

Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL24475223M Date Concluded: April 18, 2023

Compliance #: HL244278920C

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

Minnesota Department of Health

AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ´	E CONSTRUCTION	COMPLETED
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0 000 Initial Comments		0 000		
*****ATTENTION**	****		The Minnesota Department of Head documents the State Licensing Conders using federal software. Tag numbers have been assigned to	rrection
ASSISTED LIVING CORRECTION OR	PROVIDER LICENSING DER		Minnesota State Statutes for Assistant Living Facilities. The assigned tag appears in the far left column entit	number
144G.08 to 144G.9	Minnesota Statutes, section 5, these correction orders are a complaint investigation.		Prefix Tag." The state statute num the corresponding text of the state out of compliance are listed in the "Summary Statement of Deficienc	statute
requires compliance	Determination of whether a violation is corrected requires compliance with all requirements findings that are in violati		column. This column also includes findings that are in violation of the requirement after the statement, "	s the state
When a Minnesota	Statute contains several nply with any of the items will		Minnesota requirement is not met evidenced by." Following the surve findings is the Time Period for Cor	as eyors '
INITIAL COMMENT	S:		Per Minnesota Statute §144G.30, (c), the assisted living facilities mu	
HL244278920C/HL HL244278195C/HL HL244278935C/HL HL244278176C/HL	244274763M 244275183M		document any action taken to come the correction order. A copy of the 's records documenting those action may be requested for follow-up su The home care provider is not requested.	ply with provider ions rveys.
of Health conducted the above provider, orders are issued.	the Minnesota Department a complaint investigation at and the following correction at the time of the complaint were 16 clients receiving		submit a plan of correction for app please disregard the heading of th column, which states "Provider's Correction."	roval; e fourth
services under the A	Assisted Living with Dementia		The letter in the left column is used tracking purposes and reflects the and level issued pursuant to Minn.	scope
issued for HL24427 identification 2320,	diate correction orders is 8195C/HL244274763M, tag 244275223M tag identification		144G.31, Subd. 2 and 3.	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

Minnesota Department of Health

STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	E CONSTRUCTION	(X3) DATE	
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	HL244278935C/HL identification 1620,	, ,				
	HL244278920C/HL identification 2350,	. •				
0 620 SS=E	144G.42 Subd. 6 (a requirements for re	•	0 620			
	the requirements formaltreatment of vul 626.557. The facility implement a written	ing facility must comply with or the reporting of nerable adults in section y must establish and procedure to ensure that all maltreatment are reported.				
	by: Based on observation review, the licenses to the Minnesota Action (MAARC) suspected	ent is not met as evidenced on, interview and record e failed to immediately report dult Abuse Reporting Center d maltreatment and complete ation for three of three				

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residents (R2, R12, R13) with records reviewed.

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	resided on Fjord. R R2 was admitted Ja diagnoses of sever disturbance and be R2's service plan in assistance with me dressing, grooming	at indicated R2, R12, and R13 2 and R13 were roomates. anuary 19, 2023, with e dementia with psychotic havioral disturbance. Idicated R2 required dication management, and bathing. R2's service or management interventions.				
		se prevention plan (IAPP) February 3, 2023, indicated				

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	other resident's who R2 would try to pus other resident room re-direction. The sa would go into other night. The IAPP lac identified vulnerabil R2's progress notes - January 23, 2023, to get out of the fac became very upset - January 25, 2023, wanted to go outsid sundowning and an around 3:00 p.m For days have increase another resident (Remergency room for the sundowning and an around 3:00 p.m For days have increased another resident (Remergency room for the sundowning and an around 3:00 p.m For days have increased another resident (Remergency room for the sundowning and an around 3:00 p.m For days have increased another resident (Remergency room for the sundowning and an around 3:00 p.m For days have increased another resident (Remergency room for the sundowning and an around 3:00 p.m For days have increased another resident (Remergency room for the sundowning and an around 3:00 p.m For days have increased another resident (Remergency room for the sundowning and an around 3:00 p.m For days have increased another resident (Remergency room for the sundowning and an around 3:00 p.m For days have increased another resident (Remergency room for the sundowning and an around 3:00 p.m For days have increased another resident (Remergency room for the sundowning and an around 3:00 p.m.)	s indicated the following: R2 wandered the halls, tried ility multiple times and				
	admission.	R2 paced back and forth				
	from the front door	was exit seeking, and would me the door would open.				
	door was locked and The staff opened the in front of R12. R2 staff. R2 then left R	staff went to R12's room; the d staff could hear R2 talking. e door and found R2 standing started yelling and swearing at 12's room and came back in sisting R12 with toileting.				
	to pull his wheelcha	R2 was fixated on R12 trying ir out of staff's hand. 911 was 2 to the emergency room.				

Minnesota Department of Health

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0 620	removing her from R2 threatened to he into R12's room. - February 5, 2023, frightened of her rowas rummaging thr R13 in the room wit (RN)-A felt scared to want to make R2 methem alone. - February 5, 2023, of the day looking for resident rooms look. - February 6, 2023, the past week with harmful to herself a safe to be in AL and resident rooms look. - February 6, 2023, Geri-psych facility of for 72 hour hold for behavior to self and resident (R got between the resident (R got between the resident to yell at hin respond to her in the self and respond to her in the resident to yell at hin respond to her in the self and respond to her in the s	R2 was upset at staff for R12's room and yelled at staff. Int staff if they did not allow her R13 stated she was ommate R2. R13 stated R2 ough her things and locked h R2. Registered nurse o open it because she did not ad but also felt scared leaving R2 wandered the halls most or R12 and went into other sing for R12. - physician visit sent to ER behaviors that are both s well as others. She is not I needs geri-psych evaluation. MD order- Please send to on physician recommendation diagnoses or harmful				
	resident and kissed	R12. R13. R13.				

Minnesota Department of Health

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	R2 was outside of Formula because she thinks she thinks R12 was	R12's room and yelling it's her significant other and faking his identity.				
	staff's hands and tr	B, - R2 grabbed a hold of ied pulling another resident's eir hand. R2 started yelling at be re-directed.				
		2 was yelling at R12 and told drive her somewhere.				
	a black strap going asked unlicensed p	at 9:53 a.m., R12's room had across the door. The surveyor ersonnel (ULP)-E what the JLP-E stated it was to keep m.				
		at 10:00 a.m., the investigator nd R13 continued to share a				
	R2 was fixated on F husband or boyfrier eloping with R12. R locked herself into I often. RN-A also ve stated when R2 get one to one staffing, also stated there was residents with demand going to move R2 to became busy and of	at 11:05 a.m., RN-A stated R12 and thought he was her ad. RN-A stated R2 tried RN-A also stated R2 had R12's room and yelled at R12 erified R2 kissed R12. RN-A is riled up she needs to have which was not possible. RN-A as not enough training for entia. RN-A stated she was to the other locked unit but lidn't have time. RN-A eidents were not reported to point.				
	she was not aware	, at 11:45 p.m., RN-J stated of the multiple incidents that R2 with R12 and R13. RN-J				

Minnesota Department of Health

STATE FORM 7FS711 If continuation sheet 6 of 52

Minnesota Department of Health

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	verified these incide reported.	ents should have been				
	September 5, 2022 should be made if the abuse, neglect or fine	erable Adult policy dated, indicated a MAARC report here is reason to believe nicial exploitation of a curred and should be reported on provided.				
	TIME PERIOD FOR days	R CORRECTION: Seven (7)				
0 630 SS=H	144G.42 Subd. 6 (b) requirements for re	,	0 630			
	individual abuse prevulnerable adult. The individualized review person's susceptibilities individual, including person's risk of abuse and statements of the taken to minimize the individual including and statements of the individual including and including an analysis and including an analysis and including an analysi	t develop and implement an evention plan for each ne plan shall contain an w or assessment of the lity to abuse by another other vulnerable adults; the sing other vulnerable adults; he specific measures to be ne risk of abuse to that person e adults. For purposes of the lan, abuse includes				
	by: Based on observati review, the licensee	ent is not met as evidenced on, interview and record failed to ensure individual lans (IAPP)s were updated to				

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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

