Electronically Delivered

February 12, 2025

Licensee
Diamond Willow Assisted Living
949 Sw 11th Avenue
Grand Rapids, MN  55744

RE:  Project Number(s) SL24815016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on January 8, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the

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

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

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

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

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

If you have any questions, please contact me.

Sincerely,

Jessie Chenze

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

HHH

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 24815 | A. BUILDING: _____ B. WING _____ | 01/08/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| DIAMOND WILLOW ASSISTED LIVING | 949 SW 11TH AVENUE GRAND RAPIDS, MN 55744 |

| (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 |
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| 0 000 | Initial Comments<br><br>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S)<br><br>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey.<br><br>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.<br><br>INITIAL COMMENTS:<br><br>SL24815016<br><br>On January 6, 2025, through January 8, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 25 residents receiving services under the Assisted Living Facility with Dementia Care license. | 0 000 | Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction.<br>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.<br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.<br>THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3. | |
| 0 480 SS=F | 144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services<br><br>(a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter | 0 480 | | |

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| 0 480 | Continued From page 1<br>4626.<br>(b) For an assisted living facility with a licensed capacity of ten or fewer residents:<br>(1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation;<br>(2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570;<br>(3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage;<br>(4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink;<br>(5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition;<br>(6) notwithstanding Minnesota Rules, part | 0 480 | | |

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| 0 480 | Continued From page 2<br><br>4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code.<br><br>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).<br><br>The findings include:<br><br>Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated January 6, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.<br><br>TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates. | 0 480 | | |

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| 0 485 | Continued From page 3 | 0 485 | | |
| 0 485 SS=C | 144G.41 Subdivision 1.a (a) Minimum requirements; required food services<br><br>All assisted living facilities must offer to provide or make available at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes. The facility must not require a resident to include and pay for meals in the resident's contract.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure weekly menus were made available to the residents. This had the potential to affect all 25 residents.<br><br>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).<br><br>The findings include:<br><br>During the entrance conference on January 6, 2025, at approximately 9:30 a.m., licensed | 0 485 | | |

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| 0 485 | Continued From page 4<br><br>assisted living director in residency/clinical nurse supervisor (LALDR/CNS)-A stated the licensee provided three meals daily to include fresh fruits and vegetables, snacks were offered, residents had input with menus, and residents were made aware of changes to the menu.<br><br>During a tour of the facility on January 6, 2025, at approximately 9:50 a.m., the surveyor observed that the facility was separated into two units (Mississippi Suites, Eagle Pines) joined by a "link" (common area). In both houses the surveyor observed a single-day menu written on a white board near each kitchen. In Eagle Pines the surveyor observed a hanging rack near the nurse's office with a slot titled, menus, which was empty.<br><br>On January 6, 2025, at 9:56 a.m., LALDR/CNS-A stated the weekly menu was not normally accessible for the residents.<br><br>The licensee's Food Service & Menu Planning policy dated January 1, 2025, noted menus would be prepared at least one week in advance and made available to all residents.<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 485 | | |
| 0 510 SS=F | 144G.41 Subd. 3 Infection control program<br><br>(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.<br>(b)The facility's infection control program must be | 0 510 | | |

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| 0 510 | Continued From page 5<br><br>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.<br>(c) The facility must maintain written evidence of compliance with this subdivision.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure infection control standards were followed for personal care products for the residents. In addition, the licensee failed to ensure reusable equipment was cleaned in-between resident use. Further, the licensee failed to ensure infection control standards were followed by one of two unlicensed personnel (ULP-E) while providing assistance to residents.<br><br>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).<br><br>The findings include:<br><br>The assisted living was a secured building with a current censes of 25 residents. The facility was separated into two units (Mississippi Suites, Eagle Pines) joined by a "link" (commons area).<br><br>PERSONAL CARE PRODUCTS | 0 510 | | |

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| 0 510 | Continued From page 6<br><br>MISSISSIPPI SUITES<br>On January 6, 2025, at 12:12 p.m., the surveyor and registered nurse (RN)-B observed a plastic storage unit positioned between the toilet and the spa tub which included several drawers in the bathroom/tub/spa room. The drawers contained several unmarked/unlabeled personal care products such as reusable stick deodorants and antiperspirants. In addition, an opened unmarked/unlabeled container of vapor rub was observed. The items did not contain a resident name identifying who they belonged to.<br><br>EAGLE PINES<br>On January 6, 2025, at 12:20 p.m., the surveyor and RN-B observed a plastic storage unit positioned between the toilet and the spa tub which included several drawers in the bathroom/tub/spa room. The drawers contained several unmarked personal care products such as reusable stick deodorants and antiperspirants. In addition, an opened unmarked container of therapeutic dry skin cream (wide top container) was observed. RN-B stated personal care products should be labeled with resident's name.<br><br>On January 6, 2025, at 2:36 p.m., licensed assisted living director in residency/clinical nurse supervisor (LALDR/CNS)-A stated she would have the house coordinator go through the personal care products and indicate which resident used which item. LALDR/CNS-A added she did not know which items belonged to each resident. LALDR/CNS-A stated personal care products need to be labeled for whom the item belonged to and was used on. LALDR/CNS-A confirmed not labeling personal care products for individual use was an infection control concern.<br><br>REUSABLE EQUIPMENT | 0 510 | | |

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| 0 510 | Continued From page 7<br><br>MISSISSIPPI SUITES<br>On January 7, 2025, at 7:59 a.m., the surveyor observed ULP-I take a wrist blood pressure (BP) cuff machine out of a medication cart. ULP-I took the BP machine to R11's room. While R11 was laying in bed, ULP-I placed the BP cuff on R11's right wrist and asked R11 to place his wrist on his chest. ULP-I obtained a BP reading of 122/50 for R11. ULP-I returned the BP cuff to the medication cart. The surveyor did not observe ULP-I sanitize the BP cuff prior to or after use.<br><br>On January 7, 2025, at 8:13 a.m., ULP-I stated she was trained to return the BP cuff to medication cart after completing the task. ULP-I said she was not aware of any BP cuff cleaning requirement.<br><br>EAGLE PINES<br>On January 7, 2025, at 8:37 a.m., ULP-K asked ULP-J if there was a wrist BP cuff in the medication cart ULP-J was positioned near. ULP-J removed a BP wrist cuff machine and handed the BP cuff to ULP-K. ULP-K removed an SpO2 monitor (device to measure blood oxygen level) from the medication cart near her. ULP-K took the SpO2 monitor and the BP cuff to R8's room. ULP-K placed the BP wrist cuff machine onto R8's right wrist and obtained a reading of 116/60. ULP-K placed the SpO2 monitor onto the middle finger of R8's right hand and obtained a reading of 93%. ULP-K handed the BP cuff to ULP-J and returned the SpO2 monitor to the medication cart. The surveyor did not observe ULP-K sanitize the BP cuff or the SpO2 monitor prior to or after use.<br><br>On January 7, 2025, at 8:46 a.m., ULP-K stated she should have cleaned the SpO2 monitor after use, and said, "my bad." ULP-K said they (ULPs) | 0 510 | | |

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| 0 510 | Continued From page 8<br><br>don't do anything for the BP cuff (sanitizing). ULP-K asked ULP-J about the health monitoring equipment used and whether cleaning was required. ULP-J stated she was "not sure", and added they (ULPs) should have "wipes here" (near medication cart) to wipe down the health monitoring equipment after use.<br><br>On January 8, 2025, at 10:49 a.m., LALDR/CNS-A stated health monitoring equipment should be disinfected after use with wipes, and then allowed to dry.<br><br>GAIT BELT<br>On January 6, 2025, at 2:37 p.m., the surveyor observed ULP-E remove a gait belt from R4's walker and place the gait belt around R5's waist. ULP-E and ULP-F assisted R5 from the wheelchair into a recliner. ULP-E removed the gait belt from R5's waist and returned the gait belt to R4's walker.<br><br>On January 6, 2025, at 2:40 p.m., ULP-E stated she should have gone to get R5's gait belt and not have used another resident's gait belt. ULP-E stated she did not want to leave R5 "out there" (in common's area). ULP-E added she did not want R5 to fall, as R5 may have attempted to self-transfer into the recliner.<br><br>On January 6, 2025, at 2:49 p.m., LALDR/CNS-A stated each resident should have their own gait belt, and added gait belts should not be shared among residents.<br><br>The licensee's Infection Control policy dated January 1, 2025, noted the licensee's infection control program would be consistent with current guidelines from CDC (Center for Disease Control) for prevention control in long-term care facilities, | 0 510 | | |

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| 0 510 | Continued From page 9<br>where applicable in assisted living facilities.<br><br>The licensee's Cleaning of Shared Medical Equipment policy dated January 1, 2025, noted the licensee would implement and maintain processes to ensure all reusable resident care equipment was routinely cleaned, and when appropriate, disinfected, before and after reuse.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 510 | | |
| 0 780 SS=F | 144G.45 Subd. 2 (a) (1) Fire protection and physical environment<br><br>for dwellings or sleeping units, as defined in the State Fire Code:<br>(i) provide smoke alarms in each room used for sleeping purposes;<br>(ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms;<br>(iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics;<br>(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<br>(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 10<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee failed to comply with the requirements of the Minnesota State Fire Code. This had the potential to directly affect all residents, staff, and visitors.<br><br>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).<br><br>Findings include:<br><br>On a facility tour on January 7, 2025, from 11:00 a.m. to 12:00 a.m., with maintenance (M)-G, the surveyor made the following observations of non-compliance with the requirements of the Minnesota State Fire Code (MSFC) in Minnesota Rules Chapter 7511:<br><br>CARBON MONOXIDE ALARMS/ DETECTION<br><br>A carbon monoxide detection system was installed and tied into the building fire alarm system for notification of the presence of carbon monoxide. There was one detector installed in each of the boiler rooms and tied into the building fire alarm system for notification.<br><br>There were single station carbon monoxide alarms installed by the fireplaces that were not tied into the building fire alarm system for | 0 780 | | |

