*Protecting, Maintaining and Improving the Health of All Minnesotans*

# State Rapid Response Investigative Public Report

*Office of Health Facility Complaints*

**Maltreatment Report #:** HL253806722M
**Compliance #:** HL253801160C

**Date Concluded:** January 14, 2025

**Name, Address, and County of Licensee Investigated:**
Diamond Willow Assisted Living
1558 Randolph Road
Detroit Lakes, MN 56501
Becker County

**Facility Type:** Assisted Living Facility with Dementia Care (ALFDC)

**Evaluator's Name:**
Katherine Barnhardt RN, Special Investigator

**Finding:** Substantiated, facility responsibility

**Nature of Investigation:**
The Minnesota Department of Health investigated an allegation of maltreatment, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557, and to evaluate compliance with applicable licensing standards for the provider type.

**Initial Investigation Allegation(s):**
The alleged perpetrator (AP), facility staff, neglected the resident when the AP did not follow the resident's plan of care, falsely documented services were completed, and the resident fell from a mechanical lift.

**Investigative Findings and Conclusion:**
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. Facility licensed staff failed to accurately assess and care plan in order to provide the resident with appropriate transfer assistance following the resident's change in condition. As a result, the resident fell from a standing lift.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted a hospice agency and a family member. The investigation included review of the resident record, death record, hospital records, pharmacy records, facility incident reports, personnel files, staff schedules, and related

facility policy and procedures. Also, the investigator observed facility staff provide cares and transfer a resident.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia. The resident's service plan included assistance with medication administration and activities of daily living (ADL's). The resident's assessment indicated the resident was disoriented daily, had a lumbar (low back) fracture, was a full code (CPR), was dependent on staff for wheelchair mobility, and oxygen assistance.

The resident's record indicated the resident was hospitalized for pain from a compression fracture (break in the bones of the back causing a collapse) and returned to the facility. Discharge instructions from the first hospitalization included a specialized orthopedic back brace, several new pain medications, supplemental oxygen, and two staff for all transfers.

The resident's record indicated the resident had received the new pain medications for three days when licensed staff observed the resident with increased lethargy, shallow breathing, and leaning to one side. The resident's record indicated licensed staff had not reassessed the resident's ability to safely transfer and interventions were not implemented with the change in the resident's condition. The resident's plan of care for transfers had not changed from a standing lift (utilizes hydraulic arms and a sling requiring participation from the resident to stand and hold on) and three days after the observation by licensed staff the resident fell from the lift. The resident was hospitalized for two days.

Hospital records indicated the resident was seen at the emergency room after falling from the standing lift. An emergency room physician diagnosed the resident with acute hypoxic (inadequate supply of oxygen) respiratory failure due to sedation, somnolence (excessive sleepiness), and possible restriction to breathing caused by the resident's back brace. The physician immediately discontinued the resident's new pain medications that caused the heavy sedation. The resident was hospitalized for two nights and discharged back to the facility with hospice orders.

Hospice records indicated the resident was admitted after a hospitalization from a fall from a standing lift. Hospice records indicated the resident experienced pain, decreased activity, increased confusion, and lethargy likely from sedating medications. Physical therapy and occupational therapy attempted to evaluate the resident; however, the resident was unable to stay alert long enough to complete therapy. Hospice records indicated the resident fell from the mechanical standing lift because the resident was unable to hang on.

During an interview, unlicensed staff stated she and a second unlicensed staff had started to transfer the resident with a standing lift when the resident was not able to hang on and fell. Unlicensed staff stated the resident's ability to assist staff with using the standing lift had declined and the standing lift "didn't seem like the proper transfer equipment".

During an interview, the AP stated she and a second unlicensed staff had started to transfer the resident in the standing lift when the resident could not hold on and fell from the lift. The AP stated transfer concerns had been reported to two licensed staff several times and the AP was unsure if anything had been done about the reports. The AP stated she was uncomfortable with the directives given by licensed staff for the transfers and the transfers were difficult with two unlicensed staff.