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	residents for three of R13) reviewed.	of three residents (R2, R12,				
	violation that harmed not including serious or a violation that has serious injury, impairs and at a pattern limited number of rethan a limited number.	ed in a level three violation (a ed a resident's health or safety, injury, impairment, or death, as the potential to lead to irment, or death), and was scope (when more than a esidents are affected, more per of staff are involved, or the red repeatedly; but is not ve).				
	The findings include	e:				
	units (Scandia and (large community ro hallway which measin length. The link which and was septexit doors, which re The Scandia unit had occupied by seven	of the facility consisted of two Fjord) connected by a link com). Each unit consisted of a sured approximately 139 feet was approximately 51 feet in earated from the units by fire quired a key code to open. ad 10 resident rooms, and was residents. The Fjord unit also ms, occupied by nine				
		list indicated R2, R12, and rd. R2 and R13 were				
	R2					
	diagnoses of sever	anuary 19, 2023, with e dementia with psychotic havioral disturbance.				
	·	dicated R2 required dication management,				

Minnesota Department of Health

AND PLAN OF COR		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	COMP	SURVEY
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R2's 2023 issue asse or did asse inside R2's asse R2 wother re-dir would night ident R2's indica aftern fixate asse prote R2's - Jan to ge beca - Jan want	lacked behavior admission ass , indicated R2 es and had per ssment identific d not show sign ssment further e, but did not le individual abus ssment dated as physically a resident's who ould try to pus rection. The sa d go into other . The IAPP lace ified vulnerabil 14-day assess ated R2 becan noon and show ed on a specific ssment indicate e and was not ssment did not est other reside progress notes uary 23, 2023, t out of the fact me very upset uary 25, 2023, ed to go outsid ed to go outsid	and bathing. R2's service or management interventions. sessment dated January 19, had cognitive or behavior iods of paranoia. R2's ied R2 as not at risk for abuse as to abuse others. The indicated R2 wandered eave the building. se prevention plan (IAPP) February 3, 2023, indicated abusive and would try and grab eelchairs out of staff's hands. In through staff to get into an and did not respond to ame document indicated R2 resident rooms during the eked interventions for the	0 630			

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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
0 630	Continued From page	ge 9	0 630			
ti	days have increase another resident (R emergency room fo	R2's behaviors the last few d, leading up to R2 pushing 12). R2 was sent to the revaluation and sent back to be was no reason for				
f	rom the front door,	R2 paced back and forth was exit seeking, and would me the door would open.				
I I I S	door was locked an The staff opened th In front of R12. R2 s Staff. R2 then left R	staff went to R12's room; the d staff could hear R2 talking. e door and found R2 standing started yelling and swearing at 12's room and came back in sisting R12 with toileting.				
t	o pull his wheelcha	R2 was fixated on R12 trying ir out of staff's hand. 911 was 2 to the emergency room.				
tl	hat a psychiatric st	R2's guardian was updated ay was being pursued due to rs and fixation on another				
r F	emoving her from I	R2 was upset at staff for R12's room and yelled at staff. Interpretation of the staff if they did not allow her				
f V F	rightened of her room vas rummaging three R13 in the room wite RN)-A felt scared to	R13 stated she was ommate R2. R13 stated R2 ough her things and locked h R2. Registered nurse o open it because she did not ad but also felt scared leaving				

Minnesota Department of Health

NAME OF PROVIDER OR SUPPLIER 14396 GRAND DAKS DRIVE DIAMOND WILLOW OF BAXTER STREET ADDRESS, CITY, STATE, ZIP CODE 14396 GRAND DAKS DRIVE BAXTER, MN 56425 CAMPINION STATEMENT OF DEFICIENCIES DEPROVIDERS PLAN OF CORRECTION SHOULD BE PREED BY PILL PROVIDERS PLAN OF CORRECTION SHOULD BE PREED BY PILL PROVIDERS PLAN OF CORRECTION SHOULD BE PROVIDERS PLAN OF CORRECTION SHOULD BE PROVIDERS PLAN OF CORSS-REFERENCE TO THE APPROPRIATE DATE. O 630		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	COMF	PLETED
DIAMOND WILLOW OF BAXTER 14396 GRAND OAKS DRIVE BAXTER, MN 56425 SUMMARY STATEMENT OF DEFICIENCIES GEACH DEFICIENCY MUST BE PRECEDED BY FULL FRETRY TAG 10 630 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 nand. R2 started yelling at staff and could not be re-directed.			24427	B. WING			
CACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION PREFIX TAG CROSS-REFERENCED TO THE APPROPRIATE DATE			14396 GR	AND OAKS		-	
- 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.	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	ULD BE	COMPLETE
- March 8, 2023, R2 was yelling at R12 and told R12 he needed to drive her somewhere.	0 630	- February 5, 2023, of the day looking for resident rooms look - February 6, 2023, the past week with harmful to herself a safe to be in AL and - February 6, 2023, Geri-psych facility of for 72 hour hold for behavior to self and - February 13- start - February 14, 2023 another resident (R got between the resident (R got between the resident of the same self-and to yell at him respond to her in the was upset that she continued to yell at the continued to yell at the resident and kissed attempted to re-direct R2 was outside of February 28, 2023 resident and kissed attempted to re-direct R2 was outside of February 28, 2023 staff's hands and triwheelchair out of the staff and could not be safe and c	R2 wandered the halls most or R12 and went into other sing for R12. - physician visit sent to ER behaviors that are both s well as others. She is not I needs geri-psych evaluation. MD order- Please send to an physician recommendation diagnoses or harmful others. ed on Depakote twice daily. R2 became angry with 12), and went to hit him. Staff sidents and separated them. R3, R2 was upset with R12 and a because he was unable to e way that she wanted and cannot get into his room. R2 R12. R4, R2 went up to another him without approval. Staff set and she laughed at staff. R12's room and yelling it's her significant other and a faking his identity. R5, - R2 grabbed a hold of see pulling another resident's eir hand. R2 started yelling at the re-directed.	0 630			

Minnesota Department of Health

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	` '	E SURVEY PLETED
		24427	B. WING			C 07/2023
NAME OF	PROVIDER OR SUPPLIER		DORESS, CITY, S	·		
DIAMON	ID WILLOW OF BAXT	FR	, MN 56425	RIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
0 630	Continued From pa	page 11 0 630				
	assessments and uservice plan following seeking behaviors, aggressive behavior potential for harm to incidents that occur R13. On March 3, 2023, ULP-D stated R2 wout R12 because R she knew. ULP-C a R12 and stated the training to care for ULP-C and ULP-D	d lacked evidence of apdates to the IAPP and and the occurance of exit physical and verbal abuse, ars, hospitilizations, and a self or others, regarding the red between R2 and R12 and as aggressive and would seek 2 thought R12 was a person and ULP-D stated R2 pushed y did not have enough staff or residents with behaviors. stated they had tried to behaviors occurred but that did				
	the interventions for redirection. ULP-I so interventions on R2 intervention for behaviors were mo	, at 9:00 a.m., ULP-I stated r R2 included calling 911 and tated there were no 's service plan regarding staff aviors. ULP-I stated R2's re than they could handle. is moved to another unit on				
	R12					
	diagnoses including	on September 2, 2022, with g late onset Alzheimer's navioral disturbances.				
	2023, indicated R12 activities of daily liv	and IAPP dated February 9, 2 required assistance with all ing (ADL)'s. The IAPP at risk to be abused and the				

Minnesota Department of Health

	NT OF DEFICIENCIES NOF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE	LETED
		24427	B. WING		03/0	; 7/2023
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	•	
DIAMON	ID WILLOW OF BAXTI	FR	AND OAKS MN 56425	DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
0 630	Continued From pa	ge 12	0 630			
	completed on admisto assure the vulner IAPP also identified report abuse, was plan. The IAPP didincidents or interverbetween R12 and FR12's progress not information regardinoccurred with R2. R12's medical recompdated assessment following the numer On March 1, 2023, observed to have a door. The surveyor (ULP)-E what the steep in the surveyor (ULP)-E what the steep is a server in the surveyor (ULP)-E what the steep is a server in the surveyor (ULP)-E what the steep is a server in the surveyor (ULP)-E what the steep is a server in the surveyor (ULP)-E what the steep is a server in the surveyor (ULP)-E what the steep is a server in the surveyor (ULP)-E what the steep is a server in the surveyor (ULP)-E what the steep is a server in the server in the steep is a server in the	d an assessment would be ssion and annually thereafter, rabilities were identified. The R12 may not be able to ohysically abusive or on a behavior monitoring not include information of ations for occurrences R2. Be and medical record lackeding the multiple incidents that and ats, including an IAPP, rous incidents with R2. Bat 9:53 a.m., R12's room was black strap going across the asked unlicensed personnel trap was for, and ULP-E p R2 out of R12'S room.				
	R12's record containance assessment or evaluation across R12's door.	ned no information, luation of the strap placed				
	R13					
		on August 23, 2022, with cluded hemiplegia following a of falls.				
	R13 required assist left-sided weakness at risk to be abused was that an assess	December 28, 2022, indicated ance with transfers related to s. The IAPP indicated R13 was and the intervention identified ment would be completed on ually thereafter, to assure the				