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|---|---|---|---|
| | 24815 | A. BUILDING: _____ B. WING _____ | 01/08/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| DIAMOND WILLOW ASSISTED LIVING | 949 SW 11TH AVENUE GRAND RAPIDS, MN 55744 |

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|---|---|---|---|---|
| 0 780 | Continued From page 11<br><br>notification. All required carbon monoxide detectors are required to be installed between each source of carbon monoxide and tied into the building fire alarms system.<br><br>When carbon monoxide alarms are not tied into the building fire alarm system, carbon monoxide alarms are required to be installed within ten feet of all sleeping rooms.<br><br>Carbon monoxide alarm and detections systems in existing buildings are required to be installed in accordance with MSFC in Minnesota Rules Chapter 7511.<br><br>DOOR LOCKING<br><br>The marked interior exit door magnetic locking device was not working properly making the door difficult to open while traveling from the Eagle Pine side into the link between Eagle Pine and Mississippi wings. All marked exit doors are required to be readily openable from the egress side without the use of keys, tools or special knowledge. During the tour M-G, stated a contractor was called to repair the problem.<br><br>The marked exterior exit door leading outside to the front of the building from link near Eagle Pine Wing magnetic locking device would not open with the numerical keypad as required when activated by M-G.<br><br>FIRE SPRINKLER SYSTEM MAINTENANCE<br><br>The provided fire sprinkler maintenance record dated February 2024, indicated the fire sprinkler system was due for a five-year test but did not indicate the test was completed as required. Fire sprinkler systems are required to be tested and | 0 780 | | |

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|---|---|---|---|---|
| 0 780 | Continued From page 12<br><br>maintained in accordance with MSFC in Minnesota Rules Chapter 7511.<br>During the facility tour M-G, verified the above listed observations while accompanying on the tour.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days. | 0 780 | | |
| 0 810 SS=F | 144G.45 Subd. 2 (b-f) Fire protection and physical environment<br><br>(b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to:<br>(1) location and number of resident sleeping rooms;<br>(2) staff actions to be taken in the event of a fire or similar emergency;<br>(3) fire protection procedures necessary for residents; and<br>(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.<br>(c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter.<br>(d) Fire safety and evacuation plans shall be readily available at all times within the facility.<br>(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.<br>(f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill | 0 810 | | |

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|---|---|---|---|
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| 0 810 | Continued From page 13<br><br>every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review, the licensee failed to develop the fire safety and evacuation plan with required content and provide required training and drills. This had the potential to directly affect all residents, staff, and visitors.<br><br>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 potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>On January 7, 2025, at 10:10 a.m., licensed assisted living director in residence/ clinical nurse supervisor (LALDR/CNS)-A, provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility.<br><br>FIRE SAFETY AND EVACUATION PLAN<br><br>The licensee provided FSEP, failed to include the following:<br><br>The available FSEP included standard employee procedures, but failed to provide specific | 0 810 | | |

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|---|---|---|---|---|
| 0 810 | Continued From page 14<br><br>employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan failed to include specific detailed procedures for employees to take in the event of a fire or similar emergency in this facility. There were three different documents provided containing conflicting procedures for employees.<br><br>The available FSEP did not identify specific fire protection actions for residents as evident by not providing procedures for residents to take in this specific facility in the event of a fire or similar emergency in writing in the FSEP.<br><br>During an interview on January 8, 2025, at 10:30 a.m., LALDR/CNS-A, stated they have been working on updating the FSEP employee procedures and there were not procedures for residents to take in the event of a fire or similar emergency in writing in the plan.<br><br>TRAINING<br><br>Record review of the available documentation indicated the licensee failed to provide training to employees on the FSEP upon hire and at least twice per year as evident by providing documentation the employee training provided was general fire safety training and not specific to the FSEP for this facility.<br><br>Record review of the available documentation indicated the licensee failed to provide evacuation training to residents at least once per year as evident by not providing documentation the residents were provided FSEP training as required.<br><br>During an interview on January 8, 2025, at 10:45 | 0 810 | | |

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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|---|---|---|---|---|
| 0 810 | Continued From page 15<br><br>a.m., LALDR/CNS-A, stated training provided to employees was general fire safety training and not specific to the facility FSEP. LALDR/CNS-A also stated documentation was not available for FSEP training provided to residents.<br><br>DRILLS<br><br>Record review of the available documentation indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month as evident by providing documentation a drill was completed in January 2023, May 2024, and January 2025 only.<br><br>No further documentation was provided.<br><br>During an interview on January 8, 2025, at 10:45 a.m., LALDR/CNS-A, stated evacuation drills were completed in January 2023, May 2024 and January 2025 only.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 0 810 | | |
| 01420 SS=F | 144G.62 Subd. 2 Delegation of assisted living services<br><br>(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 the unlicensed personnel has not regularly performed the delegated assisted living task for a period of | 01420 | | |

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|---|---|---|---|
| | 24815 | A. BUILDING: _____ B. WING _____ | 01/08/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
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|---|---|---|---|---|
| 01420 | Continued From page 16<br><br>24 consecutive months, the unlicensed personnel 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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) provided written instructions in the resident's record for the delegated tasks provided by the unlicensed personnel (ULP) for two of two residents (R5, R9) whose delegated tasks included floor/fall mats and personal alarms.<br><br>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).<br><br>The findings include:<br><br>R5<br>R5's diagnoses included moderate dementia, anxiety, near syncope (fainting), and urinary frequency.<br><br>R5's service plan dated May 7, 2024, indicated R5 received the following services: medication administration, dressing, eating, grooming, hearing aid assist, mobility, toileting, transfer assist, oral care, fall coordination, and | 01420 | | |

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|---|---|---|---|
| | 24815 | A. BUILDING: _____ B. WING _____ | 01/08/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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|---|---|---|---|---|
| 01420 | Continued From page 17<br>housekeeping services.<br><br>R5's Master Care Plan dated December 31, 2024, included:<br>-August 5, 2024, fall mat next to the side of the bed<br>-August 8, 2024, motion sensor at the end of the resident's bed at night when she is sleeping<br>-October 30, 2024, pressure pad under the staff (sic) whenever she is sitting at all times as a fall preventative including recliner in the living/common spaces<br>-November 6, 2024, education to staff about residents with anxiety, restlessness, and pressure pads or alarms for falls that they should not be brought back to there (sic) rooms and left alone unless they have been given medication for relaxation purposing<br>-November 7, 2024, the resident is care planned to sleep on the floor at night next to her bed to prevent falls from her bed at night<br>-December 31, 2024, the resident was given a different pressure pad, and new batteries were placed in the alarm box for the pressure pad.<br><br>R5's assessment dated December 31, 2024, included the above information, and noted:<br>-resident is currently care planned to sleep on the floor for safety reasons<br>-pressure cushion/mattress pressure pad<br>-alarms in bed, in wheelchair at all times due to fall risk.<br><br>R5's Service Recap Summary dated December 1, 2024, through December 31, 2024, included:<br>-alarm check: 6:30 a.m., 2:30 p.m., 10:30 p.m.<br>-fall coordination 6:30 a.m., 2:30 p.m., 10:30 p.m.<br>-bed mobility/repositioning: 6:30 a.m., 2:30 p.m., 10:30 p.m. | 01420 | | |

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|---|---|---|---|
| | 24815 | A. BUILDING: _____ B. WING _____ | 01/08/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| DIAMOND WILLOW ASSISTED LIVING | 949 SW 11TH AVENUE GRAND RAPIDS, MN 55744 |

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| 01420 | Continued From page 18<br><br>On January 6, 2025, at 2:37 p.m., the surveyor observed ULP-E attach a gait belt around R5's waist. ULP-E and ULP-F assisted R5 to a standing position. ULP-E commented R5's alarm had not been turned off and the alarm sounded as the two ULP stood R5 and transferred R5 into a recliner.<br><br>On January 7, 2025, at 7:20 a.m., the surveyor observed R5 laying on a mattress on the floor in R5's room. There was a hospital bed along the wall, a mattress on the floor and a floor/fall matt positioned next to the mattress on the floor. There was a new pressure "tamper-proof chair and bed patient alarm) with instructions on a side table and what appeared to be a motion type of alarm visible on bed.<br><br>FLOOR/FALL MAT<br>R5's RTasks (computer system used) safety check, active on November 4, 2024, included:<br>-place mat on floor alongside bed. To be in place while resident is in bed.<br><br>PERSONAL ALARM<br>R5's RTasks alarm check, active November 4, 2024, included:<br>-check all client (resident) alarms at the beginning of each shift while rounding with previous shift. Check that client (resident) alarm is turned on high and properly placed or attached. Client (resident) has chair pressure pad alarm.<br><br>R5's record lacked written instructions delegated by the RN to ULPs related to monitoring the condition of the fall mat, the working condition of the personal alarm, or when to notify the RN if issues arise.<br><br>R9 | 01420 | | |

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|---|---|---|---|
| | 24815 | A. BUILDING: _____ B. WING _____ | 01/08/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| DIAMOND WILLOW ASSISTED LIVING | 949 SW 11TH AVENUE GRAND RAPIDS, MN 55744 |