During an interview, licensed staff stated the resident had many changes and two hospitalizations a couple weeks apart. Licensed staff stated the resident had several pain medications added after the first hospitalization. Licensed staff stated the second hospitalization occurred when the resident fell out of a standing lift. Licensed staff stated unlicensed staff had reported the resident had increased weakness and difficulty hanging on to the standing lift, however, it was the facility policy that each resident provide their own Hoyer lift (mechanical lift utilizes a body sling for transfers). Licensed staff stated she observed the resident's lethargy, leaning to one side and shallow breathing, however, had not changed transfer directives to a Hoyer lift because therapy had not made a recommendation for a Hoyer lift. Licensed staff stated she left for vacation two days prior to the fall and was unable to observe every transfer. Licensed staff stated a second licensed staff shared the responsibility of overseeing transfers and updating care plans.

During an interview, a family member stated licensed staff had voiced concerns to the family about the facility's ability to continue providing care for the resident because the facility did not have the proper equipment to meet the resident's needs. A family member stated unlicensed staff told the family they were uncomfortable transferring the resident with the standing lift the day the resident fell because the resident had almost slipped out of the standing lift earlier that day.

In conclusion, the Minnesota Department of Health determined neglect was substantiated.

**Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.**
"Substantiated" means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

**Neglect: Minnesota Statutes, section 626.5572, subdivision 17**
"Neglect" means neglect by a caregiver or self-neglect.
(a) "Caregiver neglect" means the failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:
(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
(2) which is not the result of an accident or therapeutic conduct.

**Vulnerable Adult interviewed**: Deceased
**Family/Responsible Party interviewed**: Yes.
**Alleged Perpetrator interviewed**: Yes

**Action taken by facility:**
The facility collaborated with an outside agency to provide services for the resident.

**Action taken by the Minnesota Department of Health:**
The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:

https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

You may also call 651-201-4200 to receive a copy via mail or email.

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Becker County Attorney
Detroit Lakes City Attorney
Detroit Lakes Police Department

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 25380 | A. BUILDING: _____ B. WING _____ | C 12/17/2024 |

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| DIAMOND WILLOW ASSISTED LIVING | 1558 RANDOLPH ROAD DETROIT LAKES, MN 56501 |

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| 0 000 | Initial Comments<br><br>ASSISTED LIVING LICENSING CORRECTION ORDER(S)<br><br>In accordance with Minnesota Statutes, section 144G.01 to 144G.95, these correction orders are issued pursuant to a complaint investigation.<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>#HL253806722M/#HL253801160C<br><br>On December 17, 2024, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 23 residents receiving services under the assisted living with dementia license.<br><br>The following correction orders are issued for #HL253806722M/#HL253801160C , tag identification 1620, 1650, 1940, 1950, 1960, and 2360. | 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><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><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.<br><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. | |
| 01620 SS=D | 144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring | 01620 | | |

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| 01620 | Continued From page 1<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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to complete an accurate comprehensive reassessment by a registered nurse (RN) for one of one resident (R1) with a change of condition, including addition of interventions as needed with a change of conditions.<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 | 01620 | | |

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| 01620 | Continued From page 2<br><br>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>R1's diagnoses included dementia and diabetes mellitus type 2.<br><br>R1's Service Plan dated July 18, 2024, indicated R1 received services to include: medication administration, safety checks, dressing, grooming, toileting, transfers, bathing, housekeeping, and laundry. R1 lacked an updated service plan to include repositioning, oxygen supplementation, and wound care.<br><br>R1's clinical monitoring and reassessment hospital return dated October 14, 2024, indicated the following:<br>- cognitive impairment;<br>- significant transfer assistance with two staff and a Sara Steady (mechanical device utilizing a lift bar and sling that requires the resident to hold on and assist staff to raise themselves from a seated to standing position);<br>- utilized a TLSO (thoracic lumbar sacral orthosis that limits spinal motion from mid back to low back) brace;<br>- had decreased muscle coordination;<br>- significant toileting assist with two staff transfer with Sara Steady;<br>- fall risk score of 8 out of 10;<br>- resuscitation code directed unlicensed personnel (ULP's) to perform CPR; and<br>- the assessment was electronically signed that all current health conditions were reviewed.<br><br>R1's October 2024 electronic medication record | 01620 | | |

