, no immediate fines are assessed.

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

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
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
	28545	A. BUILDING: _____ B. WING _____	R 01/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAMOND WILLOW OF LESTER PARK	6353 EAST SUPERIOR STREET DULUTH, MN 55804

(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: Project # SL28545015-1 On January 17, 2022, and January 18, 2022, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed October 14, 2021. At the time of the revisit survey, there were 26 residents receiving services under the Assisted Living with Dementia Care license. As a result of the revisit, the following orders were reissued and/or issued	{0 000}	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	{0 480}		

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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}		
{0 650} SS=E	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision;	{0 650}		

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{0 650}	Continued From page 2 (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. (b) Each employee record must be retained for at least three years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure employee records contained all required content for three of four unlicensed personnel ((ULP)-D, ULP-E and ULP-F) 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 ULP-D had a hire date of August 26, 2020, to provide direct care services to the licensee's	{0 650}		

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{0 650}	Continued From page 3 residents. On January 19, 2022, at approximately 8:02 a.m., the surveyor observed ULP-D assist a resident to a seated position at a table in the dining area of the "Gitchee Gammi" unit. ULP-D's employee record lacked evidence of documentation of an annual performance review that identified areas of improvement needed and training needs. ULP-E ULP-E had a hire date of October 15, 2020, to provide direct care services to the licensee's residents. ULP-E's employee record lacked evidence of documentation of an annual performance review that identified areas of improvement needed and training needs. ULP-F ULP-F had a hire date of October 15, 2020, to provide direct care services to the licensee's residents. ULP-F's employee record lacked evidence of documentation of an annual performance review that identified areas of improvement needed and training needs. On January 18, 2022, at approximately 3:45 p.m., licensed practical nurse (LPN)-A stated in regard to employee records, "corporate HR" (human resources) was formulating a spreadsheet that would track when an employee's review was to be completed, but did not know the status. LPN-A said, "to my knowledge" employees have not been given annual performance reviews.	{0 650}		

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{0 650}	Continued From page 4 On January 19, 2022, at approximately 9:59 a.m., licensed assisted living director (LALD)-B confirmed annual performance reviews for ULP-D, ULP-E and ULP-F had not been completed since the original survey. LALD-B stated soon following the survey exit, the site was without registered nurse leadership and a newly hired RN would not be able to begin for a couple more weeks. LALD-B stated without the leadership, that task did not get done. The licensee's 4.05 Employment Records policy, dated August 1, 2021, indicated the licensee would keep an employee record for all paid employees; and also, the records would be confidential and up-to-date. The policy further indicated documentation of annual performance reviews that identify areas of improvement needed and training needs would be among items included in the file. No further information was provided.	{0 650}		
{0 900} SS=D	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable.	{0 900}		

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{0 900}	Continued From page 5 (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and execute a written contract, prior to the start of services, with the required content to provide assisted living services for one of five residents (R4) 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	{0 900}		

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{0 900}	Continued From page 6 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R4 was admitted for services on August 4, 2021. R4's Service Plan dated August 4, 2021, indicated R4's services included activity coordination, assistance with activities of daily living, transferring, anti-embolytic stocking care (treatment), medication management and housekeeping assistance with socialization, cares, ambulation/exercise and behavior monitoring. R4's record lacked a written contract from the licensee with the following required content: (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the	{0 900}		

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{0 900}	Continued From page 7 contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. On January 18, 2022, at approximately 4:34 p.m., licensed assisted living director (LALD)-B acknowledged R4 may not have had a new assisted living contract. LALD-B stated R4 originally moved into a sister-site, had a contract, then transferred. LALD-B further stated after getting a citation for the resident not having a contract, it was tasked to the nurse, who subsequently left employment, and the resident (R4) still had no new contract. LALD-B verified each facility where R4 resided held its own assisted living license. The licensee's 1.05 Signing an Assisted Living Contract, dated August 1, 2021, indicated when a prospective resident decides to move into Twin Diamond LLC (the licensee) an assisted living contract is signed and received by the facility. The policy also indicated two copies of the contract are signed; one copy is retained for the resident record and the other given to the prospective resident/responsible party. No further information was provided.	{0 900}		
{01620} SS=E	144G.70 Subd. 2 Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days	{01620}		