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|---|---|---|---|---|
| 01420 | Continued From page 19<br><br>R9's diagnoses included heart disease, muscle weakness, chronic pain, lack of coordination, macular degeneration (vision impairment resulting from deterioration of the central part of the retina, affecting central vision), and history of falling.<br><br>R9's service plan dated January 3, 2025, indicated R9 received the following services: transfer assist, alarm check, bed mobility, repositioning, behavior management, and housekeeping services.<br><br>R9's Service Recap Summary dated December 1, 2024, through December 31, 2024, included:<br>-alarm check: 6:30 a.m., 2:30 p.m., 10:30 p.m.<br>-bed mobility/repositioning: 6:30 a.m., 2:30 p.m., 10:30 p.m.<br><br>On January 7, 2025, at 9:51 a.m., the surveyor observed ULP-J pick up a floor/fall mat (covered with a plastic covering) positioned along R9's bed and place it near a chair in R9's room.<br><br>On January 7, 2025, at 9:52 a.m., the surveyor observed ULP-J dress R9's lower body. ULP-J summonsed ULP-L. ULP-J and ULP-L moved a fall/floor mat from along R9's bed and assisted R9 out of bed.<br><br>On January 8, 2025, at approximately 11:30 a.m., the surveyor observed R9 sitting in a recliner in the common's area. There was a string/cord to an alarm visible.<br><br>FLOOR/FALL MAT<br>R9's resident notes-nurse dated December 20, 2024, noted:<br>-the resident's wife was notified today that the current foam fall mat that the resident has in his | 01420 | | |

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|---|---|---|---|
| | 24815 | A. BUILDING: _____ B. WING _____ | 01/08/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| DIAMOND WILLOW ASSISTED LIVING | 949 SW 11TH AVENUE GRAND RAPIDS, MN 55744 |

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|---|---|---|---|---|
| 01420 | Continued From page 20<br><br>room is not up to state requirements and that a new one needs to be provided by her as they are private pay if she would like us to continue to use one for him as a fall intervention. The resident's wife was informed that the fall mat will be pulled from his room until a new one can be provided. She reported once she is feeling better, she will order one.<br><br>PERSONAL ALARM<br>R9's RTasks alarm check, active August 7, 2024, included:<br>-check all client (resident) alarms at the beginning of each shift while rounding with previous shift. Check that client (resident) alarm is turned on high and properly placed or attached. Ensure Tab alarm on and functioning properly.<br><br>R9's record lacked written instructions delegated by the RN to ULPs related to monitoring the condition of the fall mat, the working condition of the personal alarm, or when to notify the RN if issues arise.<br><br>On January 8, 2025, at 10:20 a.m., licensed assisted living director in residency/clinical nurse supervisor (LALDR/CNS)-A stated R5 and R9 have many fall interventions. LALDR/CNS-A said the instructions in R5 and R9's records for alarms were "very generic." LALDR/CNS-A confirmed R5 and R9's records required more information and did not include specific directions for device use, to include R5's fall mat was to be placed by mattress on the floor and alarm was to be used at all times. LALDR/CNS-A stated R9's record did not include instructions for R9's floor/fall mat for staff as she had waited to add instructions once new mat arrived. CNS-A said she was going to remove the floor/fall mat; however, a makeshift cover was found and applied to the mat. | 01420 | | |

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|---|---|---|---|
| | 24815 | A. BUILDING: _____ B. WING _____ | 01/08/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| DIAMOND WILLOW ASSISTED LIVING | 949 SW 11TH AVENUE GRAND RAPIDS, MN 55744 |

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|---|---|---|---|---|
| 01420 | Continued From page 21<br><br>LALDR/CNS-A confirmed there were not directions in R5 or R9's records for alarms or floor/fall mat as what to report to nursing, such as rips in mats or concerns related to use.<br><br>The licensee's Delegation of Assisted Living Services policy dated January 1, 2025, noted the registered nurse or licensed health professional would document instructions for the delegated tasks in the resident's records. Specify, in writing, specific instructions for each resident and documented those instructions in the resident's record.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 01420 | | |
| 01550 SS=D | 144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED<br><br>(4) staff who do not provide direct care, including maintenance, housekeeping, and food service staff, must have at least four hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; and<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure employees that did not provide direct care received at least two hours of annual dementia training for one of one employee (maintenance (M)-G). | 01550 | | |

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|---|---|---|---|
| | 24815 | A. BUILDING: _____ B. WING _____ | 01/08/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| 01550 | Continued From page 22<br><br>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).<br><br>The findings include:<br><br>During the entrance conference on January 6, 2025, at 9:35 a.m., M-G was introduced as the maintenance staff for the facility. Licensed assisted living director in residency/clinical nurse supervisor (LALDR/CNS)-A and registered nurse (RN)-B stated they would let M-G know he would be needed at the site on January 7, 2025, to complete a tour of the facility.<br><br>The assisted living held an Assisted Living with Dementia Care license and was a secured building with a current censes of 25 residents. The facility was separated into two units (Mississippi Suites, Eagle Pines) joined by a "link" (commons area).<br><br>M-G was hired on March 27, 2023, to perform maintenance at the facility.<br><br>On January 5, 2025, at 9:35 a.m., the surveyor observed M-G working on the interior "link" door in the Eagle Pines unit.<br><br>On January 5, 2025, at 10:10 a.m., RN-B noted via email communication M-G had not completed at least two hours of annual dementia training.<br><br>The licensee's Additional Dementia Staff Training | 01550 | | |

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|---|---|---|---|
| | 24815 | A. BUILDING: _____ B. WING _____ | 01/08/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| DIAMOND WILLOW ASSISTED LIVING | 949 SW 11TH AVENUE GRAND RAPIDS, MN 55744 |

| (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 |
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| 01550 | Continued From page 23<br><br>policy dated January 1, 2025, noted it was the policy of the [licenses] that staff who worked with residents with Alzheimer's disease and other dementia's had proper training for the tasks assigned.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) days | 01550 | | |
| 01620 SS=D | 144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring<br><br>(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.<br>(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.<br>(e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. | 01620 | | |

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|---|---|---|---|
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| 01620 | Continued From page 24<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) completed a fall matt assessment for one of two residents, (R9).<br><br>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).<br><br>The findings include.<br><br>R9's diagnoses included heart disease, muscle weakness, chronic pain, lack of coordination, macular degeneration (vision impairment resulting from deterioration of the central part of the retina, affecting central vision), and history of falling.<br><br>R9's service plan dated January 3, 2025, indicated R9 received the following services: transfer assist, alarm check, dressing and grooming assist, medication administration, repositioning, behavior management, and housekeeping services.<br><br>On January 7, 2025, at 9:51 a.m., the surveyor observed unlicensed personnel (ULP)-J pick up a floor/fall mat (cushioned mat covered with a plastic covering) positioned along R9's bed and place the mat near a chair in R9's room.<br><br>On January 7, 2025, at 9:52 a.m., the surveyor | 01620 | | |

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|---|---|---|---|
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
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| 01620 | Continued From page 25<br><br>observed ULP-J dress R9's lower body. ULP-J summonsed ULP-L. ULP-J and ULP-L assisted R9 into a wheelchair.<br><br>R9's Resident Notes-Nurse, dated December 20, 2024, noted:<br>-the resident's wife was notified today that the current foam fall mat that the resident has in his room is not up to state requirements and that a new one needs to be provided by her as they are private pay if she would like us to continue to use one for him as a fall intervention. The resident's wife was informed that the fall mat will be pulled from his room until a new one can be provided. She reported once she is feeling better, she would order one.<br><br>On January 7, 2025, at 2:08 p.m., licensed assisted living director in residency/clinical nurse supervisor (LALDR/CNS)-A stated she did not have a floor mat/ fall mat assessment for R9. LALDR/CNS-A added she was not sure why it (assessment) was not "there" (located) in R9's record. LALDR/CNS-A confirmed the floor/fall mat in place, surface was "slippery."<br><br>On January 7, 2025, at 2:25 p.m., LALDR/CNS-A stated she did not remove the fall mat as a cover was found for the mat (but was slippery).<br><br>On January 8, 2025, at 11:48 a.m., LALDR/CNS-A stated she found the fall risk assessment for R9 that included a fall/floor matt assessment.<br><br>On January 8, 2025, at 5:42 p.m., via email communication the surveyor requested R9's fall report which included R9's floor mat/ fall mat addition/ assessment. | 01620 | | |

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|---|---|---|---|
| | 24815 | A. BUILDING: _____ B. WING _____ | 01/08/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| 01620 | Continued From page 26<br><br>On January 9, 2025, via email communication LALDR/CNS-A noted she reviewed R9's record and R9's fall mat was not an intervention on any of R9's falls. The fall mat was an added safety measure that the wife requested and brought in on her own. "We had a conversation about it (mat) and it was implemented to be used and added for staff to use while he was in bed."<br><br>Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0140, Subp. 2, effective October 2022, a nursing assessment or reassessment under Minnesota Statutes, section 144G.70, subdivision 2, paragraphs (b) and (c), must be conducted on a prospective resident or resident receiving any of the assisted living services identified in Minnesota Statutes, section 144G.08, subdivision 9, clauses (6) to (12).<br>B. The nursing assessment or reassessment under item A must:<br>(1) address part 4659.0150, subpart 2, items A to N;<br>(2) be conducted in person unless an exception under Minnesota Statues, section 144G.70, subdivision 2, paragraph (b), applies;<br>(3) be conducted using a uniform assessment tool that complies with part 4659.0150; and<br>(4) be in writing, dated, and signed by the registered nurse who conducted the assessment.<br><br>The licensee's Assessments, Reviews & Monitoring policy dated January 1, 2025, noted ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the residents.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) days | 01620 | | |

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|---|---|---|---|
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| 01640 SS=F | 144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to<br><br>(a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan.<br>(b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities.<br>(c) The facility must implement and provide all services required by the current service plan.<br>(d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable.<br>(e) Staff providing services must be informed of the current written service plan.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure service plans were revised to include provided services for three of three residents (R5, R9, R10).<br><br>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 | 01640 | | |

