Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL244273984M
Compliance #: HL244276603C

Date Concluded: February 1, 2023

Name, Address, and County of Licensee Investigated:
Diamond Willow 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: Inconclusive

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 staff failed to reorder the resident's pain medication. The resident went several days without pain medication, resulting in the resident experiencing uncontrolled pain.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. Over a two-week period, the resident's narcotic pain medication was unavailable after it was not refilled on two separate occasions. This caused the resident to miss a total of 16 scheduled doses. However, once the facility became aware the medication was unavailable, they made attempts to refill the medication as soon as possible and took corrective actions to prevent further occurrences. Due to lack of documentation, it is unable to be determined if the resident suffered significant adverse effects due to the missed pain medication. Licensing orders were issued in relation to this incident.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident's progress notes, care plan, service plan, assessments, and medication administration record. Also, the investigator observed medication administration in the facility.

The resident resided in an assisted living with dementia care facility. The resident's diagnoses included chronic pain, obesity, and type two diabetes. The resident's service plan included assistance with medication administration. The resident's assessment indicated the resident required a mechanical lift with two people for transfers, had chronic pain, and experienced increased pain to his lower legs due to multiple fractures.

Progress notes indicated the resident was readmitted to the hospital the same day he admitted to the facility after he fell in his room and broke both of his legs. The resident was hospitalized for surgical repair to both legs and returned to the facility 13 days later with orders for Oxycodone (a narcotic pain medication) every six hours for pain.

Medication administration records indicated on two occasions, the facility failed to obtain a new prescription and refill the Oxycodone before it ran out. On the first occurrence, the resident missed a total of seven scheduled doses of Oxycodone over two days. During this time, the resident was given three doses of a non-narcotic as needed (PRN) pain medication after reporting a "solid STRONG 9 [out of 10] in pain". Medication administration records indicated the PRN pain medication was not effective at reducing the pain. The resident's medication was refilled and resumed but five days later, the resident's Oxycodone ran out again. Over four days, the resident missed another nine doses of scheduled Oxycodone. During this time, the resident was administered five doses of PRN pain medication for pain rated at a 9 out of 10.

Review of the resident's medical record included no documentation of how the facility managed the resident's pain while he was out of the Oxycodone medication. The nurse did not reassess the resident following his reports of increased and uncontrolled pain.

During an interview, a facility nurse confirmed the resident's Oxycodone had run out twice. The nurse stated they had some issues with getting orders back from the resident's doctor. The nurse confirmed they did not request a refill until the resident had already run out of the medication, but they offered the resident ice and Tylenol to help with the pain. The nurse stated the facility has since implemented a new process of "Medication Mondays" to check every resident's medication cabinet weekly to see if refills are needed.

During an interview, the licensed assisted living director stated he was not aware of any issues with the resident's medications and not aware that the resident's pain medication had run out on two separate occasions. The licensed assisted living director stated the facility previously did not have a good process to monitor medication refills but felt since they recently implemented the new system of "Medication Mondays", things had improved.

During an interview, the resident stated he has dealt with pain for many years but experienced increased pain after he returned from the hospital with leg fractures. The resident stated he was aware the facility ran out of his Oxycodone a few times and stated he wasn't offered any other medications of that strength to deal with the pain. The resident stated he would sleep so he didn't have to deal with the pain.

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

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or did not occur.

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: Yes
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
The facility implemented a new process to provide additional oversight to ensure medication availability.

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.

cc:

The Office of Ombudsman for Long Term Care

The Office of Ombudsman for Mental Health and Developmental Disabilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24427	A. BUILDING: _____ B. WING _____	C 01/09/2023

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 ******ATTENTION****** 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: #HL244273984M, #HL244276603C #HL244273983M, #HL244276602C #HL244273963M, #HL244276488C On January 9, 2023, 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 #HL244273984M, #HL244276603C, tag identification 0250, 0470, 0510, 1760, and 2160.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 250 SS=I	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a	0 250		

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 01/09/2023

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
0 250	Continued From page 1 result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4; (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;	0 250		

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 01/09/2023

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
0 250	Continued From page 2 (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 demonstrate they met the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations 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 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: On January 9, 2023, 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.	0 250		

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 01/09/2023

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
0 250	Continued From page 3 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 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	0 250		

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 01/09/2023

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
0 250	Continued From page 4 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 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	0 250		

