Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL24475223M
Compliance #: HL244278920C

Date Concluded: April 18, 2023

Name, Address, and County of Licensee Investigated:
Diamond Willow Assisted Living
14398 Grand Oaks Dr.
Baxter, MN 56425
Crow Wing County

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

Evaluator's Name: Erin Johnson-Crosby, RN
Special Investigator

Finding: Substantiated, facility responsibility

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

Initial Investigation Allegation(s):
Facility staff/alleged perpetrators (AP)s neglected a resident when they left the resident on a bed pan for over three hours. The resident was found with his legs out of bed covered in fecal matter.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. Care was not provided in accordance with the resident's service plan. The resident was left on a bed pan for over three hours and was found by family falling out of bed and covered in feces. Although the facility had prior knowledge of concerns regarding staff availability, training, competencies, and communication, the facility did not ensure unlicensed staff/alleged perpetrators (AP)s completed required trainings or evaluation of competencies prior to providing direct resident cares.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident's medical record, facility policies and procedures, and employee records. Also, the investigator observed resident cares.

The resident resided in an assisted living facility with dementia care. The resident's diagnoses included multiple sclerosis (disease of the central nervous system) and type two diabetes. The resident's service plan indicated the resident had minor forgetfulness and was disoriented with new situations and upon wakening. The resident was non-ambulatory and required total assistance with cares, including assistance of two staff and a mechanical lift for bed mobility, toileting, and transfers. The resident's service plan and service recap sheet identified the resident was scheduled to be toileted and repositioned every two hours.

The day the incident occurred facility staff/alleged perpetrators (AP)s assisted the resident on to the bed pan, then left the room. Fifteen minutes later, staff documented the resident had been toileted and repositioned. However, the resident remained on the bed pain for an additional three hours. When staff did not return to assist the resident off the bed pan, the resident called a family member via an Alexa (voice activated virtual assistant technology) device he had in his room. The resident told his family he had been pressing his light, yelling, no one was coming to help him, and "something bad was going on".

Upon receiving the call, the family member went to the facility to check on the resident. When the family member arrived, they found the resident falling out of bed. The resident was hanging on to the bed rail with both legs off the bed and covered in feces. The family member had to find staff themselves and inform them that the resident needed assistance.

At the time of the onsite investigation, the resident's bed rails were observed to be very loose and not securely attached to the bed.

A facility documented timeline of events, indicated the resident was found "fearful and confused" and was falling out of bed with visible feces on himself and the bedding. The timeline identified staff failed to follow facility policies on providing resident assistance, completing shift-to-shift report, and identified inaccuracies of staff documentation. The timeline indicated administrative and corporate staff were informed of the incident. No documentation of review or follow-up to the incident was included on the timeline.

Video footage from the day of the incident was reviewed. Two staff members were observed entering the resident's room and exited the room a short time later. Three hours and 17 minutes later, the resident's family member entered the room, then left the room to locate staff. No staff were observed entering the resident's room after he was placed on the bed pan, until after the resident's family member arrived. Facility administrative staff had not reviewed video footage prior to the investigator's onsite investigation and had no documentation of an internal investigation into the incident.

The employee file of the unlicensed personnel (ULP) who assisted the resident on to the bed pan contained no documentation of required training or evaluation of competencies. Additional employee files reviewed identified numerous staff were not provided required training and had no documentation of demonstrated competencies completed prior to working with residents and providing direct care and services.

During an interview, registered nurse (RN) #1 indicated facility administration was aware multiple unlicensed staff, who provided direct care to residents, had not received required training and/or evaluation of competencies. RN #1 stated she was also not provided any training prior to becoming a clinical nursing supervisor.

During an interview, the unlicensed personnel (ULP) who worked the day of the incident, said she and another ULP assisted the resident on to the bed pan. The ULP checked on the resident shortly after and he was not ready to get off the bed pan. The ULP stated she had not received any training and had not completed competencies prior to providing resident care. The ULP indicated proper training could have helped her understand the seriousness of this incident.

During an interview, registered nurse (RN) #2 stated the day of the incident she was summoned to the resident's room by ULP who needed further assistance. RN #2 stated the resident was found halfway off the bed and had fecal matter on him. The resident was holding on to his bed rail and was very afraid and scared. RN #2 called RN #3 (an administrative nurse) to report what happened but was provided no direction on what action to take following the incident. RN #2 confirmed no immediate interventions were created or implemented within the resident's medical record and staff had not received any re-training or re-education following this incident. RN #2 indicated administrative staff did not review video footage from the day of the incident until the day of the investigator's onsite visit, 10 days later.

During an interview, RN #3 was aware the resident's family member had voiced concerns regarding staffing and communication prior to the incident. RN #3 stated an intervention should have been implemented immediately following the incident. RN #3 confirmed staff were not re-trained after the incident. RN #3 indicated within the next few weeks the facility was holding an all-staff training and she thought the education could be completed at that time. RN #3 acknowledged that ULP not having required training and/or competencies completed may have been a contributing factor to this incident.

During an interview, the resident's family member recalled the day of the incident. The family member received a call from the resident before supper time. The resident said, "something bad was going on" and told her he had been pressing his pendant, yelling for help, and no one was coming. The resident told the family member he was falling out of bed. When the family member arrived, the resident's legs were out of the bed and the resident was holding on to the side rail with both hands. The resident had fecal matter all over himself, the sheets, and the floor. The resident was confused and distressed. The family member stated prior to this incident

she had shared numerous concerns regarding staffing and staff communication and assumed these concerns would be addressed by management staff.

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

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.

“Substantiated” means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17

Neglect means neglect by a caregiver or self-neglect.

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

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

Action taken by facility:
The facility provided education to the staff members including walking room to room at shift change and writing updated in a communication log after the onsite visit was initiated.

Action taken by the Minnesota Department of Health:

The responsible party will be notified of their right to appeal the maltreatment finding. The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:

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

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies. You may also call 651-201-4200 to receive a copy via mail or email

cc:

The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Crow Wing County Attorney
Baxter City Attorney
Baxter Police Department
Minnesota Board of Executives for Long Term Services and Supports

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 03/07/2023

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: HL244278920C/HL244275223M HL244278195C/HL244274763M HL244278935C/HL244275183M HL244278176C/HL244274783M On March 1-7, 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 16 clients receiving services under the Assisted Living with Dementia Care license. The following immediate correction orders is issued for HL244278195C/HL244274763M, tag identification 2320, HL244278920C/HL244275223M tag identification 2310.	0 000	The Minnesota Department of Health documents the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that 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. Per Minnesota Statute §144G.30, Subd. 5 (c), the assisted living facilities must document any action taken to comply with the correction order. A copy of the provider ' s records documenting those actions may be requested for follow-up surveys. The home care provider is not required to submit a plan of correction for approval; please disregard the heading of the fourth column, which states "Provider ' s Plan of Correction." The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to Minn. Stat. § 144G.31, Subd. 2 and 3.	

