Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL244272744M
Compliance #: HL244274636C

Date Concluded: November 17, 2022

Name, Address, and County of Licensee Investigated:
Diamond Willow of Baxter
14396 Grand Oaks Drive
Baxter, MN 56425
Crow Wing County

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

Evaluator's Name: Barbara Axness, RN
Special Investigator

Finding: Substantiated, facility responsibility

Nature of Visit:
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 they failed to monitor and assess a wound on the resident's heel, resulting in the resident being hospitalized, where she died of septic shock.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The facility failed to assess and monitor the resident's heel wound and failed to inform the physician of the wound as it worsened. The resident was admitted to the hospital with septic shock and died five days later.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator also contacted the resident's physician. The investigation included review of progress notes, assessments, the service plan, hospital records, and the resident's death record.

The resident resided in an assisted living memory care unit. The resident's diagnoses included Alzheimer's dementia and type two diabetes. The resident's service plan included assistance with dressing, grooming, bathing, transfers, and medication administration. The resident's assessment indicated the resident was pleasantly confused and forgetful at times.

The resident's most recent assessment, completed three months prior to the resident's death, indicated the resident did not have any skin issues. The resident's progress notes, seven weeks before the resident died, identified a blister was observed on her left heel and the physician was updated. The next day a progress note indicated the blister had popped open, leaving a wound 3.5 centimeters (cm) by 4 centimeters wide. Optifoam (type of wound dressing) was applied to the wound and the physician was again updated.

The resident's medical record contained no follow up correspondence from the physician and no indication that family was notified of the wound.

A progress note about a week and a half later, indicated the blister had dried up but an open area measuring 3.5 cm by 4 cm remained. No further notes or monitoring were documented until 8 days before the resident's death.

A progress note entered three days before the resident was hospitalized and 8 days before her death, indicated a blister had broken open on the heel, leaving an open area measuring 8 cm by 5 cm. A fax was sent to the physician which read, "Resident had a blister on her entire left heel, blister has broken open and caused a large open area to her heel, measures approx. 8cm x 5cm. How would you like to treat the heel?" The fax was sent on a Thursday.

No response or further follow up with the physician was documented.

A progress note the next day, a Friday afternoon, indicated the registered nurse (RN) had observed the wound while the resident's family member was present. No measurements or further assessments were documented. The wound was dressed with a clean dressing and the nurse supervisor was updated. The note indicated the family would follow up on the wound at an appointment the next week.

The resident's hospital records indicated the resident admitted to the hospital with the following diagnoses: septic shock (widespread organ failure), failure to thrive with physical deconditioning and poor oral intake, acute metabolic encephalopathy with concern for left hemianopsia (condition that affects the brain structure or function, causing confusion or altered mental state), swelling of the left arm and left leg, dehydration, a stage 1 pressure sore to the sacrum, and a stage two pressure ulcer of the left heel. The resident also had vital signs and several lab results that were abnormal. The resident was started on antibiotics for her heel wound, a head CT scan was completed, and an ultrasound was done on left upper and lower extremities. The resident died five days after admission to the hospital.

The resident's death record indicated the resident's cause of death was septic shock (a widespread infection causing organ failure and dangerously low blood pressure).

During an interview, an unlicensed personnel (ULP) stated she was aware the resident had a wound on her heel and thought it developed about two months before she went to the hospital. The ULP thought the blister started when a staff member put slippers on the resident's wet feet. The ULP stated the blister popped open after a staff member put too tight of wraps on the resident's legs. The ULP stated the wound healed for a brief amount of time, but redeveloped sometime in June. The ULP stated it looked like it was getting infected towards the time she went to the hospital. The ULP described the wound as "seeping with a lot of pus and didn't seem to be getting any better". The ULP stated staff were trying to keep it clean and put dressings on it, but she was unsure if there were physician orders in place. The ULP stated the nurse was aware of the wound and she thought it was being monitored.

During an interview, a former nurse stated the resident had a blister on her heel but wasn't exactly sure when it developed. The former nurse thought the wound had healed and then redeveloped but could not recall the exact timeline of events. The former nurse stated the licensed practical nurse (LPN) had managed most of the skin assessments and she had only communicated that the resident had a blister on her heel from staff putting on her slippers while her skin was still wet. The former nurse stated they were putting bandages and/or mepilex (a wound care bandage) on the resident's heel but did not recall if there were doctor's orders for the dressings. The former nurse stated she put in her resignation a month before the resident was sent to the hospital and had no further involvement with the resident's care. The Regional Director of Nursing (RDON) took over nursing responsibilities for the four-week period before the next nurse started.

During an interview, another former nurse stated she had observed the resident's heel wound two days before she was sent to the hospital. The nurse stated she heard the resident had a blister on her heel but when she looked at it "it was far more than a blister, it was probably the size of a golf ball and encompassed her entire heel…It was very concerning looking and looked extremely painful, I have no idea how no one was notified of it." The former nurse stated the wound would have taken a lot more than a couple of days to advance to that stage of a wound. The former nurse indicated it was at the end of her shift on a Friday when she observed the wound. After visiting with the resident's family, it was decided to have the wound addressed the following week at an appointment. The former nurse stated she did not immediately contact the resident's physician since "I had no formal training, no guidance. I didn't know protocol and I didn't know how to handle the situation." The former nurse stated she had only worked for the facility for about two weeks and resigned due to not receiving any training or orientation for her position and stated she had told management "I feel my hard-earned license is on the line and in the interest of retaining my license, I am resigning immediately."

During an interview, a facility nurse stated staff had noticed the wound a few days before reporting it to her. The facility nurse stated there was frequent turnover of staff and those who

worked during the time the resident's wound developed, were new staff. The facility nurse stated she had "been working 100 hours a pay period just trying to get new staff trained, keep the building intact." The facility nurse stated one of her responsibilities was to complete weekly skin checks but noted it was hard to keep up with all the tasks assigned to her with the turnover in nursing management.

The facility nurse was shown several pictures of the resident's heel wound. The pictures had an electronic time stamp date of the same day this nurse entered a progress note on the heel wound (three days before the resident went to the hospital). The facility nurse stated she had not seen the photos before and had not seen the wound in that condition. The facility nurse identified the wound in the photos looked red and concerning. The facility nurse said she had not entered a more detailed progress note "because of understaffing. I can't be up 24 hours writing notes, I know that's my job, but I can't do it all."

During an interview, the former Regional Director of Operations (RDO) stated she had been involved with the facility during the time the resident's heel wound developed, but did not observe it. The former RDO stated she was only aware of a blister on the heel that she thought resolved in early June. She was made aware of the wound when a facility nurse called her two days before the resident was sent to the hospital. The former RDO indicated she did not know why facility staff sent a fax about the blister to the provider and stated "from my standpoint, if the wound was what you're describing, the LPN should have sent her in at the time it was first identified rather than wrapping it up. What you're describing is not a paper fax update to a doctor."

During an interview, the former licensed assisted living director (LALD) stated she was not at the facility often and had little involvement with day-to-day operations. The LALD stated she was aware of multiple families with concerns about the facility, but she did not get involved. She assumed the Ombudsman was investigating and addressing these concerns. The LALD stated she was not aware of this resident's family member's concerns about care; she thought staff on site were managing everything.

During an interview, the resident's physician stated he could not recall being updated about the resident having a pressure ulcer or wound to her heel. The physician stated based off the pictures taken of the wound when she admitted to the hospital, he would not consider that to be a blister and that it was definitely a pressure ulcer.

During an interview, the resident's family members stated they had brought forward numerous complaints regarding the resident's care to staff. The family member said they were told the resident had a "little blister" after staff put on her shoes without socks. The family member indicated they tried to visit daily, and the resident used to walk independently. There was a two-week period when family was unable to visit and when they returned, the resident was unable to walk and required a lift for transfers. The family thought this was "bizarre" and did not know why the resident would have become immobile. However, when they found out

about the resident's wound a few weeks later, it made sense why she was no longer able to walk. The family was not aware of the wound until a few days before the resident went to the hospital. The family member indicated a staff member had mentioned the wound and they requested to observe it with the nurse. The family member stated they observed that the bed sheets and dressing on the heel were saturated with drainage. The family member reported the room smelled of a foul wound and she told the nurse the wound "was serious and going to need wound care." The family member stated the facility nurse said, "It's probably easier for you to get ahold of the doctor," and suggested that they contact the physician about the wound. The family member was not able to send the physician pictures of the wound because it was a Friday at 4 p.m. A family member returned to visit the resident over the weekend as she wasn't sure what the facility was doing for the wound, so decided to dress the wound herself. The family member observed the bed sheets and the wound dressing had not been changed since the previous day. As the resident's condition changed over the weekend, the family member decided to call 911. The resident was transported to the hospital for further evaluation and died five days later.

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:
(a) 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.
(b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.

Vulnerable Adult interviewed: No, deceased
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
No action was taken by the facility.