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|---|---|---|---|
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| 01640 | Continued From page 28<br>of the residents).<br><br>The findings include:<br><br>R5<br>R5's diagnoses included moderate dementia, anxiety, near syncope (fainting), and urinary frequency.<br><br>R5's service plan dated May 7, 2024, indicated R5 received the following services: medication administration, dressing, eating, grooming, hearing aid, mobility, toileting, transfer assist, oral care, fall coordination (fall/floor mat), and housekeeping services.<br><br>R5's Service Recap Summary dated December 1, 2024, through December 31, 2024, included:<br>-alarm check: 6:30 a.m., 2:30 p.m., 10:30 p.m.<br>-bed mobility/repositioning: 6:30 a.m., 2:30 p.m., 10:30 p.m.<br><br>On January 6, 2025, at 2:37 p.m., the surveyor observed unlicensed personnel (ULP)-E attach a gait belt around R5's waist. ULP-E and ULP-F assisted R5 into a standing position. ULP-E commented R5's alarm had not been turned off and the alarm sounded as the two ULPs stood R5 and transferred R5 into a recliner.<br><br>R5's service plan had not been revised to include bed mobility/repositioning and alarm check/use.<br><br>R9<br>R9's diagnoses included heart disease, muscle weakness, chronic pain, lack of coordination, macular degeneration (vision impairment resulting from deterioration of the central part of the retina, affecting central vision), and history of falling. | 01640 | | |

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|---|---|---|---|
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
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| 01640 | Continued From page 29<br><br>R9's service plan dated January 3, 2025, indicated R9 received the following services: transfer assist, alarm check, dressing and grooming assist, medication administration, repositioning, behavior management, and housekeeping services.<br><br>On January 7, 2025, at 9:51 a.m., the surveyor observed ULP-J pick up a floor/fall mat (cushioned mat covered with a plastic covering) positioned along R9's bed and place the mat near a chair in R9's room.<br><br>On January 7, 2025, at 9:52 a.m., the surveyor observed ULP-J dress R9's lower body. ULP-J summonsed ULP-L. ULP-J and ULP-L assisted R9 into a wheelchair.<br><br>R9's resident notes-nurse dated December 20, 2024, noted:<br>-the resident's wife was notified today that the current foam fall mat that the resident has in his room is not up to state requirements and that a new one needs to be provided by her as they are private pay if she would like us to continue to use one for him as a fall intervention. The resident's wife was informed that the fall mat will be pulled from his room until a new one can be provided. She reported once she is feeling better, she will order one.<br><br>On January 7, 2025, at 2:25 p.m., licensed assisted living director in residency/clinical nurse supervisor (LALDR/CNS)-A did not remove the fall mat as a cover was found for the mat and the fall/floor mat was currently in use.<br><br>R9's service plan had not been revised to include fall/floor mat (fall coordination). | 01640 | | |

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|---|---|---|---|
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
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| 01640 | Continued From page 30<br><br>R10<br>R10 diagnoses included diabetes.<br><br>R10's service plan dated July 22, 2024, and authenticated October 10, 2024, indicated R10 received the following services: medication administration, assist with dressing, eating, grooming, hearing aids, mobility: walking/locomotion, oral care, toileting, transfers, and housekeeping services.<br><br>R10's prescriber order dated December 9, 2024, included:<br>-recommend alternating heat and ice for musculoskeletal aches and pain as well as right knee and right shoulder. Ice or heat for 10-15 minutes three times daily as needed (PRN).<br><br>R10's RTasks (computer system used) services included:<br>-offer her warm pack or ice pack for right knee and right shoulder: 10-15 minutes up to three times a day as needed. Please document if it was offered and if she accepted or refused it.<br><br>On January 6, 2025, at 12:58 p.m., the surveyor observed ULP-C administer 650 milligrams (mg) of Tylenol (mild pain) to R10.<br><br>R10's service plan had not been revised to include ice/warm packs PRN.<br><br>On January 8, 2025, at 11:59 a.m., LALDR/CNS-A stated service plans were updated with assessments. LALDR/CNS-A said service plans were added to as "we go along." LALDR/CNS-A stated service plans were not revised as required. LALDR/CNS-A added, "I am learning." | 01640 | | |

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|---|---|---|---|
| | 24815 | A. BUILDING: _____ B. WING _____ | 01/08/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| DIAMOND WILLOW ASSISTED LIVING | 949 SW 11TH AVENUE GRAND RAPIDS, MN 55744 |

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| 01640 | Continued From page 31<br><br>The licensee's Service Plan Modifications policy dated January 1, 2025, noted, if the service plan needed to be modified due to a change in a prescriber's order or a change in the resident's needs, the registered nurse (RN) would update the resident's service plan that included:<br>-describe changes in service and whether the service was added (new), changed, or discontinued<br>-frequency of new service or if service was terminated<br>-identification the staff would perform the service<br>-schedule and methods of monitoring staff<br>-fee for the service<br>-date/signature of RN making changes<br>-date/signature of resident or the resident's representative each time a modification was made.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION:<br>Twenty-One (21) days | 01640 | | |
| 01760 SS=E | 144G.71 Subd. 8 Documentation of administration of medication<br><br>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 | 01760 | | |

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|---|---|---|---|
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|---|---|
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| 01760 | Continued From page 32<br><br>the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure one of two unlicensed personnel (ULP)-J followed registered nurse (RN) written instructions for one of two residents (R6). Additionally, the licensee failed to ensure medications were administered as ordered for one of three residents (R9).<br><br>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).<br><br>The findings include:<br><br>WRITTEN INSTRUCTION<br>R6<br>R6 diagnoses included shortness of breath, high blood pressure, and mild cognitive impairment.<br><br>R6's service plan dated December 27, 2024, indicated R6 received medication administration.<br><br>R6's medication administration record (MAR) dated December 1, 2024, through December 31, 2024, included:<br>-Dulera (shortness of breath) 100 micrograms (mcg)/5 mcg, inhale two puffs into the lungs twice | 01760 | | |

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|---|---|---|---|
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| 01760 | Continued From page 33<br><br>a day<br>- *wait one minute in between puffs<br>- *rinse mouth after use.<br><br>R6's prescriber order dated September 24, 2024, included the above order.<br><br>On January 7, 2025, at 7:35 a.m., the surveyor observed ULP-J prepare R6's oral medication and removed a Dulera inhaler from the medication cart. ULP-J got a glass of water and took the water and R6's medication to R6's room. ULP-J administered R6's oral medication and R6 drank most of the water.<br><br>On January 7, 2025, at 7:45 a.m., ULP-J asked R6 if she (R6) wanted to do the inhaler herself or if R6 wanted ULP-J to "do" the inhaler (administer). R6 stated she wanted ULP-J to administer the inhaler. ULP-J said, "1, 2, 3, (breath in) and again 1, 2, 3, (breath in). OK, all is good." ULP-J returned R6's inhaler to the medication cart.<br><br>On January 7, 2025, at 7:46 a.m., the surveyor reviewed R6's MAR with ULP-J. ULP-J stated she did not follow the directions on R6's Dulera inhaler even though she had just looked at the instructions on R6's MAR.<br><br>On January 8, 2025, at 9:40 a.m., licensed assisted living director in residency/clinical nurse supervisor (LALDR/CNS)-A stated ULP-J should have followed the directions on R6's MAR for R6's inhaler administration.<br><br>ADMINISTERED AS ORDERED<br>R9<br>R9's diagnoses included heart disease, muscle weakness, chronic pain, lack of coordination, | 01760 | | |

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|---|---|---|---|
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| 01760 | Continued From page 34<br><br>macular degeneration (vision impairment resulting from deterioration of the central part of the retina, affecting central vision), and history of falling.<br><br>R9's service plan dated January 3, 2025, indicated R9 received medication administration.<br><br>On January 7, 2025, at 9:52 a.m., the surveyor observed ULP-J dress R9's lower body. ULP-J summonsed ULP-L. ULP-J and ULP-L moved a fall/floor mat from along R9's bed and assisted R9 out of bed.<br><br>R9's prescriber order dated September 12, 2024, included:<br>-Metamucil (bowel health) one tablespoon in eight ounces of water daily.<br><br>R9's MAR dated December 1, 2024, through December 31, 2024, included:<br>-Metamucil (psyllium) chew three gummies (five mg) by mouth one time a day for constipation.<br><br>On January 8, 2025, at 9:58 a.m., LALDR/CNS-A stated R9 would not take Metamucil powder and R9's wife had brought in Metamucil gummies. LALDR/CNS-A stated she should have updated R9's provider but had not. LALDR/CNS-C said she did not have an order for R9's Metamucil gummies as required.<br><br>The licensee's Inhaler policy dated January 1, 2025, noted compare the medication administration record with the medication container label, ensuring the following information matched, to include special instructions. Offer the resident an opportunity to rinse their mouth after using the inhaler to reduce the risk of irritation or infection, especially if the medication contained | 01760 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 24815 | A. BUILDING: _____ B. WING _____ | 01/08/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| DIAMOND WILLOW ASSISTED LIVING | 949 SW 11TH AVENUE GRAND RAPIDS, MN 55744 |

| (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 |
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| 01760 | Continued From page 35<br>steroids.<br><br>The licensee's Medication & Treatment Orders-Receiving policy dated January 1, 2025, noted all orders for medications and treatments must be dated and signed by the prescriber and must be current and consistent with the nursing assessment.<br><br>The licensee's Medication & Treatment Orders-Implementing dated January 1, 2025, noted orders can only be implemented when in direct contact with the licensed nurse. The original signed order or axed order would be placed in a designated place for the nurse to review and sign at the next scheduled licensed nurse visit.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01760 | | |
| 01880 SS=D | 144G.71 Subd. 19 Storage of medications<br><br>An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure medications were secure and permitted access to only authorized personnel for one of four residents (R7). | 01880 | | |