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 01/09/2023

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
0 250	Continued From page 5 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 six was electronically signed by licensed assisted living director (LALD)-J on November 8, 2022. The licensee had an assisted living license with dementia care license issued on January 1, 2023, with an expiration date of December 31, 2023. The licensee failed to ensure the following policies and procedures were developed and/or implemented: - infection control practices; -orientation to and implementation of the assisted living bill of rights; -medication and treatment management; As a result of this survey, the following orders were issued: 0470, 0510, 1760, 2160, 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		
0 470 SS=I	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	0 470		

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 01/09/2023

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
0 470	Continued From page 6 determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide adequate staffing to meet the needs of one of one resident (R1) who required two person assistance with repositioning, with records reviewed. In addition, the licensee failed to develop and implement a staffing plan for determining staffing levels. This has the potential to affect all residents. This practice resulted in a level three violation (a	0 470		

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 01/09/2023

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
0 470	Continued From page 7 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: STAFFING PLAN The licensee failed to develop and implement a staffing plan for determining its staffing level that: - included an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; - ensured sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and - ensured that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility. On January 14, 2023, at 9:30 a.m., licensed assisted living director (LALD)-J stated the facility completes staffing based on census. LALD-J confirmed that a staffing plan had not been completed at this location and there was no current staffing plan in place. LALD-J stated he was aware there has to be an assessment at least twice annually of the acuity of residents and that their staffing is based off that. LALD-J stated he thought approximately 7 out of the 20 residents currently in the facility required an assist of two. LALD-J stated he felt the facility's staffing ratios were pretty good and that the tasks	0 470		

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 01/09/2023

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
0 470	Continued From page 8 expected of the ULPs were reasonable and felt the difficulties with completing all tasks as directed by service plans had to do more with "are people are trained the best they can be and what the expectations are." LALD-J was asked if the facility had ever considered limiting admissions until they were able to get more staff hired and trained and ensure they could provide sufficient staffing to ensure care needs were met. LALD-J stated that he "recognizes the need to provide care, but I also know to be financially stable and not have a census of 12 or 13, we have to keep the census at a reasonable point." STAFFING TO MEET RESIDENT NEEDS R1's service plan, dated December 15, 2022, indicated the resident was turned and repositioned three times per day, transferred with two people and a mechanical lift, and required assistance with dressing, grooming, and bathing. During frequent observations completed on January 9, 2023, during the hours of 6:30 a.m.-2:30 p.m., the investigator did not observe R1 being turned or repositioned. R1's assessment dated November 23, 2022, indicated the resident was to be turned and repositioned every two hours with the assistance of one to two ULPs. R1's service recap summary for January 9, 2023, did not include documentation to reflect turning and repositioning was completed. The licensee's undated Staffing Pattern based on Number of Residents, indicated staffing numbers were determined by the number of residents residing in the facility. The facility census on January 9, 2023, was 20 residents. The facility	0 470		

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 01/09/2023

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
0 470	Continued From page 9 had a capacity of 26 residents. According to the staffing grid, the staffing numbers for a census of 20-22 residents were to be: 4 day shift (6:30 a.m. to 2:30 p.m.) unlicensed personnel (ULP) 1 household coordinator (6:30 a.m. to 2:30 p.m.) 2 PM shift (2:30 p.m. to 10:30 p.m.) ULP 1 PM lead (4:00 p.m. to 8:00 p.m.) ULP 1 PM short shift (4:00 p.m. to 10:00 p.m.) ULP 2 NOC (night) shift (10:30 p.m. to 6:30 a.m.) ULP 1 NOC float (10:30 p.m. to 6:30 p.m.) ULP The staffing grid further indicated 1 registered nurse/licensed practical nurse (RN/LPN) would prepare and assist for all three meals and one RN/LPN would be working normal nursing duties and would not be working the floor providing support services to the ULP. During observations completed on January 9, 2023, during the hours of 6:30 a.m.- 2:30 p.m., the investigator observed RN-A and RN-B providing direct care and services to the residents. The licensee's Uniform Disclosure of Assisted Living Services and Amenities (UDALSA), last updated November 30, 2022, indicated on page 2, the number of unlicensed direct care staff typically scheduled per shift were: 6 ULP on the day shift 6 ULP on the evening shift 3 ULP on the evening shift Page 16 of the UDALSA indicated an RN and LPN were on site full-time and had a temporary licensed assisted living director (LALD) working part-time with a shared directorship (overseeing	0 470		