Minnesota Department of Health

	NT OF DEFICIENCIES NOF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			71. BOILBING.			
		24427	B. WING			, 7/2023
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
DIAMON	ID WILLOW OF BAXTI	14396 GR	AND OAKS I	DRIVE		
DIAMON	ND WILLOW OF BAX II	BAXTER,	MN 56425			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
0 630	Continued From pa	ge 13	0 630			
	vulnerabilities were	identified.				
		es lacked information ent(s) that occurred with R2.				
	updated assessment following the incider lacked follow up with her safety and this included on R13's L	rd lacked incident reports, hts, including an IAPP, ht(s) with R2. The record also h R13's voiced concern for was also not identified or APP. at 10:00 a.m., the investigator				
	observed that R2 arroom.	nd R13 continued to share a				
	R2 was fixated on Fixated or busband or boyfrier eloping with R12. R locked herself into Foften. RN-A also verstated when R2 get one to one staffing, also stated there was residents with demonstrated became busy and deconfirmed R2, R12, updated as she was that. RN-A also con assessments comp	at 11:05 a.m., RN-A stated R12 and thought he was her ad. RN-A stated R2 tried N-A also stated R2 had R12's room and yelled at R12 rified R2 kissed R12. RN-A is riled up she needs to have which is not possible. RN-A as not enough training for entia. RN-A stated she was the other locked unit but lidn't have time. RN-A and R13's IAPPs were not is not aware she had to do firmed there were no updated leted or interventions added to ensure their safety.				
	she was not aware occurred between F confirmed R2, R12, have been updated	, at 11:45 p.m., RN-J stated of the multiple incidents that R2 with R12 and R13. RN-J and R13's IAPPs should and include interventions. he service plans should have				

Minnesota Department of Health

	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
)
		24427	B. WING			7/2023
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
DIAMON	D WILLOW OF BAXTI	FR	AND OAKS	DRIVE		
		BAXTER,	MN 56425			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUT) CROSS-REFERENCED TO THE APPRODEFICIENCY)	LD BE	(X5) COMPLETE DATE
0 630	Continued From pa	ge 1 4	0 630			
	residents safe. RN-training and competed how staff responded verified the lack of chave lead to an increase lead to an increase to the other unit.	J stated the lack of staff tencies may have impacted to R2's behaviors. RN-J also daily structured activities could rease in R2's behaviors. RN-J hy it took so long to move R2 by dated September 5, 2022,				
	titled, Nursing Asse Prevention Plans w	ssment Individual Abuse and as not updated to the current tes and did not include when				
	TIME PERIOD FOR days	R CORRECTION: Seven (7)				
01320 SS=F	144G.60 Subd. 4 (a) Unlicensed personnel	01320			
	services must have (1) successfully concompetency evaluated services provided by listed in section 144 paragraph (a); or (2) demonstrated completing a written unlicensed personntopics listed in section paragraph (a); and competency on topic subdivision 2, paragraph (8), by a practical section of the competency of the	inpleted a training and tion appropriate to the ty the facility and the topics IG.61, subdivision 2, ompetency by satisfactorily nor oral test on the tasks the lel will perform and on the on 144G.61, subdivision 2, successfully demonstrated ics in section 144G.61, graph (a), clauses (5), (7), and kills test. The lel who only provide assisted in section 144G.08, tes (1) to (5), shall not perform				

Minnesota Department of Health

	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	E CONSTRUCTION	COMP	LETED
					С	
		24427	B. WING		03/0	7/2023
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
DIAMON	D WILLOW OF BAXTI	FR	AND OAKS I MN 56425	DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
01320	Continued From pa	ge 15	01320			
	Based on interview failed to ensure two personnel (ULP)-H and competency everaining topics. This residents living in the violation that did not safety but had the president's health or widespread scope (or represent a system or has the potential the residents).	ed in a level two violation (a t harm a resident's health or ootential to have harmed a safety) and was issued at a when problems are pervasive emic failure that has affected to affect a large portion or all				
	The findings include ULP-H	3.				
	On November 4, 20 (ULP)-H was hired	22, unlicensed personnel as an assisted living sists as-needed as a resident				
		nt record lacked ompleted training and in topics listed in 144G.61,				
	requested. ULP-H's reviewed and all tra	ULP-H's employee record was employee record was ining sign offs were blank. ation training or competencies or to ULP-H providing resident				

Minnesota Department of Health

	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		24427	B. WING		03/0	; 7/2023
NIAME OF			DDECC OITY O	TATE 710 000E	1 00/0	172020
NAME OF	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
DIAMON	D WILLOW OF BAXTI	FR	RAND OAKS I MN 56425	JRIVE		
(V 1) ID	SI IMMARV STA	TEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTI	ION	(V5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
01320	Continued From pa	ge 16	01320			
	she was hired in Occarreceived training or she had provided d	at 9:16 a.m., ULP-H stated ctober 2022, and had not competencies. ULP-H stated irect care to residents n administration without ncies completed.				
	nurse (RN)-A stated	at 12:50 p.m., registered d ULP-H administered seven residents on the unit in				
	ULP-I					
		January 12, 2023, as an dinator and assists as needed ant.				
		employee completed training sting in topics listed in				
	requested. ULP-I's and all training sign no indication trainin	ULP-I's employee file was employee file was reviewed offs were blank. There was g or competencies were providing resident care				
	she did not have an ULP-I stated the lice provided cares incluadministration with	at 10:11 a.m., ULP-I stated by competencies or training. ensee was aware she uding medication but training or competencies. dministered medications this				
	nurse (RN)-A stated	at 10:28 a.m., registered a staff have been allowed to g and competencies. RN-A				

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY
		24427	B. WING		02/0	
		24421			03/0	7/2023
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
DIAMON	D WILLOW OF BAXT	FR	AND OAKS	DRIVE		
		<u> </u>	MN 56425			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
01320	Continued From pa	ige 17	01320			
	confirmed the licens working without train the last survey that RN-A verified ULP-competencies were confirmed staff shout training before provided Nursing 2022, indicated a Reservices to a person completed staff ories provided and demonstrated and demonstrated and demonstrated staff or services and demonstrated and demonstrated and demonstrated staff or services and demonstrated staff or services and demonstrated and demonstrated staff or services and demonstrated st	see was aware staff were ining or competencies since occurred in January 2023. H and ULP-I's training and not completed. RN-A old have all competencies and viding services, including				
	client.	R CORRECTION: Twenty-one				
01330 SS=F	(b) Unlicensed personursing tasks in an (1) have successful demonstrated completing a written section 144G.61, so and (b), and a praction section 144G.61, (a), clauses (5) and (6), and (7), and all perform; (2) satisfy the curre for training or completing assistant	connel performing delegated assisted living facility must: lly completed training and petency by successfully n or oral test of the topics in ubdivision 2, paragraphs (a) tical skills test on tasks listed , subdivision 2, paragraphs (7), and (b), clauses (3), (5), the delegated tasks they will ent requirements of Medicare petency of home health aides its, as provided by Code of s, title 42, section 483 or	01330			

Minnesota Department of Health

STATE FORM 7FS711 If continuation sheet 18 of 52

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY
		24427	B. WING		03/0	7/2023
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE DRIVE		
DIAMON	D WILLOW OF BAXTI	- R	MN 56425			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
01330	training course for rapproved by the control of the	ril 19, 1993, completed a nursing assistants that was mmissioner. ent is not met as evidenced and record review, the facility of two employees, unlicensed and ULP-I) completed training aluations in all required to performing delegated had the potential to affect all the facility. ed in a level two violation (and tharm a resident's health or extential to have harmed a safety) and was issued at a swhen problems are pervasive emic failure that has affected to affect a large portion or all		DELITORIY		
		or to performing delegated				