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| 01880 | Continued From page 36<br><br>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).<br><br>The findings include:<br><br>R7's diagnoses included Alzheimer's dementia.<br><br>R7's service plan dated January 6, 2025, included medication administration five times daily.<br><br>R7's individualized medication management plan dated December 23, 2024, indicated:<br>medications are stored in the locked medications carts. Only authorized staff have access to medications.<br><br>On January 7, 2025, at 8:47 a.m., the surveyor observed unlicensed personnel (ULP)-L prepare R7's morning medication using correct technique.<br><br>On January 7, 2025, at 8:53 a.m., the surveyor observed ULP-L administer R7's oral medication. Observed on a table in R7's room was an opened container of TUMS (stomach acid/heartburn) which was approximately half full.<br><br>On January 7, 2025, at 12:00 p.m., licensed assisted living director in residency/clinical nurse supervisor (LALDR/CNS)-A stated R7 should not have had TUMS in his room. LALDR/CNS-A stated R7's medications were to be secured.<br><br>The licensee's Medication Storage policy dated | 01880 | | |

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|---|---|---|---|
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
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|---|---|---|---|---|
| 01880 | Continued From page 37<br><br>January 1, 2025, noted medications managed by the resident or non-staff member inside a resident's private "living space" must be in securely locked and substantially constructed compartments and permit only authorized personnel to have access. This may be a locked drawer, cabinet, etc.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01880 | | |
| 01890 SS=F | 144G.71 Subd. 20 Prescription drugs<br><br>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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure medications were maintained bearing the original prescription label with legible information, including the expiration date, for time sensitive medications in two of two medication carts (Mississippi Suites, Eagle Pines) connected by a commons area.<br><br>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 | 01890 | | |

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|---|---|---|---|
| | 24815 | A. BUILDING: _____ B. WING _____ | 01/08/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
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| 01890 | Continued From page 38<br>or has the potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>On January 6, 2025, at approximately 10:15 a.m., the surveyor and assisted living director in residency/clinical nurse supervisor (LALDR/CNS)-A and registered nurse (RN)-B reviewed the contents of the locked medication carts. LALDR/CNS-A and RN-B observed and confirmed the following:<br><br>MISSISSIPPI SUITES<br>TIME SENSITIVE MEDICATION<br>-three opened latanoprost (high eye pressure) eye solution bottles for R2: one dated October 30, 2024, one dated December 4, 2024, and one not dated. All three bottles lacked expiration dates.<br><br>PRESCRIPTION LABEL<br>-one opened brimonidine tartrate (eye high pressure) eye solution for R2 lacked legible information to include open/expiration date (date written with black marker was not legible).<br><br>Directly after the above observation LALDR/CNS-A stated the date written on R2's brimonidine eye solution had worn off however, the expiration date on the bottle noted April of 2025 (which was the expiration date of the unopened medication). RN-B stated labels of time sensitive medication should include the date opened and date the medication would expire.<br><br>EAGLE PINES<br>TIME SENSITIVE MEDICATION<br>-one opened Refresh Tears (dry eyes) dated October 12, 2024, for R3, with no expiration date. | 01890 | | |

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|---|---|---|---|
| | 24815 | A. BUILDING: _____ B. WING _____ | 01/08/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| 01890 | Continued From page 39<br><br>PRESCRIPTION LABEL<br>-one opened polyvinyl eye drops (dry eyes) with several dates written on the label: June 10, December 2024, May 74 (sic), for R3.<br><br>On January 6, 2025, at 11:41 a.m., RN-B stated only one date was noted on all time sensitive medications. RN-B added she "thought" it was the open date, but she was not positive. RN-B confirmed time sensitive medication should include both the open and the expiration date. In addition, RN-B confirmed the open date on R3's polyvinyl eye solution was not legible.<br><br>The manufacturer's instructions for latanoprost dated February 1, 2023, directed to discard within 4 weeks of opening.<br><br>The manufacturer's instructions for brimonidine dated December 7, 2021, noted eye drops can be used for four weeks once the bottle had been opened. Even if there is still some solution remaining after this time, throw it.<br><br>The manufacturer's instructions for Refresh Tears dated June 2022, noted do not use more than 90 days after first opening.<br><br>The manufacturer's instructions for polyvinyl eye drops dated January 9, 2024, noted most eye drops in bottles only keep for four weeks once the container had been opened, so do not use the drops if the bottle had been opened for longer than this. This helps to reduce the risk of eye infection.<br><br>The licensee's Medication Storage policy dated January 1, 2025, noted medications would be stored consistent with manufacturer's recommendations (refrigerated, room | 01890 | | |

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|---|---|---|---|
| | 24815 | A. BUILDING: _____ B. WING _____ | 01/08/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| 01890 | Continued From page 40<br>temperature, or frozen).<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01890 | | |
| 01940 SS=D | 144G.72 Subd. 3 Individualized treatment or therapy managemen<br><br>For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following:<br>(1) a statement of the type of services that will be provided;<br>(2) documentation of specific resident instructions relating to the treatments or therapy administration;<br>(3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel;<br>(4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and<br>(5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any | 01940 | | |

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|---|---|---|---|
| | 24815 | A. BUILDING: _____ B. WING _____ | 01/08/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
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| 01940 | Continued From page 41<br>changes.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for one of three residents (R10) who had treatments managed by the facility.<br><br>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).<br><br>The findings include:<br><br>During the entrance conference on January 6, 2025, at approximately 9:45 a.m., licensed assisted living director in residency/clinical nurse supervisor (LALDR/CNS)-A stated the licensee offered treatment and therapy services.<br><br>R10's diagnoses included diabetes.<br><br>R10's service plan dated July 22, 2024, and authenticated October 10, 2024, indicated R10 received the following services: medication administration, assist with dressing, eating, grooming, hearing aids, mobility: walking/locomotion, oral care, toileting, transfers, and housekeeping services.<br><br>R10's prescriber order dated December 9, 2024, | 01940 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 24815 | A. BUILDING: _____ B. WING _____ | 01/08/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
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| 01940 | Continued From page 42<br><br>included:<br>-recommend alternating heat and ice for musculoskeletal aches and pain as well as right knee and right shoulder. Ice or heat for 10-15 minutes three times daily as needed (PRN).<br><br>R10's RTasks (computer system used) services included:<br>-offer her warm pack or ice pack for right knee and right shoulder: 10-15 minutes up to three times a day as needed. Please document if it was offered and if she accepted or refused it.<br><br>On January 6, 2025, at 12:58 p.m., the surveyor observed unlicensed personnel (ULP)-C administer 650 milligrams (mg) of Tylenol (mild pain) to R10.<br><br>R10's record did not include evidence of an individualized treatment management plan for R10's including a statement of type of service provided: warm/ice packs.<br><br>On January 8, 20245, at 10:35 a.m., R10's record was reviewed with LALDR/CNS-A. LALDR/CNS-A stated she had not added warm/ice packs to R10's service plan/treatment plan as required.<br><br>The licensee's Treatment & Therapy Management Plan policy dated January 1, 2025, noted the licensee would develop and maintain a current individualized treatment and therapy management record for each resident which must contain a statement of the type of services that would be provided. The treatment or therapy management record must be current and updated when there are any changes.<br><br>No further information provided. | 01940 | | |

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|---|---|---|---|
| | 24815 | A. BUILDING: _____ B. WING _____ | 01/08/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| DIAMOND WILLOW ASSISTED LIVING | 949 SW 11TH AVENUE GRAND RAPIDS, MN 55744 |

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| 01940 | Continued From page 43<br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01940 | | |
| 01950 SS=F | 144G.72 Subd. 4 Administration of treatments and therapy<br><br>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:<br>(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;<br>(2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure prior to delegating nursing tasks, the registered nurse (RN) trained unlicensed personnel (ULP) and had ULP demonstrated the ability to follow the procedure to perform the tasks using warm/ice packs for two of two residents (R5, R10). In addition, the licensee failed to ensure the RN prepared in writing specific instructions for each resident and documented those instructions for two of two residents (R5, R10) receiving | 01950 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 24815 | A. BUILDING: _____ B. WING _____ | 01/08/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
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| 01950 | Continued From page 44<br><br>treatments of warm/ ice packs, and for two of two residents (R8, R6) receiving treatments of daily weights.<br><br>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).<br><br>The findings include:<br><br>TRAINING AND DEMONSTRATION OF COMPETENCY<br>WARM/ICE PACKS<br>R5<br>R5's diagnoses included moderate dementia, anxiety, near syncope (fainting), and urinary frequency.<br><br>R5's service plan dated May 7, 2024, indicated R5 received the following services: medication administration, dressing, eating, grooming, hearing aid, mobility, toileting, transfer assist, oral care, fall coordination, and housekeeping services.<br><br>R5's service plan did not include warm/ice packs.<br><br>R5's prescriber order dated April 25, 2024, included, standing orders:<br>-warm pack as needed for pain/discomfort, as needed (PRN)<br>-ice pack PRN for pain/discomfort.<br><br>R5's medication administration record (MAR) | 01950 | | |

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|---|---|---|---|
| | 24815 | A. BUILDING: _____ B. WING _____ | 01/08/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| DIAMOND WILLOW ASSISTED LIVING | 949 SW 11TH AVENUE GRAND RAPIDS, MN 55744 |