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{01620}	Continued From page 8	{01620}		

after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment.
(d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review.
(e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to ensure the registered nurse completed a follow-up assessment within 14 days of start of services two of five residents (R1, R3) 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

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{01620}	Continued From page 9 found to be pervasive). The findings include: R1 R1 was admitted for services on October 26, 2021, with diagnoses including congestive heart failure, glaucoma, depression and hypertension. On January 18, 2022, at approximately 4:08 p.m., the surveyor observed unlicensed personnel (ULP)-K take R1's blood sugar then subsequently administer medications in R1's room. R1's record indicated the registered nurse (RN) completed an initial nursing assessment on October 27, 2021. R1's next assessment completed by RN-J was dated November 29, 2021, or thirty-one (31) days after the first assessment, and not within the 14-day requirement. R3 R3 was admitted for services on December 15, 2021, with diagnoses including dementia, glaucoma and hypertension. R3's record indicated the RN completed an initial nursing assessment on December 15, 2021. R3's next assessment completed by RN-L was dated January 10, 2022, or twenty-six (26) days after the first assessment, and not within the 14-day requirement. On January 18, 2022, at approximately 4:46 p.m., licensed assisted living director (LALD)-B acknowledged R1 and R3's assessments were late and were out of compliance. LALD-B stated she had registered nurses filling in until a replacement for the previous RN was hired, and	{01620}		

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{01620}	Continued From page 10 the lack of local leadership resulted in late assessments. The licensee's Nursing Assessments, Delegated Nursing Services and Supervision Policy and Procedures policy, revised February 20, 2020, indicated the registered nurse would reassess each client (resident) on an on-going basis, to include monitoring and assessment no later than 14 days after the initial assessment, and then not to exceed 90 days from the last assessment. No additional information was provided.	{01620}		

Electronically Delivered

November 22, 2021

Administrator
Diamond Willow Of Lester Park
6353 East Superior Street
Duluth, MN 55804

RE: Project Number(s) SL28545015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on October 14, 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,

Jodi Johnson, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jodi.johnson@state.mn.us
Telephone: 507-696-2437 Fax: 651-215-9697

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28545	A. BUILDING: _____ B. WING _____	10/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAMOND WILLOW OF LESTER PARK	6353 EAST SUPERIOR STREET DULUTH, MN 55804

(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(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: Project # SL28545015 On October 11, 2021, through October 14, 2021, surveyors of this Department's staff visited the above Assisted Living licensed provider, and the following correction orders are issued. At the time of the survey, there were 21 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 License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.A The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	0 470		

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0 470	Continued From page 1 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 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 develop, implement or post in the facility a staffing plan to meet the needs of all residents. This had the potential to affect all 21 current residents, staff and visitors of the facility. 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	0 470		

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0 470	Continued From page 2 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: The licensee held an assisted living facility with dementia care license. The facility has a licensed bed capacity of 26 residents, and at start of the survey there was a current census of 21 residents. On October 11, 2021, at approximately 10:10 a.m. at the Gitchee Gammi entrance, there was no posting or signage that disclosed the number and type of staff currently working, or notice of a staffing plan. At the entry, there was a wall-mounted flip chart, a series of paper-sized, window sleeves, each contained information such as food menu (which was blank), an activity calendar, and information about how to contact the ombudsman, the licensee's UDALSA (uniform disclosure of assisted living services) and other information. During a subsequent tour of the facility's other main entry, Lester River, at approximately 1:30 p.m., a similar flip chart was also observed, but there was no staffing plan or schedule displayed. During the entrance conference on October 11, 2021, at approximately 10:58 a.m. registered nurse (RN)-A and the assistant director of operations and licensed assisted living director (ADO/LALD) acknowledged the lack of a written staffing plan or staff schedule posted. RN-A stated the staffing plan concept was "self-explanatory." The DOR/LALD	0 470		