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

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

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

You may also call 651-201-4890 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
Crow Wing County Attorney
Baxter City Attorney
Baxter Police Department
Minnesota Board of Executives for Long Term Services and Supports
Minnesota Board of Nursing
Medical Examiner

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24427	A. BUILDING: _____ B. WING _____	C 11/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAMOND WILLOW OF BAXTER	14396 GRAND OAKS DRIVE BAXTER, MN 56425

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments Initial comments ******ATTENTION****** HOME CARE PROVIDER/ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: HL244272744M/HL244274636C and HL244275370C. On October 25, 2022, through November 2, 2022, 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 20 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for HL244272744M/HL244274636C, tag identification 0110, 0250, 0430, 0650, 0730, 1460, 1620, 1940, 1960, 1970, 2310, 2360. The following correction orders are issued for HL244275370C, tag identification 0110, 0250, 0430, 1820, 1940, 1950, 1970, 2320.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	

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0 110	Continued From page 1	0 110		
0 110 SS=I	144G.10 Subdivision 1a Assisted living director license required Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the original licensed assisted living director's (LALD) board-issued license was displayed in the facility. The licensee also failed to ensure a shared director plan was established and failed to ensure a secondary assisted living director application was submitted to the Minnesota Board of Executives for Long Term Services and Support (BELTSS). This had the potential to affect all the licensee's residents, staff, and visitors. 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: LALD-E A review of the BELTSS website indicated LALD-E was the Director of Record effective September 3, 2021, through August 31, 2022. LALD-E was listed as being Director of Record	0 110		

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0 110	Continued From page 2 over two locations, however she did not have a shared director license issued that would allow her to oversee more than one location. On October 26, 2022, at LALD-E confirmed she was the Director of Record for the licensee during the dates listed above. LALD-E stated, "I was not in Baxter much at all. I didn't have much to do with the facility or their clients. I'd occasionally stop in or call to see how they're doing." LALD-E confirmed she was aware of multiple family concerns and knew some were meeting with nursing staff and the ombudsman but did not get involved with the concerns as she assumed the ombudsman was investigating and handling it. LALD-E stated she knew she was supposed to have a dual license but "was just put as the LALD up there by corporate." LALD-E stated she was kind of concerned because "I wasn't sure I was able to be the LALD because of that dual license." LALD-E stated she was not very involved with the facility's day to day operations, and it was more so the licensed practical nurse (LPN)-B who was taking care of things. LALD-E stated she didn't do much for the facility and "they never really told me things, I'd check charting every now and then, though...I'd call and see how they were doing, and they'd say fine." On October 26, 2022, at 7:45 p.m., family member (FM)-H stated they visited R1 almost daily. FM-H did not recognize LALD-E's name and did not know if there was an assisted living director working at the facility as they had never met with her or was informed she was in charge, despite meeting with nursing staff many times from May through July 2022 to discuss several concerns. FM-H stated, "there was never any clarification of who was in charge, they'd say it's a gray area about who is responsible for stuff so it	0 110		

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0 110	Continued From page 3 wasn't clear who was in charge of anything." On October 31, 2022, at 11:20 a.m., regional director (RD)-J confirmed LALD-E was not involved with day-to-day oversight of the facility and did not really come on site. RD-J stated since there weren't a lot of LALDs across the state, they had tried a shared site LALD at this location. RD-J stated the LALD's main job duties were to make sure quality assurance was done and that required postings were in place. RD-J stated she was probably more involved with day-to-day operations than the LALD was, even though she was also not on site consistently. LALD-F On October 25, 2022, at 11:50 a.m., the surveyor observed a photocopy of LALD-F's license posted near the main entrance of the facility. A review of the BELTSS website on October 25, 2022, indicated LALD-F was the Director of Record effective August 1, 2022, through October 31, 2022. On October 25, 2022, at 11:55 a.m., the surveyor requested to meet with LALD-F. Registered nurse (RN)-A stated LALD-F was the current Director of Record for the facility but did not work onsite. RN-A stated LALD-F would come to the facility about once every two weeks, and they would call him if they had any questions. RN-A was not sure why a photocopy of his license was displayed. LALD-F stated he intended to continue being Director of Record after October 31, 2022, and that he would update his online profile to reflect this. On October 26, 2022, at 12:25 p.m., LALD-F stated his original license was in his employee file	0 110		

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0 110	Continued From page 4 and he was not aware the original must be posted. LALD-F confirmed he was on site at the facility about once every two weeks. On October 31, 2022, at 10:00 a.m., family member (FM)-N stated she had numerous concerns with R2 and R3's care and services from the time they admitted in August through when she moved them out the end of October. FM-N stated she had contacted LALD-F numerous times and informed staff she wanted to visit with him regarding her concerns, but she never heard back from him. On November 1, 2022, a review of the BETLSS website indicated LALD-F's end date at the facility was October 31, 2022. A current Director of Record was not listed for the licensee. Attempts to contact LALD-F via email and phone were made on November 1, 2022, with no response back. Administrative Rule 6400.6720 Displaying Licenses indicates a licensee actively practicing shall display the board-issued license, not a photocopy, in a conspicuous place in the facility which the licensee administers, visible to residents and visitors. Administrative Rule 6400.7085 Shared Director indicates that an assisted living facility may share the services of a licensed assisted living director with approval of the board. The application for shared director must be submitted within 15 days of assuming the shared director position. If the board approves the shared director plan, the following must be established and implemented: -procedures and delegate authority for on-site operations in the director's or assisted living	0 110		

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0 110	Continued From page 5 director in residence's absence; -be available to staff at each assisted living facility that the licensee or permit holder directs; -post at each assisted living facility a board-issued license or permit in a conspicuous place within the assisted living facility; -post at each assisted living facility the procedure to contact the person in charge on the premises in the absence of the director or assisted living director in residence; and -make communication plans available to residents, families, and staff at each assisted living facility the licensee or permit holder directs. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110		
0 250 SS=L	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	0 250		

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0 250	Continued From page 6 material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04; (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 show they met the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations	0 250		

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0 250	Continued From page 7 understood applicable statutes and rules; nor developed and/or implemented current policies and procedures as required with records reviewed. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level four violation (a violation that results in serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On October 25, 2022, at 12:20 p.m., registered nurse (RN)-A stated the licensee's employees in charge of the facility were familiar with the assisted living regulations and the licensee provided medication and treatment management services. The licensee's Application for Assisted Living License, section titled Official Verification of Owner or Authorized Agent 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	0 250		

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0 250	Continued From page 8 applicable. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G. - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659. - Reporting of Maltreatment of Vulnerable Adults. - Electronic Monitoring in Certain Facilities. - 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, in some circumstances, be disclosed to the appropriate state, federal or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices. - I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons (opens in a new window), all data submitted on this application shall be classified as public information upon issuance of	0 250		

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0 250	Continued From page 9 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 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. - 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 and Minn. Rules chapter 4659 in place upon licensure and to keep them current as applicable. Page seven was electronically signed by regional director (RD)-J on May 31, 2022. The licensee had an assisted living license with dementia care issued on August 1, 2022 with an expiration date of December 31, 2022. The licensee failed to ensure the following policies and procedures were developed and/or implemented: - orientation, training, and competency	0 250		

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0 250	Continued From page 10 evaluations of staff, and a process for evaluating staff performance; - infection control practices; -orientation to and implementation of the assisted living bill of rights; -medication and treatment management; Attempts to contact licensed assisted living director (LALD)-F via phone and email on November 1, 2022, were unsuccessful. As a result of this survey, the following orders were issued: 0110, 0430, 0650, 0730, 1460, 1620 1820, 1940, 1950, 1960, 1970, 2310, 2320, and 2360, indicating the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 250		
0 430 SS=C	144G.40 Subd. 2 Uniform checklist disclosure of services (a) All assisted living facilities must provide to prospective residents: (1) a disclosure of the categories of assisted living licenses available and the category of license held by the facility; (2) a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and (3) an oral explanation of the services offered	0 430		

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0 430	Continued From page 11 under the contract. (b) The requirements of paragraph (a) must be completed prior to the execution of the assisted living contract. (c) The commissioner must, in consultation with all interested stakeholders, design the uniform checklist disclosure form for use as provided under paragraph (a). This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure its uniform checklist disclosure of services (UDALSA) accurately reflected services provided by the licensee. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: The licensee's UDALSA, dated May 28, 2022, indicated a licensed assisted living director was on site full time. LALD-E A review of the BELTSS website indicated LALD-E was the Director of Record effective September 3, 2021, through August 31, 2022. LALD-E was listed as being Director of Record over two locations, however she did not have a shared director license issued that would allow her to oversee more than one location.	0 430		

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0 430	Continued From page 12 On October 26, 2022, at LALD-E confirmed she was the Director of Record for the licensee during the dates listed above. LALD-E stated, "I was not in Baxter much at all. I didn't have much to do with the facility or their clients. I'd occasionally stop in or call to see how they're doing." LALD-E confirmed she was aware of multiple family concerns and knew some were meeting with nursing staff and the ombudsman but did not get involved with the concerns as she assumed the ombudsman was investigating and handling it. LALD-E stated she knew she was supposed to have a dual license but "was just put as the LALD up there by corporate." LALD-E stated she was kind of concerned because "I wasn't sure I was able to be the LALD because of that dual license." LALD-E stated she was not very involved with the facility's day to day operations, and it was more so the licensed practical nurse (LPN)-B who was taking care of things. LALD-E stated she didn't do much for the facility and "they never really told me things, I'd check charting every now and then, though...I'd call and see how they were doing, and they'd say fine." On October 26, 2022, at 7:45 p.m., family member (FM)-H stated they visited R1 almost daily. FM-H did not recognize LALD-E's name and did not know if there was an assisted living director working at the facility as they had never met with her or was informed she was in charge, despite meeting with nursing staff many times from May through July 2022 to discuss several concerns. FM-H stated, "there was never any clarification of who was in charge, they'd say it's a gray area about who is responsible for stuff so it wasn't clear who was in charge of anything." On October 31, 2022, at 11:20 a.m., regional	0 430		

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0 430	Continued From page 13 director (RD)-J confirmed LALD-E was not involved with day-to-day oversight of the facility and did not really come on site. RD-J stated since there weren't a lot of LALDs across the state, they had tried a shared site LALD at this location. RD-J stated the LALD's main job duties were to make sure quality assurance was done and that required postings were in place. RD-J stated she was probably more involved with day-to-day operations than the LALD, even though she was also not on site consistently. LALD-F A review of the BELTSS website on October 25, 2022, indicated LALD-F was the Director of Record effective August 1, 2022, through October 31, 2022. On October 25, 2022, at 11:55 a.m., the surveyor requested to meet with LALD-F. Registered nurse (RN)-A stated LALD-F was the current Director of Record for the facility but did not work onsite. RN-A stated LALD-F would come to the facility about once every two weeks, and they would call him if they had any questions. On October 26, 2022, at 12:25 p.m., LALD-F confirmed he came to the facility about once every two weeks and felt that presence was sufficient at this time. On October 31, 2022, at 10:00 a.m., family member (FM)-N stated she had numerous concerns with R2 and R3's care and services from the time they admitted in August through when she moved them out the end of October. FM-N stated she had contacted LALD-F numerous times and informed staff she wanted to visit with him regarding her concerns, but she never heard back from him.	0 430		

