Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL236094061M
Compliance #: HL236094665C

Date Concluded: September 26, 2024

Name, Address, and County of Licensee Investigated:
Diamond Willow
915 Old Hwy 2
Proctor, MN 55810
St. Louis 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 facility neglected the resident when the facility failed to ensure the resident received necessary care and services and as a result, the resident developed pressure sores, a urinary tract infection, and weight loss.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The facility failed to ensure staff provided the resident with his care planned needs including catheter care, repositioning, and assist with eating. Due to the lack of care, the resident developed pressure sores, a urinary tract infection, and a 30-pound weight loss.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, unlicensed staff, and family members. The investigator contacted a home care agency and a staffing agency. The investigation included review of the resident record(s),

hospital records, pharmacy records, facility internal investigation, facility incident reports, personnel files, staff schedules, and related facility policy and procedures. The investigator observed staff provide direct cares for the residents.

The resident resided in an assisted living memory care unit. The resident's diagnoses included a double below the elbow amputation and diabetes. The resident's service plan included assistance with wound care, transfers, toileting, hygiene, eating and drinking. The resident's assessment indicated the resident was totally dependent on staff for assistance, at risk for dehydration and nutritional deficiencies, dependent on staff for catheter cares to prevent infection, and repositioning to prevent pressure ulcers. The resident was alert and oriented to person, place, and time.

The resident record indicated the resident had a recurring pressure sore on the coccyx (tailbone area), development of a pressure sore on the right shoulder blade, and a 30-pound weight loss over 8 months before discharge from the facility.

The resident's record indicated every day in one month, there were life sustaining services not provided for the resident. The resident's wound care services were to be completed by a licensed staff twelve times during the same month and were not completed six of the scheduled times. Also, staff failed to complete the resident's catheter cares, monitoring catheter output, eating and snack assistance, hygiene and toileting cares daily as assessed, care planned, and required for the resident.

Hospital records indicated the resident had catheter complications the first week of that same month and was evaluated at an emergency room. The resident's catheter bag contained dark red urine and blood. The resident was diagnosed with a severe urinary tract infection, prescribed antibiotics (medication to fight infection) and returned to the facility. Two days later staff told a contracted visiting home care nurse the resident's antibiotic had not been administered because the order had not been processed by a licensed nurse into the resident's electronic medication record. The first dose of antibiotic was administered over 48 hours after it was ordered by the emergency room physician.

During an interview, a contracted home care licensed staff stated her outside agency was asked to provide supplemental wound care services and catheter management for the resident due to the lack of staff at the resident's facility. The contracted licensed home care staff stated unlicensed personnel were expected to assist the resident twice daily with cleaning the catheter tube, emptying, and changing the catheter bag. The contracted licensed home care staff stated hygiene and catheter cares were not done and it contributed to the resident's urinary tract infection, skin breakdown and wound development. The licensed home care staff stated the resident had a coccyx pressure sore that would heal and reopen at various times, and repositioning the resident was important, but was not done. Licensed home care staff stated the lack of repositioning resulted in the development of a new pressure ulcer on the resident's right shoulder blade. The contracted licensed home care staff stated it was difficult to get

wound care and catheter orders processed or supplies ordered for the resident's cares because the facility had so few staff and often, she would see no staff when visiting the resident. The contracted licensed home care staff stated lack of repositioning, lack of hygiene assistance, poor nutritional intake, and rapid weight loss contributed to a decline in the resident's emotional and physical health. The contracted licensed home care staff stated she shared concerns about the resident's inability to access water and the lack of proper cares with a licensed facility nurse and requested a care conference on behalf of the resident.

During an interview, a facility licensed staff stated because the facility was unable to provide resident cares the facility contracted with a home care agency and two temporary staffing agencies. The licensed staff stated resident cares suffered because there was never enough staff. Licensed staff stated the resident's catheter changes and wound cares were managed by an outside agency, and she was grateful for their assistance. Licensed staff stated she had concerns for the health and safety of the residents.

During an interview, another licensed staff stated there were a lot of staffing shortages, even after temporary staff were contracted. The licensed staff stated she had not received any training for her role at the facility, and it was "heartbreaking to say", but the residents did not receive the cares assigned to them. Licensed staff stated repositioning, hygiene and shower services would not be completed for long periods of time due to lack of staff. The licensed staff denied the resident's wound cares were not completed however, stated if not documented the wound care was not completed. Licensed staff stated the resident would state he felt he was being emotionally and physically neglected. Licensed staff stated the resident told the contracted licensed home health staff he was not being fed but the resident denied saying that during the resident's care conference.

During an interview, the resident stated when he was a resident at the facility, the facility was "always short on help". The resident stated staff were scheduled to assist with catheter cares twice daily, however, "they didn't know anything about catheters". The resident stated he had help from a licensed home care for wounds and catheter care. The resident stated there were hygiene concerns, but staff did not have time to assist with showers, "there were some problems". The resident stated he would push his call pendant for assistance and "wait hours" because staff were "at another building across the road". The resident stated he did not care for the food and staff would "forget to come and get me". The resident stated he had a thirty-pound weight loss while a resident at the facility.

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: Yes
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: N/A

Action taken by facility:
The facility was in the process of hiring individuals to fill leadership roles on campus.

Action taken by the Minnesota Department of Health:
The responsible party will be notified of their right to appeal the maltreatment finding.