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0 470	Continued From page 3 acknowledged their short coming with the staffing plan and said it was something they would address and work on. On October 13, 2021, at approximately 12:02 p.m. RN-A stated the staffing plan would be the driver of how it would determine staffing levels, and be based on resident needs, such as if a resident needed two people for transfers, overall acuity of the residents, and also meet their safety needs. RN-A expressed understanding there needed to be a staffing plan, and the plan needed to be revised as needed and be reviewed at least twice each year. "We're learning this," RN-A stated. A policy regarding development of a staffing plan was requested, but none was provided. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) 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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0 480	Continued From page 4 to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This had the potential to affect all 21 current residents residing at the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated October 11, 2021, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 480		
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and	0 510		

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0 510	Continued From page 5 nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure infection control standards were followed during medication administration for two of four residents (R4, R3) observed during a medication pass. 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: R4 R4's diagnoses included, but were not limited to hyper lipidemia, depression, gastro-esophageal reflux disease, constipation and pain. R4's service plan dated July 29, 2021, indicated the resident received medication management services including medication administration two times per day. R4's prescriber's orders dated August 27, 2021,	0 510		

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0 510	Continued From page 6	0 510		

included, but were not limited to the following medications: a combination drug to reduce pain, fever, inflammation and blood clots; a statin drug to help lower cholesterol; and antidepressant; a acid-reducing drug; a multi vitamin; and a probiotic.
On October 12, 2021, at approximately 7:23 a.m. the surveyor accompanied unlicensed personnel (ULP)-C into R4's room to observe treatments. ULP-C carried a small medicine cup filled with a number of pills, which ULP-C stated she had just set up, and was also going to administer to R4. After greeting R4 and explaining what was going to happen, ULP-C donned a pair of gloves and proceeded with two treatments for R4, who was seated at the side of her bed. ULP-C placed anti-embolism stockings on R4's legs, then applied an orthotic brace on R4's right foot. ULP-C started the medication administration and retrieved the pill cup and a glass of water, then dumped R4's pills into her own gloved hand. One at a time, R4 took the pills from ULP-C's gloved hand and swallowed them with water. Prior to exiting the room, ULP-C removed her gloves and washed her hands with running hot water and soap in R4's room.

R3
R3's diagnoses included, but were not limited to atrial fibrillation.
R3's service plan, dated July 29, 2021, indicated the resident received medication management services, including medication administration multiple times daily.
R3's prescriber's orders dated August 25, 2021, included, but were not limited to, the following orders: a blood thinner, aspirin for prophylaxis; a diuretic; anti depressant; cholesterol lowering medication; one blood pressure medication; a drug to treat gastro-esophageal reflux; a mood

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0 510	Continued From page 7	0 510		

stabilizer; a bowel medication; multi vitamin; and pain reliever.
On October 12, 2021, at approximately 7:53 a.m. ULP-C began set up of R3's medications, which were stored in a locked cabinet in the resident's room. ULP-C donned a pair of gloves, and using an iphone to access the electronic medication administration record, began to check and compare R3's medications in the room to the record, and then placed the medications into a small medicine cup. ULP-C punched out three medications that were in a pharmacy-prepared blister pack. Other medications were from pharmacy-labeled bottles. With gloved hands, ULP-C reached into the bottles with a finger and retrieved the medications and placed each into the medication cup. At 8:03 a.m., ULP-C administered the medications to R3, who accepted the medicines from the cup and swallowed them with water. Before leaving the room, ULP-C removed gloves and washed hands with running hot water and soap.
At 8:19 a.m., ULP-C was asked about the medication administration for R4 and R3. ULP-C acknowledged she reached into the bottles to get the pills out for R3, stating "I thought it was fine" as long as I have my gloves on. ULP-C also acknowledged pouring R4's pills onto her gloved hands when she offered the resident the medications. ULP-C stated "it was emphasized" to wear gloves during medication administration, and re-stated as long as I was wearing gloves, "that was the right thing" when passing medications.
On October 13, 2021, at approximately 10:31 a.m. registered nurse (RN)-A stated staff were trained to wash hands, don gloves and gather supplies, then completed the required checks to set up medications right before administration. RN-A stated staff were trained to gently shake