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0 000	Continued From page 1 On March 3, 2023, an immediate correction order was issued for HL244278195C/HL244274763M and HL244278920C/HL244275223M tag identification 1750 The following correction orders are issued for #HL244278920C/HL244275223M, HL244278195C/HL244274763M, HL244278935C/HL244275183M, and HL244278176C/HL244274783M, tag identification 1320, 1330, 2480. HL244278176C/HL244274783M, tag idenfification 0620, 0630, 2360, 3000 HL244278935C/HL244275183M, tag identification 1620, 2360 HL244278920C/HL244275223M, tag identification 2350, 2360	0 000		
0 620 SS=E	144G.42 Subd. 6 (a) Compliance with requirements for reporting ma (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to immediately report to the Minnesota Adult Abuse Reporting Center (MAARC) suspected maltreatment and complete a thorough investigation for three of three residents (R2, R12, R13) with records reviewed.	0 620		

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0 620	Continued From page 2 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). Findings include: 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 seven residents. The Fjord unit also had 10 resident rooms, occupied by nine residents. A facility resident list indicated R2, R12, and R13 resided on Fjord. R2 and R13 were roomates. R2 was admitted January 19, 2023, with diagnoses of severe dementia with psychotic disturbance and behavioral disturbance. R2's service plan indicated R2 required assistance with medication management, dressing, grooming, and bathing. R2's service plan lacked behavior management interventions. R2's individual abuse prevention plan (IAPP) assessment dated February 3, 2023, indicated	0 620		

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0 620	Continued From page 3 R2 was physically abusive and would try and grab other resident's wheelchairs out of staff's hands. R2 would try to push through staff to get into other resident rooms and did not respond to re-direction. The same document indicated R2 would go into other resident rooms during the night. The IAPP lacked interventions for the identified vulnerabilities. R2's progress notes indicated the following: - January 23, 2023, R2 wandered the halls, tried to get out of the facility multiple times and became very upset and frustrated. - January 25, 2023, R2 was agitated twice and wanted to go outside. R2 was showing signs of sundowning and anxiety starting in the afternoon around 3:00 p.m.. R2's behaviors the last few days have increased, leading up to R2 pushing another resident (R12). R2 was sent to the emergency room for evaluation and sent back to the licensee as there was no reason for admission. - January 26, 2023, R2 paced back and forth from the front door was exit seeking, and would go to the door anytime the door would open. - January 31, 2023, staff went to R12's room; the door was locked and staff could hear R2 talking. The staff opened the door and found R2 standing in front of R12. R2 started yelling and swearing at staff. R2 then left R12's room and came back in while staff were assisting R12 with toileting. - February 2, 2023, R2 was fixated on R12 trying to pull his wheelchair out of staff's hand. 911 was called to transfer R2 to the emergency room.	0 620		

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0 620	Continued From page 4 - February 4, 2023, R2 was upset at staff for removing her from R12's room and yelled at staff. R2 threatened to hurt staff if they did not allow her into R12's room. - February 5, 2023, R13 stated she was frightened of her roommate R2. R13 stated R2 was rummaging through her things and locked R13 in the room with R2. Registered nurse (RN)-A felt scared to open it because she did not want to make R2 mad but also felt scared leaving them alone. - February 5, 2023, R2 wandered the halls most of the day looking for R12 and went into other resident rooms looking for R12. - February 6, 2023, - physician visit-. sent to ER the past week with behaviors that are both harmful to herself as well as others. She is not safe to be in AL and needs geri-psych evaluation. - February 6, 2023, MD order- Please send to Geri-psych facility on physician recommendation for 72 hour hold for diagnoses or harmful behavior to self and others. - February 14, 2023, R2 became angry with another resident (R12), and went to hit him. Staff got between the residents and separated them. - February 27, 2023, R2 was upset with R12 and started to yell at him because he was unable to respond to her in the way that she wanted and was upset that she cannot get into his room. R2 continued to yell at R12. - February 28, 2023, R2 went up to another resident and kissed him without consent. Staff attempted to re-direct and she laughed at staff.	0 620		

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0 620	Continued From page 5 R2 was outside of R12's room and yelling because she thinks it's her significant other and she thinks R12 was faking his identity. - February 28, 2023, - R2 grabbed a hold of staff's hands and tried pulling another resident's wheelchair out of their hand. R2 started yelling at staff and could not be re-directed. - March 8, 2023, R2 was yelling at R12 and told R12 he needed to drive her somewhere. On March 1, 2023, at 9:53 a.m., R12's room had a black strap going across the door. The surveyor asked unlicensed personnel (ULP)-E what the strap was for, and ULP-E stated it was to keep R2 out of R12'S room. On March 7, 2023, at 10:00 a.m., the investigator observed that R2 and R13 continued to share a room. On March 7, 2023, at 11:05 a.m., RN-A stated R2 was fixated on R12 and thought he was her husband or boyfriend. RN-A stated R2 tried eloping with R12. RN-A also stated R2 had locked herself into R12's room and yelled at R12 often. RN-A also verified R2 kissed R12. RN-A stated when R2 gets riled up she needs to have one to one staffing, which was not possible. RN-A also stated there was not enough training for residents with dementia. RN-A stated she was going to move R2 to the other locked unit but became busy and didn't have time. RN-A confirmed these incidents were not reported to the common entry point. On March 17, 2023, at 11:45 p.m., RN-J stated she was not aware of the multiple incidents that occurred between R2 with R12 and R13. RN-J	0 620		

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0 620	Continued From page 6 verified these incidents should have been reported. The licensee's Vulnerable Adult policy dated September 5, 2022, indicated a MAARC report should be made if there is reason to believe abuse, neglect or finicial exploitation of a vulnerable adult occurred and should be reported within 24 hours. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 620		
0 630 SS=H	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure individual abuse prevention plans (IAPP)s were updated to include a resident's susceptibility to abuse, risk of abuse to self or others, and failed include specific measures to minimize the risk of abuse to	0 630		

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0 630	Continued From page 7 residents for three of three residents (R2, R12, R13) 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 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: 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 seven residents. The Fjord unit also had 10 resident rooms, occupied by nine residents. The facility resident list indicated R2, R12, and R13 resided on Fjord. R2 and R13 were roomates. R2 R2 was admitted January 19, 2023, with diagnoses of severe dementia with psychotic disturbance and behavioral disturbance. R2's service plan indicated R2 required assistance with medication management,	0 630		

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0 630	Continued From page 8 dressing, grooming, and bathing. R2's service plan lacked behavior management interventions. R2's admission assessment dated January 19, 2023, indicated R2 had cognitive or behavior issues and had periods of paranoia. R2's assessment identified R2 as not at risk for abuse or did not show signs to abuse others. The assessment further indicated R2 wandered inside, but did not leave the building. R2's individual abuse prevention plan (IAPP) assessment dated February 3, 2023, indicated R2 was physically abusive and would try and grab other resident's wheelchairs out of staff's hands. R2 would try to push through staff to get into other resident rooms and did not respond to re-direction. The same document indicated R2 would go into other resident rooms during the night. The IAPP lacked interventions for the identified vulnerabilities. R2's 14-day assessment dated February 3, 2023, indicated R2 became more agitated in the afternoon and showed signs of anxiety and was fixated on a specific resident (R12). The assessment indicated R2 was not at risk for abuse and was not at risk to abuse others. The assessment did not include any interventions to protect other residents, including R12. R2's progress notes indicated the following: - January 23, 2023, R2 wandered the halls, tried to get out of the facility multiple times and became very upset and frustrated. - January 25, 2023, R2 was agitated twice and wanted to go outside. R2 was showing signs of sundowning and anxiety starting in the afternoon	0 630		