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 01/09/2023

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
0 470	Continued From page 10 more than one facility). The physical layout of the facility consisted of two units (Scandia and Fjord) connected by a link (large community room). Each unit consisted of a hallway which measured approximately 139 feet in length. The link was approximately 51 feet in length and was separated from the units by fire exit doors, which required a key code to open. The Scandia unit had 10 resident rooms, and was occupied by eleven residents. The Fjord unit also had 10 resident rooms, occupied by nine residents. The posted staffing schedule for January 9, 2023, indicated 2 ULPs were scheduled to work on Fjord and 2 ULPs were scheduled to work on Scandia for the day shift. On January 9, 2023, at 6:50 a.m., the investigator observed two ULPs (ULP-C and ULP-E) working on the Fjord unit. ULP-C stated ULP-E was still shadowing and on orientation and had not been signed off on some competencies yet, so was not able to work independently or provide direct care to residents. The investigator observed direct cares provided by ULP-C for approximately two hours and conducted frequent observations throughout the unit during the day shift. During the observations, ULP-E did not shadow ULP-C, who was the only other unlicensed staff member on that unit. During observations completed the morning of January 9, 2023, ULP-E was observed preparing breakfast independently and was not observed to be shadowing any other staff members. ULP-E stated she was supposed to be shadowing another staff member and was still on orientation so there was technically only one ULP working that wing.	0 470		

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 01/09/2023

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
0 470	Continued From page 11 The licensee provided the investigator with a Root Cause Analysis worksheet detailing an investigation into a facility acquired pressure ulcer. The July 15, 2022, worksheet identified a number of factors that led to the development of the pressure ulcer. Page 6 of the document identified that "a lack of supervision was a factor in the event" and "actual staffing deviated from the planned staffing at the time of the adverse event or during key times that led up to the adverse event." The worksheet indicated the licensed practical nurse (LPN) was filling non-licensed staff hours in addition to her scheduled hours. The worksheet included the following text, "LPN believed she was overwhelmed and working extra hours due to new staff and felt workload was high. Review of time sheets showed on average worked 10 hours of overtime each week for the past three months." The worksheet indicated there was also turnover of two RNs during that time period. On January 9, 2023, at 6:40 a.m., ULP-D stated staffing can be challenging because it's hard to say who is going to show up or not and sometimes shifts can't be filled, so they have to work short staffed. ULP-D stated the facility doesn't mandate staff to stay, so there are times when only two ULPs are working in the entire building. ULP-D stated there have been times they called to let the nurse know that no staff came in for their scheduled shift and the nurse didn't answer; if the nurse did answer, they'd say it'd be a few hours before someone could come in. On January 9, 2023, at 8:10 a.m., ULP-C stated some mornings are difficult due to staffing and that she was behind this morning because the second ULP wasn't fully trained and couldn't work	0 470		

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 01/09/2023

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
0 470	Continued From page 12 on her own yet, so she was responsible for medications and cares for all residents on that side. On January 9, 2023, at 1:40 p.m., family member (FM)-F stated she had many concerns about staffing and she has noticed the posted schedule does not match the staffing levels in the facility. FM-F stated she visits frequently and has been told many times how the facility is short staffed. FM-F stated her family member has had to eat some meals in his room when he would rather eat out in the dining room. FM-F stated when she asked about why he couldn't come out to eat, she was told they [the facility] were short staffed and had to feed everyone in their rooms. FM-F stated she was concerned her family member did not get turned and repositioned as often as he should since he requires two people to assist with transfers and turning. On January 9, 2023, at 3:00 p.m., R1 stated he felt the facility was short of help and due to that, he doesn't always get his meals or medications on time. R1 stated he has voiced his preference to staff that he would like to have his medications and meals on time but he has been told, due to staffing, there isn't much they can do. On January 9, 2023, at 3:15 p.m., RN-A confirmed the UDALSA reflected the staffing levels that would be used if the facility was at its maximum census (26 residents). RN-A stated she could not recall the last time the facility was full but thought it had been at least six months. On January 13, 2023, at 9:30 a.m., RN-A stated that over the last few weeks that staffing "just kind of fell apart." RN-A stated she worked the floor to fill ULP shifts and had been working extra	0 470		

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 01/09/2023

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
0 470	Continued From page 13 hours to fill holes in the schedule. RN-A confirmed she had worked a few weekends, some evening shifts, and some 16 hour shifts. RN-A stated she felt the staffing issues were just temporary and she didn't foresee it being a long term problem. RN-A confirmed ULPs are expected to complete all resident cares, medication administration, meal preparation, housekeeping, and assist with other duties as necessary. RN-A stated a household coordinator or the nurses would help with meal preparation and meal service when able, but on weekends, the ULPs are expected to complete all that. RN-A stated they have had some staff turnover with the household coordinator position recently so they have not had that person to assist with meals and activities. RN-A confirmed staffing levels of the facility are determined by census only, not acuity. RN-A confirmed that almost half of the 20 residents in the building require two staff members for transfers and assistance and almost all the other residents require one staff member for transfers and assistance. RN-A stated two residents were independent with transfers and assistance. RN-A stated of the two wings in the building, the Fjord wing required a higher level of care. RN-A was asked if one ULP was able to get all residents up, medications passed, and breakfast prepared, after the investigator observed ULP-C taking approximately 90 minutes to get one resident up, dressed, and medications administered on January 9, 2023. RN-A stated she felt the staffing was appropriate since it was consistent with the census guidelines and it could be possible to complete all required tasks, as long as the staff member had good time management. On January 13, 2023, at 9:55 a.m., RN-A stated she had previously discussed staffing to acuity	0 470		