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| 01620 | Continued From page 3<br><br>(EMAR) indicated from October 14 through October 16, 2024; the following pain medications were added to R1's daily medication administration:<br>- Doxepin 10 milligrams (mg) daily every bedtime for sleep started August 2021;<br>- Oxycodone 5 mg two times daily for pain started October 14, 2024;<br>- Oxycodone 2.5 mg every four hours as needed (PRN) for pain started October 14, 2024;<br>- Gabapentin 100 mg three times daily for pain started on October 15, 2024; and<br>- Tylenol 1000 mg three times daily for pain, not to exceed 3000 mg in 24-hour period started October 16, 2024.<br><br>R1's progress note dated October 17, 2024, at 3:45 p.m., indicated clinical nurse supervisor (CNS)-B observed R1's increased lethargy, leaning slightly to the right, arousing with verbal stimuli, shallow breathing and fluctuating oxygen saturations levels ranging from 80% to 92%.<br><br>R1's clinical monitoring and change in condition reassessment dated October 18, 2024, indicated the following:<br>- cognitive impairment;<br>- decreased muscle coordination;<br>- significant two staff transfer assistance with a Sara Steady;<br>- TLSO back brace due to a lumbar fracture when up;<br>- dependent on staff for administration of as needed (PRN) oxygen;<br>- as needed oxycodone, however, did not include scheduled oxycodone;<br>- resuscitation code directed ULP's to perform CPR; and<br>- the assessment was electronically signed that all current health conditions and medications | 01620 | | |

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| 01620 | Continued From page 4<br>were reviewed.<br><br>R1's assessment dated October 18, 2024, lacked to include a fall risk assessment and review of the safe transfer ability of R1 with a Sara Steady.<br><br>R1's progress notes dated October 18, 2024, indicated CNS-B updated a provider R1 was administered oxygen overnight, and R1 was not participating in activities of daily living (ADL's). CNS-B requested an oxygen order. The provider discussed hospice with CNS-B, however, the provider did not feel R1 was hospice appropriate. Physical therapy was ordered, and an evaluation completed.<br><br>R1's record indicated on October 20, 2024, R1 fell from a Sara Steady when two staff transferred R1 as directed by R1's plan of care. R1 was transported to the emergency room.<br><br>R1's clinical monitoring and reassessment dated October 21, 2024, (R1 was hospitalized until October 22, 2024) indicated the following:<br>- cognitive impairment;<br>- extensive assistance of 1-2 staff for repositioning;<br>- significant two staff transfer assistance with a Sara Steady;<br>- TLSO back brace due to a lumbar fracture when up;<br>- dependent on staff for oxygen administration of 1-4 liters per minute (LPM) per nasal cannula;<br>- significant two staff assist transfer to a bathroom with Sara Steady for toileting services;<br>- resuscitation code directed ULP's to perform CPR; and<br>- the assessment was electronically signed that all current health conditions including a face-to-face assessment/ medication review for | 01620 | | |