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0 630	Continued From page 9 around 3:00 p.m.. R2's behaviors the last few days have increased, leading up to R2 pushing another resident (R12). R2 was sent to the emergency room for evaluation and sent back to the licensee as there was no reason for admission. - January 26, 2023, R2 paced back and forth from the front door, was exit seeking, and would go to the door anytime the door would open. - January 31, 2023, staff went to R12's room; the door was locked and staff could hear R2 talking. The staff opened the door and found R2 standing in front of R12. R2 started yelling and swearing at staff. R2 then left R12's room and came back in while staff were assisting R12 with toileting. - February 2, 2023, R2 was fixated on R12 trying to pull his wheelchair out of staff's hand. 911 was called to transfer R2 to the emergency room. - February 3, 2023, R2's guardian was updated that a psychiatric stay was being pursued due to aggressive behaviors and fixation on another resident. - February 4, 2023, R2 was upset at staff for removing her from R12's room and yelled at staff. R2 threatened to hurt staff if they did not allow her into R12's room. - February 5, 2023, R13 stated she was frightened of her roommate R2. R13 stated R2 was rummaging through her things and locked R13 in the room with R2. Registered nurse (RN)-A felt scared to open it because she did not want to make R2 mad but also felt scared leaving them alone.	0 630		

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	24427	A. BUILDING: _____ B. WING _____	C 03/07/2023

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0 630	Continued From page 10 - February 5, 2023, R2 wandered the halls most of the day looking for R12 and went into other resident rooms looking for R12. - February 6, 2023, - physician visit-. sent to ER the past week with behaviors that are both harmful to herself as well as others. She is not safe to be in AL and needs geri-psych evaluation. - February 6, 2023, MD order- Please send to Geri-psych facility on physician recommendation for 72 hour hold for diagnoses or harmful behavior to self and others. - February 13- started on Depakote twice daily. - February 14, 2023, R2 became angry with another resident (R12), and went to hit him. Staff got between the residents and separated them. - February 27, 2023, R2 was upset with R12 and started to yell at him because he was unable to respond to her in the way that she wanted and was upset that she cannot get into his room. R2 continued to yell at R12. - February 28, 2023, R2 went up to another resident and kissed him without approval. Staff attempted to re-direct and she laughed at staff. R2 was outside of R12's room and yelling because she thinks it's her significant other and she thinks R12 was faking his identity. - February 28, 2023, - R2 grabbed a hold of staff's hands and tried pulling another resident's wheelchair out of their hand. R2 started yelling at staff and could not be re-directed. - March 8, 2023, R2 was yelling at R12 and told R12 he needed to drive her somewhere.	0 630		

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0 630	Continued From page 11 R2's medical record lacked evidence of assessments and updates to the IAPP and service plan following the occurance of exit seeking behaviors, physical and verbal abuse, aggressive behaviors, hospitilizations, and potential for harm to self or others, regarding the incidents that occurred between R2 and R12 and R13. On March 3, 2023, at 2:20 p.m., ULP-C and ULP-D stated R2 was aggressive and would seek out R12 because R2 thought R12 was a person she knew. ULP-C and ULP-D stated R2 pushed R12 and stated they did not have enough staff or training to care for residents with behaviors. ULP-C and ULP-D stated they had tried to re-direct R2 when behaviors occurred but that did not work. On March 16, 2023, at 9:00 a.m., ULP-I stated the interventions for R2 included calling 911 and redirection. ULP-I stated there were no interventions on R2's service plan regarding staff intervention for behaviors. ULP-I stated R2's behaviors were more than they could handle. ULP-I stated R2 was moved to another unit on March 15, 2023. R12 R12 was admitted on September 2, 2022, with diagnoses including late onset Alzheimer's disease without behavioral disturbances. R12's assessment and IAPP dated February 9, 2023, indicated R12 required assistance with all activities of daily living (ADL)'s. The IAPP indicated R12 was at risk to be abused and the	0 630		

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0 630	Continued From page 12 intervention included an assessment would be completed on admission and annually thereafter, to assure the vulnerabilities were identified. The IAPP also identified R12 may not be able to report abuse, was physically abusive or disruptive, and was on a behavior monitoring plan. The IAPP did not include information of incidents or interventions for occurrences between R12 and R2. R12's progress notes and medical record lacked information regarding the multiple incidents that occurred with R2. R12's medical record lacked incident reports and updated assessments, including an IAPP, following the numerous incidents with R2. On March 1, 2023, at 9:53 a.m., R12's room was observed to have a black strap going across the door. The surveyor asked unlicensed personnel (ULP)-E what the strap was for, and ULP-E stated it was to keep R2 out of R12'S room. R12's record contained no information, assessment or evaluation of the strap placed across R12's door. R13 R13 was admitted on August 23, 2022, with diagnoses which included hemiplegia following a stroke and a history of falls. R13's IAPP dated December 28, 2022, indicated R13 required assistance with transfers related to left-sided weakness. The IAPP indicated R13 was at risk to be abused and the intervention identified was that an assessment would be completed on admission and annually thereafter, to assure the	0 630		

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0 630	Continued From page 13 vulnerabilities were identified. R13's progress notes lacked information regarding the incident(s) that occurred with R2. R13's medical record lacked incident reports, updated assessments, including an IAPP, following the incident(s) with R2. The record also lacked follow up with R13's voiced concern for her safety and this was also not identified or included on R13's IAPP. On March 7, 2023, at 10:00 a.m., the investigator observed that R2 and R13 continued to share a room. On March 7, 2023, at 11:05 a.m., RN-A stated R2 was fixated on R12 and thought he was her husband or boyfriend. RN-A stated R2 tried eloping with R12. RN-A also stated R2 had locked herself into R12's room and yelled at R12 often. RN-A also verified R2 kissed R12. RN-A stated when R2 gets riled up she needs to have one to one staffing, which is not possible. RN-A also stated there was not enough training for residents with dementia. RN-A stated she was going to move R2 to the other locked unit but became busy and didn't have time. RN-A confirmed R2, R12, and R13's IAPPs were not updated as she was not aware she had to do that. RN-A also confirmed there were no updated assessments completed or interventions added for R2, R12, or R13 to ensure their safety. On March 17, 2023, at 11:45 p.m., RN-J stated she was not aware of the multiple incidents that occurred between R2 with R12 and R13. RN-J confirmed R2, R12, and R13's IAPPs should have been updated and include interventions. RN-J also verified the service plans should have	0 630		

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0 630	Continued From page 14 been updated to include interventions to keep the residents safe. RN-J stated the lack of staff training and competencies may have impacted how staff responded to R2's behaviors. RN-J also verified the lack of daily structured activities could have lead to an increase in R2's behaviors. RN-J could not explain why it took so long to move R2 to the other unit. The licensee's policy dated September 5, 2022, titled, Nursing Assessment Individual Abuse and Prevention Plans was not updated to the current assisted living statutes and did not include when an IAPP should be completed. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
01320 SS=F	144G.60 Subd. 4 (a) Unlicensed personnel (a) Unlicensed personnel providing assisted living services must have: (1) successfully completed a training and competency evaluation appropriate to the services provided by the facility and the topics listed in section 144G.61, subdivision 2, paragraph (a); or (2) demonstrated competency by satisfactorily completing a written or oral test on the tasks the unlicensed personnel will perform and on the topics listed in section 144G.61, subdivision 2, paragraph (a); and successfully demonstrated competency on topics in section 144G.61, subdivision 2, paragraph (a), clauses (5), (7), and (8), by a practical skills test. Unlicensed personnel who only provide assisted living services listed in section 144G.08, subdivision 9, clauses (1) to (5), shall not perform delegated nursing or therapy tasks.	01320		