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.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23609	A. BUILDING: _____ B. WING _____	C 09/04/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments *****ATTENTION****** ASSISTED LIVING LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.01 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #HL236094061M/ HL236094665C #HL236094381M/HL236095270C On September 4, 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 30 residents receiving services under the assisted living with dementia license. The following correction orders are issued for # HL236094061M/#HL236094665C, tag identification 0250, 0470, 0730, 1350, 1450, 1750, 1760, 1960, 2070, and 2360. The following correction orders are issued for #HL236094381M#HL236095270C tag identification 0250, 0730, 1350, 1460, 1750, 1760, and 2070.	0 000	Assisted Living Provider 144G. Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23609	A. BUILDING: _____ B. WING _____	C 09/04/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 250	Continued From page 1	0 250		
0 250 SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4, or interferes with or impedes access by the Office of Ombudsman for Mental Health and Developmental Disabilities according to section 245.94, subdivision 1; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department;	0 250		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23609	A. BUILDING: _____ B. WING _____	C 09/04/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 250	Continued From page 2 (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the management officials who were in charge of the day-to-day operations; and responsible for the residents' assisted living services, understood all of the assisted living provider regulations; and the licensee failed to ensure policies and procedures were developed and/or implemented. This had the potential to affect all thirty (30) residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	0 250		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23609	A. BUILDING: _____ B. WING _____	C 09/04/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 250	Continued From page 3 The findings include: During an interview on September 13, 2024, at 11:30 a.m., registered nurse (RN)-H confirmed she was responsible for and participated in the facility's day-to-day operations. RN-H stated she was becoming familiar with the Assisted Living with Dementia licensing rules. The licensee's Application for Assisted Living License, section titled Official Verification of Owner or Authorized Agent, (page four and five of the application), identified, I certify I have read and understand the following: [a check mark was placed before each of the following]: - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45, my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17. - I have read and fully understand Minn. Stat. sect. 144G.80, 144G.81 and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22, my building(s) must comply with these sections if applicable. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G. - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659 (proposed and not final). - Reporting of Maltreatment of Vulnerable Adults. - Electronic Monitoring in Certain Facilities.	0 250		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23609	A. BUILDING: _____ B. WING _____	C 09/04/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 250	Continued From page 4 - I understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data, the Commissioner will use information provided in this application, which may include an in-person or telephone conference, to determine if the applicant meets requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying a license. I understand that information submitted to the commissioner in this application may, ins some circumstances, be disclosed to the appropriate state, federal or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices. - I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons, all data submitted on this application shall be classified as public information upon issuance of a provisional license or license. All data submitted are considered private until MDH issues a license. - I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659 (proposed and not final), governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract.	0 250		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23609	A. BUILDING: _____ B. WING _____	C 09/04/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 250	Continued From page 5 - I have examined this application and all attachments, and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct and complete. I will notify MDH, in writing, of any changes to this information as required. - I attest to have all required policies and procedures of Minn. Stat. chapter 144G (opens in new window). and Minn. Rules chapter 4659 (proposed and not final), in place upon licensure and to keep them current as applicable. Page five was electronically signed by the authorized agent, director of operations (DOO)-L on October 24, 2023. The licensee had an assisted living with dementia license issued on January 1, 2024, with an expiration date of December 31, 2024. The licensee had attested they read and understood the Assisted Living/Dementia Care licensing statues. The licensee failed to implement the following required policies and procedures: - orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; - medication and treatment management; - delegation of tasks by registered nurses or licensed health professionals; and	0 250		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23609	A. BUILDING: _____ B. WING _____	C 09/04/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 250	Continued From page 6 -supervision of unlicensed personnel performing delegated tasks. Refer to licensing order at Statute 144G.41, Subd. 1 (11-12). The licensee failed to provide adequate staffing to meet the needs of one of one resident (R1) who was fully dependent on staff for all needs. This failure had the potential to affect all residents requiring staff assistance. Refer to licensing order at Statute 144G.43, Subd. 3. The licensee failed to ensure licensee's staff documented services provided to resident services according to the residents' service plans for two of two residents (R1, R2) reviewed. This failure had the potential to affect all residents that resided at the licensee. Refer to licensing order at Statute 144G.60, Subd. 5. The licensee failed to ensure contracted staff met all requirements required for personnel employed by the facility for three of three unlicensed personnel (ULP-I, ULP-J, ULP-K) reviewed. This failure had the potential to affect all residents that resided at the licensee. Refer to licensing order at Statute 144G.63, Subd. 1. The licensee failed to ensure employees received orientation training to the assisted living licensing requirements and regulations for three of three unlicensed personnel (ULP)-I, ULP-J, ULP-K) reviewed. This failure had the potential to affect all residents that resided at the licensee. Refer to licensing order at Statute 144G.71, Subd. 7. The licensee failed to ensure prior to delegating the nursing task of medication administration, unlicensed personnel (ULP) were trained in the proper methods to perform the task	0 250		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23609	A. BUILDING: _____ B. WING _____	C 09/04/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 250	Continued From page 7 or procedure for each resident and were able to demonstrate the ability to competently follow the procedure for three of three unlicensed personnel (ULP)-I, ULP-J, ULP-K) reviewed. This failure had the potential to affect all the residents that resided at the facility. Refer to licensing order at Statute 144G.71, Subd. 8. The licensee failed to ensure medication administration documentation included the name and title of the person who administered the medication for two of two residents (R1, R2) with records reviewed. The licensee failed to transcribe physician orders on the medication administration record (MAR) to ensure medication was administered as prescribed for one of one resident (R1) reviewed. This failure had the potential