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| 01620 | Continued From page 5<br><br>side effects, adverse reactions and contraindications was completed.<br><br>R1's assessment dated October 21, 2024, (R1 was hospitalized until October 22, 2024) lacked to include a fall risk assessment and review of the safe transfer ability of R1 with a Sara Steady.<br><br>R1's hospital after visit summary (AVS) dated October 22, 2024, indicated R1 was diagnosed by the emergency room physician with acute hypoxic respiratory failure due to sedation, excessive sleepiness, and possible restriction from TLSO (thoracic lumbar sacral orthosis that limits spinal motion from mid back to low back) brace. R1 returned to the facility with orders for sedation medications to be discontinued "right now", start hospice services and oxygen supplement. The AVS indicated R1's resuscitation code as do not resuscitate (DNR).<br><br>On October 22, 2024, R1 was admitted to hospice services.<br><br>R1's hospice records dated October 22, 2024, indicated R1's diagnosis included end stage dementia and a lumbar fracture. R1's hospice evaluation included compromised nutritional status, oxygen 2-4 LPM as needed and directed no intervention in the event of a cardiac event (DNR).<br><br>R1's clinical monitoring and return from hospital reassessment dated October 22, 2024, indicated the following:<br>- cognitive impairment;<br>- extensive assistance of 1-2 staff for repositioning;<br>- transfer category - directed two staff transfer with Hoyer (mechanical device utilizing a body | 01620 | | |

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| 01620 | Continued From page 6<br><br>sling) lift;<br>- mobility category - directed two staff utilize a sit-to-stand (ex: Sara Steady) for mobility;<br>- respiratory equipment category - no special respiratory equipment (R1 utilized oxygen concentrator daily with staff assistance);<br>- TLSO back brace due to a lumbar fracture when up;<br>- monitor oxygen due to history of dropping oxygen levels;<br>- respiratory function category - staff directed to encourage cough and deep breathe if oxygen level drops below 90%, PRN oxygen available for oxygen level below 90%;<br>- resuscitation code directed ULP's to perform CPR; and<br>- the assessment was electronically signed that all current health conditions were reviewed.<br><br>R1's assessment dated October 22, 2024, lacked accuracy, and included conflicting instructions for ULP's who provided cares and services for R1.<br><br>R1's clinical monitoring and reassessment dated October 23, 2024, indicated the following:<br>- cognitive impairment;<br>- extensive assistance of 1-2 staff for repositioning;<br>- respiratory equipment category - no special respiratory equipment (R1 utilized oxygen concentrator daily with staff assistance);<br>- TLSO back brace due to a lumbar fracture when up;<br>- monitor oxygen due to history of dropping oxygen levels;<br>- respiratory function category - staff directed to encourage cough and deep breathe if oxygen level drops below 90%, PRN oxygen available for discomfort;<br>- resuscitation code directed ULP's to perform | 01620 | | |

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| 01620 | Continued From page 7<br><br>CPR; and<br>- the assessment was electronically signed that all current health conditions were reviewed.<br><br>R1's assessment dated October 23, 2024, lacked accuracy, and included conflicting instructions for ULP's who provided cares and services for R1.<br><br>On December 20, 2024, at 11:01 a.m., ULP-D stated R1 was initially sent to the emergency room for back pain and the hospital found a compression fracture. ULP-D stated R1 returned to the facility and staff assisted R1 with supplemental oxygen and a back brace. ULP-D stated R1 had a significant decline in abilities to assist staff with cares, was difficult to transfer with a sit-to-stand lift, and R1 "was clearly not getting enough oxygen" indicated by bluish lips. ULP-D stated she and other ULP's reported concerns about cares and transfers with a sit-to-stand lift because the sit-to-stand "didn't seem like the proper transfer equipment" and "the care plan needed to be reassessed for sure".<br><br>On December 23, 2024, at 1:34 p.m., CNS-B stated she was still in training and was learning the assessment process with a second licensed staff. CNS-B stated staff had reported R1 had a significant change in ability to transfer. CNS-B stated staff were directed to follow R1's master care plan, however, they should know not to follow the directive to start CPR on a hospice resident and a Hoyer (mechanical transfer utilizing a body sling) lift was not used before R1's fall because therapy had not recommended it. CNS-B stated ULP's should have contacted a licensed staff if R1 had symptoms of low oxygen levels, however, instructions for ULP's to contact a licensed staff were not included in the assessment and, "they should know that, it's | 01620 | | |