Minnesota Department of Health

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	.E CONSTRUCTION	COMPI	LETED
		24427	B. WING		03/0	; 7/2023
NAME OF I	PROVIDER OR SUPPLIER		DDESS CITY S	STATE ZID CODE	1 00/0	172020
INAIVIE OF I	PROVIDER OR SUPPLIER		AND OAKS	STATE, ZIP CODE DRIVE		
DIAMON	D WILLOW OF BAXTI	ER	MN 56425			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
01330	Continued From pa	ge 19	01330			
	she was hired in Occarreceived training or she had performed	at 9:16 a.m., ULP-H stated stober 2022, and had not competencies. ULP-H stated medication administration competencies completed.				
	nurse (RN)-A stated	at 12:50 p.m., registered described by the seven residents on the unit in				
	ULP-I					
		January 12, 2023, as an dinator and assists as-needed				
	requested. ULP-I's and all training and blank. There was no	ULP-I's employee file was employee file was reviewed competency sign offs were indication training or completed prior to performing asks.				
	she had not complete training. ULP-I state performed delegate	at 10:11 a.m., ULP-I stated ted any competencies or ed the licensee was aware she d nursing tasks such as tration without training or				
	documentation of p listed in section 144 paragraphs (a), cla	mployee records lacked ractical skills test on tasks IG.61, subdivision 2, uses (5) and (7), and (b), and (7), and (7), and (8),				
	On March 3, 2023,	at 10:28 a.m., registered				

Minnesota Department of Health

AND PLAN OF CORRECTION (X	IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	COMPI	
	24427	B. WING		03/0°	; 7/2023
NAME OF PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	TATE, ZIP CODE		
DIAMOND WILLOW OF BAXTER		AND OAKS I MN 56425	DRIVE		
PREFIX (EACH DEFICIENCY MU	MENT OF DEFICIENCIES UST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF CORRECTION SHOUL CROSS-REFERENCED TO THE APPROPERTION (INC.)	.D BE	(X5) COMPLETE DATE
01330 Continued From page	20	01330			
work without training a confirmed the licensed working without training the last survey that oc RN-A verified ULP-H a competencies were not confirmed staff should training before providing nursing tasks including. The licensee's Orienta Delegated Nursing Se 2022, indicated a RN is services to a person we completed staff oriental provided and demonst to competently follow to client. TIME PERIOD FOR O	ot complete. RN-A have all competencies and ng services and delegated g medication administration. ation and Training-ervices dated September 4, may delegate nursing				
be conducted no more after initiation of service reassessment and more as needed based on control and cannot extend the last date of the (d) For residents only services specified in services specified in services (1) to (5), the individualized initial read and preferences. The	ment and monitoring must than 14 calendar days ces. Ongoing resident onitoring must be conducted changes in the needs of the exceed 90 calendar days he assessment. receiving assisted living section 144G.08, subdivision he facility shall complete an eview of the resident's needs	01620			

Minnesota Department of Health

STATE FORM 7FS711 If continuation sheet 21 of 52

Minnesota Department of Health

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	COMP	LETED
		24427	B. WING		03/0	; 7/2023
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
DIAMON	D WILLOW OF BAXTI	FR .	AND OAKS MN 56425	DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF CORRECTION SHOULD CROSS-REFERENCED TO THE APPROPERTION OF CORRECTION O	D BE	(X5) COMPLETE DATE
01620	Continued From pa		01620			
	be conducted as needs of the rescalendar days from (e) A facility must in of the availability of long-term care consistent care consistent care consistent care consistent acility or the date of resident moves in, which resident care a care can admission assessminitial skin assessminiti	eded based on changes in sident and cannot exceed 90 the date of the last review. form the prospective resident and contact information for sultation services under prior to the date on which a t executes a contract with a n which a prospective whichever is earlier. ent is not met as evidenced and record review, the facility omplete and accurate nent was conducted when an ent was not completed and rk was not thoroughly sulted in failure to identify a lement physician orders, and as to prevent further skin of one resident (R4) with				
	violation that harmed not including serious or a violation that has serious injury, impairs a limited number of a limited number of a limited number of	ed in a level three violation (a ed a resident's health or safety, injury, impairment, or death, as the potential to lead to irment, or death) and was discope (when one or a esidents are affected or one or staff are involved or the red only occasionally).				
	a stage 2 pressure	e: Is indicated January 20, 2023, injury was noted with partial with measurement of 1 cm x				

Minnesota Department of Health

PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPL		NT OF DEFICIENCIES NOF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	` '	E SURVEY PLETED
DIAMOND WILLOW OF BAXTER 14396 GRAND OAKS DRIVE BAXTER, MN 56425			24427	B. WING		03/	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) O1620 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 R4's preadmission assessment dated January	NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) O1620 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	DIAMON	ID WILLOW OF BAXT	FR		PRIVE		
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	PRÉFIX	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	I SHOULD BE	(X5) COMPLETE DATE
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	01620	1 cm x 0.1 cm newled combination of high pressure. R4's discharge insteadated January 31, 2 dressing was applied protective boots should be a service of physic mobility, and cognite pressure injury on February 2023, indicated R4 dressing, bathing, the skin assessment did the pressure injury. R4's admission assessing, bathing, the pressure injury. R4's admission services we three times daily, we transfer assist three did not include more on R4's coccyx, application on R4's coccyx, application on R4's coccyx, application on R4's coccyx, application on R4's representation on R4's coccyx, application on R4's representation on R4's progress notes. R4's progress notes. R4's progress notes.	ly opened likely due to a moisture, friction, and ructions from the hospital 2023, indicated a Mepilex ed to R4's sacrum and heel ould be put on daily. In January 31, 2023, with cal deconditioning, reduced tive impairment. It is assessment dated January formation regarding the R4's sacrum. It is essment dated January 31, is required assistance with ransfers, and ambulation. The d not include identification of the pressure injury plication of protective heel in of R4's heels. It is the pressure injury plication of protective heel in of R4's heels. It is the pressure injury plication of protective heel in of R4's heels. It is the pressure injury plication of protective heel in of R4's heels. It is included the following: It is the pressure requested wound orders were requested wound orders were requested.				