to affect all residents that resided at the licensee. Refer to licensing order at Statute 144G.72, Subd. 5. The licensee failed to ensure treatments or therapies were administered as prescribed and if not administered, the reason why they were not provided was documented for one of one resident (R1) reviewed with wounds managed by the provider. This practice had the ability to affect all residents that resided at the licensee who required any type of treatment and therapy services. Refer to licensing order at Statute 144G.81, Subd. 4. The licensee failed to ensure one or more persons were physically present and available 24 hours a day, seven days a week, who were responsible for responding to requests for assistance with health and safety needs of residents in four of four secured memory care buildings on campus. This had the potential to affect all 30 residents residing in the memory care	0 250		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23609	A. BUILDING: _____ B. WING _____	C 09/04/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 250	Continued From page 8 buildings. On September 13, 2024, at 11:30 a.m., RN-H stated temporary staff were setup through the scheduling department and would show up at the facility ready to work. RN-H stated temporary staff were allowed to administer medications based off agency information. RN-H stated temporary staff were not medication trained or competency tested by facility nurses. Four (4) level 3 orders were issued, which indicated the licensee's understanding of the Minnesota statutes were limited or not evident for compliance with sections 144G.08 to 144G.9999. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 250		
0 470 SS=H	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week,	0 470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23609	A. BUILDING: _____ B. WING _____	C 09/04/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 470	Continued From page 9 who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide adequate staffing to meet the needs of one of one resident (R1) reviewed who was fully dependent on staff for all needs. This failure caused the resident actual harm and had the potential to affect all residents requiring staff assistance. 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 a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 admitted to the facility on November 7, 2023, and resided in one of four buildings on the campus.	0 470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23609	A. BUILDING: _____ B. WING _____	C 09/04/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 470	Continued From page 10 R1's assessment dated May 1, 2024, indicated R1's diagnoses included included a double amputation below the elbows and diabetes mellitus. The resident required one to two staff for all cares due to R1's below the elbow double amputation. The assessment indicated the resident required two staff to assist with all transfers, repositioning, toileting and one staff to provide feeding and hydration assistance. R1's record lacked a signed service plan. R1's hospital record dated June 2, 2024, indicated R1 was transported to the emergency room due to blood in his catheter bag and skin breakdown around the insertion site of the catheter. Hospital notes indicated R1's catheter bag was "nearly full of dark red urine" and positive for urinary tract infection (UTI). The emergency room physician prescribed an antibiotic (used to fight infection) to be started June 2, 2024, for twice daily treatments. R1 returned to the facility the same day. R1's electronic medication administration record (EMAR) dated June 2024, indicated the first dose of antibiotic was administered at 5:00 p.m. on June 4, 2024, forty-eight (48) hours after the physician ordered the antibiotic. R1's Service Recap Summary for May 2024 through July 2024, indicated the following dates and shifts priority cares and services were not completed: CATHETER CARES May 12, 23,24, 26, 31, 2024. a.m. shift May 1, 15, 18, 22, 23, 26, 27, 31, 2024. p.m. shift May 11, 12, 29, 30, 2024. overnight shift June 1, 2, 5, 7, 8, 9, 10, 16, 19, 20, 21, 22, 23,	0 470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23609	A. BUILDING: _____ B. WING _____	C 09/04/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 470	Continued From page 11 24, 29, 2024. a.m. shift June 2, 5, 7, 8, 10, 28, 2024. p.m. shift June 24, 2024. overnight shift July 3, 6, 9, 12, 14, 2024. a.m. shift July 12, 15, 2024. p.m. shift July 10, 10, 15, 2024. overnight shift EATING ASSIST May 12, 23, 24, 26, 31, 2024. a.m. shift May 15, 18, 22, 23, 26, 27, 31, 2024. p.m. shift May 11, 29, 30, 2024. overnight shift June 1, 2, 5, 7, 8, 9, 10, 19, 20, 21, 22, 23, 24, 29, 2024. a.m. shift June 2, 5, 7, 8, 10. 2024. p.m. shift June 1, 24, 2024. overnight shift July 3, 6, 9, 12, 14, 2024. a.m. shift July 11, 15, 2024. p.m. shift FOOD INTAKE May 1, 3, 12, 16, 23, 24, 26, 27, 29, 31, 2024. Scheduled 9:00 a.m. assist May 1, 3, 12, 13,16, 20, 21, 23, 24, 26, 27, 28, 29, 31, 2024. Scheduled 1:00 p.m. assist May 1, 4, 8, 10, 15, 18, 20, 22, 23, 26, 27, 28, 31, 2024. Scheduled 6:00 p.m. assist June 1, 2, 5, 6, 7, 8, 9, 10, 11, 13, 17, 19, 20, 21, 22, 23, 24, 25, 29, 30, 2024. Scheduled 9:00 a.m. assist June 1, 2, 5, 6, 7, 8, 9, 10, 13, 16, 19, 20, 21, 22, 23, 24, 25, 29, 30, 2024. Scheduled 1:00 p.m. assist June 2, 4, 5, 7, 8, 10, 11, 12, 13, 22, 25, 29, 2024. Scheduled 6:00 p.m. assist July 2, 3, 6, 9, 12, 14, 2024. Scheduled 9:00 a.m. assist July 2, 3, 6, 9, 11, 12, 14, 2024. Scheduled 1:00 p.m. assist July 1, 10, 11, 15, 2024. Scheduled 6:00 p.m. assist	0 470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23609	A. BUILDING: _____ B. WING _____	C 09/04/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 470	Continued From page 12 WOUND CARES May 2, 9, 20, 27, 2024, four out of nine scheduled times. June 3, 17, 20, 24, 2024, four out of eight scheduled times. July 4, 8, 15, 2024, three out of four scheduled times. SKIN CHECKS May 6, 20, 27, 2024, three out of four scheduled times. June 3, 17, 24, 2024, three out of four scheduled times. July 8, 15, 2024, two out of two scheduled times. A staffing schedule dated June 1, 2024, through July 12, 2024, indicated the following dates R1's building was staffed inadequately to meet R1's needs. The building R1 resided in required two staff scheduled per shift, with the exception of night shift, due to the level of cares and mechanical lift equipment used in the building. The building lacked two staff per shift for the following dates and shifts: JUNE 2024 June 1, 2024 - no staff scheduled 6:30 a.m. to 2:30 p.m., one staff scheduled 2:30 to 10:30 p.m. June 2, 2024 - one staff scheduled 6:30 a.m. to 2:30 p.m. June 3, 2024 - one staff scheduled 6:30 a.m. to 2:30 p.m., one staff scheduled 2:30 to 10:30 p.m. June 4, 2024 - one staff scheduled 6:30 a.m. to 2:30 p.m., one staff scheduled 2:30 to 10:30 p.m. June 5, 2024 - one staff scheduled 6:30 a.m. to 2:30 p.m., one staff scheduled 2:30 to 10:30 p.m. June 6, 2024 - no staff scheduled 6:30 a.m. to 2:30 p.m. June 7, 2024 - one staff scheduled 6:30 a.m. to 2:30 p.m., one staff scheduled 2:30 to 10:30 p.m.	0 470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23609	A. BUILDING: _____ B. WING _____	C 09/04/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 470	Continued From page 13 June 8, 2024 - no staff scheduled 6:30 a.m. to 2:30 p.m., no staff scheduled 2:30 to 10:30 p.m. June 9, 2024 - one staff scheduled 6:30 a.m. to 2:30 p.m., one staff scheduled 2:30 to 10:30 p.m. June 10, 2024 - one staff scheduled 6:30 a.m. to 2:30 p.m., one staff scheduled 2:30 to 10:30 p.m. June 11, 2024 - one staff scheduled 6:30 a.m. to 2:30 p.m., one staff scheduled 2:30 to 10:30 p.m. June 12, 2024 - no staff scheduled 6:30 a.m. to 2:30 p.m., one staff scheduled 2:30 to 10:30 p.m. June 13, 2024 - no staff scheduled 6:30 a.m. to 2:30 p.m., one staff scheduled 2:30 to 10:30 p.m. June 14, 2024 - one staff scheduled 6:30 a.m. to 2:30 p.m., one staff scheduled 2:30 to 10:30 p.m. June 15, 2024 - one staff scheduled 6:30 a.m. to 2:30 p.m., one staff scheduled 2:30 to 10:30 p.m. June 16, 2024 - one staff scheduled 6:30 a.m. to 2:30 p.m. June 17, 2024 - no staff scheduled 6:30 a.m. to 2:30 p.m. June 18, 2024 - no staff scheduled 6:30 a.m. to 2:30 