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 01/09/2023

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
0 470	Continued From page 14 instead of census and didn't know where things had gone from that conversation. RN-A stated she has tried to put more staff on the schedule but she will get a notice from the corporate office that she is over budget for staffing hours. RN-A stated the facility does not currently mandate staff to stay if there's an open shift and they do not currently have any kind of stay program that would identify who would need to stay longer if a shift was open. RN-A stated she has been trying to fill shifts but if that's not possible, she will work it herself. RN-A stated to her knowledge, they've always had at least three ULPs working in the building at all times. On January 13, 2023, at 10:42 a.m., RN-A stated that on January 9, 2023, ULP-E should have been shadowing someone and had a staff member with her at all times as she was still training. RN-A stated she was not aware ULP-E had been observed working alone for several hours on January 9, 2023. On January 13, 2023, at 11:30 a.m., RN-B stated that "in healthcare, we could always use more staff." RN-B stated the facility will complete a twice a year review of their staffing plan and base their staffing on acuity. RN-B stated she was not sure when this was last done for the facility and advised the investigator to follow up with LALD-J to see if that had actually been completed. RN-B stated she felt there was some room for improvement with staff turnover and how long it takes to learn the job to be efficient. RN-B stated there are some staff members who have been here for years that are very efficient and can get through all their tasks in their shift and some of the new staff might not be as efficient and felt that should be taken in to consideration for staffing. RN-B stated some of the concerns on staffing	0 470		

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 01/09/2023

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
0 470	Continued From page 15 could be due to how staff present it to families and "we could go above and beyond staffing requirements and there could be a day that's still busy and everything's happening at once. That doesn't stop staff from feeling overwhelmed and voicing something unprofessional in front of a family member." On January 18, 2023, at 1:30 p.m., family member (FM)-H stated she had voiced multiple concerns to facility management, including RN-A and LALD-J, about staffing levels. FM-H stated she visits her relative often and she has seen many times where just one staff member is working on her relative's wing and the ULP had to leave the unit to go help the other side. FM-H stated there have been multiple times she has looked at the posted staffing schedule and compared it to the staff who were actually in the building and noticed it did not match and the schedule would show more people working than what was actually there. FM-H stated she and several other family members have voiced concerns to management that there is not enough staff to handle the number of residents who require lifts or need two people to transfer and their concerns have not been addressed. FM-H stated she called RN-A one weekend when only three ULPs were working and that they weren't able to keep up with cares and services. She was informed that LALD-J had approved them working with three ULP and it was ok. FM-H stated her relative is supposed to get two baths per week but has often gotten no baths or only one. FM-H stated she has noticed tasks like cleaning dentures, trimming nails, and daily cares are missed. FM-H stated there often isn't enough staff to conduct activities and that they'll get calendars with all these activities on them but when she's in the building visiting, there isn't	0 470		

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 01/09/2023

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
0 470	Continued From page 16 anyone available to lead the activities so they aren't done. FM-H stated it is difficult to trust facility management because they keep telling her to "hang in there, it's going to get better," but she hasn't noticed any changes and feels like things are getting worse. On January 19, 2023, at 11:30 a.m., ULP-I stated they are responsible for getting residents up, passing medication, making breakfast, cleaning up after breakfast/doing dishes, answering call lights, light housekeeping, laundry, taking residents to the bathroom, doing activities, doing baths or showers, and preparing lunch/cleaning up after lunch. ULP-I stated she has sometimes been the only aide working on her unit and it has been challenging to get all her tasks completed, especially with so many residents who require an assist of two. ULP-I stated each side has about five or six residents each that need an assist of two and depending on who's working, getting help with getting everyone up can be hard and sometimes some staff will just do the two person transfers on their own. ULP-I stated staff have expressed their concerns about staffing to management but are just told that they are waiting on people's background studies to clear. ULP-I stated some days, there are staff working that aren't medication trained and can't pass medications, so someone from the opposite side has to go over and pass medications for them, which takes them away from getting everything done for the residents on their side. ULP-I stated she has noticed residents aren't getting showers done and she has come to work some days where the residents were still wearing the clothes she had put on them the prior day. On January 14, 2023, at 9:30 a.m., LALD-J acknowledged the findings of a root cause	0 470		