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| 01620 | Continued From page 8<br>building standard".<br><br>Licensee's Assessments, Reviews and Monitoring policy reviewed and updated December 11, 2024, indicated a reassessment must include all the elements of the uniform assessment tool as required, conducted in person, in writing, dated and signed by the registered nurse who conducted the assessment.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) days. | 01620 | | |
| 01650 SS=D | 144G.70 Subd. 4 (f) Service plan, implementation and revisions to<br><br>(f) The service plan must include:<br>(1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences;<br>(2) the identification of staff or categories of staff who will provide the services;<br>(3) the schedule and methods of monitoring assessments of the resident;<br>(4) the schedule and methods of monitoring staff providing services; and<br>(5) a contingency plan that includes:<br>(i) the action to be taken if the scheduled service cannot be provided;<br>(ii) information and a method to contact the facility;<br>(iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has | 01650 | | |

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| 01650 | Continued From page 9<br><br>authority to sign for the resident in an emergency; and<br>(iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure the service plan included all required content for one of one resident (R1) with records reviewed.<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>R1's medical record indicated R1's diagnoses included dementia and diabetes mellitus type 2.<br><br>R1's Service Plan dated July 18, 2024, indicated R1 received services to include: medication administration, safety checks, dressing, grooming, toileting, transfers, bathing, housekeeping and laundry. R1 lacked an updated service plan to include repositioning and treatments.<br><br>R1's record included two prescriber orders dated October 18, 2024, and October 21, 2024, | 01650 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| DIAMOND WILLOW ASSISTED LIVING | 1558 RANDOLPH ROAD DETROIT LAKES, MN 56501 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
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| 01650 | Continued From page 10<br><br>respectively and indicated R1 received treatments/therapy services to include: oxygen as needed to keep saturations above 90% and oxygen as needed 2-4 liter per minute (LPM) per comfort and wound care.<br><br>R1's service plan lacked the following required content:<br>- a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; and<br>-the identification of staff or categories of staff who will provide the services.<br><br>R1's Service Recap Summary dated October 2024 and November 2024, respectively, indicated unlicensed personnel (ULP) signed off assistance to R1 with daily oxygen, repositioning every two hours and wound care.<br><br>On December 23, 2024, at 1:34 p.m., CNS-B stated she updated service plans with a second licensed staff, and she was in training when significant changes occurred with R1. CNS-B stated the signed service plan did not include repositioning, oxygen, or wound care services.<br><br>Licensee's Service Plan policy dated October 23, 2024, indicated service plans shall be revised, if needed, based on resident reassessments and monitoring, and include a signature or other authentication by the licensee, resident or resident's representative, documenting agreement on services to be provided. Service plans shall include fees for the services, description of services, frequency of service based on most recent assessment and identification of staff or category of staff who will provide services. | 01650 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| 01650 | Continued From page 11<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION:<br>Twenty-One (21) days. | 01650 | | |
| 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 changes. | 01940 | | |