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0 510	Continued From page 8 medications into the covers of pill bottles, but not "to stick your gloved hand" into a medication bottle. RN-A also stated it was "not protocol" to pour a resident's meds into the gloved hands when administering them. RN-A stated both of these actions were "infection control" issues; "staff were not taught to pass meds that way." RN-A said following the surveyor's observation, the ULP came to her and "I provided some re-education." ULP-C's personnel record indicated the employee received an overview and training on numerous routes of medication administration (including oral route) on August 20, 2020. ULP-C's Demonstration/Skill Assessment for Medications, indicated the ULP passed the skills test to administer oral medications on August 25, 2020; however, the assessment checklist did not specify how oral medications were to be removed from their packaging when setting up medications. A policy regarding infection control guidelines during medication administration was requested, but none was provided. No further information was provided. TIME PERIOD TO CORRECT: 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, interview and document review, the licensee failed to display its current assisted living license in the main entrance of the	0 570		

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0 570	Continued From page 9 facility. This had the potential to affect all 21 current residents, staff, and visitors to the facility. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On October 11, 2021, at approximately 10:30 a.m. upon entering the facility at the Gitchee Gammi entry, the current license was not observed to be posted at the facility entrance as required. On October 12, 2021, at approximately 7:20 a.m. at the Lester River entryway, there was no license displayed. The current license was found displayed upon a shelf in the nursing office, the door to which was most often locked. On October 13, 2021, at approximately 1:37 p.m. registered nurse (RN)-A confirmed the original license was not posted at any entrance in the assisted living building. RN-A stated they were aware of the requirement and the maintenance staff would be taking care of that. The licensee's 1.50 Assisted Living License and Posting policy effective/revised dated July 29, 2021, indicated the licensee will maintain a current Assisted Living License issued by the Minnesota Department of Health. Further, the issued license will be posted at the main entrance of the facility. No further information provided.	0 570		

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0 570	Continued From page 10 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. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to engage in and maintain documentation of quality management activities, commensurate with the size of the business. This had the potential to affect all 21 current residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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).	0 580		

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0 580	Continued From page 11 The findings include: On October 11, 2021, at approximately 11:39 a.m. during the entrance conference, registered nurse (RN)-A said "We're going to be honest" and stated they did not have any quality management project or documentation of any quality activity going on. RN-A stated "it's my job" to get this rolling for this site but, to be honest, you will not find anything. RN-A and the assistant director of operations said they were aware of the requirement for "QA" (quality assurance) and acknowledged they were deficient in this area. The licensee's 1.35 Quality Improvement Project policy revised February 20, 2020, indicated the licensee will have at least one documented quality management project in place at all times, and retain records of such projects for at least two years. The licensee shall engage in quality management appropriate to the size of the provider and relevant to the type of services it provides. The policy also indicated information about quality management must be available to surveyors or investigators upon request. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	0 580		
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information:	0 650		

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0 650	Continued From page 12 (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. (b) Each employee record must be retained for at least three years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure employee records contained all required content for two of four unlicensed personnel ((ULP)-A and ULP-B) 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	0 650		

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0 650	Continued From page 13 was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-A ULP-A had a hire date of August 26, 2020, to provide direct care services to the licensee's residents. On October 12, 2021, between 7:30 a.m. and 10:00 a.m. ULP-A administered medications to several residents, including R1 and R2. ULP-A's employee record lacked evidence of documentation of an annual performance review that identified areas of improvement needed and training needs. ULP-A's record also lacked a current job description. ULP-B ULP-B had a hire date of August 18, 2020, to provide direct care services to the licensee's residents. On October 12, 2021, between 7:12 a.m. and 8:35 a.m. ULP-B was observed administering prescribed medications to multiple residents, including R3 and R4. ULP-B's employee record lacked evidence of documentation of an annual performance review that identified areas of improvement needed and training needs. ULP-B's record also lacked a current job description. On October 12, 2021, at approximately 1:58 p.m. registered nurse (RN)-A stated annual	0 650		