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 01/09/2023

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
0 470	Continued From page 17 analysis identified the nurse working extra hours as a ULP as being a contributing cause to a negative outcome, but felt this situation was different. LALD-J stated that while the nurse was working extra hours as a ULP, they now have better processes in place. LALD-J stated he felt the staffing levels were sufficient based off their census. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an infection control program that complies with accepted health care, medical and nursing standards for infection control. The deficient practice had the potential to affect residents, employees, and visitors.	0 510		

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 01/09/2023

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
0 510	Continued From page 18 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 all staff, residents and visitors.) The findings include: HAND HYGIENE On January 9, 2023, at 8:00 a.m., unlicensed personnel (ULP)-C was observed touching her mask, then removing her mask and wiping her nose with a tissue, putting her mask back on and not performing hand hygiene. ULP-C then immediately proceeded to administer insulin to a resident. Throughout observations completed the morning of January 9, 2023, ULP-C was observed on multiple occasions to not perform hand hygiene between residents. COVID-19 On January 9, 2023, at 6:30 a.m., the investigator entered the facility. ULP-D and ULP-E were observed to not be wearing a mask. On January 9, 2023, at 7:02 a.m., ULP-C was observed not wearing a mask. ULP-C answered R1's call light and interacted with the resident while not wearing a mask. On January 9, 2023, at 7:10 a.m., ULP-C provided direct care to a resident and assisted him with getting up for the day. ULP-C was observed not wearing a mask. ULP-E entered the room to assist and was also not wearing a mask.	0 510		

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 01/09/2023

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
0 510	Continued From page 19 On January 9, 2023, at 7:45 a.m., ULP-C exited the room and when she returned, she was wearing a mask. On January 9, 2023, at 8:10 a.m., ULP-C stated she wasn't familiar with the facility's masking requirements and they would wear them when nursing told them to do so. On January 9, 2023, at 12:30 p.m., RN-A stated the facility would mask based off transmission rate and the corporate office would send out the rates weekly. RN-A stated it would be expected for staff to mask based off the most recent community transmission rates. RN-A provided the investigator with an email sent by the corporate offices on January 9, 2023, at 11:23 a.m., indicating Crow Wing county's community transmission rate had not changed from the previous week and was high and that masking would be required. DIRTY PLATES On January 9, 2023, at 7:20 a.m., R1 requested breakfast and it was served to the resident in his room. On January 9, 2023, at 10:30 a.m., R1's breakfast dishes were observed sitting on his bedside table. On January 9, 2023, at 3:00 p.m., R1's lunch dishes were observed sitting on his bedside table. On January 19, 2023, at 10:05 a.m., licensed assisted living director (LALD)-J stated the facility does not have a policy directing when dirty dishes should be removed from the room but he would not expect it to be left there for several hours. LALD-J stated it would be reasonable to have	0 510		

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 01/09/2023

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
0 510	Continued From page 20 dirty dishes removed from the room within an hour. ANIMALS AT WORK On January 9, 2023, 8:45 a.m., ULP-C was observed sitting in a resident's room with a dog. The dog was a medium sized Australian Shepherd and was observed to be pacing and panting heavily. ULP-C stated the dog was hers and had some anxiety as it had been in her car the last three hours. ULP-C stated the dog normally takes Trazodone (an antidepressant medication) for anxiety and didn't get it today. On January 9, 2023, at 9:00 a.m., ULP-C assisted a hospice worker with a mechanical lift transfer for another resident. The dog was observed to be panting and pacing around the room with a leash trailing behind it. Throughout the morning, ULP-C was observed bringing the dog in to multiple resident rooms with the leash dragging on the floor behind it. On January 9, 2023, at 9:55 a.m., ULP-C was observed getting another resident's medication from his room to bring it to the dining room where he was sitting. While in the room, the dog made a loud hacking sound and coughed up some white sputum on the resident's carpet. While walking down the hallway with the investigator, ULP-C stated the dog "couldn't be in the dining room so she would put him in this room." ULP-C opened a resident's door that had signage posted indicating the resident was in isolation on contact precautions. On January 9, 2023, at 1:10 p.m., RN-A confirmed the resident was in isolation for C. Diff (a bacterial infection of the large intestine). RN-A	0 510		