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| 01940 | Continued From page 12<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to develop an individualized treatment management plan to include all required content for one of one resident (R1) who received supplemental oxygen treatments.<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>R1's Service Plan dated July 18, 2024, indicated R1 received services to include: medication administration, safety checks, dressing, grooming, toileting, transfers, bathing, housekeeping, and laundry. R1 lacked an updated service plan to include treatments.<br><br>R1's prescriber's orders dated October 18, 2024, indicated R1 received treatments/therapy services to include: oxygen as needed 2-4 liters per minute (LPM) to keep saturations above 90%. R1's record lacked additional instructions for R1's oxygen use.<br><br>R1's electronic treatment administration record (ETAR) did not include oxygen.<br><br>R1's Service Recap Report dated October 2024, indicated staff signed off oxygen administration at | 01940 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| 01940 | Continued From page 13<br>12:00 a.m., and as a reminder service.<br><br>R1's progress notes dated October 18, 2024, through November 17, 2024, indicated the following written by clinical nurse supervisor (CNS)-B:<br>- continued oxygen overnight, verbal order: oxygen as needed to keep saturations above 90% due to low saturations at this time/past hypertension. Will continue to monitor.<br>- new order for oxygen. Oxygen arrived and set up at this time;<br>- vitals out of range, has prn oxygen;<br>- vitals out of range, has prn oxygen;<br>- vitals out of range, had staff do breathing exercises with her;<br>- on her way back, is on two liters per minute. Oxygen saturation 100%; and<br>- on two LPM.<br><br>On December 20, 2024, at 11:01 a.m., unlicensed personnel (ULP)-D stated ULP's applied oxygen as needed via nasal cannula when R1's oxygen saturation levels dropped below 90%. ULP-D stated when symptoms like bluish lips were noted the ULP's would apply the oxygen if R1 would allow it. ULP-D was unsure of what oxygen liters per minute (LPM) the concentrator was to be set at.<br><br>R1's record of treatment/therapy management plan lacked evidence of:<br>- documentation of specific resident instructions relating to the treatments or therapy administration;<br>- identification of treatment or therapy tasks that will be delegated to unlicensed personnel;<br>- procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy | 01940 | | |

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| 01940 | Continued From page 14<br><br>services; and<br>-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.<br><br>On December 20, 2024, at 1:01 p.m., clinical nurse supervisor (CNS)-B acknowledged R1's prescriber orders contained oxygen treatment and R1's treatment therapy plan did not include instructions for staff; however, staff could contact a nurse for direction.<br><br>Licensee's Medication and Treatment - Administration and Delegation policy, dated August 15, 2024, indicated the registered nurse would specify, in writing, specific instructions for each resident and document those instructions in the resident's record.<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days. | 01940 | | |
| 01950 SS=G | 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 | 01950 | | |

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| 01950 | Continued From page 15<br><br>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 interview and record review, the licensee failed to ensure specific written instructions for each resident were documented in one of one resident's record (R1) who received treatments. This failure had the potential to affect R1's health and safety.<br><br>This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to 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>R1's medical record indicated R1's diagnoses included dementia and diabetes mellitus type 2.<br><br>R1's Service Plan dated July 18, 2024, indicated R1 received services to include: medication administration, safety checks, dressing, grooming, toileting, transfers, bathing, housekeeping, and laundry. R1 lacked an | 01950 | | |

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| 01950 | Continued From page 16<br><br>updated service plan to include oxygen treatments, Prevalon boots, and wound care.<br><br>OXYGEN<br>R1's prescriber's orders dated October 18, 2024, and October 21, 2024, respectively, indicated R1 received treatments/therapy services to include: oxygen as needed (PRN) to keep saturations above 90% and oxygen as needed 2-4 liters per minute (LPM) for comfort.<br><br>R1's electronic treatment administration record (ETAR) dated October 2024 and November 2024 did not include oxygen.<br><br>R1's Service Recap dated October 2024 and November 2024, respectively, indicated unlicensed personnel (ULP) assisted R1 with application and removal of oxygen via nasal cannula daily starting on October 18, 2024, through November 18, 2024.<br><br>R1's October 2024 and November 2024 record lacked documentation of when and how much oxygen R1 was administered and by which staff.<br><br>On December 20, 2024, at 11:01 a.m., unlicensed personnel (ULP)-D stated ULP's knew R1 needed oxygen when R1 had increased confusion, or her lips were bluish in color. ULP-D was unaware of how many liters per minute (LPM) of oxygen was ordered and/or administered to R1. ULP-D stated the concentrator was usually always on and ULP's did not have to set up or look at anything other than to assist R1 with placement of the nasal cannula. ULP-D stated she had never verified the LPM on the concentrator.<br><br>PREVALON BOOTS<br>R1's prescriber's orders dated October 24, 2024, | 01950 | | |