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| 01950 | Continued From page 45<br><br>dated January 1, 2025, through January 6, 2025, included:<br>-warm pack PRN for pain/discomfort<br>-ice pack PRN for pain/discomfort.<br><br>On January 6, 2025, at 2:40 p.m., the surveyor observed ULP-E ask R5 if R5 would like "this" (warm pack) "warmed up" for you. ULP-E took R5's warm pack to the microwave.<br><br>Directly after the above observation licensed assisted living director in residency/clinical nurse supervisor (LALDR/CNS)-A stated she stopped ULP-E from heating up R5's warm pack as warm packs were not a service offered at the facility. LALDR/CNS-A stated R5's family brought in the warm pack and R5's family could warm the pack up for R5.<br><br>R10<br>R10's diagnoses included diabetes.<br><br>R10's service plan dated July 22, 2024, and authenticated October 10, 2024, indicated R10 received the following services: medication administration, assist with dressing, eating, grooming, hearing aids, mobility: walking/locomotion, oral care, toileting, transfers, and housekeeping services.<br><br>R10's service plan did not include warm/ice packs.<br><br>R10's prescriber order dated December 9, 2024, included:<br>-recommend alternating heat and ice for musculoskeletal aches and pain as well as right knee and right shoulder. Ice or heat for 10-15 minutes three times daily PRN. | 01950 | | |

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|---|---|---|---|
| | 24815 | A. BUILDING: _____ B. WING _____ | 01/08/2025 |

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|---|---|
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| 01950 | Continued From page 46<br><br>R10's RTasks (computer system used) services included:<br>-offer her warm pack or ice pack for right knee and right shoulder: 10-15 minutes up to three times a day as needed. Please document if it was offered and if she accepted or refused it.<br><br>On January 7, 2025, at 1:02 p.m., LALDR/CNS-A stated she never thought about training ULP's for warm/ice packs and added none of the ULPs were trained or deemed competent to perform the treatment/task.<br><br>SPECIFIC INSTRUCTIONS<br>WARM/ICE PACKS<br>On January 8, 2025, at 10:36 a.m., LALDR/CNS-A stated resident records did not include specific instructions for warm/ice packs. LALDR/CNS-A said items such as if the pack was reusable, not to place on direct skin, and when to call RN should be in resident's record.<br><br>WEIGHTS<br>R8<br>R8s diagnoses included heart failure, major depressive disorder, cellulitis of left lower limb, and morbid severe obesity.<br><br>R8's service plan dated December 27, 2024, included: weight daily.<br><br>R8's prescriber order dated January 10, 2024, included: daily weight monitoring.<br><br>R8's RTasks services included: weights, active January 10, 2023, noted:<br>-record daily weight, two pounds in one day or five pounds in a week.<br><br>On January 6, 2025, at 1:01 p.m., the surveyor | 01950 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 24815 | A. BUILDING: _____ B. WING _____ | 01/08/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| DIAMOND WILLOW ASSISTED LIVING | 949 SW 11TH AVENUE GRAND RAPIDS, MN 55744 |

| (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 |
|---|---|---|---|---|
| 01950 | Continued From page 47<br><br>observed ULP-C escort R8 to a scale to obtain a weight.<br><br>On January 6, 2025, at 3:21 p.m., R8's record was reviewed with LALDR/CNS-A and licensed practical nurse (LPN)-K. LALDR/CNS-A and LPN-K both stated it was difficult to get R8's weight. LALDR/CNS-A said information such as obtaining weight prior to a meal and when to notify nursing should be included in R8's record. LALDR/CNS-A stated that R8's record did not have specific instructions for ULPs regarding R8's weight monitoring.<br><br>R6<br>R6's diagnoses included mild cognitive impairment.<br><br>R6's service plan dated December 27, 2024, included: daily weight.<br><br>R8's RTasks services included: weights, active on October 16, 2024, noted:<br>-obtain weight daily before breakfast and record.<br><br>R6's prescribe order dated October 16, 2024, included daily weight.<br><br>On January 7, 2025, at 7:05 a.m., the surveyor observed ULP-J escort R6 to a scale to obtain a weight of 163 pounds.<br><br>On January 7, 2025, at 7:35 a.m., the surveyor reviewed R6's record for daily weights with ULP-J. ULP-J stated R6's record did not include what to report for R6's weight, just to take weight before breakfast.<br><br>On January 7, 2025, at 12:02 p.m., LALDR/CNS-A stated resident records should | 01950 | | |

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|---|---|---|---|
| | 24815 | A. BUILDING: _____ B. WING _____ | 01/08/2025 |

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|---|---|---|---|---|
| 01950 | Continued From page 48<br><br>include when/what to report to nursing for weights and confirmed R6's record lacked required instructions for ULPs regarding R6's weight monitoring.<br><br>The Minnesota Bill of Rights for Assisted Living Residents dated November 8, 2022, noted residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan.<br><br>The licensee's Treatment & Therapy Management Plan policy dated January 1, 2025, noted the resident's record would contain:<br>- documentation of specific resident instructions relating to the treatments or therapy administration<br>- procedures for notifying a registered nurse or appropriate licensed health professional when a problem arose with treatments or therapy services<br>- resident-specific requirements relating to documentation of treatment and therapy received.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01950 | | |
| 02310 SS=F | 144G.91 Subd. 4 (a) Appropriate care and services<br><br>(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 | 02310 | | |

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|---|---|---|---|
| | 24815 | A. BUILDING: _____ B. WING _____ | 01/08/2025 |

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|---|---|
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|---|---|---|---|---|
| 02310 | Continued From page 49<br><br>service plan subject to accepted health care standards.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards for storage of cleaning supplies in one of two laundry rooms (Eagle Pines,) in two of two public bathrooms (Eagle Pines, Mississippi Suites), and in two of two kitchens (Eagle Pines, Mississippi Suites).<br><br>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).<br><br>The findings include:<br><br>The assisted living held a dementia care license and was a secured unit with a current census of 25 residents. The facility was separated into two units (Mississippi Suites, Eagle Pines) joined by a "link" (commons area).<br><br>EAGLE PINE LAUNDRY ROOM<br>On January 6, 2025, at 10:18 a.m., during a tour of the facility with licensed assisted living director in residency/clinical nurse supervisor (LALDR/CNS)-A, the surveyor observed the door to the laundry room not closed. LALDR/CNS-A stated the door should be locked and LALDR/CNS-A closed and locked the door. | 02310 | | |

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|---|---|---|---|
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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|---|---|---|---|---|
| 02310 | Continued From page 50<br><br>LALDR/CNS-A observed and confirmed the following:<br>- two opened bottles of Medline Micro-Kill<br>- opened disinfectant spray (Great Value)<br>- opened Medline multi-surface polish<br>- container (pop-top) Medline micro-kill bleach germicidal bleach wipes<br>- opened Medline ammoniated glass cleaner.<br><br>On January 6, 2025, at 12:28 p.m., the surveyor and LALDR/CNS-A observed the door to the Eagle Pines laundry room unsecured. LALDR/CNS-A informed staff (unlicensed personnel/ ULP) that the door to the Eagle Pine's laundry room was not locking, and asked if the ULPs had a key to the door to secure it that way (with aid of key).<br><br>BATHROOMS<br>MISSISSIPPI SUITES<br>On January 7, 2025, at 12:12 p.m., the surveyor and registered nurse (RN)-B observed and confirmed the following:<br>-opened vaporizing rub<br>-opened XtraCare after shave<br>-opened Head & Shoulders shampoo<br>-opened Medline shaving cream<br>-opened Old Spice Fiji deodorant<br>-opened Linen Fresh air freshener spray (Great Value)<br>Directly after the above observation, the surveyor and registered nurse (RN)-B looked at several of the product labels listed above for warnings. RN-B stated the items were not secure and should have been.<br><br>EAGLE PINES (what location/room?)<br>On January 7, 2025, at 12:20 p.m., the surveyor and RN-B observed and confirmed the following:<br>-opened Whirlpool disinfectant and cleaner | 02310 | | |

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|---|---|---|---|
| | 24815 | A. BUILDING: _____ B. WING _____ | 01/08/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
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|---|---|---|---|---|
| 02310 | Continued From page 51<br><br>-opened Aussie Mega hairspray<br>-opened Power Stick, powder fresh antiperspirant/deodorant<br>-opened Hawaiian air freshener spray (Great Value)<br>Directly after the above observation RN-B stated the items in both of the bathrooms where not secure and added her sister ate her (RN-Bs) deodorant once and that was not good.<br><br>Both units (Eagle Pines and Mississippi Suites) had an unlocked bathroom off the main entry, in the commons area. The bathrooms contained a toilet, a walk-in tub, an unsecured storage unit, and a can of room deodorizing room spray positioned near the sink.<br><br>On January 6, 2025, at 2:36 p.m., LALDR/CNS-A confirmed products in bathrooms should be secured. LALDR/CNS-A commented even the room air freshener spray should not be on the counters.<br><br>KITCHENS<br>Both units (Eagle Pines and Mississippi Suites) had a kitchen in the commons area. There were counter height doors (half doors) on two sides of the kitchen that could be secured.<br><br>EAGLE PINES<br>On January 7, 2025, at 6:30 a.m., the surveyor observed the half kitchen door open and a bottle of Ultra dish liquid with approximately a quarter of the contents in the bottle near the sink. No ULPs were in the area.<br><br>MISSISSIPPI SUITES<br>On January 7, 2025, at 6:33 a.m., the surveyor observed the kitchen door open and a bottle of Ultra dish liquid with approximately a third of the | 02310 | | |