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 01/09/2023

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
0 510	Continued From page 21 confirmed the observations the investigator reported would be infection control concerns. MEDICATIONS ON FLOOR On January 9, 2023, at 10:10 a.m., ULP-C was observed getting medications to administer to a resident. ULP-C did not perform hand hygiene before getting the medications out of the cabinet. ULP-C dropped one of the resident's medications on the floor and picked it up with a bare hand and put it in the cup that was then administered to the resident. On January 19, 2023, at 10:00 a.m., LALD-J confirmed it would not be the facility standard of practice to administer medication that had fallen on the floor. CRACKED PHONE SCREENS On January 9, 2023, at 7:50 a.m., ULP-C was observed taking her personal cell phone out of her pocket and accessed R Tasks (clinical documentation software) to review a resident's Medication Administration Record (MAR) as she prepared to administer medications. ULP-C's personal phone screen was observed to be cracked with the entire screen appearing to be shattered. Throughout frequent observations completed on January 9, 2023, ULP-C was not observed to have sanitized the personal cell phone. On January 9, 2023, at 1:15 p.m., RN-A confirmed a cracked cell phone screen would be an infection control concern. RN-A confirmed the facility did not have a policy on use of personal cell phones and ensuring they are in good condition and sanitized while providing direct care and services to residents.	0 510		

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 01/09/2023

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
0 510	Continued From page 22 No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
01760 SS=G	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure medications were administered as prescribed for one of one resident (R1) with records reviewed. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).	01760		

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 01/09/2023

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
01760	Continued From page 23 The findings include: R1 admitted to the facility on November 8, 2022. On November 8, 2022, the resident had a fall in his room and fractured both of his legs. The resident was hospitalized for a surgical repair and returned to the facility on November 21, 2022. R1's record contained a prescriber order for 5 mg Oxycodone (narcotic medication for pain) every 6 hours, dated November 30, 2022, and an order for 5 mg Oxycodone every 8 hours as needed for pain, dated December 13, 2022. R1's record contained a prescriber order for 650 mg of Tylenol four times per day, dated November 21, 2022. R1's record contained a prescriber order for 10 mg of Flexeril (a medication for muscle spasms and pain) twice a day as needed for pain, dated November 21, 2022. R1's December 2022 medication administration record (MAR) included the following documentation for the resident's Oxycodone from December 1st through December 5th: -December 1, 2022 at 2:00 a.m., a ULP wrote: two Oxycodone were given instead of the prescribed one. A call was placed to the RN to get advice on what to do, but there was no answer. -December 4, 2022, at 4:00 a.m., a ULP wrote: don't have medication. A nurse commented: refill request sent to [doctor], script sent to Thrifty White. -December 4, 2022, at 10:00 a.m., a ULP wrote: the medication was not available. A nurse commented: refill request sent to [doctor], script	01760		

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 01/09/2023

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
01760	Continued From page 24 sent to Thrifty White. -December 4, 2022, at 4:00 p.m., a ULP wrote the medication was out. A nurse commented refill request sent to [doctor], script sent to Thrifty White. -December 5, 2022, at 10:00 a.m., a ULP wrote: the medication was out. A nurse commented: refill request sent to [doctor], script sent to Thrifty White. The MAR indicated from December 4th through December 5th, 2022, seven doses of scheduled Oxycodone were missed due to the medication not being available. R1's record did not contain documentation of a refill order being obtained. R1's December 2022 PRN (as needed) medication administration record (MAR) included the following documentation for administration of the resident's PRN Flexeril (a pain medication): -December 4, 2022, 3:33 a.m., 10 mg given, [R1] stating he is a solid STRONG 9 in pain and since he has no Oxy, he would like this. Upon follow up, the resident reported his pain was only down to an 8. -December 4, 2022, at 10:46 a.m., 10 mg given for pain, out of regular pain meds. Upon follow up, the resident's pain was "a little better." -December 5, 2022, at 10:25 a.m., 10 mg given for pain. Upon follow up, it was effective. During this time period, R1 also ran out of Tylenol. R1's December 2022 MAR included the following documentation for the resident's Tylenol: -December 1, 2022, at 2:00 a.m., a ULP wrote: only administered one Tylenol (325 mg, half the	01760		