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| 01950 | Continued From page 17<br><br>indicated R1 was to have Prevalon boots (used to reduce the risk of bedsores by keeping the heel floated) to both feet at all times.<br><br>R1's electronic treatment administration record (ETAR) dated October 2024 and November 2024 did not include Prevalon boots and did not include specific instructions to ULP's for the placement or removal of the boots.<br><br>R1's progress note dated November 11, 2024, indicated a Prevalon boot had been placed on R1's left foot, however, R1 had not had a right boot placed due to a delay in the facility receiving the right boot.<br><br>R1's October 2024 and November 2024 record lacked documentation the ULP's provided assistance to R1 for the application or removal of Prevalon boots as ordered. R1's record lacked specific instructions for ULP's.<br><br>WOUND CARE<br>R1's progress note dated October 9, 2024, indicated R1 had two coccyx wounds. R1's progress note dated October 18, 2024, indicated physical therapy (PT) had reported two new wound areas of concern to clinical nurse supervisor (CNS)-B. One pressure injury to left heel and a second pressure injury to right outer ankle. Progress notes indicated CNS-B requested treatment orders from R1's provider.<br><br>R1's prescriber orders dated October 24, 2024, indicated R1 was to have Prevalon boots applied to both feet at all times, however, did not include wound care orders.<br><br>R1's Service Recap dated October 2024 indicated ULP's assisted with uncomplicated | 01950 | | |

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| 01950 | Continued From page 18<br><br>wound care every three days. R1's Service Recap dated November 2024 did not include wound care.<br><br>R1's hospice plan of care dated November 13, 2024, included instructions for a licensed nurse to establish a skin care regimen, pressure relieving boots and "monitor for area on left shin as it appears it may open and drain".<br><br>On December 23, 2024, CNS-B stated licensed staff oversaw wound care weekly, updated the provider or hospice and CNS-B had requested wound care orders from the provider, however, the provider "didn't think the orders were necessary". CNS-B stated ULP's provided R1's wound care every three days to include wound cleaning, apply ordered ointment, and application/removal of mepilex (wound bandage).<br><br>Licensee's Medication and Treatment Record policy dated August 15, 2024, indicated licensee would create and maintain a correct and accurate treatment /therapy record for each resident receiving treatments and the registered nurse must specify in writing, specific instructions for each resident and document those instructions in the resident's record.<br><br>Licensee's Medication and Treatments Order policy dated October 23, 2024, indicated nursing was responsible for a current, authorized prescriber order for treatments administered by staff and kept on file in the resident's record.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days. | 01950 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| 01960 | Continued From page 19 | 01960 | | |
| 01960 SS=D | 144G.72 Subd. 5 Documentation of administration of treatments<br><br>Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure treatments or therapies were monitored and/or followed up on for effectiveness for one of one resident (R1) with supplemental oxygen, pressure sore reducing boots and wound care managed by the provider.<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>R1's medical record indicated R1's diagnoses included dementia and diabetes mellitus type 2. | 01960 | | |

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| 01960 | Continued From page 20<br><br>R1's Service Plan dated July 18, 2024, indicated R1 received services to include: medication administration, safety checks, dressing, grooming, toileting, transfers, bathing, housekeeping, and laundry. R1 lacked an updated service plan to include oxygen treatments, pressure sore reducing boots and wound care.<br><br>OXYGEN<br>R1's prescriber's orders dated October 18, 2024, and October 21, 2024, respectively, indicated R1 received treatment/therapy services to include: oxygen as needed (PRN) to keep saturations above 90% and oxygen as needed 2-4 liters per minute (LPM) per comfort.<br><br>R1's electronic treatment administration record (ETAR) dated October 2024 and November 2024 did not include oxygen.<br><br>R1's Service Recap dated October 2024 and November 2024, respectively, indicated unlicensed personnel (ULP) assisted R1 with application and removal of oxygen via nasal cannula daily starting on October 18, 2024. The Service Recap record lacked documentation of when and how much oxygen R1 was administered and by which staff.<br><br>R1's record did not include any follow up documentation by ULP's when as needed oxygen was administered and R1's record lacked documentation licensed staff followed up with ULP's when R1 was administered as needed oxygen.<br><br>On December 20, 2024, at 11:01 a.m., unlicensed personnel (ULP)-D stated ULP's knew R1 needed oxygen when R1 had increased confusion or lips | 01960 | | |