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0 430	Continued From page 14 On November 1, 2022, a review of the BETLSS website indicated LALD-F's end date at the facility was October 31, 2022. A current Director of Record was not listed for the licensee. Attempts to contact LALD-F via email and phone were made on November 1, 2022, with no response back. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 430		
0 650 SS=A	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and	0 650		

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0 650	Continued From page 15 (6) documentation of the background study as required under section 144.057. (b) Each employee record must be retained for at least three years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee records included all the required content for one of three employees (registered nurse (RN)- D) with employee records reviewed. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: RN-D was hired April 27, 2021, to provide supervision and oversight of unlicensed personnel and provide direct care and services to the licensee's residents. RN-D's employee record lacked the following required content: -documentation of annual performance reviews that identify areas of improvement needed and training needs	0 650		

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0 650	Continued From page 16 On October 27, 2022, at 12:15 p.m., corporate accountant (CA)-K confirmed RN-D's record did not contain an annual evaluation and stated if it was not in the record, it was not completed. The licensee's Personnel Files/Employee Records policy, last updated July 25, 2021, indicated the employee file would contain documentation of annual performance reviews that identify areas of improvement needed and training needs. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
0 730 SS=D	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; (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;	0 730		

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0 730	Continued From page 17 (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 documentation of wound measurements were maintained for one of one residents (R1) with an open area. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number	0 730		

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0 730	Continued From page 18 of staff are involved, or the situation has occurred only occasionally). The findings include: R1's diagnoses included Alzheimer's dementia and type two diabetes. R1 admitted to the licensee on February 3, 2022. The resident's assessment dated May 19, 2022, indicated the resident's skin was intact with no areas of concern. R1's provider orders did not contain orders for wound care or wound dressings. A provider notification correspondance was sent to the resident's primary care provider (PCP) on May 26, 2022, indicating the resident had a fluid filled blister on her left heel pop that morning and that Optifoam (wound dressing) was applied to cover the area. The correspondance also included an update about an increase in edema. No response from the PCP regarding the blister was noted in the resident's record. A progress note entered by registered nurse (RN)-D on May 27, 2022, indicated the resident had a fluid filled blister on her left heel that had opened that morning. The wound was documented to measure 3.5 centimeters (cm) by 4 cm and a Mepilex (wound dressing) was applied. A progress note entered by RN-D on June 9, 2022, indicated the resident's left heel where the blister was had dried up and looks well, no signs or symptoms of infection, area measures 3.5 cm by 4 cm. Old skin removed.	0 730		

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0 730	Continued From page 19 From June 10, 2022, through July 7, 2022, three RNs, one licensed practical nurse (LPN), and at least 12 unlicensed personnel (ULP) were scheduled to work at the facility. No further reports or measurements of the resident's heel wound were reported or documented until July 7, 2022. The resident's Service Recap Summary for June 2022 did not have a category to document a weekly skin check. The resident's Service Recap Summary for July 2022 had a documented skin check on July 4, 2022, completed by LPN-B. No skin concerns were reported or noted. A progress note entered by LPN-B on July 7, 2022 at 6:14 p.m. indicated the resident had a blister on her left heel, "blister has broken open leaving an open area measuring approximately 8 cm by 5 cm. Non-stick bandage and gauze wrap applied. A referral has been sent to PCP." A provider notification correspondance was sent to the PCP on July 7, 2022, indicating the blister on the left heel had broken open and "caused a large open area to her heel." The resident's record lacks evidence of further follow up or a response from the provider. Photos of the resident's heel wound, which had an electronic date of July 7, 2022, showed a large, unstagable pressure injury covered in thick, yellow slough with drainage present. The area covered the entire surface and inner aspect of the left heel. The surrounding tissue was red and inflammed. The outer aspect of the heel had peeling skin exposing dark red skin underneath.	0 730		

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0 730	Continued From page 20 A progress note entered by RN-C on July 8, 2022, indicated the RN and R1's granddaughter "unwrapped [the resident's] bandage and assessed area and rewrapped it. Supervisor was contacted with an update on condition of wound." The note further indicated the family would discuss wound care and hospice at her appointment on July 12, 2022. R1's hospital records indicated at the time of the resident's admission on July 10, 2022, the resident had a stage 1 pressure ulcer to her sacrum and a stage 2 pressure ulcer to the left heel. The resident's admitting diagnoses included dehydration, acute renal failure, septic shock (widespread infection causing organ failure), hyperkalemia (high potassium), and acute metabolic encephalopathy (condition that affects the brain structure or function, causing confusion or altered mental state). The hospital records indicate the resident was treated with intravenous antibiotics for the pressure ulcer on her heel and it was also debrided (a procedure to remove infected/dead tissue from a wound). On October 25, 2022, at 12:50 p.m., licensed practical nurse (LPN)-B stated staff had noticed the wound a few days before reporting it to her. LPN-B stated, "I believe it was a lot of the situation we were in because I was the only nurse and working obscene hours and I think staff were hesitant to call me or bother me whenever I had time off." LPN-B stated there had been a lot of turnover and most of the staff working during the time period the resident's wound developed were newer. LPN-B stated one of her responsibilities was to do weekly skin checks but noted it was hard to keep up with all the tasks assigned to her while there was turnover in nursing management.	0 730		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 730	Continued From page 21 LPN-B was shown several pictures of the resident's heel wound, which had an electronic time stamp date of July 7, 2022. LPN-B stated she had not seen those photos before and stated she had not seen the wound in that condition. LPN-B stated the wound in the photos looked red and concerning. LPN-B stated she had not entered a more detailed progress note "because of understaffing. I can't be up 24 hours writing notes, I know that's my job but I can't do it all." On October 25, 2022, at 2:55 p.m., unlicensed personnel (ULP)-G stated she was aware the resident had a wound to her heel and thought it had developed around the end of May. ULP-D thought the blister started when a staff member put slippers on while the resident's feet were wet. ULP-D stated the blister popped open after another ULP put wraps on the resident's legs and wrapped them too tightly, causing the blister to pop open. ULP-D stated the wound did healed briefly, then re developed some time in June. ULP-D stated it looked like it was getting infected towards the time she went to the hospital on July 10, 2022 and it was seeping with a lot of pus and didn't seem to be getting any better. ULP-D stated the nurse was aware of the wound and she thought it was being monitored. On October 26, 2022, at 8:55 a.m., RN-C stated she had observed the resident's heel wound on July 8, 2022. RN-C stated she had heard the resident had a blister on her heel but when she looked at it "it was far more than a blister, it was probably the size of a golf ball and encompassed her entire heel ...It was very concerning looking and looked extremely painful, I have no idea how no one was notified of it." RN-C stated the wound would have taken a lot more than a couple of days to get to that stage of a wound. RN-C stated	0 730		

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	24427	A. BUILDING: _____ B. WING _____	C 11/02/2022

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0 730	Continued From page 22 it was at the end of her shift on Friday, July 8, 2022, when she observed the wound so after visiting with the family, it was decided to address it further the next week. RN-C confirmed no further documentation or measurements were taken for the wound. On October 26, 2022 at 9:15 a.m., RN-D stated the resident had a blister on her heel but wasn't sure exactly when it developed. RN-D thought the wound had healed and then came back but could not recall the exact timeline of events. RN-D stated the licensed practical nurse had managed most of the skin assessments and she had only communicated that the resident had a blister on her heel from staff putting on her slippers while her skin was still wet. RN-D stated they were putting bandages and/or mepilex (a wound care dressing) on the resident's heel but wasn't sure if there were doctor's orders for the dressings or if the doctor was aware of the condition of the wound. RN-D was not sure if measurements had been maintaned or tracked. On October 26, 2022, at 7:45 p.m., family member (FM)-H stated they were told the resident had a little blister after staff put on a shoe without socks around the end of May but didn't have any further updates on the resident's heel. FM-H stated they normally tried to visit daily but there was a two week period in June where they were unable to visit. FM-H stated the resident was previously able to walk on her own and when they came back after two weeks, she wasn't able to walk and they were using a lift to transfer her, which family thought was bizarre, and they didn't know why she would have lost her mobility. FM-H stated when they found out about the resident's wound a few weeks later, it made sense why she was no longer able to walk	0 730		

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0 730	Continued From page 23 independently. FM-H stated they were not aware of the wound until July 8, 2022. FM-H stated an unlicensed personnel had mentioned the wound to them so they went with the nurse to look at it. FM-H stated she observed the bed sheets to be saturated from wound drainage and that there was a dressing on the heel that was also saturated with drainage. FM-H reported the room smelled of a foul wound. FM-H stated she told the nurse the wound "was serious and going to need wound care." FM-H stated the facility nurse said "It's probably easier for you to get ahold of the doctor," and suggested the family contact the physician about the wound. FM-H stated she was not able to send the physician the pictures of the wound because it was a Friday at 4 p.m. FM-H came to see the resident over the weekend as she wasn't sure what the facility would be doing for dressings to the wound so decided to do it herself. FM-H stated the resident's condition began to change over the weekend to the point she called 911 to have the resident transported to the hospital for further evaluation as she didn't think the nurse had been updated on the resident's condition. On October 31, 2022, at 11:45 a.m, regional director (RD)-J confirmed she had been assisting with RN duties at the facility during the time the resident's pressure ulcer developed but had not personally observed the resident's heel. RD-J stated, "from my standpoint, if the wound was what you're describing, the LPN should have sent her in at the time when it was first identified [on July 7, 2022] rather than wrapping it up. What you're describing is not a paper fax update to a doctor." RD-J stated she was only aware of a blister to the resident's heel and was under the impression it had resolved early June until she was updated by RN-C on July 8, 2022. RD-J	0 730		