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|---|---|---|---|
| | 24815 | A. BUILDING: _____ B. WING _____ | 01/08/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
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|---|---|---|---|---|
| 02310 | Continued From page 52<br><br>contents in the bottle near the sink. No ULPs were in the area.<br><br>On January 7, 2025, at 6:36 a.m., LALDR/CNS-A and the surveyor reviewed the back of the dish soap label. LALDR/CNS-A stated dish soap should not be located near kitchen sinks and left unattended. LALDR/CNS-A motioned to a locked cabinet under the sink as to where the dish soap should/ could be kept.<br>The undated Ultra dish liquid label read:<br>caution: keep out of reach of children<br>- keep from eyes. If eye contact occurred, rinse thoroughly with water. If swallowed, drink a full glass of water to dilute or contact a Poison Control Center.<br><br>MICRO-KILL FOAMING DISINFECTANT CLEANER<br>Safety Data Sheet dated November 21, 2022, noted:<br>- do not spray in eyes. In case of eye contact, flush thoroughly with water. If irritation persists, get medical attention. Avoid spraying on food<br>- may cause skin irritation after contact with skin. Frequent or widespread contact may result on skin absorption of potentially harmful amounts<br>- conventional eyeglasses to guard against splashing, household type gloves, use in a well-ventilated area only. Wash hands after use. Keep out of reach of children.<br><br>DISINFECTANT SPRAY, ALL SCENTS<br>Safely Data Sheet dated July 30, 2021, noted:<br>- keep out of reach of children. Use only in a well-ventilated area. Handle with care. Wear protective gloves and eye/face protection: chemical splash goggles or face shield. Use chemical-resistant, impervious gloves.<br>- do not spray in eyes, on skin or on clothing. | 02310 | | |

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|---|---|---|---|
| | 24815 | A. BUILDING: _____ B. WING _____ | 01/08/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
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|---|---|---|---|---|
| 02310 | Continued From page 53<br><br>Wash thoroughly with soap and water after handling and before eating, drinking, chewing gum, using tobacco or using the toilet.<br><br>MEDLINE MULTI-SURFACE POLISH<br>Safety Data Sheet dated February 2, 2025, noted:<br>- keep out of the reach of children<br>- first aid measures: have the label with you when calling poison control center or doctor, or going for treatment.<br>- skin contact: remove contaminated clothing and wash before reuse. Wash contaminated area with soap and water for 15- 20 minutes. If irritation occurs, get medical advice<br>- eye contact: hold eye open and rinse slowly and gently with water for 15-20 minutes. Remove contact lenses, if present and easy to do. Continue rinsing. If eye irritation occurs get medication advice/attention<br>- ingestion: call a poison control center or doctor immediately for treatment advice. Have person sip a glass of water if able to swallow. Do not induce vomiting unless told to do so by the poison control center or doctor. If vomiting occurs, keep head below hips to reduce risk of aspiration.<br><br>MICRO-KILL BLEACH GERMICIDAL BLEACH WIPES<br>Safety Data Sheet dated November 22, 2022, noted:<br>- serious eye damage/eye irritation<br>- causes moderate eye irritation. Avoid contact with eyes and clothing. Wash thoroughly with soap and water after handling and before eating, drinking, chewing gum, using tobacco, or using the toilet. Do not use this product with other chemicals such as ammonia, toilet bowl cleaners, rust removers, or acid, as this releases hazardous gases. | 02310 | | |

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|---|---|---|---|
| | 24815 | A. BUILDING: _____ B. WING _____ | 01/08/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
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|---|---|---|---|---|
| 02310 | Continued From page 54<br><br>AMMONIATED READY TO USE GLASS CLEANER<br>Safety Data Sheet dated November 1, 2024, noted:<br>- avoid contact with eyes, avoid contact with skin, avoid breathing vapors or mists<br>- do not taste or swallow<br>- keep out of the reach of children.<br><br>VAPORUB<br>Safety Data Sheet dated July 26, 2011, noted:<br>- eye: transitory irritation is expected with accidental exposure to the eye and/or eyelid. Routine eye flush is recommended along with cartful follow-up to assure that the product has been completely removed and the irritation is cleaning<br>- skin: avoid contact with broken or damaged skin. If unusual or severe redness or irritation occurred as a result of skin contact, remove the product with warm water and mild soap. Apply cold compress to relieve irritation. If irritation persists, see a physician<br>- ingestion: do not induce vomiting. Dilute with fluids (water or mild) and treat symptomatically.<br><br>XTRACARE SHAVE CREAM<br>Safety Data Sheet dated February 2, 2020, noted:<br>- causes serious eye irritation, if in eyes, hold eyelids apart and flush the eye continuously with running water. Continue flushing until advised to stop by the Poison Information Center or a doctor<br>- ingestion: immediately give a glass of water. Call Poison Information Center if in doubt.<br><br>HEAD & SHOULDERS SHAMPOO<br>Safety Data Sheet dated July 2011, noted:<br>- eye: contact may cause mild, transient irritation. Some redness and/or stinging may occur<br>ingestion: product used as intended is not | 02310 | | |

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|---|---|---|---|
| | 24815 | A. BUILDING: _____ B. WING _____ | 01/08/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| DIAMOND WILLOW ASSISTED LIVING | 949 SW 11TH AVENUE GRAND RAPIDS, MN 55744 |

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|---|---|---|---|---|
| 02310 | Continued From page 55<br><br>expected to cause gastrointestinal irritation. Accidental ingestion of undiluted product may cause mild gastrointestinal irritation with nausea, vomiting and diarrhea.<br><br>MEDILINE SHAVING CREAM<br>Safety Data Sheet dated May 28, 2015, noted:<br>- handle in accordance with good industrial hygiene and safety practice. Wash thoroughly with soap and water after handling and before eating, drinking, or smoking tobacco. Safety shower and eye wash should be available close to work areas. If swallowed, call a physician immediately. Rinse mouth and throat thoroughly with water. Do not induce vomiting unless directed to do so by a physician.<br><br>OLD SPICE FIJI DEODORANT<br>Safety Data Sheet dated June 2009, noted:<br>- eye, contact may cause mild, transient irritation. Some redness and/or stinging may occur<br>- ingestion: product used as intended is not expected to cause gastrointestinal irritation. Accidental ingestion of undiluted product may cause mild gastrointestinal irritation with nausea, vomiting and diarrhea.<br>- keep out the reach of children.<br><br>CLASSIC WHIRLPOOL DISINFECTANT CLEANER<br>Safety Data Sheet dated May 1, 2014, noted:<br>- health hazards: will cause eye irritation and skin irritation prolonged exposure. Can be harmful if swallowed or if spray mist is inhaled<br>- if on skin: redness, irritation, or burning sensation with prolonged exposure<br>if spray mist is inhaled: possible irritation and/or burning sensation, possible dizziness or headache<br>- if swallowed: possible gastrointestinal irritation, | 02310 | | |

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|---|---|---|---|
| | 24815 | A. BUILDING: _____ B. WING _____ | 01/08/2025 |

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|---|---|
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|---|---|---|---|---|
| 02310 | Continued From page 56<br><br>disturbance or pain<br>- storage: keep out of reach of children.<br><br>AUSSIE MEGA HAIRSPRAY<br>Safety Data Sheet dated November 2012, noted:<br>- keep out of reach of children<br>- eyes, contact may cause mild, transient irritation. Some redness and/or stinging may occur<br>- inhalation: may cause mild, transient respiratory irritation. Avoid prolonged contact to concentrated vapors<br>- ingestion: product used as intended is not expected to cause gastrointestinal irritation. Accidental ingestion of undiluted product may cause mild gastrointestinal irritation with nausea, vomiting, and diarrhea.<br><br>POWER STICK ANTIPERSPIRANT<br>Safety Data Sheet dated September 26, 2015, noted:<br>- if swallowed, clean mouth with water and drink afterwards plenty of water. Do not give mil or alcoholic beverages<br>- in case of eye contact: flush eyes with water as a precaution<br>- in inhaled: move to fresh air in case of accidental inhalation of dust or fumes from overheating or combustion. If symptoms persist, call a physician.<br><br>ULTRA DISHWASHING DETERGENT<br>Safety Data Sheet dated May 20, 2015, noted:<br>- harmful if swallowed, immediately call a Poison Center or doctor<br>- causes mild skin irritation, causes serious eye damage<br>- handle containers carefully to prevent damage and spillage. | 02310 | | |

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|---|---|---|---|
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| 02310 | Continued From page 57<br><br>The licensee's Physical Environment, Fire Protection & Staffing policy dated January 1, 2025, noted the licensee would be in compliance with the additional requirements regarding for licensed assisted living facilities with secured dementia care units.<br><br>The Minnesota Home Care Bill of Rights for Assisted Living Residents dated November 8, 2022, noted 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.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 02310 | | |
| 02320 SS=E | 144G.91 Subd. 4 (b) Appropriate care and services<br><br>(b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards by four of eight employees, (unlicensed personnel (ULP)-J, ULP-L, and two unidentified ULPs) during | 02320 | | |