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01320	Continued From page 15 This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to ensure two of two employees, unlicensed personnel (ULP)-H and ULP-I) completed training and competency evaluations in all required training topics. This had the potential to affect all residents living in the facility. 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 the residents). The findings include: ULP-H On November 4, 2022, unlicensed personnel (ULP)-H was hired as an assisted living coordinator and assists as-needed as a resident assistant. ULP-H's employment record lacked documentation of completed training and competency testing in topics listed in 144G.61, subdivision 2. On March 2, 2023, ULP-H's employee record was requested. ULP-H's employee record was reviewed and all training sign offs were blank. There was no indication training or competencies were completed prior to ULP-H providing resident care.	01320		

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01320	Continued From page 16 On March 2, 2023, at 9:16 a.m., ULP-H stated she was hired in October 2022, and had not received training or competencies. ULP-H stated she had provided direct care to residents including medication administration without training or competencies completed. On March 3, 2023, at 12:50 p.m., registered nurse (RN)-A stated ULP-H administered medications for all seven residents on the unit in the last month. ULP-I ULP-I was hired on January 12, 2023, as an assisted living coordinator and assists as needed as a resident assistant. ULP-I's employment record lacked documentation the employee completed training and competency testing in topics listed in 144G.61, subdivision 2. On March 3, 2023, ULP-I's employee file was requested. ULP-I's employee file was reviewed and all training sign offs were blank. There was no indication training or competencies were completed prior to providing resident care On March 3, 2023, at 10:11 a.m., ULP-I stated she did not have any competencies or training. ULP-I stated the licensee was aware she provided cares including medication administration without training or competencies. ULP-I stated she administered medications this morning. On March 3, 2023, at 10:28 a.m., registered nurse (RN)-A stated staff have been allowed to work without training and competencies. RN-A	01320		

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01320	Continued From page 17 confirmed the licensee was aware staff were working without training or competencies since the last survey that occurred in January 2023. RN-A verified ULP-H and ULP-I's training and competencies were not completed. RN-A confirmed staff should have all competencies and training before providing services, including medication administration. The licensee's Orientation and Training-Delegated Nursing Services dated September 4, 2022, indicated a RN may delegate nursing services to a person who has successfully completed staff orientation, trained in the service provided and demonstrated to the RN the ability to competently follow the procedures for the client. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	01320		
01330 SS=F	144G.60 Subd. 4 (b) Unlicensed personnel (b) Unlicensed personnel performing delegated nursing tasks in an assisted living facility must: (1) have successfully completed training and demonstrated competency by successfully completing a written or oral test of the topics in section 144G.61, subdivision 2, paragraphs (a) and (b), and a practical skills test on tasks listed in section 144G.61, subdivision 2, paragraphs (a), clauses (5) and (7), and (b), clauses (3), (5), (6), and (7), and all the delegated tasks they will perform; (2) satisfy the current requirements of Medicare for training or competency of home health aides or nursing assistants, as provided by Code of Federal Regulations, title 42, section 483 or 484.36; or	01330		

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01330	Continued From page 18 (3) have, before April 19, 1993, completed a training course for nursing assistants that was approved by the commissioner. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to ensure two of two employees, unlicensed personnel (ULP)-H and ULP-I) completed training and competency evaluations in all required training topics prior to performing delegated nursing tasks. This had the potential to affect all residents living in the facility. 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 the residents). The findings include: ULP-H On November 4, 2022, unlicensed personnel (ULP)-H was hired as an assisted living coordinator and assists as needed as a resident assistant. On March 2, 2023, ULP-H's employee record was requested. ULP-H's employee record was reviewed and all training and competency sign offs were blank. There was no indication training or competencies were completed prior to performing delegated nursing tasks.	01330		

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01330	Continued From page 19 On March 2, 2023, at 9:16 a.m., ULP-H stated she was hired in October 2022, and had not received training or competencies. ULP-H stated she had performed medication administration without training or competencies completed. On March 3, 2023, at 12:50 p.m., registered nurse (RN)-A stated ULP-H administered medications for all seven residents on the unit in the last month. ULP-I ULP-I was hired on January 12, 2023, as an assisted living coordinator and assists as-needed as a resident assist. On March 3, 2023, ULP-I's employee file was requested. ULP-I's employee file was reviewed and all training and competency sign offs were blank. There was no indication training or competencies were completed prior to performing delegated nursing tasks. On March 3, 2023, at 10:11 a.m., ULP-I stated she had not completed any competencies or training. ULP-I stated the licensee was aware she performed delegated nursing tasks such as medication administration without training or competencies. ULP-H and ULP-I employee records lacked documentation of practical skills test on tasks listed in section 144G.61, subdivision 2, paragraphs (a), clauses (5) and (7), and (b), clauses (3), (5), (6), and (7), and all the delegated tasks they will perform. On March 3, 2023, at 10:28 a.m., registered	01330		

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01330	Continued From page 20 nurse (RN)-A stated staff have been allowed to work without training and competencies. RN-A confirmed the licensee was aware staff were working without training or competencies since the last survey that occurred in January 2023. RN-A verified ULP-H and ULP-I's training or competencies were not complete. RN-A confirmed staff should have all competencies and training before providing services and delegated nursing tasks including medication administration. The licensee's Orientation and Training-Delegated Nursing Services dated September 4, 2022, indicated a RN may delegate nursing services to a person who has successfully completed staff orientation, trained in the service provided and demonstrated to the RN the ability to competently follow the procedures for the client. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	01330		
01620 SS=G	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 completed within 30 calendar days of the start of	01620		

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01620	Continued From page 21 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 interview and record review, the facility failed to ensure a complete and accurate admission assessment was conducted when an initial skin assessment was not completed and discharge paperwork was not thoroughly reviewed, which resulted in failure to identify a pressure ulcer, implement physician orders, and develop interventions to prevent further skin breaksown for one of one resident (R4) 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). The findings include: R4's hospital records indicated January 20, 2023, a stage 2 pressure injury was noted with partial thickness skin loss, with measurement of 1 cm x	01620		

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01620	Continued From page 22 1 cm x 0.1 cm newly opened likely due to a combination of high moisture, friction, and pressure. R4's discharge instructions from the hospital dated January 31, 2023, indicated a Mepilex dressing was applied to R4's sacrum and heel protective boots should be put on daily. R4 was admitted on January 31, 2023, with diagnoses of physical deconditioning, reduced mobility, and cognitive impairment. R4's preadmission assessment dated January 27, 2023, lacked information regarding the pressure injury on R4's sacrum. R4's admission assessment dated January 31, 2023, indicated R4 required assistance with dressing, bathing, transfers, and ambulation. The skin assessment did not include identification of the pressure injury. R4's admission service plan was not signed and included services with assistance of bed mobility three times daily, walking three times daily, and transfer assist three times daily. The service plan did not include monitoring of the pressure injury on R4's coccyx, application of protective heel boots or monitoring of R4's heels. R4's February 2023, treatment recap summary did not include wound care, heel boots, or skin checks. R4's progress notes included the following: - February 6, 2023, wound orders were requested from the provider and indicated an open area on R4's coccyx that measured 0.5 cm x 0.5 cm,	01620		