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0 730	Continued From page 24 stated she remembered talking to RN-C but could not recall exactly what RN-C had updated her on. RD-J stated she was not aware of the pressure ulcer to the sacrum that was described in the resident's hospital admission records. RD-J was not sure if measurements had been taken to monitor or track the residen'ts wound. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		
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 interview and record review, the licensee failed to provide staff orientation to assisted living licensing requirements and regulations for one of three employees (registered nurse (RN)-C) with records reviewed. This has the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	01460		

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01460	Continued From page 25 cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: RN-C was hired July 5, 2022, to work as the clinical nurse supervisor providing oversight to unlicensed personnel and direct care and services to the licensee's residents. RN-C's employee record lacked evidence orientation or training was completed to include the following required content: -overview of assisted living statutes; -review of providers' policies and procedures; -handling of emergencies and using emergency services; -reporting maltreatment of vulnerable adults or minors; -assisted living bill of rights; -handling of resident's complaints, reporting of complaints, where to report; -consumer advocacy services; -review of the types of assisted living services the employee will provide and providers' scope of license; -principles of person-centered planning/service delivery; and -hearing loss training (optional). On October 26, 2022, at 8:55 a.m., RN-C stated she had only received one day of training and had no further orientation or guidance before she was put on the floor to work. RN-C stated she had never worked as a clinical nurse supervisor before so was not sure of the processes or the protocol. RN-C stated the lack of orientation and	01460		

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01460	Continued From page 26 training led her to turn in her immediate resignation on July 21, 2022. On October 27, 2022, at 12:15 p.m., corporate accountant (CA)-K confirmed RN-C's employee record lacked evidence of orientation or training and stated if it wasn't in the file, it was likely not completed. CA-K stated RN-C was assigned education in their online education portal, but she had not completed any of it. On October licensed assisted living director (LALD)-F stated since he was not the LALD at the time of RN-C's employment, he was not sure if orientation or training was completed. LALD-F stated the usual process is the RN would complete training and orientation prior to working on their own. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01460		
01620 SS=L	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be	01620		

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01620	Continued From page 27 completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) completed assessments as required for one of one residents (R1) with records reviewed. In addition, the licensee failed to ensure the RN completed assessments that accurately reflected the resident's current condition for one of one residents (R1). This practice resulted in a level four violation (a violation that results in 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 RN failed to monitor skin condition and assess wounds for changes for R1. R1's diagnoses included Alzheimer's dementia and type two diabetes. R1 admitted to the licensee on February 3, 2022.	01620		

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01620	Continued From page 28 The resident's assessment dated May 19, 2022, indicated the resident's skin was intact with no areas of concern. R1's provider orders did not contain orders for wound care or wound dressings. A provider notification correspondence was sent to the resident's primary care provider (PCP) on May 26, 2022, indicating the resident had a fluid filled blister on her left heel pop that morning and that Optifoam (wound dressing) was applied to cover the area. The correspondence also included an update about an increase in edema. No response from the PCP regarding the blister was noted in the resident's record. A progress note entered by RN-D on May 27, 2022, indicated the resident had a fluid filled blister on her left heel that had opened that morning. The wound was documented to measure 3.5 centimeters (cm) by 4 cm and a Mepilex (wound dressing) was applied. A progress note entered by RN-D on June 9, 2022, indicated the resident's left heel where the blister was had dried up and looks well, no signs or symptoms of infection, area measures 3.5 cm by 4 cm. "Old skin" was removed. From June 10, 2022, through July 7, 2022, three RNs, one LPN, and at least 12 unlicensed personnel (ULP) were scheduled to work at the facility. No further reports of the resident's heel wound were reported or documented until July 7, 2022. The resident's Service Recap Summary for June 2022 did not have a category to document a	01620		

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01620	Continued From page 29 weekly skin check. The resident's Service Recap Summary for July 2022 had a documented skin check on July 4, 2022, completed by LPN-B. No skin concerns were reported or noted. A progress note entered by LPN-B on July 7, 2022, at 6:14 p.m. indicated the resident had a blister on her left heel, "blister has broken open leaving an open area measuring approximately 8 cm by 5 cm. Non-stick bandage and gauze wrap applied. A referral has been sent to PCP." A provider notification correspondence was sent to the PCP on July 7, 2022, indicating the blister on the left heel had broken open and "caused a large open area to her heel." The resident's record lacks evidence of further follow up or a response from the provider. Photos of the resident's heel wound, which had an electronic date of July 7, 2022, showed a large, unstageable pressure injury covered in thick, yellow slough with drainage present. The area covered the entire surface and inner aspect of the left heel. The surrounding tissue was red and inflamed. The outer aspect of the heel had peeling skin exposing dark red skin underneath. A progress note entered by RN-C on July 8, 2022, indicated RN-C and R1's granddaughter "unwrapped [the resident's] bandage and assessed area and rewrapped it. Supervisor was contacted with an update on condition of wound." The note further indicated the family would discuss wound care at her appointment on July 12, 2022. A progress note entered by RN-C on July 11,	01620		

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01620	Continued From page 30 2022, indicated the resident was in the intensive care unit (ICU). A progress note entered by LPN-B on July 15, 2022, indicated the resident had passed away that morning. R1's death record listed the cause of death as septic shock. R1's hospital records indicated at the time of the resident's admission on July 10, 2022, the resident had a stage 1 pressure ulcer to her sacrum and a stage 2 pressure ulcer to the left heel. The resident's admitting diagnoses included dehydration, acute renal failure, septic shock (widespread infection causing organ failure), hyperkalemia (high potassium), and acute metabolic encephalopathy (condition that affects the brain structure or function, causing confusion or altered mental state). The hospital records indicate the resident was treated with intravenous antibiotics for the pressure ulcer on her heel and it was also debrided (a procedure to remove infected/dead tissue from a wound). On October 25, 2022, at 12:50 p.m., licensed practical nurse (LPN)-B stated staff had noticed the wound a few days before reporting it to her. LPN-B stated, "I believe it was a lot of the situation we were in because I was the only nurse and working obscene hours and I think staff were hesitant to call me or bother me whenever I had time off." LPN-B stated there had been a lot of turnover and most of the staff working during the time period the resident's wound developed were newer. LPN-B stated one of her responsibilities was to do weekly skin checks but noted it was hard to keep up with all the tasks assigned to her while there was turnover in nursing management. LPN-B was shown several pictures of the resident's heel wound, which had an electronic	01620		

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01620	Continued From page 31 time stamp date of July 7, 2022. LPN-B stated she had not seen those photos before and stated she had not seen the wound in that condition. LPN-B stated the wound in the photos looked red and concerning. LPN-B stated she had not entered a more detailed progress note "because of understaffing. I can't be up 24 hours writing notes, I know that's my job but I can't do it all." On October 25, 2022, at 2:55 p.m., unlicensed personnel (ULP)-G stated she was aware the resident had a wound to her heel and thought it had developed around the end of May. ULP-D thought the blister started when a staff member put slippers on while the resident's feet were wet. ULP-D stated the blister popped open after another ULP put wraps on the resident's legs and wrapped them too tightly, causing the blister to pop open. ULP-D stated the wound did heal briefly, then re developed sometime in June. ULP-D stated it looked like it was getting infected towards the time she went to the hospital on July 10, 2022, and it was seeping with a lot of pus and didn't seem to be getting any better. ULP-D stated the nurse was aware of the wound and she thought it was being monitored. On October 26, 2022, at 8:55 a.m., RN-C stated she had observed the resident's heel wound on July 8, 2022. RN-C stated she had heard the resident had a blister on her heel but when she looked at it "it was far more than a blister, it was probably the size of a golf ball and encompassed her entire heel ...It was very concerning looking and looked extremely painful, I have no idea how no one was notified of it." RN-C stated the wound would have taken a lot more than a couple of days to get to that stage of a wound. RN-C stated it was at the end of her shift on Friday, July 8, 2022, when she observed the wound so after	01620		

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01620	Continued From page 32 visiting with the family, it was decided to address it further the next week. RN-C confirmed no further documentation or measurements were taken for the wound. On October 26, 2022, at 9:15 a.m., RN-D stated the resident had a blister on her heel but wasn't sure exactly when it developed. RN-D thought the wound had healed and then came back but could not recall the exact timeline of events. RN-D stated the licensed practical nurse had managed most of the skin assessments and LPN-B had only communicated that the resident had a blister on her heel from staff putting on her slippers while her skin was still wet. RN-D stated they were putting bandages and/or mepilex (a wound care dressing) on the resident's heel but wasn't sure if there were doctor's orders for the dressings or if the doctor was aware of the condition of the wound. On October 26, 2022, at 7:45 p.m., family member (FM)-H stated they were told the resident had a little blister after staff put on a shoe without socks around the end of May but didn't have any further updates on the resident's heel. FM-H stated they normally tried to visit daily but there was a two-week period in June where they were unable to visit. FM-H stated the resident was previously able to walk on her own and when they came back after two weeks, she wasn't able to walk and they were using a lift to transfer her, which family thought was bizarre, and they didn't know why she would have lost her mobility. FM-H stated when they found out about the resident's wound a few weeks later, it made sense why she was no longer able to walk independently. FM-H stated they were not aware of the wound until July 8, 2022. FM-H stated an unlicensed personnel had mentioned the wound	01620		

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01620	Continued From page 33 to them so they went with the nurse to look at it. FM-H stated she observed the bed sheets to be saturated from wound drainage and that there was a dressing on the heel that was also saturated with drainage. FM-H reported the room smelled of a foul wound. FM-H stated she told the nurse the wound "was serious and going to need wound care." FM-H stated the facility nurse said, "It's probably easier for you to get ahold of the doctor," and suggested the family contact the physician about the wound. FM-H stated she was not able to send the physician the pictures of the wound because it was a Friday at 4 p.m. FM-H came to see the resident over the weekend as she wasn't sure what the facility would be doing for dressings to the wound so decided to do it herself. FM-H stated the resident's condition began to change over the weekend to the point she called 911 to have the resident transported to the hospital for further evaluation as she didn't think the nurse had been updated on the resident's condition. On October 31, 2022, at 11:45 a.m., regional director (RD)-J confirmed she had been assisting with RN duties at the facility during the time the resident's pressure ulcer developed but had not personally observed the resident's heel. RD-J stated, "from my standpoint, if the wound was what you're describing, the LPN should have sent her in at the time when it was first identified [on July 7, 2022] rather than wrapping it up. What you're describing is not a paper fax update to a doctor." RD-J stated she was only aware of a blister to the resident's heel and was under the impression it had resolved early June until she was updated by RN-C on July 8, 2022. RD-J stated she remembered talking to RN-C but could not recall exactly what RN-C had updated her on. RD-J stated she was not aware of the pressure	01620		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAMOND WILLOW OF BAXTER	14396 GRAND OAKS DRIVE BAXTER, MN 56425