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 01/09/2023

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
01760	Continued From page 25 prescribed dose) -December 2, 2022, at 10:00 a.m., a ULP wrote: out. A nurse commented: refill requested-waiting on authorization. R1's Oxycodone ran out again approximately five days after the last refill was obtained. R1's December 2022 MAR included the following documentation for the resident's Oxycodone from December 10th through December 13th: -December 10, 2022 at 10:00 p.m., a ULP wrote: skipped-med out of stock. A nurse commented: PCP notified of new script needed. -December 11, 2022, at 4:00 a.m., a ULP wrote: "OOS" [out of stock]. A nurse commented: PCP notified of new script needed. -December 11, 2022, at 4:00 p.m., a ULP wrote: skipped, med out of stock. A nurse commented: PCP notified of new script needed. -December 11, 2022, at 10:00 p.m., a ULP wrote: skipped, med out of stock. A nurse commented: PCP notified of new script needed. -December 12, 2022, at 4:00 a.m., a ULP wrote: out. A nurse commented: PCP notified of new script needed. -December 12, 2022, at 10:00 a.m., a ULP wrote: out. A nurse commented: PCP notified of new script needed. -December 12, 2022, at 10:00 p.m., a ULP wrote: skipped, med out of stock. A nurse commented: order changed from scheduled to PRN (as needed), pharmacy wil deliver this afternoon. -December 13, 2022, at 4:00 a.m., a ULP wrote: skipped, med out of stock, nurse notified. A nurse commented: order changed from scheduled to PRN, pharmacy will deliver this afternoon. -December 13, 2022, at 10:00 a.m., a ULP wrote: out. A nurse commented: order changed from scheduled to PRN, pharmacy will deliver this	01760		

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 01/09/2023

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
01760	Continued From page 26 afternoon. The MAR indicated from December 10 through December 13th, nine doses of scheduled Oxycodone were missed due to the medication not being available. R1's December 2022 PRN MAR included the following documentation for administration of the resident's PRN Flexeril due to pain: -December 10, 2022, at 1:06 a.m., a ULP wrote: 10 mg given for pain, upon follow up it was effective. -December 11, 2022, at 9:07 p.m., a ULP wrote: 10 mg given for pain, upon follow up it was effective. -December 12, 2022, at 10:48 a.m., a ULP wrote: 10 mg given for pain, upon follow up it was effective. -December 12, 2022, at 8:57 p.m., a ULP wrote: 10 mg given for pain at a 9 out of 10, upon follow up it was effective. -December 13, 2022, at 1:29 p.m., a ULP wrote :10 mg given for pain, no follow up was documented. Progress notes from December 2, 2022, through December 21, 2022, did not contain any documentation of pain levels or interventions for pain while narcotic pain medication was not available. R1's assessment dated December 5, 2022, indicated the resident had frequent pain in his lower legs due to multiple fractures. On January 9, 2023, at 3:10 p.m., R1 stated he has dealt with pain for many years but experienced increased pain after he returned from the hospital with leg fractures. R1 stated he	01760		

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 01/09/2023

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
01760	Continued From page 27 was aware the facility ran out of his Oxycodone a few times and stated he wasn't offered any other medications of that strength to deal with the pain. R1 stated he would sleep so he didn't have to deal with the pain. R1 stated his medications were often late and when he asked why he couldn't get them on time, he was told they were short staffed. On January 18, 2023, at 11:50 a.m., RN-A confirmed R1's Oxycodone had run out twice. RN-A stated they had some issues with getting orders back from R1's doctor but they did not request a refill until the resident had already run out of the medication. RN-A stated they had offered the resident Tylenol and ice to help with pain, but the resident declined those interventions. RN-A stated the resident would often go to doctor's appointments without facility staff and they would not get any orders or updates from those appointments if the resident didn't tell them about any changes. RN-A confirmed she missed a phone call from staff about a medication error on December 1, 2022. RN-A initially stated she thought that was the day she had worked almost 20 hours and didn't hear the phone because she was sleeping. RN-A stated if staff don't get an answer, they are supposed to call back in 15 minutes and the staff member did not call back. RN-A stated another nurse came in at 6:30 that morning and the ULP updated the nurse of the medication error at that time. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	01760		

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 01/09/2023

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
02160	Continued From page 28	02160		
02160 SS=E	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (a) In addition to the minimum services required in section 144G.41, an assisted living facility with dementia care must also provide the following services: (1) assistance with activities of daily living that address the needs of each resident with dementia due to cognitive or physical limitations. These services must meet or be in addition to the requirements in the licensing rules for the facility. Services must be provided in a person-centered manner that promotes resident choice, dignity, and sustains the resident's abilities; (2) nonpharmacological practices that are person-centered and evidence-informed; (3) services to prepare and educate persons living with dementia and their legal and designated representatives about transitions in care and ensuring complete, timely communication between, across, and within settings; and (4) services that provide residents with choices for meaningful engagement with other facility residents and the broader community. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure services were provided in a person-centered manner that promoted resident dignity and choices for meaningful engagement with other facility residents for two of two residents (R1, R4) who resided in the Assisted Living with Dementia Care unit. This practice resulted in a level two violation (a violation that did not harm a resident's health or	02160		