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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 23 lightly red. The note indicated to continue to reposition every one to two hours to offload pressure. - February 20, 2023, a progress note indicated the area of pressure injury had significantly increased in size and now measured 2 cm x 3.5 cm, and another small area had opened to the right of that measuring 0.5 cm x 0.2 cm with purple areas that were not blanchable. A small amount of serosanguinous (thin watery pink) drainage was noted on the dressing and a slight foul odor was noted. - February 23, 2023, a new order was added for cream to be applied to R4's coccyx twice daily. R4's medical record did not include documentation or identification of the pressure ulcer from upon admission January 31, 2023-February 6, 2023. R4's medical record from February 7, 2023, through February 19, 2023, lacked documentation of monitoring, treatment, or follow up related to R4's pressure injury. R4's medical record lacked documentation of any interventions that were added from admission on January 31, 2023, until February 23, 2023, to prevent worsening of the pressure injury. R4's 14 day assessment should have been completed by February 14, 2023, but was not completed until February 28, 2023. The assessment indicated a new vulnerability was added regarding bed mobility and requiring 1-2 staff for repositioning, a new pressure ulcer on R4's coccyx and a pressure injury on R4's right inner heel. Foam boots were added on February	01620		

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01620	Continued From page 24 28, 2023 [despite intial admission orders on January 31, 2023] and staff were to continue the turning and repositioning schedule. The wound assessment indicated the pressure injury on R4's coccyx was now a stage 3, and the pressure injury on R4's heel was a stage one. On March 7, 2023, at 11:05 a.m., registered nurse (RN)-A stated she completed the pre-admission assessment prior to R4's admission but did not get a chance to complete a skin assessment as she did not have time. RN-A stated staff noticed the pressure injury on February 6, 2023. RN-A stated turning and repositioning was added to the service plan on February 8, 2023. RN-A stated during the week of R4's admission there were three admissions and she was continually being pulled to work as an unlicensed personnel so she was not able to complete her RN responsibilities. RN-A showed the investigator a text message, sent on February 1, 2023, to corporate staff requesting assistance with staffing as she was not able to complete her responsibilities and admission assessments. The corporate staff did not respond to this text message. RN-A verified she skimmed over the admission orders and was not aware of the pressure injury and was not aware the protective boots were ordered. On March 17, 2023, at 11:00 a.m., RN-B stated staffing was a huge concern and a lot of things weren't getting done that should have been and this was not brought to her attention. RN-B was not aware a skin assessment was not completed upon R4's admission. RN-B stated during this time she was off of work and RN-A was very frustrated and struggling and had reached out for help from corporate staff.	01620		

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01620	Continued From page 25 On March 17, 2023, at 11:45 a.m., RN-J confirmed a skin assessment should have been completed on pre-admission and admission for R4. RN-J stated if an area of impaired skin integrity is noted it should be assessed weekly. RN-J stated the 14 day assessment should be completed on or prior to the 14th day. RN-J also verified a service plan should have been signed. RN-J stated she did not remember the text message sent by RN-A requesting assistance and did not know what was done about this request. The licensee's Skin Assessment policy dated August 15, 2022, indicated a pre-admission assessment will gather information regarding any pre-existing skin issues as part of the screening to assure the licensee can safety and appropriately manage skin issue. Upon admission the RN will completed the admission assessment including skin health, nutrition and hydration. The initial skin assessment will be head to toe and the bases for the service plan that the RN will recommend to the resident and for staff to implement. The reassessment must be conducted no more than 14 days after the initiation of services. TIME PERIOD FOR CORRECTION: Seven (7) days	01620		
01750 SS=I	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications,	01750		

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01750	Continued From page 26 and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure competencies were completed by the Registered Nurse prior to delegating the nursing task of medication administration, for two of two unlicensed personnel (ULP-H, ULP-I) who administered medications. This had a potential to affect all residents who recieved medication administration. 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). This resulted in a immediate correction order on March 3, 2023, at 10:40 a.m. The findings include: ULP-H On November 4, 2022, unlicensed personnel (ULP)-H was hired as an assisted living coordinator and assists as needed as a resident assistant.	01750		

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01750	Continued From page 27 On March 2, 2023, at 9:16 a.m., ULP-H stated she was hired in October 2022, and had not received training or competencies including medication administration. ULP-I stated she has also passed medications on multiple occasions without having any training or competencies completed. On March 2, 2023, ULP-H's employee record was requested. ULP-H's employee record was reviewed and all training sign offs were blank. There was no indication training or competencies were completed prior to providing resident care and/or medication administration. On March 3, 2023, at 12:50 p.m., registered nurse (RN)-A confirmed ULP-H administered medications for all seven residents on the unit in the last month. ULP-I ULP-I was hired on January 12, 2023, as an assisted living coordinator and assists as needed as a resident assistant. On March 3, 2023, at 10:11 a.m., ULP-I stated she had not recieved any competencies signed off or training. ULP-I stated the licensee was aware she provided cares including medication administration without training or competencies. ULP-I stated she administered medications this morning. On March 3, 2023, ULP-I's employee file was requested. ULP-I's employee file was reviewed and all training sign offs were blank. There was no indication training or competencies were completed prior to providing resident care or medication administration.	01750		

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01750	Continued From page 28 On March 3, 2023, at 12:50 p.m., RN-A confirmed ULP-I administered medications for two residents that morning. On March 3, 2023, at 10:28 a.m., registered nurse (RN)-A stated staff have been allowed to work without training and competencies. RN-A confirmed the licensee's administration was aware staff were working without training or competencies since the last survey that occurred in January 2023. RN-A verified staff should have all competencies and training completed before providing services including medication administration. On March 2, 2023, at 10:40 a.m., RN-J also confirmed staff should be trained and competent prior to providing services. No further information was provided. TIME PERIOD OF CORRECTION: IMMEDIATE Immediacy was removed as confirmed by investigator's onsite observation on March 7, 2023 and reviewed by evaluation supervisor on March 7, 2023, however noncompliance remains at a scope and severity of F. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
02310 SS=I	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 resident's needs and according to an up-to-date	02310		

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02310	Continued From page 29 service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure care and services were provided according to acceptable health care, medical, or nursing standards for seven out of nine residents (R1, R3, R5, R6, R7, R8, and R9) who utilized side rails (bed rails). This resulted in an immediate correction order on March 1, 2023, at 4:30 p.m., 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: R3's diagnoses included multiple sclerosis (disease of the central nervous system) and type two diabetes. R3's care plan dated January 29, 2023, indicated R3 had minor forgetfulness, gets disoriented with new situations and when he first wakes up. The care plan identified R3 required assistance with all activities of daily living including two staff for assistance with bed mobility and a mechanical lift for transfers. The care plan indicated R3 had side rails used for turning and repositioning every two to three hours and that the bedrail and mattress spacing was appropriate and the side rails were	02310		