p.m. June 19, 2024 - no staff scheduled 6:30 a.m. to 2:30 p.m. June 20, 2024 - one staff scheduled 6:30 a.m. to 2:30 p.m. June 21, 2024 - one staff scheduled 6:30 a.m. to 2:30 p.m., one staff scheduled 2:30 to 10:30 p.m. June 22, 2024 - no staff scheduled 6:30 a.m. to 2:30 p.m., one staff scheduled 2:30 to 10:30 p.m. June 23, 2024 - no staff scheduled 6:30 a.m. to 2:30 p.m. June 24, 2024 - one staff scheduled 6:30 a.m. to 2:30 p.m. June 25, 2024 - one staff scheduled 6:30 a.m. to 2:30 p.m., one staff scheduled 2:30 to 10:30 p.m. June 26, 2024 - one staff scheduled 6:30 a.m. to 2:30 p.m., one staff scheduled 2:30 to 10:30 p.m. June 27, 2024 - one staff scheduled 6:30 a.m. to 2:30 p.m.	0 470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23609	A. BUILDING: _____ B. WING _____	C 09/04/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 470	Continued From page 14 June 28, 2024 - one staff scheduled 6:30 a.m. to 2:30 p.m., one staff scheduled 2:30 to 10:30 p.m. June 29, 2024 - one staff scheduled 6:30 a.m. to 2:30 p.m., one staff scheduled 2:30 to 10:30 p.m. June 30, 2024 - one staff scheduled 6:30 a.m. to 2:30 p.m. JULY 2024 July 1, 2024 - no staff scheduled 6:30 a.m. to 2:30 p.m. July 2, 2024 - one staff scheduled 2:30 to 10:30 p.m. July 3, 2024 - no staff scheduled 6:30 a.m. to 2:30 p.m., one staff scheduled 2:30 to 10:30 p.m. July 4, 2024 - no staff scheduled 6:30 a.m. to 2:30 p.m. July 5, 2024 - one staff scheduled 6:30 a.m. to 2:30 p.m. July 6, 2024 - no staff scheduled 6:30 a.m. to 2:30 p.m., one staff scheduled 2:30 to 10:30 p.m. July 7, 2024 - one staff scheduled 6:30 a.m. to 2:30 p.m., one staff scheduled 2:30 to 10:30 p.m. July 8, 2024 - no staff scheduled 6:30 a.m. to 2:30 p.m. July 9, 2024 - one staff scheduled 6:30 a.m. to 2:30 p.m. July 10, 2024 - one staff scheduled 6:30 a.m. to 2:30 p.m., one staff scheduled 2:30 to 10:30 p.m. July 11, 2024 - one staff scheduled 6:30 a.m. to 2:30 p.m., one staff scheduled 2:30 to 10:30 p.m. July 12, 2024 - one staff scheduled 6:30 a.m. to 2:30 p.m. On September 4, 2024, at 11:10 a.m., the clinical nurse supervisor (CNS)-A stated she was unable to locate a service plan for R1 and provided an unsigned service plan printout from the electronic system to show R1's services. Services provided included medication administration, wound care, catheter care, ambulation, oral care, toileting,	0 470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23609	A. BUILDING: _____ B. WING _____	C 09/04/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 470	Continued From page 15 transfer assist, food intake, grooming, dressing, bathing, housekeeping and laundry. On September 10, 2024, at 9:00 a.m., LPN-C stated the facility never had enough staff and the majority of her time was spent working on the floor. LPN-C stated shortly after she started the clinical nurse supervisor (CNS) and licensed assisted living director (LALD) left employment with the facility and it left nobody onsite in charge. LPN-C stated staff would leave during shifts and just click tasks "complete" in the electronic system before their shift started, "it was really bad". LPN-C stated licensed staff knew unlicensed staff were not completing cares but staff were marking them completed because the time stamps would indicate all the services were completed at the same time. LPN-C stated R1 was a double arm amputee and was unable to do anything for himself. During an interview on September 10, 2024, at 2:00 p.m., the contracted home care registered nurse (RN)-D stated during a visit on June 4, 2024, she asked staff if R1 was getting the antibiotic that had been ordered from the emergency room physician and was told by unlicensed personnel (ULP), it had not been started because there was not a nurse available to enter it into the electronic medication system. RN-D stated she requested a care conference with the care management team and R1 to address the lack of staff and the lack of cares provided for R1. RN-D stated R1 could not even get himself water without staff assistance and she was concerned. RN-D stated the facility had very few staff and the only person in charge she could find was a LPN and often could not find the LPN, "a lot of times I seen nobody" (referring to staff) when visiting R1. Additionally, RN-D stated R1	0 470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23609	A. BUILDING: _____ B. WING _____	C 09/04/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 470	Continued From page 16 had lost 30 pounds since moving into the facility eight months prior. On September 13, 2024, at 11:30 a.m., RN-H stated temporary staff were brought in frequently, everyday, to assist the facility with staffing because of staff burnout. RN-H stated she was aware services were not being completed and would be alerted on the electronic system dashboard which services were not completed. RN-H stated it was possible at times only one staff would be present in each of the buildings. The licensee's staffing plan revised April 26, 2024, indicated two staff present each shift in the two larger, higher acuity buildings and one staff each in each of the two smaller, lower acuity buildings, with the exception of nights which required one staff in each building at night with a float to go between each house and assist. No additional information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 470		
0 730 SS=F	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known;	0 730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23609	A. BUILDING: _____ B. WING _____	C 09/04/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 730	Continued From page 17 (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure licensee's staff	0 730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23609	A. BUILDING: _____ B. WING _____	C 09/04/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 730	Continued From page 18 documented services provided according to the residents' service plans for two of two residents (R1, R2) reviewed. This failure had the potential to affect all residents that resided at the licensee. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1's assessment dated May 1, 2024, indicated R1's diagnoses included Type II diabetes mellitus and a double below the elbow amputation. R1's record lacked a signed service plan. R1's service recap summary for June 2024, included the following scheduled services: catheter care, dressing, eating, grooming, mobility, oral care, toileting, transfer assist, behavior management, fall coordination, housekeeping, medication administration, miscellaneous tasks, monitor bowel movement, safety call pendant check, skin coordination/wound care, food intake, assistance with a snack and drink, monitoring urine output, and bathing assistance. R1's record lacked documentation verifying R1 received the following services from June 1, 2024, through June 30, 2024: - 23 of 180 scheduled services for medication administration; - 14 of 42 scheduled services for monitoring urine	0 730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23609	A. BUILDING: _____ B. WING _____	C 09/04/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 730	Continued From page 19 output; - 23 of 90 scheduled services for catheter cares; - 19 of 60 scheduled services for dressing; - 21 of 90 scheduled services for eating; - 20 of 60 scheduled services for grooming; - 22 of 90 scheduled services for mobility; - 21 of 60 scheduled services for oral care; - 38 of 90 scheduled services for toileting; - 24 of 90 scheduled services for transfers; - 24 of 90 scheduled services for behavior management; - 23 of 90 scheduled services for fall coordination; - 15 of 60 scheduled services for housekeeping; - 46 of 123 scheduled services for miscellaneous tasks; - 25 of 60 scheduled services for monitoring bowel movements; - 20 of 60 scheduled services for safety pendant checks; - 50 of 90 scheduled services for food intake; - 45 of 90 scheduled services for offering snack and drink; - 50 of 90 scheduled services for food intake; and - 7 of 12 scheduled services for wound care, skin checks by facility nurses. R2's resident profile with an admission date of November 16,2023, indicated R1's diagnoses included dementia and hypertension (elevated blood pressure). R2's service plan dated November 16, 2023, indicated