Minnesota Department of Health

NAME OF PROVIDER OR SUPPLIER DIAMOND WILLOW OF BAXTER SUMMARY STATEMENT OF DEPICIENCIES BAXTER, MN 56425 CX4) ID PREFIX REACH CORRECTION AND THE PRECEDED BY PALL PREFIX REACH CORRECTION AND THE PREFIX REACH COMMENT AND THE PREFIX REACH CORRECTION AND THE PREFIX REACH COMMENT AND THE PREFIX REACH CORRECTION AND THE PREFIX REACH COMMENT AND THE PREFIX REACH CORRECTION AND THE PREFIX REACH COMMENT AND THE PREFIX REACH CORRECTION AND THE		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	COMPI	LETED
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PREFIX TAG REGULATORY OR ISC IDENTIFYING INFORMATION) O1620 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 or 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 28, 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			14396 GR	AND OAKS			
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	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE	COMPLETE
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	lightly red. The note reposition every one pressure. - February 20, 2023 the area of pressure increased in size arcm, and another smright of that measur purple areas that we amount of serosang drainage was noted foul odor was noted foul odor was noted. - February 23, 2023 cream to be applied. R4's medical record documentation or in ulcer from upon add 2023-February 6, 2023-February 6, 2023-February 19 documentation of mup related to R4's personal prevent worsening of R4's medical record any interventions the on January 31, 2022 prevent worsening of R4's 14 day assess completed by February 19 documentation of mup related to R4's personal prevent worsening of R4's 14 day assess completed until February 19 documentation of mup related to R4's personal prevent worsening of R4's 14 day assess completed by February 19 documentation of mup related to R4's personal prevent worsening of R4's 14 day assess completed by February 19 documentation of mup related to R4's personal prevent worsening of R4's 14 day assess completed until February 19 documentation of mup related to R4's personal prevent worsening of R4's 14 day assess completed until February 19 documentation of mup related to R4's personal prevent worsening of R4's 14 day assess completed until February 19 documentation of mup related to R4's personal prevent worsening of R4's 14 day assess completed until February 19 documentation of mup related to R4's personal prevent worsening of R4's 14 day assess completed by February 19 documentation of mup related to R4's personal prevent worsening of R4's 14 day assess completed by February 19 documentation of mup related to R4's personal prevent worsening of R4's 14 day assess completed by February 19 documentation of mup related to R4's personal prevent worsening of R4's 14 day assess completed by February 19 documentation of mup related to R4's personal prevent worsening of R4's 14 day assess completed by February 19 documentation of R4's 14 day assess completed by February 19 documentation of R4's 14 day assess	e indicated to continue to e to two hours to offload 3, a progress note indicated e injury had significantly and now measured 2 cm x 3.5 hall area had opened to the ring 0.5 cm x 0.2 cm with ere not blanchable. A small guinous (thin watery pink) on the dressing and a slight l. 4, a new order was added for a to R4's coccyx twice daily. 5, a new order was added for a to R4's coccyx twice daily. 6 did not include dentification of the pressure mission January 31, 223. 7 from February 7, 2023, 2023, lacked nonitoring, treatment, or follow ressure injury. 6 lacked documentation of at were added from admission 3, until February 23, 2023, to of the pressure injury. 7 ment should have been lary 14, 2023, but was not or any 14, 2023, but was not or any 28, 2023. The ed a new vulnerability was and mobility and requiring 1-2 ng, a new pressure ulcer on or essure injury on R4's right				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE : COMPI	
				C	;
	24427	B. WING		03/0	7/2023
NAME OF PROVIDER OR SUPPLIER DIAMOND WILLOW OF BAXTE	14396 GR	DRESS, CITY, S	STATE, ZIP CODE DRIVE		
DIAMOND WILLOW OF BAXTI	BAXTER,	MN 56425			
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
01620 Continued From pa	ge 24	01620			
28, 2023 [despite in January 31, 2023] a turning and reposition assessment indicate coccyx was now a sinjury on R4's heel was admission but did not skin assessment as stated staff noticed. February 6, 2023. For repositioning was as February 8, 2023. For R4's admission their she was continually unlicensed personnounce complete her RN responsibilities and corporate staff did not staffing as she responsibilities and corporate staff did not sage. RN-A ver admission orders as pressure injury and boots were ordered. On March 17, 2023 staffing was a huge weren't getting done this was not brough not aware a skin as upon R4's admission time she was off of	tial admission orders on and staff were to continue the oning schedule. The wound ed the pressure injury on R4's stage 3, and the pressure was a stage one. at 11:05 a.m., registered as she completed the essment prior to R4's ot get a chance to complete a she did not have time. RN-A the pressure injury on RN-A stated turning and dded to the service plan on RN-A stated during the week of the were three admissions and a being pulled to work as an el so she was not able to sponsibilities. RN-A showed ext message, sent on February e staff requesting assistance was not able to complete her admission assessments. The not respond to this text iffied she skimmed over the not was not aware of the was not aware the protective was not aware the protective of the to have been and to her attention. RN-B stated concern and a lot of things that should have been and to her attention. RN-B was sessment was not completed on. RN-B stated during this work and RN-A was very gling and had reached out for				

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					c	;
		24427	B. WING		03/0	7/2023
NAME OF PRO\	/IDER OR SUPPLIER		, ,	STATE, ZIP CODE		
DIAMOND W	ILLOW OF BAXTE	FR .	AND OAKS MN 56425	DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
Or con con R4 into RN con ver RN man recommend to appear	nfirmed a skin as mpleted on pre-a land RN-J stated if a legrity is noted it shows a service pland on a service pland on a service pland on a service pland on a service shows a service the license propriately manage RN will complete pland on a service pland on a service pland on a service pland of a service and a service pland of a service and a service pland of a service and a servi	sessment should have been dmission and admission for an area of impaired skin should be assessed weekly. day assessment should be or to the 14th day. RN-J also an should have been signed. I not remember the text N-A requesting assistance hat was done about this. Assessment policy dated dicated a pre-admission ther information regarding any sues as part of the screening ee can safety and ge skin issue. Upon admission ed the admission assessment in, nutrition and hydration. The ent will be head to toe and the se plan that the RN will resident and for staff to ssessment must be than 14 days after the	01620			
	4G.71 Subd. 7 Deministration	elegation of medication	01750			
to mu (1)	unlicensed persoust ensure that the instructed the ur	n of medications is delegated nnel, the assisted living facility e registered nurse has: nlicensed personnel in the administer the medications,				

Minnesota Department of Health

STATE FORM 7FS711 If continuation sheet 26 of 52

Minnesota Department of Health

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	COMP	SURVEY
		24427	B. WING		03/0) 7/2023
	PROVIDER OR SUPPLIER	14396 GR	DRESS, CITY, S AND OAKS I MN 56425	STATE, ZIP CODE DRIVE		
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROIDEFICIENCY)	.D BE	(X5) COMPLETE DATE
01750	the ability to compe (2) specified, in write each resident and of in the resident's red (3) communicated value about the individual. This MN Requirements by: Based on observation review, the licensed competencies were Nurse prior to delegate medication administration administered medicaffect all residents value administration. This practice resultation including serious or a violation that harmen not including serious or a violation that has serious injury, impaissued at a widesprare pervasive or rephas affected or has portion or all of the This resulted in a in March 3, 2023, at 1. The findings include ULP-H On November 4, 20 (ULP)-H was hired	personnel has demonstrated tently follow the procedures; ing, specific instructions for documented those instructions cords; and with the unlicensed personnel needs of the resident. ent is not met as evidenced on, interview, and record failed to ensure completed by the Registered gating the nursing task of tration, for two of two fiel (ULP-H, ULP-I) who eations. This had a potential to who recieved medication ed in a level three violation (and a resident's health or safety, is injury, impairment, or death, as the potential to lead to irment, or death) and was lead scope (when problems oresent a systemic failure that potential to affect a large residents).	01750			

Minnesota Department of Health

STATE FORM 7FS711 If continuation sheet 27 of 52

Minnesota Department of Health

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	COMP	SURVEY
		24427	B. WING		03/0) 7/2023
	PROVIDER OR SUPPLIER D WILLOW OF BAXTI	14396 GR	DRESS, CITY, S AND OAKS MN 56425	STATE, ZIP CODE DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
01750	she was hired in Occreceived training or medication administ also passed medication without having any completed. On March 2, 2023, requested. ULP-H's reviewed and all trace was no indication and/or medication and/or medication and/or medications for all state last month. ULP-I ULP-I was hired on assisted living coord as a resident assist.	at 9:16 a.m., ULP-H stated ctober 2022, and had not competencies including tration. ULP-I stated she has ations on multiple occasions training or competencies ULP-H's employee record was ining sign offs were blank. ation training or competencies or to providing resident care administration. at 12:50 p.m., registered med ULP-H administered seven residents on the unit in January 12, 2023, as an dinator and assists as needed	01750			
	she had not recieve off or training. ULP- aware she provided administration with	ed any competencies signed of stated the licensee was loares including medication out training or competencies. It is a stated the licensee was loares including medication out training or competencies. It is a stated the licensee was long the licensee was long to the licensee was long to licensee was long the licensee was long to licensee was long the licensee was long th				
	requested. ULP-I's and all training sign no indication trainin	ULP-I's employee file was employee file was reviewed offs were blank. There was g or competencies were providing resident care or tration.				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		24427	B. WING		03/0	7/2023
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
DIAMON	D WILLOW OF BAXTI	ER	AND OAKS I MN 56425	DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
01750	Continued From pa	ge 28	01750			
	·	at 12:50 p.m., RN-A confirmed medications for two residents				
	nurse (RN)-A stated work without training confirmed the license aware staff were we competencies since in January 2023. RN all competencies ar	at 10:28 a.m., registered distaff have been allowed to g and competencies. RN-A see's administration was orking without training or the last survey that occurred N-A verified staff should have not training completed before including medication				
	•	at 10:40 a.m., RN-J also uld be trained and competent ervices.				
	No further informati	on was provided.				
	TIME PERIOD OF	CORRECTION: IMMEDIATE				
	investigator's onsite 2023 and reviewed	noved as confirmed by observation on March 7, by evaluation supervisor on ever noncompliance remains erity of F.				
	TIME PERIOD FOR days	R CORRECTION: Seven (7)				
02310 SS=I	144G.91 Subd. 4 (a services) Appropriate care and	02310			
	living services that	the right to care and assisted are appropriate based on the daccording to an up-to-date				