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02310	Continued From page 30 secure and close to the mattress. On March 1, 2023, 10:30 a.m., R3's bed rails were observed to be loose. The bed rails were not secured to the bed and were able to be pulled out, causing a large gap between the side rails and the mattress. On March 1, 2023, at 1:30 p.m., registered nurse (RN)-A stated maintenance puts the side rails on resident beds, but was not sure what the process was regarding who checked the side rails or how often the side rails were to be checked. RN-A stated she would find out. RN-A verified she could not ensure the bed rails utilized in the facility were installed or used according to manufacturer instructions. RN-A was not aware of where the side rails were stored or where they were obtained, but indicated maintenance was responsible for the installation of the side rails. On March 1, 2023, at 3:25 p.m., RN-B stated she was not responsible for side rail assessments and did not know the process for how often side rails were checked. RN-B and the investigator checked all of the resident side rails which confirmed R1, R3, R5, R6, R7, R8, and R9,'s side rails were not secured and all were very loose. R1, R3, R5, R6, R7, R8, and R9 all utilized different types of bed rails. RN-B stated there was no current process in place for side rails to be checked and stated the side rails should probably be re-assessed monthly. R3's medical record was reviewed and included a January 29, 2023, Side Rail Assessment indicating R3 utilized a partial side rail with upper rails utilized to aid in repositioning. The assessment did not indicate which side of the bed the partial side rail was on or if there was use of	02310		

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02310	Continued From page 31 bilateral side rails. The assessment was marked "yes" when asked if the bed rail was installed and maintained according to manufactuer guidelines and also marked "yes" that the bed rails were reviewed for any recalls with the Consumer Product Safety Commission. The facility lacked manufacturer information for the bed rails that were in use at the facility, and without that information, they were unable to assess and determine if the bed rails were being used appropriately and installed properly, which resulted in imminent safety risks for the residents. On March 1, 2023, at 4:28 p.m., RN-A stated the corporate office was not able to explain the process for follow up with side rails. On March 1, 2023, at 4:30 p.m. the investigator discussed with nursing and administration that an immediate correction order would be issued. On March 1, 2023, at 4:30 p.m. the investigator requested further medical record information, side rail assessments, and manufactuer guidelines for the side rails in use for R1, R5, R6, R7, R8, and R9. The surveyor indicated this information could be emailed directly to the investigator as the information was collected. On March 1, 2023 at 9:07 p.m., the requested information for R1, R5, R6, R7, R8, and R9 had not yet been provided by the facility. The Food and Drug Administration (FDA) "A Guide to Bed Safety" revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also	02310		

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02310	Continued From page 32 identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." The Food and Drug Administration (FDA), "Recommendations for Health Care Providers about Bed Rails," dated July 9, 2018, included the following information: -Follow the health care facility's procedures and/or manufacturer's recommendations/specifications for installing and maintaining bed rails for the particular bed frame and bedside rails used. -Inspect and regularly check the mattress and bedrails to make sure they are still installed correctly and for areas of possible entrapment and falls. Regardless of mattress width, length, and/or depth, the bed frame, bed side rail, and mattress should leave no gap wide enough to entrap a patient's head or body. -Regularly assess that bed rails remain appropriately matched to the equipment and to the patient's needs, considering all relevant risk factors. -Inspect, evaluate, maintain, and upgrade equipment (beds/mattresses/bed rails) to identify and remove potential fall and entrapment hazards. -Re-assess the person's needs and re-evaluate the equipment if an episode of entrapment or near-entrapment occurs, with or without serious injury. This should be done immediately because fatal "repeat" events can occur within minutes of the first episode. -Be aware that gaps can be created by	02310		

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02310	Continued From page 33 movement or compression of the mattress which may be caused by patient weight, patient movement or bed position, or by using a specialty mattress, such as an air mattress, mattress pad or water bed. -When in doubt, call the manufacturer of the rails for assistance. RN-A and RN-B expressed lack of knowledge regarding the following requirements: -There should be documentation of installation, use, and maintenance according to manufacturer's guidelines; -Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation should be documented; -Necessary information related to interventions to mitigate safety risks should be documented; -Bed rail assessments should be completed at least every 90 days; -It should be documented that bed rails were installed and maintained according to the manufacturer's guidelines; -Manufacturer's bed rail guidelines should be readily accessible. The licensee's Nursing Assessment Side Rail policy dated June 20, 2022, indicated a nursing assessment is completed by the RN prior to the delivery of nursing services. The policy did not include any specific information regarding the appropriate use of side rails, the specific requirements to be included in side rail assessments, when side rail re-assessments are completed, or information about ensuring side rails are installed and used according to manufactuer guidelines.	02310		

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02310	Continued From page 34 TIME PERIOD FOR CORRECTION: Immediate Immediacy was removed as confirmed with an onsite observation on March 7, 2023, and reviewed by a supervisor on March 7, 2023, however noncompliance remains at a scope and severity of F. 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 observation, interview, and record review, the licensee failed to ensure health care and other assisted living services were provided, by people who were trained and competent to perform their duties, and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and service plan for two of two residents (R1 and R6) reviewed. The registered nurse (RN)-A did not follow R1's service plan, performed an improper transfer, and three days later R1 was diagnosed with T6 and T7 compression fractures. In addition, service plans were not followed due to a lack of sufficient	02320		

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02320	Continued From page 35 staffing and several staff did not have completed education, training, or competencies signed off by the RN. This resulted in an immediate order issued on March 1, 2023, at 4:30 p.m. 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: An email provided by the licensee included a staffing plan and indicated the licensee was in the process of working with a consultant to review a plan for staffing to align with the resident's needs and services required. The email identified the following acuity levels for residents: Level 1: Residents who were self sufficient, ambulatory and required minimal nursing care = two residents Level 2: Residents who are ambulatory, and require moderate nursing care = six residents Level 3: Residents who are non-ambulatory and require frequent supportive nursing care and observation = seven residents. Level 4: Residents who are non-ambulatory and require continuous nursing care and observation= one resident. The licensee's Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) dated February, 1, 2023, indicated staffing pattern by census was located in the entryway of the	02320		

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02320	Continued From page 36 building. The UDALSA also indicated the licensee provided one to two staff assist transfers, sit to stand lifts, and mechanical lifts. A Minnesota Adult Abuse Reporting Center (MAARC) report indicated on the late afternoon evening on January 22, 2023, R1 requested assistance with a transfer and told staff two people were needed to transfer her. The staff member [RN-A] told R1 they would do it themselves. R1 stated the staff picked me up and plopped me down. R1 demonstrated a bear hug technique where staff lifted the top half under R1's arms and pulled on her lower back. R1 stated since that time she has had lower back pain that is worse with movement. R1's service task list indicated R1 required assistance of two staff with a gait belt. Two days later, R1 reported mild to moderate back pain that started after the one assist transfer. The next morning R1 complained of pain and rated it 10/10 in her low back with movement. Staff called 911 and R1 was sent to the emergency department. R1 was found to have T6 and T7 compression fractures. On March 1, 2023, at 2:10 p.m., unlicensed personnel (ULP)-G stated within the last week she was the only staff working on one side of the facility. ULP-G stated R6 required a hoyer lift with two staff for assistance with transfers, but ULP-G was unable to get help from the staff working on the other side, so ULP-G transferred R6 independently with a gait belt. ULP-G stated she called RN-G and reported she had to transfer R6 independently since she did not have help. On March 1, 2023, at 2:45 p.m., registered nurse (RN)- B stated an internal investigation was completed surrounding the incident from the January 22, 2023, MAARC report and identified	02320		