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01620	Continued From page 34 ulcer to the sacrum that was described in the resident's hospital admission records. On November 1, 2022, at 9:35 a.m., primary care provider (PCP)-M stated he had not been made aware the resident had a pressure ulcer to her heel. PCP-M reviewed photos taken of the resident's wound on July 10, 2022 and stated he would not consider that to be a blister and it was a large pressure ulcer. PCP-M stated he had last seen the resident in person on May 12, 2022 and did not notice any skin concerns at that time and he had not been updated of any areas of concern since that time. ACCURACY OF ASSESSMENTS The RN failed to ensure an assessment for R1 accurately reflected the resident's current condition. R1 discharged from the facility when she died in the hospital on July 15, 2022. A discharge summary was completed by RN-L on August 2, 2022, 18 days after the resident's death. R1's discharge summary indicated no skin issues were present. On October 25, 2022, at 3:30 p.m., RN-L stated she did not know R1 and had never met or worked with R1. RN-L stated she worked for the corporate offices as a travel nurse and was helping the facility get caught up on overdue assessments. RN-L stated she was not aware R1 had a wound on her heel and had used the information in the resident's record to complete her discharge assessment. RN-L stated she had spoken with LPN-B and she didn't recall anyone mentioning any really bad wounds on the resident. RN-L stated she goes to so many	01620		

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01620	Continued From page 35 facilities it is hard to remember which residents she has completed assessments on. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01620		
01820 SS=F	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a current written or electronically recorded prescription was obtained for all medications the provider managed to two of two residents (R2, R3) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a 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: R2 R2 admitted to the facility on August 19, 2022.	01820		

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01820	Continued From page 36 R2's diagnoses included type two diabetes. R2's service plan, dated August 19, 2022 indicated the resident received medication management services. R2's medication administration record (MAR) for October 2022 indicated the resident received the following medications: -Synthroid 112 micrograms (mcg) daily for underactive thyroid -Insulin lispro 6 units daily before meals for blood sugar control -Amlodipine 5 milligrams (mg) daily for high blood pressure -Ketoconazole 2% cream daily for fungal infection -Lisinopril 40 mg daily for high blood pressure -Metformin 1,000 mg twice daily for blood sugar control -Setraline 25 mg daily for depression -Simvastin 10 mg daily for high cholesterol -Vitamin B12 1,000 mg daily for supplement -Insulin glargine 30 units daily for blood sugar control -Remeron 7.5 mg daily for depression Signed physician prescribed orders for R2 were requested, but not provided. R3 R3 admitted to the facility on August 19, 2022. R3's diagnoses included gout and type two diabetes. R3's service plan, dated August 19, 2022, indicated the resident received services including assistance with dressing, grooming, bathing, oral cares, blood glucose monitoring, medication management, and housekeeping and laundry.	01820		

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01820	Continued From page 37 R3's MAR for September 2022 indicated the resident received the following medications: -Bactroban 2% topically three times daily for skin infection -Allopurinol 300 mg daily for gout -Amlodipine 5 mg daily for high blood pressure -Aspirin 81 mg daily for blood thinner -Metoprolol Succinate 200 mg daily for high blood pressure -Ofloxacin 0.3% drops in right ear twice daily for seven days for ear infection R3's MAR for October 2022 indicated the resident received the following medications: -Amlodipine 5 milligrams (mg) daily for high blood pressure -Aspirin 81 mg daily for blood thinner -Trimethoprim and sulfamethoxazole 80/400 mg twice daily for bacterial infection. Signed admission orders for R3 were requested, but not provided. Signed prescriber orders for R3 were requested, but not provided. R3's MAR indicated allopurinol was discontinued on September 2, 2022, however orders to discontinue were not in the record. R3's MAR indicated metoprolol was discontinued on September 9, however orders to discontinue were not in the record. R3's MAR indicated Bactroban was discontinued September 16, however orders to discontinue were not in the record. A progress note on October 9, 2022, indicated the	01820		

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01820	Continued From page 38 resident had tested positive for COVID-19. The resident's medical record contained a fax dated October 10, 2022, that read, "[R3] tested positive on a rapid test on 10/9/2022. Please let me know if you have any questions or concerns." The fax did not request treatment or update on the resident's condition. No response was noted from the provider. R3's October 2022 MAR indicated the resident started molnupulvir (COVID-19 antiviral medication) on October 13, 2022 through October 18, 2022. On October 31, 2022, at 10:00 a.m., family member (FM)-N stated she had to contact the resident's provider to obtain antiviral medication because she didn't think the facility had done anything to get antiviral medications. On November 1, 2022, RN-A stated she had sent a fax on October 10, 2022, however she did not realize the fax did not go through. Registered nurse (RN)-A stated she didn't think the family wanted the resident treated with any antiviral medications and the resident's symptoms were, and remained, mild. RN-A stated she was out of the office October 12th and 13th for a work conference. RN-A stated when she returned to work on October 13th, she realized the fax updating R3's provider did not get sent. RN-A stated no further follow up was done with the provider since family had already contacted the resident's doctor. On November 1, 2022, at 11:00 a.m., licensed practical nurse (LPN)-B stated the family obtained orders for antivirals for R3 as they wanted both R2 and R3 treated for their COVID-19 infections. LPN-B confirmed it was her job to order	01820		

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01820	Continued From page 39 medications and ensure prescriptions are managed but stated, "it's kind of crazy around here, those are a lot of the reasons it got missed." A copy of the order for molnupulvir was requested, but not provided. The licensee's Medication & Treatment policy dated August 1, 2021, indicated all orders for medications would be dated and signed by the prescriber and must be current and consistent with the nursing assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
01940 SS=F	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or	01940		

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01940	Continued From page 40 appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop a treatment management plan to include all required content for two of two residents receiving treatments (R1, R3) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 R1's diagnoses included Alzheimer's dementia and type two diabetes. R1's service plan, dated April 7, 2022, indicated the resident received services including assistance with dressing, grooming, bathing, eating, mobility, toileting, and transfers,	01940		

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01940	Continued From page 41 housekeeping, laundry, blood glucose monitoring, and medication management. R1's service plan did not indicate R1 was receiving any wound care services or other treatments. In addition, R1's record did not have evidence of a treatment management plan with the following required content: -a statement of the type of services that will be provided; -documentation of specific resident instructions relating to the treatments or therapy administration; -identification of treatment or therapy tasks that will be delegated to unlicensed personnel; -procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and -any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. R1's provider orders did not contain orders for wound care or wound dressings. R1's progress notes indicated various wound dressings were used on May 27, 2022 July 7, 2022, and July 8, 2022. R1's medication administration record (MAR) and service recap summary lacked documentation wound dressings had been used from May through July 2022.	01940		

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01940	Continued From page 42 On October 25, 2022, at 12:50 p.m., licensed practical nurse (LPN)-B stated they had used dressings on the resident's wound on and off from the end of May until the resident went to the hospital in July. LPN-B stated she was not sure if orders were obtained for the wound care or wound dressings. On October 25, 2022, at 2:55 p.m., unlicensed personnel (ULP)-G stated she had seen R1's wound covered with a dressing and that the nurses managed the dressings. On October 26, 2022, at 8:55 a.m., registered nurse (RN)-C stated she had observed the resident's heel wound on July 8, 2022. RN-C stated she put a dressing on the wound but was not sure if there were orders in place to do so. R3 R3's diagnoses included gout and type two diabetes. R3's service plan, dated August 19, 2022, indicated the resident received services including assistance with dressing, grooming, bathing, oral cares, blood glucose monitoring, medication management, and housekeeping and laundry. R3's service plan did not indicate R3 was receiving any wound care services or other treatments. In addition, R3's record did not have evidence of a treatment management plan with the following required content: -a statement of the type of services that will be provided; -documentation of specific resident instructions relating to the treatments or therapy administration;	01940		

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01940	Continued From page 43 -identification of treatment or therapy tasks that will be delegated to unlicensed personnel; -procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and -any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. R3's provider orders did not contain orders for wound care or dressings. R3 was receiving wound care services contracted through a home care agency. On October 9, 2022, R3 tested positive for COVID-19. The resident remained in isolation through October 18, 2022. During the time the resident was isolating, home care did not come in to provide wound care services due to his diagnosis of COVID-19. On October 31, 2022, at 10:00 a.m., family member (FM)-N stated she noticed R3's dressing had crusted to his face and appeared dirty when she went in to visit him one day. FM-N asked LPN-B about when it was changed last, and she did not know. FM-N stated she showed LPN-B how to change the dressing and provided instructions on how to do it. FM-N stated she was not aware home care was not providing services while the resident had COVID-19. On November 1, 2022, at 8:30 a.m., RN-A stated	01940		

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01940	Continued From page 44 she was not made aware home care had stopped services while R3 had active COVID-19. RN-A stated she found out with FM-N called her on October 17, 2022 with her concerns. RN-A stated she entered the dressing change as a task in the computer charting system for the LPN to complete until home care resumed services but did not check to see if the facility had orders for wound care. On November 1, 2022, at 11:00 a.m., LPN-B stated she was not aware home care was not providing wound care services while the resident had COVID-19. LPN-B stated home care staff later said they had updated her but she did not remember getting updated. LPN-B stated she followed the directions given by FM-N and completed the dressing changes on October 18, October 19, October 21, 2022. LPN-B stated the resident's provider had not been updated and she had not verified the orders for R3's dressing changes. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01950 SS=F	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment	01950		