Minnesota Department of Health

STATE FORM 7FS711 If continuation sheet 29 of 52

Minnesota Department of Health

AND DIAN OF CORRECTION TO IDENTIFICATION NITIMBER:		A. BUILDING:		COMPLETED		
		24427	B. WING		03/0	7/ 2023
	PROVIDER OR SUPPLIER	14396 GR	DRESS, CITY, S AND OAKS I MN 56425	TATE, ZIP CODE ORIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
02310	This MN Requirements by: Based on observation review, the licensed services were provious health care, medical seven out of nine received numbers	ent is not met as evidenced on, interview, and record e failed to ensure care and ded according to acceptable al, or nursing standards for esidents (R1, R3, R5, R6, R7, ilized side rails (bed rails). immediate correction order on :30 p.m., ed in a level three violation (a ed a resident's health or safety, s injury, impairment, or death, as the potential to lead to irment, or death) and was ead scope (when problems bresent a systemic failure that potential to affect a large residents).				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		` '	(X3) DATE SURVEY COMPLETED	
		24427	B. WING	_		C 07/2023
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
DIAMON	D WILLOW OF BAXT	FR	RAND OAKS D MN 56425	PRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
02310	were observed to be not secured to the key out, causing a larger and the mattress. On March 1, 2023, (RN)-A stated main resident beds, but was regarding who often the side rails was regarding who often the side rails were the bed installed or used accommon and the mattructions. RN-A side rails were store obtained, but indicate responsible for the On March 1, 2023, was not responsible and did not know the rails were checked. Checked all of the reconfirmed R1, R3, rails were not secured R1, R3, R5, R6, R7 different types of being current process checked and stated be re-assessed more R3's medical record January 29, 2023, States and R3's medical record January 29, 202	o the mattress. 10:30 a.m., R3's bed rails e loose. The bed rails were bed and were able to be pulled a gap between the side rails at 1:30 p.m., registered nurse tenance puts the side rails on was not sure what the process checked the side rails or how were to be checked. RN-And out. RN-A verified she could rails utilized in the facility were cording to manufacturer was not aware of where the ed or where they were sted maintenance was installation of the side rails. at 3:25 p.m., RN-B stated she for side rail assessments are process for how often side RN-B and the investigator esident side rails which R5, R6, R7, R8, and R9,'s side red and all were very loose. R8, and R9 all utilized and rails. RN-B stated there was in place for side rails to be at the side rails should probably				
	assessment did not	n repositioning. The tindicate which side of the bed was on or if there was use of				

Minnesota Department of Health

STATEMENT OF DEFICIENT AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IULTIPLE CONSTRUCTION LDING: (X3) DATE SURV		
		24427	B. WING			C 07/2023
NAME OF PROVIDER OR S		14396 GR	DRESS, CITY, S AND OAKS MN 56425	STATE, ZIP CODE DRIVE		
PREFIX (EACH D	EFICIENC'	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
"yes" when maintained and also maintained and also mare viewed for Product Sa. The facility the bed rail without that assess and used appropriate of process for On March corporate of process for On March discussed immediate On March requested side rail as guidelines R7, R8, an information investigato On March information investigato On March information investigato The Food and Guide to Be the following used, performation and performation investigators.	de rails. I asked in according any related to the second of the second o	The assessment was marked f the bed rail was installed and ng to manufactuer guidelines es" that the bed rails were calls with the Consumer	02310			

Minnesota Department of Health

TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY)	AND PLAN OF CORRECTION	RECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	COMPL	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 14396 GRAND OAKS DRIVE BAXTER, MN 56425 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 14396 GRAND OAKS DRIVE BAXTER, MN 56425 ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE OATE OATE					C	
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) 14396 GRAND OAKS DRIVE BAXTER, MN 56425 ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE		24427	B. WING	_		
(X4) ID PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) BAXTER, MN 56425 ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETIVE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	NAME OF PROVIDER OR SUPPLIER	R OR SUPPLIER STREET AI	DRESS, CITY, S	STATE, ZIP CODE		
(X4) ID PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) Complete C	DIAMOND WILLOW OF BAYT	OW OF BAXTER 14396 GI	RAND OAKS	DRIVE		
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DEFICIENCY)	DIAMOND WILLOW OF BAX I	BAXTER	MN 56425			
02310 Continued From page 32	PREFIX (EACH DEFICIENC	ACH DEFICIENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE	(X5) COMPLETE DATE
02010 Continued Fibrii page 32	02310 Continued From pa	ued From page 32	02310			
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 occurs, with or without serious injury. This should be done immediately because fatal "repeat" events can occur within minutes of the first episode.	identified; "Patients memory, sleeping, uncontrolled body bed and walk unsate be carefully assess them from harm, so the patient's health determine how best the patient and for manufactur recommendations/ maintaining bed rate and bedside rails to make so correctly and for an and falls. Regardle and/or depth, the best mattress should letentrap a patient's health and remove potent health and remove potent hazards. Inspect, evaluate the equipment or neal without serious injuiting immediately because the patient's process the revaluate the equipment or neal without serious injuiting immediately because the patient's process the revaluate the equipment or neal without serious injuiting immediately because the patient's process the revaluate the equipment or neal without serious injuiting immediately because the patient's process the revaluate the equipment or neal without serious injuiting immediately because the patient's process the revaluate the equipment or neal without serious injuiting immediately because the patient's process the revaluate the equipment or neal without serious injuiting immediately because the patient's process the revaluate the equipment or neal without serious injuiting immediately because the patient's process the revaluate the equipment or neal without serious injuiting immediately because the patient's process the patient's process the revaluate the equipment or neal without serious injuiting immediately because the patient's process the	ed; "Patients who have problems with ry, sleeping, incontinence, pain, prolled body movement, or who get out of a walk unsafely without assistance, must refully assessed for the best ways to keep from harm, such as falling. Assessment by the tient's health care team will help to hine how best to keep the patient safe." Food and Drug Administration (FDA), mmendations for Health Care Providers Bed Rails," dated July 9, 2018, included the right information: follow the health care facility's procedures manufacturer's mendations/specifications for installing and sining bed rails for the particular bed frame redside rails used. In the spect and regularly check the mattress and is to make sure they are still installed thy and for areas of possible entrapment and for a reas of possible entrapment and the sessional leave no gap wide enough to a patient's head or body. Regularly assess that bed rails remain or priately matched to the equipment and to the tient's needs, considering all relevant risk in the spect, evaluate, maintain, and upgrade then the deds/mattresses/bed rails to identify move potential fall and entrapment and to the equipment and to the equipment and to the equipment and to the spect, evaluate, maintain, and upgrade then the equipment if an episode of ment or near-entrapment occurs, with or the serious injury. This should be done liately because fatal "repeat" events can				

Minnesota Department of Health

AND BLAN OF CORRECTION TO IDENTIFICATION NUMBER:		` ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		24427	B. WING		03/0) 7/2023
	PROVIDER OR SUPPLIER	14396 GR	AND OAKS	STATE, ZIP CODE DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	MN 56425 ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	LD BE	(X5) COMPLETE DATE
02310	may be caused by provement or bed provement or water bed. -When in doubt rails for assistance. RN-A and RN-B expregarding the follow provement or an annufacturer's guidelines; and provement or areas of entraprovement or area	pression of the mattress which patient weight, patient position, or by using a specialty in air mattress, mattress pad it, call the manufacturer of the pressed lack of knowledge pring requirements: the documentation of domaintenance according to delines; cition of bed rail and mattress ment, stability, and correct inted; printer should be completed by the safety risks should be sments should be completed by the cumented that bed rails were ained according to the sing Assessment Side Rail 10, 2022, indicated a nursing pleted by the RN prior to the services. The policy did not information regarding the side rails, the specific included in side rail re-assessments are mation about ensuring side and used according to	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					С	
		24427	B. WING		03/0	7/2023
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
DIAMON	D WILLOW OF BAXT	FR	AND OAKS MN 56425	DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
02310	Continued From pa	ige 34	02310			
	TIME PERIOD FOR	R CORRECTION: Immediate				
	onsite observation reviewed by a supe	noved as confirmed with an on March 7, 2023, and rvisor on March 7, 2023, iance remains at a scope and				
	TIME PERIOD FOR	R CORRECTION: Seven (7)				
02320 SS=I		o) Appropriate care and	02320			
	care and other assicentinuity from peo and competent to peo- sufficient numbers	the right to receive health sted living services with ple who are properly trained erform their duties and in to adequately provide the in the assisted living contract n.				
	Based on observation review, the licensed and other assisted by people who were perform their duties adequately provide assisted living control of two residents (Roman registered nurse (Roman regist	ent is not met as evidenced ion, interview, and record e failed to ensure health care living services were provided, e trained and competent to s, and in sufficient numbers to the services agreed to in the ract and service plan for two 1 and R6) reviewed. The RN)-A did not follow R1's med an improper transfer, and was diagnosed with T6 and actures. In addition, service				