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0 650	Continued From page 14 performance reviews should be completed by the employee's anniversary date. RN-A stated ULP-A went on "casual" status, and that is perhaps why there was no review, or because of COVID; it's possible the reviews were "delayed or missed." RN-A also said employee files should have job descriptions, but could not say why there were none. RN-A verified ULP-A's and ULP-B's files contained no current job descriptions. A policy regarding content of employee records was requested, but none was provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 650		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff	0 680		

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0 680	Continued From page 15 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 document review, the licensee failed to have a written emergency preparedness plan with all the required content and failed to post an emergency preparedness plan prominently. This had the potential to affect all 21 current residents in the facility, staff and any 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: Upon entrance to the facility on October 11, 2021, at approximately 10:10 a.m. there was no signage posted or information regarding the licensee's emergency preparedness plan. Except for posting of emergency exits, nothing regarding an emergency preparedness plan was posted near the facility's main entrance, which staff noted was the "Gitchee Gammi" entry. A second entry way, named Lester River, was also observed to	0 680		

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0 680	Continued From page 16 lack any signage or information regarding the licensee's emergency plan. During the entrance conference on October 11, 2021, at approximately 11:32 a.m. a request was made to registered nurse (RN)-A to view the licensee's emergency preparedness plan. RN-A stated she had "a portion of the plan" including some policies, and they were going to be implementing monthly staff meetings, which were to include information about their emergency plan. The licensee's plan titled Emergency Plan for Diamond Willow Assisted Living Lester Park, undated, was a 10-page document that provided necessary, required emergency preparedness planning; however, the document lacked specific information and lacked content as required in Appendix Z, the state adopted rule addressing emergency preparedness. The licensee's plan lacked the following required content: -current, all-hazards approach facility assessment (although including a hazard assessment, listing likely natural and other disasters, there was no analysis or determination of what specific hazards/vulnerabilities the facility had and needed to address); -description of the population served by licensee; (the current description of its population indicated only the licensee served "elderly" clients; there lacked more specific characteristics and needs of the residents it typically served); -process for emergency preparedness (EP) cooperation with state and local EP officials/organizations; -subsistence needs for staff and residents during emergency situation;	0 680		

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0 680	Continued From page 17 -procedure for tracking staff and residents (acknowledged in the current plan); -development of all policies/procedures, based on assessment; and additional policies for: -potential evacuation; -sheltering in place; -handling medical documents; -handling and use of volunteers; (there lacked comprehensive collection of policies/procedures for hazards as noted in the licensee's polices, namely tornado, fire, snow/ice storms; the plan lacked policies for any other identified and/or required hazards, including missing person, and those noted above); -arrangement with other faculties, including sister facilities (there was an agreement with a sister facility, but it lacked acknowledgement or signature from the sister facility partner); -development of a communication plan, including primary and alternate means for communication; (the plan lacked phone lists for staff, resident physicians, state and local emergency personnel and agencies and other requirements from appendix Z) -methods for sharing information; -EP training and testing program; (the current plan lacked details regarding employee training program and any indication of on-going staff training, involvement in community testing and testing of the plan with current residents, for example); -EP training program for staff (including documentation of training provided); and -annual EP testing requirements. On August 14, 2021, at approximately 9:55 a.m. assistant director of operations (ADO), after reviewing the plan with the surveyor and registered nurse (RN)-A, acknowledged shortcomings with the current plan and	0 680		