R2 received services including medication administration, oral cares, toileting, transfers, food intake, safety pendant checks, housekeeping and laundry. R2's Service Recap Summary for June 2024 included the following scheduled services: monitor weight, activity coordination, dressing,	0 730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23609	A. BUILDING: _____ B. WING _____	C 09/04/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 730	Continued From page 20 eating, grooming, mobility, oral care, toileting, transfers, fall coordination, medication management, monitor bowel movement, observation blood thinner, safety pendant checks, food intake, snack and drink, housekeeping and laundry. R2's record lacked documentation verifying R2 received the following services from June 1, 2024, through June 30, 2024: - 24 of 150 scheduled services for medication administration; - 10 of 30 scheduled services for monitor weight; - 7 of 60 scheduled services for dressing; - 6 of 60 scheduled services for eating; - 7 of 60 scheduled services for grooming; - 12 of 90 scheduled services for mobility; - 7 of 60 scheduled services for oral care; - 17 of 90 scheduled services for toileting; - 8 of 90 scheduled services for transfers; - 9 of 90 scheduled services for fall coordination; - 10 of 60 scheduled services for housekeeping; - 8 of 60 scheduled services for safety pendant checks; - 40 of 90 scheduled services for food intake; and - 11 of 60 scheduled services for offering a snack and drink. On September 4, 2024, at 11:10 a.m., the clinical nurse supervisor (CNS)-A stated she was unable to locate a service plan for R1 and provided an unsigned service plan printout from the electronic system to show R1's services. R1's services included medication administration, wound care, catheter care, ambulation, oral care, toileting, transfer assist, food intake, grooming, dressing, bathing, housekeeping and laundry. Additionally, R1 required skin coordination and uncomplicated wound care completed by a licensed practical nurse (LPN).	0 730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23609	A. BUILDING: _____ B. WING _____	C 09/04/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 730	Continued From page 21 On September 10, 2024, at 9:00 a.m., licensed practical nurse (LPN)-C stated the licensee was short on staff to provide cares, the staff were poorly trained or had no training prior to working with residents and staff were not held accountable for services not completed. On September 13, 2024, at 11:30 a.m., registered nurse (RN)-H stated she was aware services were not completed and was alerted to incomplete services on the nurse dashboard of the electronic records program. RN-H stated she was unaware of incomplete wound cares for R1 and was unsure why wound cares were not completed. RN-H stated if the service was not documented complete, it was not done. The licensee's policy Resident Record Documentation, dated August 15, 2024, indicated staff would document in the resident record for all medications, services, treatments and therapies residents received. No additional information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 730		
01350 SS=F	144G.60 Subd. 5 Temporary staff When a facility contracts with a temporary staffing agency, those individuals must meet the same requirements required by this section for personnel employed by the facility and shall be treated as if they are staff of the facility. This MN Requirement is not met as evidenced by:	01350		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23609	A. BUILDING: _____ B. WING _____	C 09/04/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01350	Continued From page 22 Based on interview and record review, the licensee failed to ensure contracted staff met all requirements required for personnel employed by the facility for three of three unlicensed personnel (ULP-I, ULP-J, ULP-K) reviewed. This failure had the potential to affect all residents that resided at the licensee. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During an entrance conference on September 4, 2024, at approximately 9:30 a.m., the licensed assisted living director (LALD)-B stated the licensee utilized two temporary staffing agencies. ULP-I's temporary staffing agency was contracted on May 22, 2022, to provide direct care services to the licensee's residents. ULP-J's temporary staffing agency was contracted on May 22, 2022, to provide direct care services to the licensee's residents. ULP-K's temporary staffing agency was contracted on May 22, 2022, to provide direct care services to the licensee's residents. ULP-I, ULP-J and ULP-K's employee files lacked evidence of competency training for medication administration and a supervised visit with a registered nurse within 30 days of performing	01350		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23609	A. BUILDING: _____ B. WING _____	C 09/04/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01350	Continued From page 23 delegated tasks, as required. On September 11, 2024, at 3:11 p.m., registered nurse (RN)-G stated temporary staff administered medications to the facilities residents every shift they worked, however, communication between facility nurses and leadership was poor and temporary staff were not provided any training by facility nurses. On September 13, 2024, at 11:30 a.m., RN-H stated temporary staff arrived at the site ready to work a shift, administer medications and provide whatever services to the facility's residents the site required. RN-H stated temporary staff were not competency tested prior to administering medications and was unaware temporary staff had to meet the same requirements as facility staff prior to working with residents. The licensee's Competency Training Evaluations policy dated August 15, 2024, indicated when a registered nurse or licensed health professional staff delegates tasks, prior to the delegation of services they must make certain the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each client and are able to demonstrate the ability to competently follow the procedures and perform the tasks and a copy of all education, training, and competency testing shall be kept in each employee's personnel file. No additional information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	01350		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23609	A. BUILDING: _____ B. WING _____	C 09/04/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01460	Continued From page 24	01460		
01460 SS=F	144G.63 Subdivision 1 Orientation of staff and supervisors All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, licensee failed to ensure employees received orientation training to the assisted living licensing requirements and regulations for three of three unlicensed personnel (ULP)-I, ULP-J, ULP-K) reviewed. This failure had the potential to affect all residents that resided at the licensee. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During an entrance conference on September 4, 2024, at approximately 9:30 a.m., licensed assisted living director (LALD)-B stated the licensee utilized two temporary staffing agencies. ULP-I's temporary staffing agency was contracted	01460		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23609	A. BUILDING: _____ B. WING _____	C 09/04/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01460	Continued From page 25 on May 22, 2022, to provide direct care services to the licensee's residents. ULP-J's temporary staffing agency was contracted on May 22, 2022, to provide direct care services to the licensee's residents. ULP-K's temporary staffing agency was contracted on May 22, 2022, to provide direct care services to the licensee's residents. ULP-I, ULP-J and ULP-K's employee records did not contain documentation a registered nurse (RN) completed orientation to the assisted living facility licensing requirements and regulations before providing assisted living services to residents. On September 11, 2024, at 3:11 p.m., RN-G stated temporary staff worked directly with the residents every shift they worked, however, communication between facility nurses and leadership was poor and temporary staff were not provided any training by facility nurses. On September 13, 2024, at 11:30 a.m., RN-H stated temporary staff arrived at the site ready to work a shift, and provide whatever services to the facility's residents the site required. RN-H stated temporary staff were not provided any training by facility nurses and was unaware temporary staff had to meet the same requirements as facility staff prior to working with residents. The licensee's Orientation of Staff and Supervisors and Content policy dated August 15, 2024, indicated all employees must complete the orientation to assisted living facility requirements to include an overview of the appropriate assisted living statutes and rules before providing assisted	01460		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23609	A. BUILDING: _____ B. WING _____	C 09/04/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01460	Continued From page 26 living services to residents. No additional information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	01460		