Minnesota Department of Health

plans were not followed due to a lack of sufficient

Minnesota Department of Health

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
					C	С	
		24427	B. WING		03/0	7/2023	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
DIAMON	D WILLOW OF BAXTI	14396 GR	AND OAKS	DRIVE			
DIAMON	D WILLOW OF BAXTI	BAXTER,	MN 56425				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
02320	Continued From pa	ge 35	02320				
	education, training,	staff did not have completed or competencies signed off by ed in an immediate order 2023, at 4:30 p.m.					
	violation that harmed not including serious or a violation that has serious injury, impairs are pervasive or repart of the control of the con	ed in a level three violation (a ed a resident's health or safety, injury, impairment, or death, as the potential to lead to irment, or death) and was ead scope (when problems present a systemic failure that potential to affect a large residents).					
	The findings include	e:					
	staffing plan and incorprocess of working plan for staffing to a and services require The email identified residents: Level 1: Residents ambulatory and require moderate not be require moderate not be require frequent supposervation = sever Level 4: Residents and require frequent supposervation = sever be required from the first frequent supposervation = sever be re	the following acuity levels for who were self sufficient, uired minimal nursing care = who are ambulatory, and ursing care = six residents who are non-ambulatory and oportive nursing care and					
	Living Services and February, 1, 2023, i	orm Disclosure of Assisted Amenities (UDALSA) dated ndicated staffing pattern by I in the entryway of the					

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION			E SURVEY PLETED		
		24427	B. WING			C 07/2023
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
DIAMON	D WILLOW OF BAXT	ER	AND OAKS I MN 56425	DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
02320	provided one to two stand lifts, and med A Minnesota Adult A (MAARC) report indevening on January assistance with a treepople were needed member [RN-A] tokethemselves. R1 stand plopped me down, technique where stand the stated since that time pain that is worse we task list indicated R staff with a gait belth mild to moderate be one assist transfer. complained of pain back with movements of the emergent to the emergent to have T6 and T7 of the was the only stand for assistance was unable to get he the other side, so Unidependently with called RN-G and reindependently since On March 1, 2023, personnel (ULP)-G states the other side, so Unidependently with called RN-G and reindependently since On March 1, 2023,	SA also indicated the licensee staff assist transfers, sit to chanical lifts. Abuse Reporting Center dicated on the late afternoon 22, 2023, R1 requested ansfer and told staff two do to transfer her. The staff do R1 they would do it ted the staff picked me up and R1 demonstrated a bear hug aff lifted the top half under ed on her lower back. R1 ne she has had lower back with movement. R1's service 11 required assistance of two 12. Two days later, R1 reported ack pain that started after the 13. The next morning R1 and rated it 10/10 in her low 14. Staff called 911 and R1 was not department. R1 was found compression fractures. at 2:10 p.m., unlicensed stated within the last week aff working on one side of the ed R6 required a hoyer lift with not more with transfers, but ULP-Go telp from the staff working on one ILP-Go transferred R6 a gait belt. ULP-Go stated she ported she had to transfer R6 as she did not have help. at 2:45 p.m., registered nurse				
	completed surround	nternal investigation was ding the incident from the MAARC report and identified				

Minnesota Department of Health

	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY
					c	
		24427	B. WING		03/0	7/2023
	PROVIDER OR SUPPLIER D WILLOW OF BAXTI	14396 GR	AND OAKS	STATE, ZIP CODE DRIVE		
		BAXTER,	MN 56425	_		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
02320	Continued From pa		02320			
	the one assist transservice plan. RN-B but facility wide educompleted. RN-B vulp-G's concern wweekend. RN-B stated ULP-G since she was the cone side of the facilithere was no food fulp-G offered to be text corporate staff about one staff wor read the text that in make meals, answeresident safety". RN requires two staff for should be followed, can they do?" On March 1, 2023, investigator observed on the side of R6's	member that assisted R1 with afer, which did not follow R1's stated RN-A was re-educated acation had not been was asked about staffing and ith limited staff over the ated she received many calls but was not the nurse on-call. It is called and was very upset only staff member working on ity. ULP-G also notified RN-B or the residents to eat and uy the residents food. RN-B and voiced her frustration king alone on one side. RN-B dicated "one person can not er call lights, and ensure I-B verified that if a resident or assistance than that is what but if there is no staff, what at 3: 25 p.m., RN-B and the ed R6's room. R6 was in bed. bed was a wheelchair. R6's clarkets with a gait belt sitting clarkets with a gait belt sitting.				
	on top of the blanke wheelchair and put bed. RN-B confirme been put down whe	clankets with a gait belt sitting ets. RN-B moved R6's down a floor mat next to the ed the floor matt should have an staff assisted R6 to bed as				
	body mechanical lif	ervice plan. R6's hoyer lift (full t) and Broda wheelchair were nd the hoyer was in the lowest red unused.				
	1	at 4:30 p.m., RN-A stated the ration did not want to hire				
	On March 3, 2023,	at 10:28 a.m., registered				

Minnesota Department of Health

MAME OF PROVIDER OR SUPPLIER DIAMOND WILLOW OF BAXTER 14396 GRAND OAKS DRIVE BAXTER, MN 56425 PREFIX TAGX REGULATORY OR LSC IDENTIFYING INFORMATION, TAGY THE 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 and training before providing without training and competencies since the last survey that occurred in January 2023. RN-A confirmed the licensee's 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 evaluation supervisor on March 7, 2023, and reviewed by evaluation supervisor on March 7, 2023, and reviewed by evaluation supervisor on March 7, 2023, however noncompliance remains at a scope and severity of F.		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	COMPI	
NAME OF PROVIDER OR SUPPLIER DIAMOND WILLOW OF BAXTER 14396 GRAND OAKS DRIVE BAXTER, MN 56425			24427	B. WING			
DIAMOND WILLOW OF BAXTER AN	NAME OF			DDESS CITY S	TATE ZID CODE	1 00/0	172020
DIAMOND WILLOW OF BAXTER SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION CRACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) DEFICIENCY TAG DEFICIENCY	NAIVIE OF	PROVIDER OR SUPPLIER		,			
### (EACH DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ### CROSS-REFERENCED TO THE APPROPRIATE COMPUTED TAG	DIAMON	D WILLOW OF BAXTE	FR		DINIVE		
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, and reviewed by evaluation supervisor on March 7, 2023, however noncompliance remains at a scope and severity	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE	COMPLETE
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	02320	Continued From page	ge 38	02320			
TIME PERIOD FOR CORRECTION: Seven (7) days		nurse (RN)-A confir direct care and perform not have the require had not been composeen allowed to work competencies. RN-administration was without training or confirmed staff short training before provided ULP-H and competencies were confirmed staff short training before provided additional for R1 and R6, which March 1, 2023, at 9. The licensee's Service September 4, 2022 provider must impleated by the curron No further information. TIME PERIOD FOR Immediacy was remobservation on Mare evaluation supervision on compliance remof F.	med several staff providing forming delegated tasks did ed training and competencies leted. RN-A stated staff have rk without training and A confirmed the licensee's aware staff were working competencies since the last d in January 2023. RN-A ULP-I's training and not completed. RN-A uld have all competencies and iding services, including tration. at 4:30 p.m. the investigator of the had not been received as of the investigator of the had not been received as of the indicated the home care ement and provide all services ent service plan. On was provided. R CORRECTION: IMMEDIATE noved as confirmed by onsite ch 7, 2023, and reviewed by or on March 7, 2023, however tains at a scope and severity				