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| 02320 | Continued From page 58<br>personal cares for R9.<br><br>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).<br><br>The findings include:<br><br>R9's diagnoses included heart disease, muscle weakness, chronic pain, lack of coordination, macular degeneration (vision impairment resulting from deterioration of the central part of the retina, affecting central vision), and history of falling.<br><br>R9's service plan dated January 3, 2025, indicated R9 received the following services: transfer assist, alarm check, dressing and grooming assist, medication administration, repositioning, behavior management, and housekeeping services.<br><br>R9's assessment dated November 29, 2024, noted, intervention, dated October 30, 2024,<br>-provide pillows for positioning and support alongside the resident while lying in bed.<br><br>On January 7, 2025, at 7:33 a.m., ULP-J stated she checked in on R9 and R9 was not ready to get up.<br><br>On January 7, 2025, at 9:51 a.m., the surveyor observed ULP-J pick up a floor/fall mat positioned | 02320 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 24815 | A. BUILDING: _____ B. WING _____ | 01/08/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| DIAMOND WILLOW ASSISTED LIVING | 949 SW 11TH AVENUE GRAND RAPIDS, MN 55744 |

| (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 |
|---|---|---|---|---|
| 02320 | Continued From page 59<br><br>along R9's bed and place it near a chair in R9's room. ULP-J dressed R9's lower body.<br><br>On January 7, 2025, at 9:52 a.m., ULP-L entered R9's room. ULP-J and ULP-L removed two pillows that were placed under the fitted sheet on R9's bed. The two pillows were positioned along R9's body, under the fitted sheet. ULP-J stated there were no directions in R9's record for pillows under R9's fitted sheet. ULP-J added maybe there was direction for night staff regarding the pillow use. ULP-L stated the pillows may have been positioned under the sheet to keep R9 in bed.<br><br>On January 7, 2025, at 12:58 p.m., licensed assisted living director in residency/clinical nurse supervisor (LALDR/CNS)-A stated pillows should not have been placed under R9's sheet. LALDR/CNS-A added it was possible ULPs misunderstood direction. LALDR/CNS-A said pillows placed under sheet could have been considered a restraint. LALDR/CNS-A said one of the overnight ULP who worked the previous night was "newer," and the other night ULP who worked was "longer term". LALDR/CNS-A stated the ULPs should have removed the pillows. LALDR/CNS-A stated pillows were not to be used at any time under a resident's sheet. LALDR/CNS-A stated that was not the direction ULPs were given.<br><br>The Minnesota Home Care Bill of Rights for Assisted Living Residents dated November 8, 2022, noted 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. | 02320 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 24815 | A. BUILDING: _____ B. WING _____ | 01/08/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| DIAMOND WILLOW ASSISTED LIVING | 949 SW 11TH AVENUE GRAND RAPIDS, MN 55744 |

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|---|---|---|---|---|
| 02320 | Continued From page 60<br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 02320 | | |
| 02350 SS=D | 144G.91 Subd. 7 Courteous treatment<br><br>Residents have the right to be treated with courtesy and respect, and to have the resident's property treated with respect<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review, the licensee failed to ensure residents are treated with dignity and respect for one of three residents (R4) observed wearing a gait belt (a device put on a person who has mobility issues which allows a caregiver a secure place to hold onto to transfer a person to different position safely) while in the common's area.<br><br>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).<br><br>The findings include:<br><br>R4's diagnoses included dementia.<br><br>R4's service plan dated August 21, 2024, indicated R4 received the following services: mobility walking/locomotion two times daily. | 02350 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
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| DIAMOND WILLOW ASSISTED LIVING | 949 SW 11TH AVENUE GRAND RAPIDS, MN 55744 |

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|---|---|---|---|---|
| 02350 | Continued From page 61<br><br>R4's Rtasks (computer system used) service entry note dated November 19, 2024, included: ambulation<br>-resident can ambulate independently with or without walker, ambulates with one or two assist with walker and gait belt, or uses wheelchair.<br><br>On January 6, 2025, at approximately 1:00 p.m., the surveyor observed R4 seated in a recliner in the common's area partially covered with a blanket. The surveyor observed R4 wearing a gait belt.<br><br>On January 6, 2025, at 1:07 p.m., licensed assisted living director in residency/clinical nurse supervisor (LALDR/CNS)-A stated R4 was not care planned to wear a gait belt at all times and the gait belt should have been removed.<br><br>The licensee's Person-Centered Care policy dated December 4, 2024, noted the licensee was committed to providing person-centered care that emphasized the dignity, independence, and unique preferences of each resident. Employees would receive ongoing training on person-centered care practices, ensuring they have the skills and knowledge to deliver individualized care that respects each resident's dignity and preferences.<br><br>The Minnesota Bill of Rights for Assisted Living Residents dated November 8, 2022, noted residents have the right to be treated with courtesy and respect.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 02350 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 24815 | A. BUILDING: _____ B. WING _____ | 01/08/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| DIAMOND WILLOW ASSISTED LIVING | 949 SW 11TH AVENUE GRAND RAPIDS, MN 55744 |

| (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 |
|---|---|---|---|---|
| 02430 SS=F | 144G.91 Subd. 15 Confidentiality of records<br><br>(a) Residents have the right to have personal, financial, health, and medical information kept private, to approve or refuse release of information to any outside party, and to be advised of the assisted living facility's policies and procedures regarding disclosure of the information. Residents must be notified when personal records are requested by any outside party.<br>(b) Residents have the right to access their own records.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure resident's personal health and medical information was kept private. This had the potential to affect all residents residing at the assisted living facility.<br><br>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:<br><br>The findings include:<br><br>NARCOTIC LEDGER/EAGLE PINES<br>On January 6, 2025, at 2:41 p.m., the surveyor observed a narcotic ledger on a kitchen table in the common's area, in the Eagle Pines unit. The surveyor did not observe any staff in the | 02430 | | |

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| DIAMOND WILLOW ASSISTED LIVING | 949 SW 11TH AVENUE GRAND RAPIDS, MN 55744 |

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| 02430 | Continued From page 63<br><br>common's area and three residents were seated in the common's area.<br><br>On January 6, 2025, at 2:43 p.m., licensed practical nurse (LPN)-K stated the narcotic ledger should not have been left out as it contained names (residents) and drugs (medications). LPN-K added one unlicensed personnel (ULP) had just returned from maternity leave. Licensed assisted living director in residency/clinical nurse supervisor (LALDR/CNS)-A agreed the narcotic log should have been secured.<br><br>COMPUTER SCREEN/MISSISSIPPI SUITES<br>On January 6, 2025, at 2:54 p.m., the surveyor observed a computer screen in the Mississippi Suites unit with personal information visible regarding a resident's toileting, cleaning, and transferring needs in the common's area. The surveyor did not observe a ULP in the common's area, however the surveyor observed residents in the common's area.<br><br>On January 6, 2025, at 3:00 p.m., ULP-D stated she normally lowered the computer screen as personal information was visible. ULP-D added "I guess I did not put it (computer screen) down. My bad (ULP-D)". ULP-D lowered the computer screen.<br><br>On January 6, 2025, at 3:04 p.m., LALDR/CNS-A stated computer screens should be closed as it was a HIPAA issue (Health Insurance Portability and Accountability Act).<br><br>The licensee's Resident Record-Confidentiality policy dated January 1, 2025, noted no personal, financial, medical, or other information about the resident would be disclosed to any other person, except: | 02430 | | |

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| DIAMOND WILLOW ASSISTED LIVING | 949 SW 11TH AVENUE GRAND RAPIDS, MN 55744 |

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|---|---|---|---|---|
| 02430 | Continued From page 64<br><br>-as may be required by law<br>-to staff<br>-to contractors of the facility<br>-to another home care provider or inpatient facility that required information that was necessary for the provision of services<br>-to persons authorized in writing by the resident or resident's responsible person<br>-to representatives of the Minnesota Department of Health authorized to survey or investigate home care providers.<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 02430 | | |

MINNESOTA DEPARTMENT OF HEALTH
Food, Pool,& lodging Services
PO Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *01/06/25*
Time: 12:32:48
Report: 7939251004

# Food and Beverage Establishment Inspection Report



**Location:**
Diamond Willow Of Grand Rapids
949 Sw 11th Avenue
Grand Rapids, MN55744
Itasca County, 31

**Establishment Info:**
ID #: 0037731
Risk:
Announced Inspection: No

**License Categories:**

Expires on: / /

**Operator:**

Phone #: 2183279463
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.

**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.

ESTABLISHMENT IS JUST READING THE TEMPERATURE GAUGE ON THE MACHINE.

*Comply By: 01/06/25*

**Surface and Equipment Sanitizers**

Hot Water: = at >160F Degrees Fahrenheit
Location: WARE WASH MACHINE-KITCHEN 1
Violation Issued: No

Hot Water: = at >160F Degrees Fahrenheit
Location: WARE WASH MACHINE-KITCHEN 2
Violation Issued: No

Quaternary Ammonia: = 400PPM at Degrees Fahrenheit
Location: SPRAY BOTTLE
Violation Issued: No

**Food and Equipment Temperatures**

Process/Item: MILK
Temperature: 39 Degrees Fahrenheit - Location: FRIDGE KITCHEN 1
Violation Issued: No

Process/Item: MILK
Temperature: 40 Degrees Fahrenheit - Location: FRIDGE KITCHEN 2
Violation Issued: No

Type: Full
Date: *01/06/25*
Time: 12:32:48
Report: 7939251004
Diamond Willow Of Grand Rapids

# Food and Beverage Establishment Inspection Report

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

DISCUSSION
ESTABLISHMENT USES PREMIXED QUATERNARY AMMONIA SANITIZER. SANTIZER IS NOT MIXED OR CUT WITH WATER. DISCUSSED PH TEST PAPERS IF THE SANITIZER IS CUT WITH WATER OR SOMETHING ELSE

TESTING WARE WASH MACHINE OPTIONS DISCUSSED WITH CFPM AND LINKS TO DIFFERENT TESTING OPTIONS ENCLOSED WITH THIS EMAIL.

ALL MEALS COOKED FOR THE MEAL(BREAKFAST, LUNCH OR DINNER) AND LEFTOVERS TOSSED OUT.

**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 7939251004 of 01/06/25.

Certified Food Protection Manager: SHELLEY BROBERG

Certification Number: FM122429 Expires: 03/29/27

**Inspection report reviewed with person in charge and emailed.**

Signed: N R

SHELLEY BROBERG
CFPM

Signed:

RYAN TRENBERTH
SAN III
BEMIDJI DISTRICT OFFICE
218-308-2133
ryan.trenberth@state.mn.us