01750 SS=I	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to ensure prior to delegating the nursing task of medication administration, unlicensed personnel (ULP) were trained in the proper methods to perform the task or procedure for each resident and were able to demonstrate the ability to competently follow the procedure for three of three unlicensed personnel (ULP)-I, ULP-J, ULP-K) reviewed. This failure had the potential to affect all the residents that resided at the facility. This practice resulted in a level three violation (a violation that harmed a resident's health or safety,	01750		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23609	A. BUILDING: _____ B. WING _____	C 09/04/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01750	Continued From page 27 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 a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-I's temporary staffing agency was contracted on May 22, 2022, to provide direct care services to the licensee's residents. ULP-J's temporary staffing agency was contracted on May 22, 2022, to provide direct care services to the licensee's residents. ULP-K's temporary staffing agency was contracted on May 22, 2022, to provide direct care services to the licensee's residents. ULP-I, ULP-J and ULP-K's employee record lacked evidence ULP-I, ULP-J or ULP-K demonstrated competency to the registered nurse (RN) for medication administration. R1's Service Recap Summary dated June 2024, indicated temporary staff administered R1's medications on June 2, 3, 4, 8, 14 and 20, 2024. R2's Service Recap Summary dated June 2024, indicated temporary staff administered R2's medications on June 5, 6, 7, 11, 14, 15, 17, 21, 22, 23, 24, 30, 2024. During an interview on September 10, 2024, at 2:00 p.m., contracted home care registered nurse (RN)-D stated during a visit on June 4, 2024, she asked staff if R1 was getting the antibiotic that	01750		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23609	A. BUILDING: _____ B. WING _____	C 09/04/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01750	Continued From page 28 had been ordered from the emergency room physician and was told by an unlicensed personnel (ULP), it had not been started because there was not a nurse available to enter it into the electronic medication system. During interview on September 13, 2024, at 9:20 a.m., ULP-I stated temporary staff duties included medication administration to the facility's residents. ULP-I stated temporary staff were given dates and times to show up at the facility to cover shifts, provide cares and administer medications. ULP-I stated she had never seen or met RN-H and temporary staff were not medication trained by facility nurses. During interview on September 13, 2024, at 11:30 a.m., RN-H stated temporary staff were setup through the scheduling department and would show up at the facility ready to work. RN-H stated temporary staff were allowed to administer medications based off agency information. RN-H stated temporary staff were not medication trained or competency tested by facility nurses. The licensee's Competency Training Evaluations policy dated August 15, 2024, indicated when a registered nurse delegated tasks, prior to the delegation of services the registered nurse must make certain the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each resident and are able to demonstrate the ability to competently follow the procedures and perform the tasks. TIME PERIOD FOR CORRECTION: Seven (7) days.	01750		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23609	A. BUILDING: _____ B. WING _____	C 09/04/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01760	Continued From page 29	01760		
01760 SS=F	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to ensure medication administration documentation included the name and title of the person who administered the medication for two of two residents (R1, R2) with records reviewed. The licensee failed to transcribe physician orders on the medication administration record (MAR) to ensure medication was administered as prescribed for one of one resident (R1) reviewed. This failure had the potential to affect all residents that resided at the licensee. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23609	A. BUILDING: _____ B. WING _____	C 09/04/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01760	Continued From page 30 of the residents). The findings include: R1's assessment dated May 1, 2024 indicated R1's diagnoses included Type II diabetes mellitus and a double below the elbow amputation. R1's record lacked a signed service plan. R2's resident profile with an admission date of November 16,2023, indicated R1's diagnoses included dementia and hypertension (elevated blood pressure). R2's service plan dated November 16, 2023, indicated R2 received services including medication administration. R1 and R2's Service Recap Summary dated June 2024, indicated temporary staff administered medications on the following dates; June 2, 3, 4, 5, 6, 7, 8, 11, 14, 15, 17, 20, 21, 22, 23, 24, 30, 2024. The Service Recap Summaries were initialed temporary staffing (tst) and did not include the name or title of the individual signing off or administering the medications. TRANSCRIPTION ERROR R1's assessment dated May 1, 2024 indicated R1's diagnoses included Type II diabetes mellitus and a double below the elbow amputation. R1's record lacked a signed service plan. R1's hospital records dated June 2, 2024, indicated R1 was seen in the emergency room for the presence of blood in R1's catheter bag (urine collection bag). R1 was diagnosed with a	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23609	A. BUILDING: _____ B. WING _____	C 09/04/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01760	Continued From page 31 complicated urinary tract infection (UTI) and prescribed an antibiotic. R1's physician orders dated June 2, 2024, indicated R1 was prescribed Vantin (antibiotic) 200 milligrams (mg) one tablet by mouth twice daily for seven (7) days beginning June 2, 2024. R1's electronic medication record (EMAR) dated June 2024, indicated R1 was not administered the first dose of Vantin 200 mg antibiotic until 5:00 p.m. on June 4, 2024, a full 48 hours after the diagnosis of a severe urinary tract infection. During interview on September 11, 2024, RN-G stated if orders were faxed or returned with a resident from an emergency room visit on a weekend rather than electronically submitted, orders would be placed by unlicensed personnel into the nurses box and would be processed the following Monday. RN-G acknowledged at times there was a delay in processing physician orders for residents and it was "not good" for R1's antibiotics to have been delayed two days before administration. The licensee's Medication and Treatment Record - Documentation and Refusal policy dated August 23, 2024, indicated a signature and title of the authorized person who provided the assistance and/or administration of medications must be documented in the resident's record. The licensee's Medication and Treatment Orders policy updated December 17, 2023, indicated all medication orders received must be implemented within 24 hours of receipt. No additional information was provided.	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23609	A. BUILDING: _____ B. WING _____	C 09/04/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01760	Continued From page 32 TIME PERIOD FOR CORRECTION: Seven (7) days.	01760		