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01950	Continued From page 45 or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) specified, in writing, specific instructions and documented those instructions in the resident record for two of two residents receiving treatments (R1, R3) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), 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 R1's diagnoses included Alzheimer's dementia and type two diabetes. R1's service plan, dated April 7, 2022, indicated	01950		

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01950	Continued From page 46 the resident received services including assistance with dressing, grooming, bathing, eating, mobility, toileting, and transfers, housekeeping, laundry, blood glucose monitoring, and medication management. R1's service plan did not indicate R1 was receiving any wound care services or other treatments. In addition, R1's record did not have evidence of a treatment management plan or instruction for wound care services. R1's provider orders did not contain orders for wound care or wound dressings. R1's progress notes indicated various wound dressings were used on May 27, 2022 July 7, 2022, and July 8, 2022. R1's medication administration record (MAR) and service recap summary lacked documentation wound dressings had been used from May through July 2022. On October 25, 2022, at 12:50 p.m., licensed practical nurse (LPN)-B stated they had used dressings on the resident's wound on and off from the end of May until the resident went to the hospital in July. LPN-B stated she was not sure if orders were obtained for the wound care or wound dressings. On October 25, 2022, at 2:55 p.m., unlicensed personnel (ULP)-G stated she had seen R1's wound covered with a dressing and that the nurses managed the dressings. On October 26, 2022, at 8:55 a.m., registered nurse (RN)-C stated she had observed the resident's heel wound on July 8, 2022. RN-C	01950		

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01950	Continued From page 47 stated she put a dressing on the wound but was not sure if there were orders in place to do so. R3 R3's diagnoses included gout and type two diabetes. R3's service plan, dated August 19, 2022, indicated the resident received services including assistance with dressing, grooming, bathing, oral cares, blood glucose monitoring, medication management, and housekeeping and laundry. R3's service plan did not indicate R3 was receiving any wound care services or other treatments. In addition, R3's record did not have evidence of a treatment management plan or instruction for wound care services. R3's provider orders did not contain orders for wound care or dressings. R3 was receiving wound care services through a home care agency. On October 9, 2022, R3 tested positive for COVID-19. The resident remained in isolation through October 18, 2022. During the time the resident was isolating, home care did not come in to provide wound care services due to his diagnosis of COVID-19. R3's record contained scheduled chores for the nurse to perform on October 18, 19, and 20, 2022. The instructions listed stated "change bandage and cleanse per wound instructions for [R3] in room [number]. Instructions were not listed in the resident's record. On October 31, 2022, at 10:00 a.m., family	01950		

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01950	Continued From page 48 member (FM)-N stated she noticed R3's dressing had crusted to his face and appeared dirty when she went in to visit him one day. FM-N asked LPN-B about when it was changed last and she did not know. FM-N stated she showed LPN-B how to change the dressing and provided instructions on how to do it. FM-N stated she was not aware home care was not providing services while the resident had COVID-19. On November 1, 2022, at 8:30 a.m., RN-A stated she was not made aware home care had stopped services while R3 had active COVID-19. RN-A stated she found out with FM-N called her on October 17, 2022 with her concerns. RN-A stated she entered the dressing change as a task in the computer charting system for the LPN to complete until home care resumed services but did not check to see if the facility had orders for wound care. On November 1, 2022, at 11:00 a.m., LPN-B stated she was not aware home care was not providing services while the resident had COVID-19. LPN-B stated home care later said they had updated her but she did not remember getting updated. LPN-B stated she followed the directions given by FM-N and completed the dressing changes on October 18, October 19, October 21, 2022. LPN-B stated the resident's provider had not been updated and she had not verified the orders for R3's dressing changes. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		

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	24427	A. BUILDING: _____ B. WING _____	C 11/02/2022

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01960	Continued From page 49	01960		
01960 SS=D	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 document treatment administration one of two residents (R1) receiving treatments. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 R1's diagnoses included Alzheimer's dementia and type two diabetes. R1's service plan, dated April 7, 2022, indicated	01960		

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01960	Continued From page 50 the resident received services including assistance with dressing, grooming, bathing, eating, mobility, toileting, and transfers, housekeeping, laundry, blood glucose monitoring, and medication management. R1's service plan did not indicate R1 was receiving any wound care services or other treatments. In addition, R1's record did not have evidence of a treatment management plan or instruction for wound care services. R1's provider orders did not contain orders for wound care or wound dressings. R1's progress notes indicated various wound dressings were used on May 27, 2022 July 7, 2022, and July 8, 2022. R1's medication administration record (MAR) and service recap summary lacked documentation wound dressings had been used from May through July 2022. On October 25, 2022, at 12:50 p.m., licensed practical nurse (LPN)-B stated they had used dressings on the resident's wound on and off from the end of May until the resident went to the hospital in July. LPN-B stated she was not sure if orders were obtained for the wound care or wound dressings. On October 25, 2022, at 2:55 p.m., unlicensed personnel (ULP)-G stated she had seen R1's wound covered with a dressing and that the nurses managed the dressings. On October 26, 2022, at 8:55 a.m., registered nurse (RN)-C stated she had observed the resident's heel wound on July 8, 2022. RN-C	01960		

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01960	Continued From page 51 stated she put a dressing on the wound but was not sure if there were orders in place to do so. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	01960		
01970 SS=F	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed ensure up-to-date written or electronically recorded orders were maintained for two of two residents (R1, R3) receiving treatments. 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:	01970		

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01970	Continued From page 52 R1 R1's diagnoses included Alzheimer's dementia and type two diabetes. R1's service plan, dated April 7, 2022, indicated the resident received services including assistance with dressing, grooming, bathing, eating, mobility, toileting, and transfers, housekeeping, laundry, blood glucose monitoring, and medication management. R1's service plan did not indicate R1 was receiving any wound care services or other treatments. In addition, R1's record did not have evidence of a treatment management plan. R1's provider orders did not contain orders for wound care or wound dressings. R1's progress notes indicated various wound dressings were used on May 27, 2022 July 7, 2022, and July 8, 2022. R1's medication administration record (MAR) and service recap summary lacked documentation wound dressings had been used from May through July 2022. On October 25, 2022, at 12:50 p.m., licensed practical nurse (LPN)-B stated they had used dressings on the resident's wound on and off from the end of May until the resident went to the hospital in July. LPN-B stated she was not sure if orders were obtained for the wound care or wound dressings. On October 25, 2022, at 2:55 p.m., unlicensed personnel (ULP)-G stated she had seen R1's wound covered with a dressing and that the	01970		

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01970	Continued From page 53 nurses managed the dressings. On October 26, 2022, at 8:55 a.m., registered nurse (RN)-C stated she had observed the resident's heel wound on July 8, 2022. RN-C stated she put a dressing on the wound but was not sure if there were orders in place to do so. R3 R3's diagnoses included gout and type two diabetes. R3's service plan, dated August 19, 2022, indicated the resident received services including assistance with dressing, grooming, bathing, oral cares, blood glucose monitoring, medication management, and housekeeping and laundry. R3's provider orders did not contain orders for wound care or dressings. R3 was receiving wound care services through a home care agency. On October 9, 2022, R3 tested positive for COVID-19. The resident remained in isolation through October 18, 2022. During the time the resident was isolating, home care did not come in to provide wound care services due to his diagnosis of COVID-19. On October 31, 2022, at 10:00 a.m., family member (FM)-N stated she noticed R3's dressing had crusted to his face and appeared dirty when she went in to visit him one day. FM-N asked LPN-B about when it was changed last and she did not know. FM-N stated she showed LPN-B how to change the dressing and provided instructions on how to do it. FM-N stated she was not aware home care was not providing services while the resident had COVID-19.	01970		

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01970	Continued From page 54 On November 1, 2022, at 8:30 a.m., RN-A stated she was not made aware home care had stopped services while R3 had active COVID-19. RN-A stated she found out with FM-N called her on October 17, 2022 with her concerns. RN-A stated she entered the dressing change as a task in the computer charting system for the LPN to complete until home care resumed services but did not check to see if the facility had orders for wound care. On November 1, 2022, at 11:00 a.m., LPN-B stated she was not aware home care was not providing services while the resident had COVID-19. LPN-B stated home care later said they had updated her but she did not remember getting updated. LPN-B stated she followed the directions given by FM-N and completed the dressing changes on October 18, October 19, October 21, 2022. LPN-B stated the resident's provider had not been updated and she had not verified the orders for R3's dressing changes. The licensee's Treatment or Therapy Orders policy, last updated September 4, 2022, indicated treatments would be performed as prescribed by the authorized provider. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		
02310 SS=L	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the	02310		

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02310	Continued From page 55 resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards for one of one residents (R1) with a wound and change in condition. This practice resulted in a level four violation (a violation that results in 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 RN failed to monitor skin condition and assess wounds for changes for R1. R1's diagnoses included Alzheimer's dementia and type two diabetes. R1 admitted to the licensee on February 3, 2022. The resident's assessment dated May 19, 2022, indicated the resident's skin was intact with no areas of concern. R1's provider orders did not contain orders for wound care or wound dressings. A provider notification correspondence was sent to the resident's primary care provider (PCP) on May 26, 2022, indicating the resident had a fluid filled blister on her left heel pop that morning and	02310		

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02310	Continued From page 56 that Optifoam (wound dressing) was applied to cover the area. The correspondence also included an update about an increase in edema. No response from the PCP regarding the blister was noted in the resident's record. A progress note entered by RN-D on May 27, 2022, indicated the resident had a fluid filled blister on her left heel that had opened that morning. The wound was documented to measure 3.5 centimeters (cm) by 4 cm and a Mepilex (wound dressing) was applied. A progress note entered by RN-D on June 9, 2022, indicated the resident's left heel where the blister was had dried up and looks well, no signs or symptoms of infection, area measures 3.5 cm by 4 cm. "Old skin" was removed. From June 10, 2022, through July 7, 2022, three RNs, one LPN, and at least 12 unlicensed personnel (ULP) were scheduled to work at the facility. No further reports of the resident's heel wound were reported or documented until July 7, 2022. The resident's Service Recap Summary for June 2022 did not have a category to document a weekly skin check. The resident's Service Recap Summary for July 2022 had a documented skin check on July 4, 2022, completed by LPN-B. No skin concerns were reported or noted. A progress note entered by LPN-B on July 7, 2022, at 6:14 p.m. indicated the resident had a blister on her left heel, "blister has broken open leaving an open area measuring approximately 8 cm by 5 cm. Non-stick bandage and gauze wrap	02310		