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0 680	Continued From page 18 documentation of the plan. The ADO also indicated their current plan lacked a coherency of the main required parts, including the overall vulnerability assessment, a collection of policies, a communication plan and the training, testing and necessary documentation. The ADO stated they will work to revise, update and improve the plan to ensure it meets the new state requirements of emergency preparedness. The licensee's 8.01 Disaster Planning and Emergency Preparedness Plan policy revised July 25, 2021, indicated the licensee will have in place a written plan of action to facilitate the management of clients care and services in response to a natural disaster or other emergencies that may disrupt their ability to provide care and/or services. The policy indicated, among other items, there would be: a hazard, vulnerability analysis, and based on that a disaster plan for events with high probability of risk, and at minimum to include plans for tornadoes, fires, snow/ice storms; an appointed/designated person in charge; staff training during orientation on the emergency plan. The policy did not address the formation of a communication plan or specify or include details of staff training and required exercises/drills. The policy did not address numerous requirements identified in Appendix Z, as noted above. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 680		
0 900 SS=D	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or	0 900		

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0 900	Continued From page 19 provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop and execute	0 900		

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0 900	Continued From page 20 a written contract, prior to the start of services, with the required content to provided assisted living services for one of five residents (R5) 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: R5 was admitted for services on August 4, 2021. R5's Service Plan dated August 4, 2021, indicated the resident's services included, but were not limited to, activity coordination, assistance with activities of daily living, transferring, anti-embolytic stocking care (treatment), medication management and housekeeping assistance with socialization, cares, ambulation/exercise and behavior monitoring. On October 11, 2021, at approximately 2:28 p.m. R5 was observed being transferred with the assistance from staff into the bathroom with use of a mechanical lift, and subsequently following toileting, transferred back to a recliner. R5's record lacked a written contract with the following required content: (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident.	0 900		

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0 900	Continued From page 21 (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. On October 13, 2021, at approximately 2:29 p.m. registered nurse (RN)-A talked about R5's assisted living contract and verified the R5's record lacked a current, signed assisted living contract. RN-A stated R5 transferred to this place from a sister facility and told the family there were new papers to sign; but that paperwork was not received by the licensee. RN-A stated they would reach out to the family to get the required paperwork signed and put in the chart.	0 900		

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0 900	Continued From page 22 A policy regarding the requirements for an assisted living contract and when it needs to be executed and signed was requested, but none was received. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	0 900		
01610 SS=D	144G.70 Subd. 2 Initial reviews, assessments, and monitoring (a) Residents who are not receiving any services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the registered nurse completed an initial, comprehensive nursing assessment prior to signing of assisted living contract or providing	01610		

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01610	Continued From page 23 services for one of four residents (R5) 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: R5 was admitted for services on August 4, 2021, with diagnoses including, but not limited to, atrial fibrillation (type of irregular heartbeat, typically causing heart to beat too quickly) and history or recurrent trans-ischemic attacks (temporary period of symptoms similar to stroke: a temporary blockage of blood flow to the brain.). On October 11, 2021, at approximately 2:28 p.m. R5 was observed being transferred with staff assistance into the bathroom with use of a mechanical lift, and subsequently following toileting, transferred back to a recliner. R5's record lacked documentation a facility registered nurse (RN) conducted an initial assessment on R5 prior to or upon being admitted to the facility. On October 13, 2021, at approximately 10:58 a.m. RN-A stated R5 was transferred here from a sister facility, and acknowledged there was no admission assessment completed for the resident when she arrived. RN-A stated "I learned something" regarding assessments under the new rule. RN-A expressed understanding that because the resident was admitted to a new facility, R5 also required a new admission assessment at this location. The licensee's Nursing Assessments, Delegated	01610		

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01610	Continued From page 24 Nursing Services and Supervision Policy and Procedures policy revised February 20, 2020, was outdated, as the policy referenced older statutes. The policy indicated the registered nurse (RN) would conduct an initial assessment of the resident's physical and cognitive needs within five days of the initiation of home care services. The new regulations require an initial, comprehensive assessment by a registered nurse be completed when the prospective client executes an assisted living contract or on the date the client moves in, whichever is earlier. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	01610		
01620 SS=D	144G.70 Subd. 2 Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under	01620		