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02320	Continued From page 37 RN-A was the staff member that assisted R1 with the one assist transfer, which did not follow R1's service plan. RN-B stated RN-A was re-educated but facility wide education had not been completed. RN-B was asked about staffing and ULP-G's concern with limited staff over the weekend. RN-B stated she received many calls over the weekend but was not the nurse on-call. RN-B stated ULP-G called and was very upset since she was the only staff member working on one side of the facility. ULP-G also notified RN-B there was no food for the residents to eat and ULP-G offered to buy the residents food. RN-B text corporate staff and voiced her frustration about one staff working alone on one side. RN-B read the text that indicated "one person can not make meals, answer call lights, and ensure resident safety". RN-B verified that if a resident requires two staff for assistance than that is what should be followed, but if there is no staff, what can they do?" On March 1, 2023, at 3: 25 p.m., RN-B and the investigator observed R6's room. R6 was in bed. On the side of R6's bed was a wheelchair. R6's recliner was full of blankets with a gait belt sitting on top of the blankets. RN-B moved R6's wheelchair and put down a floor mat next to the bed. RN-B confirmed the floor matt should have been put down when staff assisted R6 to bed as indicated on R6's service plan. R6's hoyer lift (full body mechanical lift) and Broda wheelchair were in R6's bathroom and the hoyer was in the lowest position and appeared unused. On March 1, 2023, at 4:30 p.m., RN-A stated the licensee's administration did not want to hire temporary staff. On March 3, 2023, at 10:28 a.m., registered	02320		

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02320	Continued From page 38 nurse (RN)-A confirmed several staff providing direct care and performing delegated tasks did not have the required training and competencies had not been completed. RN-A stated staff have been allowed to work without training and competencies. RN-A confirmed the licensee's administration was aware staff were working without training or competencies since the last survey that occurred in January 2023. RN-A verified ULP-H and ULP-I's training and competencies were not completed. RN-A confirmed staff should have all competencies and training before providing services, including medication administration. On March 1, 2023, at 4:30 p.m. the investigator requested additional medical record information for R1 and R6, which had not been received as of March 1, 2023, at 9:07 p.m.. The licensee's Service Plan policy revised September 4, 2022, indicated the home care provider must implement and provide all services required by the current service plan. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE Immediacy was removed as confirmed by onsite observation on March 7, 2023, and reviewed by evaluation supervisor on March 7, 2023, however noncompliance remains at a scope and severity of F. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		

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02350	Continued From page 39	02350		
02350 SS=G	144G.91 Subd. 7 Courteous treatment Residents have the right to be treated with courtesy and respect, and to have the resident's property treated with respect This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to ensure one of one resident (R3) was treated with dignity and respect when staff left the resident on the bed pan for more than three hours. Staff did not assist R3 until after he had contacted his wife, who drove to the facility and had to locate staff. R3 was found with his legs out over the side of the bed, hanging on to the bed rail, covered in fecal matter and stated he was afraid. 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). The findings include: R3's diagnoses included multiple sclerosis (disease of the central nervous system) and type two diabetes. R3's care plan dated January 29, 2023, indicated R3 had minor forgetfulness, was disoriented with new situations and when he first woke up. R3 required assistance with all activities of daily living including requiring two staff for assistance with	02350		

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02350	Continued From page 40 bed mobility and toileting every two to three hours, and a mechanical lift for transfers. R3's care plan indicated he was not able to ambulate independently. On March 1, 2023, at 10:00 a.m., a family member (FM)-F stated she received a call from R3 on February 24, 2023, around 4:30 p.m., and R3 stated "something bad was going on". R3 told FM-F he had been pressing his pendant, yelling for help, no one was coming, and he was falling out of bed. FM-F stated she then came to the facility and when she arrived, R3's legs were hanging out of the bed and R3 was holding on to the side rail with both hands. R3 had fecal matter all over himself, the sheets, and the floor. R3 was confused and distressed. FM-F stated she had previously shared multiple concerns with multiple management staff and thought those concerns would have been addressed. Five pictures were reviewed that were taken by FM-F on February 24, 2023. The pictures identified R3 had both legs out of bed and both hands were hanging on to the side rail. On March 1, 2023, at 10:30 a.m., R3's bed rails were observed to be loose. The bed rails were not secured to the bed and were able to be pulled out, causing a large gap between the side rails and the mattress. The investigator was unable to obtain call light system audits as the licensee's call light system did not have the capability to check when or if R3 pressed his call light at the time of the incident. Video footage reviewed from February 24, 2023, indicated the following:	02350		

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02350	Continued From page 41 1:29 p.m., ULP-I and ULP-L went into R3's room. 1:38 p.m., ULP-I and ULP-L left R3's room. 2:06 p.m., ULP-L left the facility 2:43 p.m., ULP-G arrived at the facility. 3:38 p.m., ULP-M arrived at the facility. 4:55 p.m., family member (FM)-F entered facility, entered R3's room, left R3's room to find staff and returned to R3's room with ULP-G. Review of the February 24, 2023, video footage identified that no staff entered R3's room after he was placed on the bed pan at 1:38 p.m. until FM-F entered his room at 4:55 p.m. R3's service plan sign off sheet dated February 24, 2023, included ULP-I signed off toileting R3 at at 1:53 p.m., and repositioning R4 at 1:54 p.m. ULP-I ULP-I was hired on January 12, 2023, as an assisted living coordinator and assists as needed as a resident assistant. ULP-I's employment record lacked documentation the employee completed training and competency testing in topics listed in 144G.61, subdivision 2. On March 2, 2023, ULP-I stated she and another ULP assisted R3 onto the bed pan. ULP-I stated she later checked on R3 and he was not ready to get off the bedpan. ULP-I stated she told the oncoming staff at 2:30 p.m that R4 was still on the bedpan. ULP-I stated a resident should not be left on the bed pan longer than 30 minutes. On March 3, 2023, ULP-I's employee file was requested. ULP-I's employee file was reviewed and all training sign offs were blank. There was	02350		

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02350	Continued From page 42 no indication training or competencies were completed prior to providing resident care. On March 3, 2023, at 10:11 a.m., stated she did not have any competencies or training. ULP-I stated the licensee was aware she provided cares including medication administration without training or competencies. ULP-I stated she administered medications this morning On March 3, 2023, at 10:28 a.m., RN-A stated staff have been allowed to work without training and competencies. RN-A confirmed the licensee's administration was aware staff were working without training or competencies since the last survey that occurred in January 2023. RN-A verified ULP-I's training or competencies were not completed. RN-A confirmed staff should complete all competencies and training before providing services, including medication administration. On March 7, 2023, at 12:00 p.m., RN-B stated she was summoned to R3's room to assist ULP-G on February 24, 2023. RN-B stated R3 was halfway off the bed and had fecal matter on him. R3 was holding on to his bed rail and was very afraid and scared. RN-B stated she called RN-J to report what happened and was not given further instruction on what to do, but filed a Minnesota Adult Abuse Reporting Center (MAARC) report due to what she saw when she entered R3's room. RN-B stated no immediate interventions were put in place to prevent this from happening again. RN-B stated no one had watched the video of the incident until March 6, 2023, and no staff re-education or re-training had been completed following this incident. On March 17, 2023, at 11:45 a.m., RN-J	02350		

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02350	Continued From page 43 confirmed FM-F had voiced concerns regarding staff communication prior to February 24, 2023. RN-J stated an intervention should have been implemented right away to prevent this incident from occurring again. RN-J stated ULP-I not having completed competencies could have been a contributing factor to this incident. No further information was provided. The licensee's Call Pendants Policy dated September 2, 2022, indicated a resident who turns on their call light will have their light answered promprly and their requested care needs met. TIME PERIOD FOR CORRECTION: Seven (7) days	02350		
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: The facility failed to ensure one of one residents reviewed (R2, R3, R4, R12, and R13) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public	02360	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	