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02310	Continued From page 57 applied. A referral has been sent to PCP." A provider notification correspondence was sent to the PCP on July 7, 2022, indicating the blister on the left heel had broken open and "caused a large open area to her heel." The resident's record lacks evidence of further follow up or a response from the provider. Photos of the resident's heel wound, which had an electronic date of July 7, 2022, showed a large, unstageable pressure injury covered in thick, yellow slough with drainage present. The area covered the entire surface and inner aspect of the left heel. The surrounding tissue was red and inflamed. The outer aspect of the heel had peeling skin exposing dark red skin underneath. A progress note entered by RN-C on July 8, 2022, indicated RN-C and R1's granddaughter "unwrapped [the resident's] bandage and assessed area and rewrapped it. Supervisor was contacted with an update on condition of wound." The note further indicated the family would discuss wound care at her appointment on July 12, 2022. A progress note entered by RN-C on July 11, 2022, indicated the resident was in the intensive care unit (ICU). A progress note entered by LPN-B on July 15, 2022, indicated the resident had passed away that morning. R1's death record listed the cause of death as septic shock. R1's hospital records indicated at the time of the resident's admission on July 10, 2022, the resident had a stage 1 pressure ulcer to her sacrum and a stage 2 pressure ulcer to the left	02310		

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02310	Continued From page 58 heel. The resident's admitting diagnoses included dehydration, acute renal failure, septic shock (widespread infection causing organ failure), hyperkalemia (high potassium), and acute metabolic encephalopathy (condition that affects the brain structure or function, causing confusion or altered mental state). The hospital records indicate the resident was treated with intravenous antibiotics for the pressure ulcer on her heel and it was also debrided (a procedure to remove infected/dead tissue from a wound). On October 25, 2022, at 12:50 p.m., licensed practical nurse (LPN)-B stated staff had noticed the wound a few days before reporting it to her. LPN-B stated, "I believe it was a lot of the situation we were in because I was the only nurse and working obscene hours and I think staff were hesitant to call me or bother me whenever I had time off." LPN-B stated there had been a lot of turnover and most of the staff working during the time period the resident's wound developed were newer. LPN-B stated one of her responsibilities was to do weekly skin checks but noted it was hard to keep up with all the tasks assigned to her while there was turnover in nursing management. LPN-B was shown several pictures of the resident's heel wound, which had an electronic time stamp date of July 7, 2022. LPN-B stated she had not seen those photos before and stated she had not seen the wound in that condition. LPN-B stated the wound in the photos looked red and concerning. LPN-B stated she had not entered a more detailed progress note "because of understaffing. I can't be up 24 hours writing notes, I know that's my job but I can't do it all." On October 25, 2022, at 2:55 p.m., unlicensed personnel (ULP)-G stated she was aware the resident had a wound to her heel and thought it	02310		

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02310	Continued From page 59 had developed around the end of May. ULP-D thought the blister started when a staff member put slippers on while the resident's feet were wet. ULP-D stated the blister popped open after another ULP put wraps on the resident's legs and wrapped them too tightly, causing the blister to pop open. ULP-D stated the wound did heal briefly, then re developed sometime in June. ULP-D stated it looked like it was getting infected towards the time she went to the hospital on July 10, 2022, and it was seeping with a lot of pus and didn't seem to be getting any better. ULP-D stated the nurse was aware of the wound and she thought it was being monitored. On October 26, 2022, at 8:55 a.m., RN-C stated she had observed the resident's heel wound on July 8, 2022. RN-C stated she had heard the resident had a blister on her heel but when she looked at it "it was far more than a blister, it was probably the size of a golf ball and encompassed her entire heel ...It was very concerning looking and looked extremely painful, I have no idea how no one was notified of it." RN-C stated the wound would have taken a lot more than a couple of days to get to that stage of a wound. RN-C stated it was at the end of her shift on Friday, July 8, 2022, when she observed the wound so after visiting with the family, it was decided to address it further the next week. RN-C confirmed no further documentation or measurements were taken for the wound. On October 26, 2022, at 9:15 a.m., RN-D stated the resident had a blister on her heel but wasn't sure exactly when it developed. RN-D thought the wound had healed and then came back but could not recall the exact timeline of events. RN-D stated the licensed practical nurse had managed most of the skin assessments and LPN-B had	02310		

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02310	Continued From page 60 only communicated that the resident had a blister on her heel from staff putting on her slippers while her skin was still wet. RN-D stated they were putting bandages and/or mepilex (a wound care dressing) on the resident's heel but wasn't sure if there were doctor's orders for the dressings or if the doctor was aware of the condition of the wound. On October 26, 2022, at 7:45 p.m., family member (FM)-H stated they were told the resident had a little blister after staff put on a shoe without socks around the end of May but didn't have any further updates on the resident's heel. FM-H stated they normally tried to visit daily but there was a two-week period in June where they were unable to visit. FM-H stated the resident was previously able to walk on her own and when they came back after two weeks, she wasn't able to walk and they were using a lift to transfer her, which family thought was bizarre, and they didn't know why she would have lost her mobility. FM-H stated when they found out about the resident's wound a few weeks later, it made sense why she was no longer able to walk independently. FM-H stated they were not aware of the wound until July 8, 2022. FM-H stated an unlicensed personnel had mentioned the wound to them so they went with the nurse to look at it. FM-H stated she observed the bed sheets to be saturated from wound drainage and that there was a dressing on the heel that was also saturated with drainage. FM-H reported the room smelled of a foul wound. FM-H stated she told the nurse the wound "was serious and going to need wound care." FM-H stated the facility nurse said, "It's probably easier for you to get ahold of the doctor," and suggested the family contact the physician about the wound. FM-H stated she was not able to send the physician the pictures of the	02310		

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02310	Continued From page 61 wound because it was a Friday at 4 p.m. FM-H came to see the resident over the weekend as she wasn't sure what the facility would be doing for dressings to the wound so decided to do it herself. FM-H stated the resident's condition began to change over the weekend to the point she called 911 to have the resident transported to the hospital for further evaluation as she didn't think the nurse had been updated on the resident's condition. On October 31, 2022, at 11:45 a.m., regional director (RD)-J confirmed she had been assisting with RN duties at the facility during the time the resident's pressure ulcer developed but had not personally observed the resident's heel. RD-J stated, "from my standpoint, if the wound was what you're describing, the LPN should have sent her in at the time when it was first identified [on July 7, 2022] rather than wrapping it up. What you're describing is not a paper fax update to a doctor." RD-J stated she was only aware of a blister to the resident's heel and was under the impression it had resolved early June until she was updated by RN-C on July 8, 2022. RD-J stated she remembered talking to RN-C but could not recall exactly what RN-C had updated her on. RD-J stated she was not aware of the pressure ulcer to the sacrum that was described in the resident's hospital admission records. On November 1, 2022, at 9:35 a.m., primary care provider (PCP)-M stated he had not been made aware the resident had a pressure ulcer to her heel. PCP-M reviewed photos taken of the resident's wound on July 10, 2022 and stated he would not consider that to be a blister and it was a large pressure ulcer. PCP-M stated he had last seen the resident in person on May 12, 2022 and did not notice any skin concerns at that time and	02310		

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	24427	A. BUILDING: _____ B. WING _____	C 11/02/2022

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DIAMOND WILLOW OF BAXTER	14396 GRAND OAKS DRIVE BAXTER, MN 56425

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02310	Continued From page 62 he had not been updated of any areas of concern since that time. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		
02320 SS=I	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure reporting of resident condition to the appropriate supervisor or health care professional for two of two residents (R2, R3). In addition, the licensee failed to ensure accurate medication administration for one of one residents (R2). 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).	02320		

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02320	Continued From page 63 The findings include: R2 MEDICATION ERRORS The facility failed to ensure medications were reordered, resulting in R2 missing several doses of medications. R2's diagnoses included type two diabetes. R2's service plan, dated August 19, 2022 indicated the resident received medication management services. R2's medication management plan, dated September 1, 2022, indicated facility staff would be responsible for reordering and managing storage of the resident's medications. R2's September 2022 MAR indicated the resident ran out of medication and did not receive the following medications: Metformin (medication to control blood sugar): -September 11, the resident's morning dose was marked as "last one" -September 11 evening dose and September 12 both doses the resident's metforim was marked as "out" Norvasc (medication for high blood pressure) : -September 21, the dose was marked as out. The nurse commented "ordered." Simvastin (medication for high cholesterol): -September 28, 29, 30 the dose marked as out of stock. R2's October 2022 MAR indicated the resident ran out of medication and did not receive the following medications:	02320		

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02320	Continued From page 64 Simvastin: -October 1, 2, and 3 the resident's Simvastin was marked as not available. The nurse entered a note on October 2nd indicating the medication was now ordered. The resident missed a total of six days of the medication. Remeron (antidepressant medication): -October 2, 3, 4, 5, 7, 8, 9, 10, 11, 12, 13 the resident's Remeron was marked as not given. The medication was marked as administered on October 6, 2022, but this was confirmed to be a medication error and was not actually given due to the medication being out of stock. On the October MAR, the nurse commented on October 3, 10, and 11 that "pharmacy does not have an order for this, PCP is sending to pharmacy." On October 12, the nurse commented on the MAR "ordered." On October 13th, the nurse commented on the MAR, "the family is taking care of getting in touch with the PCP about this." In total, the resident missed 12 doses of the medication. Ketoconazole (medication for fungal infections): Unlicensed personnel entered the following communication notes on the MAR: -October 20, seven doses left -October 27, one dose left -October 28, last dose used -October 29 the resident's ketoconazole cream was marked as unable to give as it had run out. On October 31, 2022, at 10:00 a.m., family member (FM)-N stated she had voiced several concerns to management about R2's medications not being refilled and running out and had concerns staff were signing out medications	02320		