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01620	Continued From page 25 section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the registered nurse completed a follow-up assessment within 14 days of start of services for two of five residents (R5, R1) 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: R5 R5 was admitted for services on August 4, 2021, with diagnoses including, but not limited to, atrial fibrillation (type of irregular heartbeat condition, typically causing heart to beat too quickly) and history of recurrent trans-ischemic attacks (temporary period of symptoms, similar to stroke; a temporary blockage of blood flow to the brain). On October 11, 2021, at approximately 2:28 p.m. R5 was observed being transferred with staff assistance into the bathroom with use of a mechanical lift, and subsequently following toileting, transferred back to a recliner. R5's record lacked documentation a facility registered nurse (RN) conducted a reassessment of the resident on or before August 18th, or within	01620		

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DIAMOND WILLOW OF LESTER PARK	6353 EAST SUPERIOR STREET DULUTH, MN 55804

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01620	Continued From page 26 14 days of the start of services. R1 R1 was admitted for services on August 6, 2021, with diagnoses including, but not limited to, type 2 diabetes with diabetic polyneuropathy, atrial fibrillation, hematuria and Alzheimer's dementia. On October 12, 2021, between 7:30 a.m. and 10:00 a.m. unlicensed personnel (ULP)-A administered medications to R1. R1's record included an initial assessment by the registered nurse (RN) dated August 6, 2021. R1's record lacked a reassessment by the RN on or before August 20, or within 14 days of the start of services. On October 13, 2021, at approximately 10:58 a.m. RN-A stated R5 and R1 transferred here from a sister facility. RN-A verified she had not completed required follow-up assessments within 14 days of their admission for either R5 or R1. RN-A stated the assessments for these residents obviously "were missed." The licensee's Nursing Assessments, Delegated Nursing Services and Supervision Policy and Procedures policy revised February 20, 2020, was not up-to-date, as the policy referenced older statutes. The policy indicated the registered nurse (RN) would reassess each client on an on-gong basis, and include monitoring and assessment no later than 14 days after the initial assessment, and then not to exceed 90 days from the last date of assessment. The new regulations require a follow-up assessment by the RN be conducted no more than 14 calendar days after initiation of services.	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28545	A. BUILDING: _____ B. WING _____	10/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAMOND WILLOW OF LESTER PARK	6353 EAST SUPERIOR STREET DULUTH, MN 55804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01620	Continued From page 27 No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	01620		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors Subd. 8.Notice to visitors. (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the licensee failed to ensure a required notice was posted at the main entry way of the facility to display statutory language to disclose electronic monitoring activity. This had the potential to affect the 21 current residents, staff and any visitors to the facility. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include:	03090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28545	A. BUILDING: _____ B. WING _____	10/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAMOND WILLOW OF LESTER PARK	6353 EAST SUPERIOR STREET DULUTH, MN 55804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
03090	Continued From page 28 On October 11, 2021, at approximately 10:10 a.m. surveyors entered the facility and at the Gitchee Gammi entry way there was no signage to notify visitors of electronic monitoring. On October 12, 2021, at approximately 7:15 a.m. at the Lester River entryway, there was also no observed signage related to electronic monitoring displayed. On October 13, 2021, at approximately 10:39 a.m. registered nurse (RN)-A verified the lack of signage at the facility's two entrances regarding electronic monitoring. RN-A stated maintenance will have to put that sign up, too. The licensee's 1.51 Electronic Monitoring policy effective February 2, 2020, indicated the licensee will support the use of electronic monitoring by our residents and representatives. The policy directed under #1 of the procedure: Signs are installed at each facility entrance accessible to visitors that state: "Electronic monitoring devices, including security cameras and audio devices, may be present to records persons or activities." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	03090		

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

Type: Full
Date: *10/11/21*
Time: 10:30:00
Report: 8010211179

Food and Beverage Establishment Inspection Report

Location:
Diamond Willow Lester Park
6353 East Superior Street
Duluth, MN55804
St. Louis County, 69

Establishment Info:
ID #: N006353
Risk:
Announced Inspection: No

License Categories:

Expires on: 12/31/21

Operator:

Brenda Port
Phone #: 2185258093
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.