01960 SS=G	144G.72 Subd. 5 Documentation of administration of treatments 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. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure treatments or therapies were administered as prescribed and if not administered, the reason why they were not provided was documented for one of one resident (R1) reviewed with wounds managed by the provider. This practice had the ability to affect all residents that resided at the licensee who required any type of treatment and therapy services. 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	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23609	A. BUILDING: _____ B. WING _____	C 09/04/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01960	Continued From page 33 situation has occurred only occasionally). The findings include: R1's assessment dated May 1, 2024 indicated R1's diagnoses included Type II diabetes mellitus and a double below the elbow amputation. R1 required required one to two staff for all cares due to R1's double below the elbow amputation. R1 required two staff for all transfers, repositioning, toileting and one staff to provide feeding, hydration and catheter care assistance. R1 had one stage 2 pressure ulcer (open wound that affects both the top layer of the skin and part of the layer below it) on right buttocks that measured 0.6 cm x 0.8 cm and was managed by a facility nurse and a rounding provider. R1's record lacked a signed service plan. A progress notes dated May 3, 2024, through July 17, 2024, indicated R1 had a recurring coccyx pressure ulcer. A progress note dated May 14, 2024, indicated R1 developed a new pressure ulcer on the right shoulder blade and a facility registered nurse (RN) requested wound care orders from the provider. A progress note dated May 21, 2024, indicated seven days after the request, R1 was seen by the rounding provider and orders were provided for wound care. R1's provider orders dated May 21, 2024, indicated the provider ordered for a home health care agency to assist facility nurses with wound care to right upper back wound and pressure ulcer to coccyx.	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23609	A. BUILDING: _____ B. WING _____	C 09/04/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01960	Continued From page 34 A progress note indicated dated May 31, 2024, indicated a facility RN forwarded the wound care orders to a home health care agency, ten days after the provider supplied the order to the facility and 14 days after the pressure ulcer was noted. A progress note dated June 6, 2024, indicated R1 requested a referral to a specialized wound care clinic due to pain around the wound and the development of necrotic (dead) tissue at the wound site, twenty-three days after the new pressure sore developed on R1's right shoulder blade. R1's last wound assessment dated June 21, 2024, completed by a facility nurse indicated R1's buttock pressure ulcer had increased to 0.8 cm x 0.5 cm x 0.3 cm deep and R1 developed a right shoulder blade pressure ulcer and it had increased to a stage 3 (much deeper within the skin, affecting the fatty layer) measuring 4.0 cm x 4.0 cm x 0.1 cm full thickness skin loss. R1's Service Recap Summary dated May 2024 through July 2024, indicated facility nurses failed to provide wound care or skin checks on the following dates: WOUND CARES Wound cares were not completed May 2, 9, 20, 27, 2024, four out of nine scheduled times. Wound cares were not completed June 3, 17, 20, 24, 2024, four out of eight scheduled times. Wound cares were not completed July 4, 8, 15, 2024, three out of four scheduled times. SKIN CHECKS Skin checks were not completed May 6, 20, 27, 2024, three out of four scheduled times.	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23609	A. BUILDING: _____ B. WING _____	C 09/04/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01960	Continued From page 35 Skin checks were not completed June 3, 17, 24, 2024, three out of four scheduled times. Skin checks were not completed July 8, 15, 2024, two out of two scheduled times. On September 10, 2024, at 9:00 a.m., LPN-C stated the facility never had enough staff and the majority of her time was spent working on the floor. LPN-C stated shortly after she started the clinical nurse supervisor (CNS) and licensed assisted living director (LALD) left employment with the facility and it left nobody onsite in charge. LPN-C stated R1 was a double arm amputee and was unable to do anything for himself. LPN-C denied missing any scheduled wound cares or skin checks for R1, however, stated RN-D (a home health agency nurse) was a wonderful advocate for R1 and would often try to educate staff about R1's needs and cares. On September 10, 2024, at 2:00 p.m., RN-D stated she was R1's contracted home care nurse and the facility had requested her home care agency assist with wound cares because the facility didn't have a nurse available to provide the needed wound cares. The contracted home care RN stated "it was a mess" trying to get orders or supplies to provide wound care for R1. The home care RN stated the facility had very few staff and the only person in charge she could find was a LPN and often could not find the LPN, "a lot of times I seen nobody" (referring to staff) when visiting R1. On September 11, 2024, at 3:11 p.m., RN-G stated the level of cares in R1's building were difficult to complete due to staff shortages. RN-G stated cares such as repositioning, bathing, hygiene cares would "go to long at a time" without completion making the management of wound	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23609	A. BUILDING: _____ B. WING _____	C 09/04/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01960	Continued From page 36 healing difficult. RN-G stated R1 shared with nursing he felt emotionally and physically neglected. On September 12, 2024, at 10:20 a.m., R1 stated his secured memory care unit was "always short on help". R1 stated staff would provide bed baths but was told staff didn't have time to assist with showers or baths. R1 stated he would wait "for hours" sometimes when he pressed his call pendant and at times no staff were in the building because they were "across the road" assisting other staff. The licensee's Treatment and Therapy Order policy updated September 4, 2022, indicated documentation of treatments and therapies would be completed in the resident record or recorded in Residex. No additional information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	01960		
02070 SS=I	144G.81 Subd. 4 Awake staff requirement An assisted living facility with dementia care providing services in a secured dementia care unit must have an awake person who is physically present in the secured dementia care unit 24 hours per day, seven days per week, who is responsible for responding to the requests of residents for assistance with health and safety needs, and who meets the requirements of section 144G.41, subdivision 1, clause (12). This MN Requirement is not met as evidenced by:	02070		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23609	A. BUILDING: _____ B. WING _____	C 09/04/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02070	Continued From page 37 Based on interview, and record review, the licensee failed to ensure one or more persons were physically present and available 24 hours a day, seven days a week, who were responsible for responding to requests for assistance with health and safety needs of residents in four of four secured memory care buildings on campus. This had the potential to affect all 30 residents residing in the memory care buildings. 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 a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee held an Assisted Living with Dementia Care license with a bed capacity of 55 residents and had a current census of 30 residents. The physical layout of the facility included four secured memory care (MC) units located on one campus with driveways and rolling embankments separating the four buildings. Each MC unit required key coded access at each main entry door. R1 admitted to the secured memory care unit on November 7, 2023. R1 resided in one of the large secured memory care units with a resident capacity of 16.	