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02320	Continued From page 65 without giving them. FM-N stated there was a period of several days where R2 did not receive her antidepressant medication. FM-N stated she had noticed some changes in R2's behavior and wasn't sure why. FM-N stated she asked RN-A to print R2's MAR and at that point it was discovered R2 had not received her antidepressant for several days. On November 1, 2022, at 8:30 a.m. RN-A stated she was not initially aware R2 had run out of her antidepressant and only discovered the issue when FM-N asked her to print the MAR. RN-A stated it was the LPN's duties to monitor medications and ensure refills are obtained. RN-A stated there was a medication error form filled out after a staff member documented she administered R2's antidepressant when it was not in the cart. On November 1, 2022, at 11:00 a.m., LPN-B stated she was aware R2 had run out of one of her medications. LPN-B stated she couldn't remember if pharmacy didn't have the prescription and stated, "there was a lot of confusion with her pills and orders when they moved in." LPN-B confirmed it was her job to order medications and ensure prescriptions are managed but stated, "it's kind of crazy around here, those are a lot of the reasons it got missed." Copies of R2's admission orders were requested, but not provided. R2 COVID-19 REPORTING The facility failed to ensure R2's provider was updated of her COVID-19 infection and failed to ensure appropriate treatment was obtained. Due to the delay in updating the provider, the resident	02320		

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02320	Continued From page 66 was unable to take antiviral medication to treat her COVID-19 infection. A progress note on October 7, 2022, indicated the resident tested positive for COVID-19. The resident's medical record contained a fax dated October 7, 2022, that read "[R2] tested positive for COVID today." The fax did not request treatment or update on the resident's condition. No response was noted from the provider. A progress note on October 17, 2022, indicated the resident was removed from isolation precautions. On November 1, 2022, RN-A stated she had sent a fax on Friday, October 7, 2022, when R2 tested positive however she did not realize the fax did not go through. RN-A stated she didn't think the family wanted the resident treated with any antiviral medications and the resident's symptoms were, and remained, mild. RN-A stated she was back at work on October 10th but was out of the office October 12th and 13th for a work conference. RN-A stated when she returned to work on October 13th, six days after the resident initially tested positive, she realized the fax updating R2's provider did not get sent. RN-A stated her normal process would be to follow up with a provider if they had not gotten a response to a fax but confirmed this did not happen for R2. On November 1, 2022, at 11:00 a.m., LPN-B stated the family for R2 wanted her to be treated with antiviral medication. LPN-B stated since the doctor hadn't been updated in time, R2 was not able to start antiviral medications for her COVID-19 infection. R3	02320		

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02320	Continued From page 67 WOUND CARE The facility failed to ensure the resident's wound care services continued after home care was not able to provide care due to R3's COVID-19 infection. R3's diagnoses included gout and type two diabetes. R3's service plan, dated August 19, 2022, indicated the resident received services including assistance with dressing, grooming, bathing, oral cares, blood glucose monitoring, medication management, and housekeeping and laundry. R3's provider orders did not contain orders for wound care or dressings. R3 was receiving wound care services through a home care agency. On October 9, 2022, R3 tested positive for COVID-19. The resident remained in isolation through October 18, 2022. During the time the resident was isolating, home care did not come in to provide wound care services due to his diagnosis of COVID-19. On October 31, 2022, at 10:00 a.m., family member (FM)-N stated she noticed R3's dressing had crusted to his face and appeared dirty when she went in to visit him one day. FM-N asked LPN-B about when it was changed last, and she did not know. FM-N stated she showed LPN-B how to change the dressing and provided instructions on how to do it. FM-N stated she was not aware home care was not providing services while the resident had COVID-19. On November 1, 2022, at 8:30 a.m., RN-A stated she was not made aware home care had stopped services while R3 had active COVID-19. RN-A	02320		

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02320	Continued From page 68 stated she found out with FM-N called her on October 17, 2022 with her concerns. RN-A stated she entered the dressing change as a task in the computer charting system for the LPN to complete until home care resumed services but did not check to see if the facility had orders for wound care. On November 1, 2022, at 11:00 a.m., LPN-B stated she was not aware home care was not providing services while the resident had COVID-19. LPN-B stated home care staff later said they had updated her but she did not remember getting updated. LPN-B stated she followed the directions given by FM-N and completed the dressing changes on October 18, October 19, October 21, 2022. LPN-B stated the resident's provider had not been updated and she had not verified the orders for R3's dressing changes. R3 MEDICATION ERRORS The facility failed to ensure medications were reordered, resulting in R3 missing several doses of medications. R3's service plan, dated August 19, 2022 indicated the resident received medication management services. R3's September 2022 MAR indicated the resident ran out of medication and did not receive the following medications: Metoprolol (medication for high blood pressure): -September 1, the dose was marked as out. The nurse entered a note in the MAR that read, "Does not take per PCP." -September 2, the dose was marked as not here.	02320		

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02320	Continued From page 69 -September 3, the dose was marked as does not take -September 4, the dose was marked as not available. -September 5, the dose was marked as does not take. The nurse entered a note in the MAR that read, "does not take per PCP." -September 6, the dose was marked as does not take. The nurse entered a note in the MAR that read, "does not take per PCP." -September 7, the dose was marked as does not have. -September 8, the dose was marked as out. -September 9, the dose was marked as ordered. The MAR indicated metoprolol was discontinued on September 9, however orders to discontinue were not in the record. Allopurinol (medication for gout): -September 1, the dose was marked as out. -September 2, the dose was marked as not here The MAR indicated allopurinol was discontinued on September 2, 2022, however orders to discontinue were not in the record. Bactroban (medication for skin infection): -September 1, the dose was marked unavailable. The nurse entered a note on the MAR that read, "family says he doesn't use this, will fax PCP for clarification." -September 2, the dose was marked as does not use. -September 3, the dose was marked as med unavailable. -September 4, the dose was marked as not available. The nurse entered a note on the MAR that read, "does not take per PCP." -September 5, the overnight dose was marked as	02320		

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02320	Continued From page 70 administered. -September 6, the morning dose was marked as does not use. The nurse entered a note on the MAR that read, "does not take per PCP." -September 6, the overnight dose was marked as med out of stock, nurse notified. -September 7, the evening dose was marked as does not use. September 8, 9, 10, 11 the evening dose was marked as administered. -September 9, the morning dose was marked as administered. -September 9, the overnight dose was marked as does not use. The nurse entered a note on the MAR that read, "does not use." -September 10, the dose was marked as does not use. -September 11, the dose was marked as does not use. -September 12, the dose was marked as not available. -September 13 the evening dose was marked as administered. -September 14 and 15 the evening dose was marked as does not use. The nurse entered a note on the MAR that read, "does not use." -September 15, the morning dose was marked as administered. -September 16, the morning dose was marked as does not use. The MAR indicated Bactroban was discontinued September 16, however orders to discontinue were not in the record. R3's October 2022 MAR indicated the resident ran out of medication and did not receive the following medications: Trimethoprim and Sulfamethoxazole (medication	02320		

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02320	Continued From page 71 for bacterial infection): -October 22, the evening dose was marked as last one. The nurse entered a note on the MAR that read, "done with tx [treatment]." -October 23, the morning dose was marked as out. The prescriber order, dated October 12, 2022, did not list an end date for the medication. The MAR indicated Trimethoprim and Sulfamethoxazole was discontinued October 23, however orders to discontinue were not in the record. Signed provider orders for R3 were requested, but not provided. COVID-19 REPORTING The facility failed to ensure R3's provider was updated of his COVID-19 infection and failed to ensure appropriate treatment was obtained. A progress note on October 7, 2022 indicated the resident had tested negative for COVID-19 but was symptomatic. R3 shared an apartment with R2, who had tested positive for COVID-19 that day. A progress note on October 9, 2022, indicated the resident had tested positive for COVID-19. The resident's medical record contained a fax dated October 10, 2022, that read, "[R3] tested positive on a rapid test on 10/9/2022. Please let me know if you have any questions or concerns." The fax did not request treatment or update on the resident's condition. No response was noted from the provider. R3's October 2022 MAR indicated the resident started molnupulvir (COVID-19 antiviral medication) on October 13, 2022 through	02320		

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02320	Continued From page 72 October 18, 2022. On October 31, 2022, at 10:00 a.m., FM-N stated she had to contact the resident's provider to obtain antiviral medication because she didn't think the facility had done anything to get antiviral medications. On November 1, 2022, RN-A stated she had sent a fax on October 10, 2022, however she did not realize the fax did not go through. RN-A stated she didn't think the family wanted the resident treated with any antiviral medications and the resident's symptoms were, and remained, mild. RN-A stated she was out of the office October 12th and 13th for a work conference. RN-A stated when she returned to work on October 13th, she realized the fax updating R3's provider did not get sent. RN-A stated no further follow up was done with the provider since family had already contacted the resident's doctor. On November 1, 2022, at 11:00 a.m., LPN-B stated the family obtained orders for antivirals for R3 as they wanted both R2 and R3 treated for their COVID-19 infections. A copy of R3's antiviral medication order was requested, but not provided. The licensee's COVID-19 Testing Policy, last updated August 31, 2022, did not address reporting test results to resident's providers or how COVID-19 treatment options would be implemented. The policy did not address testing of a symptomatic resident who had known exposure but a negative rapid test. The licensee's Medication & Supplies Reordering policy, last updated December 24, 2019,	02320		

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02320	Continued From page 73 indicated on a daily basis, medications will be reordered by faxing the designated supplier. If a client [resident] needed medications reordered from the pharmacy, staff were to contact them by faxing the refill prescription or request. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02320		
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 interviews and document review, the facility failed to ensure 1 of 1 residents, (R1), reviewed was free from maltreatment. The resident was neglected. Findings include: On November 17, 2022, 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	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	