RAW SHELL EGGS WERE STORED ABOVE READY TO EAT FOODS IN THE KITCHEN REFRIGERATOR. RAW EGGS WERE MOVED TO THE LOWEST SHELF.

Corrected on Site

3-500D Microbial Control: disposition of food

3-501.18A ** Priority 1 **

MN Rule 4626.0405A Discard all TCS food prepared in the establishment or opened commercially packaged food when the time exceeds 7 days from the preparation or opening date or if the container or package is not marked.

SLICED DELI TURKEY DATE MARK WAS 10/4. BE SURE TO COUNT THE DAY THAT THE PACKAGE IS OPENED AS DAY ONE OF THE 7 DAYS. TURKEY WAS DISCARDED BY REBECCA.

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: 10/11/21

4-300 Equipment Numbers and Capacities

4-302.12B ** Priority 2 **

MN Rule 4626.0705B Provide a readily accessible food temperature measuring device with a small diameter probe to measure the temperature in thin foods such as meat patties and fish fillets.

PROVIDE A THERMOMETER WITH A THIN PROBE IN THE KITCHEN AREA.

Comply By: 10/11/21

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 IN THE KITCHEN AREA TO TEST THE CONCENTRATION OF THE QUATERNARY AMMONIUM SANITIZER.
QUATERNARY AMMONIUM SANITIZER CONCENTRATION IS BETWEEN 200-400 PPM.

Comply By: 10/11/21

Surface and Equipment Sanitizers

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

Hot Water: = at Degrees Fahrenheit
Location: TEMP TAPES RECORDED CHANGE OF COLOR AT 180F.
Violation Issued: No

Food and Equipment Temperatures

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

Process/Item: Upright Cooler
Temperature: 41 Degrees Fahrenheit - Location: SLICED DELI TURKEY-FRIGIDAIRE KITCHEN
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 41 Degrees Fahrenheit - Location: MILK-FRIGIDAIRE STOREROOM
Violation Issued: No

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

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

Type: Full
Date: *10/11/21*
Time: 10:30:00
Report: 8010211179
Diamond Willow Lester Park

Food and Beverage Establishment Inspection Report

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

COMMENTS:

DISCUSSED THE EXCLUSION OF EMPLOYEES ILL WITH VOMITING OR DIARRHEA FROM THE FOOD ESTABLISHMENT FOR 24 HOURS AFTER SYMPTOMS ARE GONE WITH BRENDA, JOANIE AND REBECCA.

DISCUSSED PREPARING TCS (TIME/TEMPERATURE CONTROL FOR SAFETY FOOD) FOODS ONLY FOR SAME DAY SERVICE AND LEFTOVER FOODS ARE NOT TO BE RESERVED TO RESIDENTS.

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 8010211179 of 10/11/21.

Certified Food Protection Manager: Rebecca J. Freeman

Certification Number: FM91334 Expires: 09/14/24

Inspection report reviewed with person in charge and emailed.

Signed: _____

Brenda Port
Assistant Director of Operatio

Signed: _____

8010

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

Report #: 8010211179

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	3	Date	10/11/21
No. of Repeat RF/PHI Categories Out	0	Time In	10:30:00
Legal Authority MN Rules Chapter 4626		Time Out	

	Address	City/State	Zip Code	Telephone
Diamond Willow Lester Park	6353 East Superior Street	Duluth, MN	55804	2185258093

License/Permit #	Permit Holder	Purpose of Inspection	Est Type	Risk Category
N006353	Brenda Port	Full		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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

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

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

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

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

GOOD RETAIL PRACTICES

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

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

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

			COS	R
		Proper Use of Utensils		
43		In-use utensils: properly stored		
44		Utensils, equipment & linens: properly stored, dried, & handled		
45		Single-use/single service articles: properly stored & used		
46		Gloves used properly		
		Utensil Equipment and Vending		
47		Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48	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:** 10/11/21

Inspector (Signature)