02070		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23609	A. BUILDING: _____ B. WING _____	C 09/04/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02070	Continued From page 38 R2 admitted to the secured memory care unit on November 16, 2023. R2 resided in one of the smaller memory care units with a resident capacity of 9. Review of the licensee's staff schedule for June 2024, indicated R1's larger secured memory care unit did not have two staff to assist residents with cares on the following days and evening shifts: June 1, 2024 - no staff scheduled 6:30 a.m. to 2:30 p.m., one staff scheduled 2:30 to 10:30 p.m. June 2, 2024 - one staff scheduled 6:30 a.m. to 2:30 p.m. June 3, 2024 - one staff scheduled 6:30 a.m. to 2:30 p.m., one staff scheduled 2:30 to 10:30 p.m. June 4, 2024 - one staff scheduled 6:30 a.m. to 2:30 p.m., one staff scheduled 2:30 to 10:30 p.m. June 5, 2024 - one staff scheduled 6:30 a.m. to 2:30 p.m., one staff scheduled 2:30 to 10:30 p.m. June 6, 2024 - no staff scheduled 6:30 a.m. to 2:30 p.m. June 7, 2024 - one staff scheduled 6:30 a.m. to 2:30 p.m., one staff scheduled 2:30 to 10:30 p.m. June 8, 2024 - no staff scheduled 6:30 a.m. to 2:30 p.m., no staff scheduled 2:30 to 10:30 p.m. June 9, 2024 - one staff scheduled 6:30 a.m. to 2:30 p.m., one staff scheduled 2:30 to 10:30 p.m. June 10, 2024 - one staff scheduled 6:30 a.m. to 2:30 p.m., one staff scheduled 2:30 to 10:30 p.m. June 11, 2024 - one staff scheduled 6:30 a.m. to 2:30 p.m., one staff scheduled 2:30 to 10:30 p.m. June 12, 2024 - no staff scheduled 6:30 a.m. to 2:30 p.m., one staff scheduled 2:30 to 10:30 p.m. June 13, 2024 - no staff scheduled 6:30 a.m. to 2:30 p.m., one staff scheduled 2:30 to 10:30 p.m. June 14, 2024 - one staff scheduled 6:30 a.m. to 2:30 p.m., one staff scheduled 2:30 to 10:30 p.m.	02070		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23609	A. BUILDING: _____ B. WING _____	C 09/04/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02070	Continued From page 39 June 15, 2024 - one staff scheduled 6:30 a.m. to 2:30 p.m., one staff scheduled 2:30 to 10:30 p.m. June 16, 2024 - one staff scheduled 6:30 a.m. to 2:30 p.m. June 17, 2024 - no staff scheduled 6:30 a.m. to 2:30 p.m. June 18, 2024 - no staff scheduled 6:30 a.m. to 2:30 p.m. June 19, 2024 - no staff scheduled 6:30 a.m. to 2:30 p.m. June 20, 2024 - one staff scheduled 6:30 a.m. to 2:30 p.m. June 21, 2024 - one staff scheduled 6:30 a.m. to 2:30 p.m., one staff scheduled 2:30 to 10:30 p.m. June 22, 2024 - no staff scheduled 6:30 a.m. to 2:30 p.m., one staff scheduled 2:30 to 10:30 p.m. June 23, 2024 - no staff scheduled 6:30 a.m. to 2:30 p.m. June 24, 2024 - one staff scheduled 6:30 a.m. to 2:30 p.m. June 25, 2024 - one staff scheduled 6:30 a.m. to 2:30 p.m., one staff scheduled 2:30 to 10:30 p.m. June 26, 2024 - one staff scheduled 6:30 a.m. to 2:30 p.m., one staff scheduled 2:30 to 10:30 p.m. June 27, 2024 - one staff scheduled 6:30 a.m. to 2:30 p.m. June 28, 2024 - one staff scheduled 6:30 a.m. to 2:30 p.m., one staff scheduled 2:30 to 10:30 p.m. June 29, 2024 - one staff scheduled 6:30 a.m. to 2:30 p.m., one staff scheduled 2:30 to 10:30 p.m. June 30, 2024 - one staff scheduled 6:30 a.m. to 2:30 p.m. During an entrance conference on September 4, 2024, at approximately 9:30 a.m., licensed assisted living director (LALD)-B stated the licensee utilized two temporary staffing agencies due to a staffing shortage and the facility was made up of four separate buildings on one campus. Two buildings required two staff each	02070		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23609	A. BUILDING: _____ B. WING _____	C 09/04/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02070	Continued From page 40 shift due to mechanical lifts (a lift utilizing a body sling for transfers) with the exception of night shift and two buildings required one staff each shift with the exception of night shift, because the residents did not require mechanical lifts, mostly supervision for dementia and one assistance for activities of daily living (ADL's). On September 9, 2024, at 2:46 p.m., the investigator requested and reviewed the licensee's staff schedule to include temporary staff. The licensee's June 2024 staff schedule included numerous shifts each week not covered by facility or temporary staff and resulted in residents left unattended in secured memory care units accessible only with a keypad code. On September 10, 2024, at 9:00 a.m., licensed practical nurse (LPN)-C stated the facility was always short on staff and LPN-C was concerned for the health and safety of the campus residents. LPN-C stated because there were not enough staff to provide two staff to each house, at times staff would leave the building they were assigned to and assist staff in another building. LPN-C stated a staff member from one of the small dementia buildings would leave to assist with a mechanical lift transfer or fall in a larger building. LPN-C stated no staff would be present to assist residents in the smaller secured building during that time. On September 11, 2024, at 3:11 p.m., RN-G stated the previous licensed assisted living director (LALD) and clinical nurse supervisor (CNS) had left employment at the same time before RN-G had taken the RN license test and that left no leadership on the campus site. RN-G stated the communication was poor and resident cares suffered due to the lack of staff present in	02070		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23609	A. BUILDING: _____ B. WING _____	C 09/04/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02070	Continued From page 41 the buildings. RN-G stated R1's larger building was staffed with one instead of two required staff "three times a week on any given shift". On September 12, 2024, at 10:20 a.m., R1 stated his secured memory care unit was "always short on help". R1 stated staff would provide bed baths but was told staff didn't have time to assist with showers or baths. R1 stated he would wait "for hours" sometimes when he pressed his call pendant and at times no staff were in the building because they were "across the road" assisting other staff. On September 13, 2024, at 9:20 a.m., unlicensed personnel (ULP)-I stated staff coverage was a challenge and it was worse on the evening shift after facility leadership left the campus. ULP-I stated she had at times left residents unattended in the smaller building to assist in the larger building. ULP-I stated " I know it is very illegal but when there is not enough staff, there's no option". The licensee's Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) dated October 25, 2023, indicated two unlicensed direct care staff on each morning and evening shift at the two larger buildings. One unlicensed direct care staff would be scheduled on each morning and evening shift at each of the smaller buildings and the night shift staffed with a staff member to float between the four buildings as needed. The licensee's Staffing Plan policy dated April 26, 2024, indicated the clinical nurse supervisor (CNS) would conduct a staffing evaluation to identify appropriateness of staffing levels to ensure that the facility is sufficiently staffed at all times in order to meet the needs of the residents and their safety. Additionally, the staffing plan	02070		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23609	A. BUILDING: _____ B. WING _____	C 09/04/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02070	Continued From page 42 would ensure the facility was sufficiently staffed at all times to meet the scheduled and reasonable foreseeable unscheduled needs of each resident. No additional information was provided. TIME PERIOD FOR CORRECTION: Two (2) days.	02070		
02360	144G.91 Subd. 8 Freedom from maltreatment 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. This MN Requirement is not met as evidenced by: Based on observations, interviews, and document review, the facility failed to ensure one of two residents reviewed (R1) was free from maltreatment. R1 was neglected. Findings include: On September 4, 2024, the Minnesota Department of Health (MDH) issued a determination that neglect occurred, and that the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. The MDH concluded there was a preponderance of evidence that maltreatment occurred.	02360		