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| 01960 | Continued From page 21<br><br>were bluish in color and would apply R1's oxygen via nasal cannula. ULP-D was unaware of how many liters per minute (LPM) of oxygen was ordered and/or administered to R1 when oxygen was provided.<br><br>PREVALON BOOTS<br>R1's prescriber's orders dated October 24, 2024, indicated R1 was to have Prevalon boots (used to reduce the risk of bedsores by keeping the heel floated) to both feet at all times.<br><br>R1's electronic treatment administration record (ETAR) dated October 2024 and November 2024 did not include Prevalon boots.<br><br>R1's Service Recap dated October 2024 and November 2024, respectively, lacked documentation ULP's provided for R1's application or removal of Prevalon boots as ordered.<br><br>R1's Progress note dated November 11, 2024, indicated a Prevalon boot had been placed on R1's left foot, however, R1 had not had a right boot placed due to a delay in the facility receiving the right boot.<br><br>R1's record lacked documentation follow up or monitoring for effectiveness of treatments provided by ULP's was completed for R1's use of Prevalon boots treatment.<br><br>WOUND CARE<br><br>R1's progress note dated October 9, 2024, indicated R1 had two coccyx wounds. R1's progress note dated October 18, 2024, indicated physical therapy (PT) had reported two new wound areas of concern to clinical nurse | 01960 | | |

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| | 25380 | A. BUILDING: _____ B. WING _____ | C 12/17/2024 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 01960 | Continued From page 22<br><br>supervisor (CNS)-B. One pressure injury to left heel and a second pressure injury to right outer ankle.<br><br>R1's record did not include wound care orders.<br><br>R1's Service Recap dated October 2024 indicated ULP's assisted with uncomplicated wound care every three days. R1's Service Recap dated November 2024 did not include wound care documentation.<br><br>R1's electronic treatment administration record (ETAR) dated October 2024 included skin coordination wound care - uncomplicated every three days, however, did not include wound care supervision by a licensed staff. R1's November 2024 did not include wound care completed by ULP's or wound care supervision by a licensed staff, however R1 was receiving wound care treatments.<br><br>R1's record lacked ULP documentation of wound care treatments completed.<br><br>R1's hospice plan of care dated November 13, 2024, included instructions for a licensed nurse to establish a skin care regimen and implement pressure relieving boots.<br><br>On December 23, 2024, CNS-B stated licensed staff oversaw wound care weekly, updated the provider or hospice and CNS-B had requested wound care orders from the provider, however, the provider "didn't think the orders were necessary". CNS-B stated ULP's provided R1's wound care every three days to include wound cleaning, apply ordered ointment, and application/removal of mepilex (wound bandage). | 01960 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 25380 | A. BUILDING: _____ B. WING _____ | C 12/17/2024 |

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|---|---|---|---|---|
| 01960 | Continued From page 23<br><br>Licensee's Medications and Treatment Record - Documentation and Refusal policy dated August 23, 2024, indicated the provider would create and maintain a correct and accurate medication and/or treatment/therapy record for each resident receiving medication assistance or administration treatments and therapies utilizing the medication administration record (MAR) in Rtasks. Documentation of medication/treatment/therapy administration will be completed by the person who performed the task immediately after the medication assistance/administration is completed.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01960 | | |
| 02360 | 144G.91 Subd. 8 Freedom from maltreatment<br><br>Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act.<br><br>This MN Requirement is not met as evidenced by:<br>The facility failed to ensure one of one residents reviewed (R1) was free from maltreatment.<br><br>Findings include:<br><br>The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details. | 02360 | No plan of correction is required for this tag. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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