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02360	Continued From page 44 maltreatment report for details The following maltreatment reports were substantiated. HL244278920C/HL244275223M HL244278935C/HL244275183M HL244278176C/HL244274783M	02360		
02480 SS=F	144G.91 Subd. 20 Grievances and inquiries Residents have the right to make and receive a timely response to a complaint or inquiry, without limitation. Residents have the right to know, and every facility must provide the name and contact information of the person representing the facility who is designated to handle and resolve complaints and inquiries. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to respond to the grievances of one of one resident (R3) reviewed for grievances. 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: On March 1, 2023, the investigator requested to review the licensee's filed grievances. The licensees' complaint/grievance forms	02480		

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02480	Continued From page 45 completed by registered nurse (RN)- J included: - On February 17, 2023, Family member (FM)-F had concerns regarding medication administration provided by unlicensed personnel (ULP). - On February 17, 2023, FM-F had concerns regarding R3's blood sugars and staff not following up after a blood glucose of 300. - On February 17, 2023, FM-F had concerns regarding staffing and staffing levels. - On February 17, 2023, FM-F had concerns regarding a delay in the resident receiving an ordered antibiotic and a lack of staff communication regarding resident information. On March 3, 2023, at 10:30 a.m., FM-F stated she was not aware of the grievance process but had shared multiple concerns with RN-J. FM-F also stated she shared concerns with RN-A prior to sharing her concerns with RN-J and had not recieved follow up on any of the concerns. R3`s record lacked evidence of responses to the grievance or attempts to resolve the grievances. The licensee had not implemented resident or family council so concerns or grievances could not be reviewed and acted upon. On March 7, 2023, at 10:45 a.m., the licensed assisted living director (LALD)-K stated the RN should notify the LALD of any grievances. LALD-K stated there was no timeline to follow up with concerns but stated they should be dealt with as soon as there is a concern. LALD-K was not aware if all grievances were documented and verified the statute regarding grievances should	02480		

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02480	Continued From page 46 be followed. On March 8, 2023, at 10:50 a.m., RN-J stated she wrote up FM-F's concerns on a complaint form but did not follow up with FM-F. The licensee's policy titled, Complaint/Grievance, dated September 4, 2022, indicated when possible and reasonable, the complaint will be resolved immediately involving others as needed. The same document indicated a prompt response to the complainant will be provided verbally and, if, desired in writing. TIME PERIOD FOR CORRECTION: seven (7) days	02480		
03000 SS=E	626.557 Subd. 3 Timing of report (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph	03000		

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03000	Continued From page 47 (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to immediately report to the Minnesota Adult Abuse Reporting Center (MAARC) suspected maltreatment/self-neglect or complete a thorough investigation for three of three residents (R2, R12, R13) with records reviewed.	03000		

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03000	Continued From page 48 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The resident list indicated R2, R12, and R13 resided on Fjord. R2 was admitted January 19, 2023, with diagnoses of severe dementia with psychotic disturbance and behavioral disturbance. R2's service plan indicated R2 required assistance with medication management, dressing, grooming, and bathing. R2's service plan lacked behavior management interventions. R2's individual abuse prevention plan (IAPP) assessment dated February 3, 2023, indicated R2 was physically abusive and would try and grab other resident's wheelchairs out of staff's hands. R2 would try to push through staff to get into other resident rooms and did not respond to re-direction. The same document indicated R2 would go into other resident rooms during the night. The IAPP lacked interventions for the identified vulnerabilities. R2's progress notes indicated the following: - January 23, 2023, R2 wandered the halls, tried to get out of the facility multiple times and became very upset and frustrated.	03000		

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03000	Continued From page 49 - January 25, 2023, R2 was agitated twice and wanted to go outside. R2 was showing signs of sundowning and anxiety starting in the afternoon around 3:00 p.m.. R2's behaviors the last few days have increased, leading up to R2 pushing another resident (R12). R2 was sent to the emergency room for evaluation and sent back to the licensee as there was no reason for admission. - January 26, 2023, R2 paced back and forth from the front door was exit seeking, and would go to the door anytime the door would open. - January 31, 2023, staff went to R12's room; the door was locked and staff could hear R2 talking. The staff opened the door and found R2 standing in front of R12. R2 started yelling and swearing at staff. R2 then left R12's room and came back in while staff were assisting R12 with toileting. - February 2, 2023, R2 was fixated on R12 trying to pull his wheelchair out of staff's hand. 911 was called to transfer R2 to the emergency room. - February 4, 2023, R2 was upset at staff for removing her from R12's room and yelled at staff. R2 threatened to hurt staff if they did not allow her into R12's room. - February 5, 2023, R13 stated she was frightened of her roommate R2. R13 stated R2 was rummaging through her things and locked R13 in the room with R2. Registered nurse (RN)-A felt scared to open it because she did not want to make R2 mad but also felt scared leaving them alone. - February 5, 2023, R2 wandered the halls most of the day looking for R12 and went into other	03000		

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 03/07/2023

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03000	Continued From page 50 resident rooms looking for R12. - February 14, 2023, R2 became angry with another resident (R12), and went to hit him. Staff got between the residents and separated them. - February 27, 2023, R2 was upset with R12 and started to yell at him because he was unable to respond to her in the way that she wanted and was upset that she cannot get into his room. R2 continued to yell at R12. - February 28, 2023, R2 went up to another resident and kissed him without approval. Staff attempted to re-direct and she laughed at staff. R2 was outside of R12's room and yelling because she thinks it's her significant other and she thinks R12 was faking his identity. - February 28, 2023, - R2 grabbed a hold of staff's hands and tried pulling another resident's wheelchair out of their hand. R2 started yelling at staff and could not be re-directed. - March 8, 2023, R2 was yelling at R12 and told R12 he needed to drive her somewhere. On March 1, 2023, at 9:53 a.m., R12's room had a black strap going across the door. The surveyor asked unlicensed personnel (ULP)-E what the strap was for, and ULP-E stated it was to keep R2 out of R12'S room. On March 7, 2023, at 10:00 a.m., the investigator observed that R2 and R13 continued to share a room. On March 7, 2023, at 11:05 a.m., RN-A stated R2 was fixated on R12 and thought he was her husband or boyfriend. RN-A stated R2 tried	03000		

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03000	Continued From page 51 eloping with R12. RN-A also stated R2 had locked herself into R12's room and yelled at R12 often. RN-A also verified R2 kissed R12. RN-A stated when R2 gets riled up she needs to have one to one staffing, which was not possible. RN-A also stated there was not enough training for residents with dementia. RN-A stated she was going to move R2 to the other locked unit but became busy and didn't have time. RN-A confirmed these incidents were not reported to MAARC. On March 17, 2023, at 11:45 p.m., RN-J stated she was not aware of the multiple incidents that occurred between R2 with R12 and R13. RN-J verified these incidents should have been reported to MAARC. The licensee's Vulnerable Adult policy dated September 5, 2022, indicated a MAARC report should be made if there is reason to believe abuse, neglect or finicial exploitation of a vulnerable adult occurred and should be reported within 24 hours. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	03000		