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 01/09/2023

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
02160	Continued From page 29 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1's diagnoses included chronic pain, obesity, and type two diabetes. R1's assessment dated November 23, 2022, indicated the resident was to be turned and repositioned every two hours with the assistance of one to two ULPs. R1's service plan dated December 15, 2022, indicated the resident received assistance with dressing, grooming, bathing, transfers, toileting, and medication management. R1's most recent assessment dated December 5, 2022, indicated R1 used a mechanical lift with two people for transfers, staff should encourage him to attend activities, and staff should assist with turning and repositioning every two hours. During frequent observations completed on January 9, 2023, between the hours of 6:30 a.m. to 2:30 p.m., R1 was observed laying in his bed. R1 was served breakfast and lunch in bed. R1 did not get out of his bed for the duration of the observation period. On January 9, 2023, at 10:20 a.m., unlicensed personnel (ULP)-C stated she thought the resident was to be turned and repositioned every	02160		

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 01/09/2023

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
02160	Continued From page 30 two hours but stated he can do it himself and usually doesn't want staff to help him. ULP-C stated R1 preferred to stay in bed. On January 9, 2023, at 3:10 p.m., R1 stated he usually spent most of his day in bed. R1 stated he would like to get out of bed occasionally, but no one ever asked if he wanted to get up. R1 stated he felt the facility was short of help and due to that, he doesn't always get his meals or medications on time. R1 stated he has voiced his preference to staff that he would like to have his medications and meals on time but he has been told, due to staffing, there isn't much they can do. R1's service recap summary for January 9, 2023, did not include documentation to reflect turning and repositioning was completed or offered to the resident. On January 13, 2023, at 9:30 a.m., RN-A stated she was aware that staff would report R1 refused to get out of bed and that he would not get out of bed very often. RN-A stated she had worked an evening shift earlier that week and noticed R1 had not been out of bed for a few days. She then approached him and said "let's get out of bed" and the resident agreed to get out of bed, so she wasn't sure if the resident was refusing or if staff did not approach him appropriately to encourage him to get out of bed. RN-A confirmed she did not identify or update this intervention to be included on R1's careplan and had not educated staff to attempt this approach to encourage R1 to get out of bed R4 R4's diagnoses included late onset Alzheimer's disease, hearing loss, and glaucoma.	02160		

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 01/09/2023

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
02160	Continued From page 31 R4's s service plan dated October 3, 2022, indicated the resident required assistance with dressing, grooming, bathing, eating, toileting, and transfers. R4's most recent assessment, dated December 21, 2022, indicated R4 required the use of a mechanical lift and two people for transfers and the resident should be taken to the bathroom every two to three hours. R4 was noted to have an open area to the coccyx, measuring approximately 5 centimeters by 0.5 centimeters. R4's December 21, 2022 assessment also directed staff to provide daily reminders and encouragement for R4 to participate in wellness activities. On January 9, 2023, at 9:20 a.m., R4 was observed sitting in his wheelchair alone at the dining room table waiting for breakfast. On January 9, 2023, at 10:15 a.m., R4 was observed sitting in his wheelchair at the dining room table eating his breakfast. On January 9, 2023, at 10:40 a.m., R4 was observed sitting in his wheelchair alone at the dining room table and had finished eating his breakfast. On January 9, 2023, at 10:55 a.m., R4 was observed sitting in his wheelchair alone at the dining room table. ULP-E was then observed pushing R4's wheelchair in front of a TV in the dining room. ULP-E turned on Netflix and put on a show for R4 to watch. On January 9, 2023, at 11:20 a.m., R4 was observed sitting in his wheelchair, alone, in front	02160		

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 01/09/2023

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
02160	Continued From page 32 of the TV in the dining room. On January 9, 2023, at 12:00 p.m., a staff member was observed pushing R4's wheelchair back to the dining room table for lunch. On January 9, 2023, at 1:20 p.m., R4 was observed to be sitting in his wheelchair in his room. No observations were made of R4 being repositioned during the investigator's frequent observations completed on January 9, 2023 from 9:20 a.m. - 1:20 p.m. of R4. On January 19, 2023 at 10:05 a.m., licensed assisted living director (LALD)-J stated the standard of care would include that a resident did not sit alone for extensive periods of time and confirmed R4 was sitting in the dining room longer than what they would expect. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02160		