Minnesota Department of Health

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	COMP	SURVEY
		24427	B. WING		03/0	7/2023
	PROVIDER OR SUPPLIER D WILLOW OF BAXTI	14396 GR	DRESS, CITY, S AND OAKS I MN 56425	STATE, ZIP CODE DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
02350	Continued From pa	ge 39	02350			
02350 SS=G		ourteous treatment	02350			
		right to be treated with ct, and to have the resident's h respect				
	Based on interview, licensee failed to en was treated with digner the resident on three hours. Staff digner had contacted his wand had to locate state he bed rail, covered was afraid. This practice result violation that harmen of including serious or a violation that harmen of a violation	and record review, the sure one of one resident (R3) unity and respect when staff the bed pan for more than id not assist R3 until after he vife, who drove to the facility taff. R3 was found with his de of the bed, hanging on to d in fecal matter and stated he ed in a level three violation (a ed a resident's health or safety, injury, impairment, or death, as the potential to lead to irment, or death) and was				
	limited number of real a limited number of	d scope (when one or a esidents are affected or one or staff are involved or the ed only occasionally).				
	The findings include	e:				
	_	uded multiple sclerosis tral nervous system) and type				
	R3 had minor forge new situations and required assistance	d January 29, 2023, indicated tfulness, was disoriented with when he first woke up. R3 with all activities of daily living wo staff for assistance with				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ´	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	24427	B. WING		03/0	; 7/2023
NAME OF PROVIDER OR SUPPLIER	.	l	STATE, ZIP CODE	1 00/0	172020
DIAMOND WILLOW OF BAXT	ER	AND OAKS I MN 56425	DRIVE		
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUT CROSS-REFERENCED TO THE APPRODEFICIENCY)	LD BE	(X5) COMPLETE DATE
02350 Continued From pa	ige 40	02350			
hours, and a mech	ileting every two to three anical lift for transfers. R3's he was not able to ambulate				
member (FM)-F sta R3 on February 24 R3 stated "somethat FM-F he had been for help, no one wat out of bed. FM-F sta facility and when sta hanging out of the the side rail with be all over himself, the confused and distre- previously shared re-	at 10:00 a.m., a family ated she received a call from 2023, around 4:30 p.m., and ng bad was going on". R3 told pressing his pendant, yelling a coming, and he was falling ated she then came to the ne arrived, R3's legs were bed and R3 was holding on to oth hands. R3 had fecal matter a sheets, and the floor. R3 was essed. FM-F stated she had multiple concerns with multiple and thought those concerns ddressed.				
FM-F on February identified R3 had b	reviewed that were taken by 24, 2023. The pictures oth legs out of bed and both g on to the side rail.				
were observed to be not secured to the	at 10:30 a.m., R3's bed rails e loose. The bed rails were bed and were able to be pulled appeared by gap between the side rails				
system audits as the did not have the ca	as unable to obtain call light ne licensee's call light system pability to check when or if R3 nt at the time of the incident.				
Video footage revie indicated the follow	ewed from February 24, 2023, ring:				

Minnesota Department of Health

STATE FORM 7FS711 If continuation sheet 41 of 52

Minnesota Department of Health

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	COMP	LETED
		24427	B. WING		03/0) 7/2023
	PROVIDER OR SUPPLIER	14396 GR	DRESS, CITY, S AND OAKS MN 56425	STATE, ZIP CODE DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
02350	1:38 p.m., ULP-I and 2:06 p.m., ULP-L le 2:43 p.m., ULP-G and 3:38 p.m., ULP-M and 4:55 p.m., family mentered R3's room, returned to R3's room, and ULP-I was hired on assisted living coom, as a resident assisted living coom, as a resident assisted ULP-I's employment documentation the and competency tended to the sed pandocument at the sed pan	d ULP-L went into R3's room. If the facility It the facility It inved at the facility. It inved				

Minnesota Department of Health

NAME OF PROVIDER OR SUPPLIER DIAMOND WILLOW OF BAXTER STREET ADDRESS, CITY, STATE, ZIP CODE 14396 GRAND OAKS DRIVE BAXTER, MN 58422. (CALI) GLACH DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG. CONTINUED 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 the licensee's administration without training and competencies. ULP-I stated 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 the licensee's administration was aware staff were working without training or competencies were not completed. RN-A confirmed the licensee's administration was aware staff were working without training or competencies were not completed. RN-A confirmed the licensee's administration was aware staff were working without provided 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 R8 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 immediate interventions were put in place to prevent this from happening again. RN-B stated no immediate interventions were put in place to prevent this from happening again. RN-B stated no immediate interventions were put		NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMF	SURVEY
DIAMOND WILLOW OF BAXTER 14396 GRAND CAKS DRIVE BAXTER, MN 50425 DREETIX SUMMARY STATEMENT OF DEFICIENCIES. MN 50425 DREETIX GRAND CAKE DRIVER MN 50425 DREETIX GRAND CAKE DRIVER DRIVER GRAND CAKE DRIVER DRIVER CROSS-REFERENCED TO THE APPROPRIATE DAMPLETE DRIVER DRIVER CROSS-REFERENCED TO THE APPROPRIATE DAMPLETE DATE DRIVER DR			24427	B. WING			
PREFIX TAG REQULATORY OR LSC IDENTIFYING INFORMATION) 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 shaff 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 noom to assist ULP-G on February 24, 2023. RN-B stated she was summoned to R3's noom to assist ULP-G on February 24, 2023. 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 one had watched the video of the incident until March 6,			14396 GR	AND OAKS			
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 one had watched the video of the incident until March 6,	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	OULD BE	COMPLETE
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	on March 3, 2023, not have any competed the licensee cares including med training or compete administered medical on March 3, 2023, staff have been allowand competencies. licensee's administration working without training or complete all competencies administration. On March 3, 2023, staff have been allowand competencies. licensee's administration working without training the last survey that RN-A verified ULP-were not complete all competence all comp	g or competencies were providing resident care. at 10:11 a.m., stated she did etencies or training. ULP-I was aware she provided dication administration without incies. ULP-I stated she cations this morning at 10:28 a.m., RN-A stated owed to work without training RN-A confirmed the ration was aware staff were ning or competencies since occurred in January 2023. It's training or competencies including medication at 12:00 p.m., RN-B stated do to R3's room to assist y 24, 2023. RN-B stated R3 bed and had fecal matter on g on to his bed rail and was red. RN-B stated she called to happened and was not given in what to do, but filed a use Reporting Center e to what she saw when she RN-B stated no immediate put in place to prevent this ain. RN-B stated no one had of the incident until March 6, re-education or re-training had lowing this incident.	02350			

Minnesota Department of Health

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
					С
		24427	B. WING		03/07/2023
DIAMOND WILLOW OF BAXTER		DRESS, CITY, S AND OAKS MN 56425	STATE, ZIP CODE DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIES (CROSS-REFERENCE)	D BE COMPLETE
02350	staff communication RN-J stated an interimplemented right a from occurring again having completed of a contributing factor. No further information of the licensee's Call September 2, 2022 turns on their call light answered promprly needs met.	d voiced concerns regarding n prior to February 24, 2023. ervention should have been away to prevent this incident in. RN-J stated ULP-I not competencies could have been r to this incident.	02350		
02360	Residents have the sexual, and emotion exploitation; and all covered under the Vince This MN Requirements. The facility failed to reviewed (R2, R3, Ffrom maltreatment.) Findings include: The Minnesota Depissued a determination and the facility was maltreatment, in comparison.	partment of Health (MDH) tion maltreatment occurred,	02360	No Plan of Correction (PoC) requi Please refer to the public maltreat report (report sent separately) for of this tag.	ment

PRINTED: 04/20/2023

	ta Department of He					
AND DIAN OF CORRECTION INTERCATION NUMBER:		1 ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		24427	B. WING			C 07/2023
NAME OF I	PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, S	TATE, ZIP CODE		
DIAMON	D WILLOW OF BAXT	ER	RAND OAKS D R, MN 56425	PRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
02360	Continued From pa	age 44	02360			
	maltreatment repor	t for details				
	The following maltrandrated. HL244278920C/HL HL244278935C/HL HL244278176C/HL	.244275183M				
02480 SS=F	I .	Grievances and inquiries	02480			
	timely response to limitation. Resident every facility must print information of the print information in the print in the print information in th	e right to make and receive a a complaint or inquiry, without as have the right to know, and provide the name and contact berson representing the facility to handle and resolve uiries.				
	by: Based on interview licensee failed to re	ent is not met as evidenced and record review, the espond to the grievances of t (R3) reviewed for grievances				

6899

O-- Marrala 4 0000 4h

The findings include:

of the residents).

On March 1, 2023, the investigator requested to review the licensee's filed grievances.

This practice resulted in a level two violation (a

violation that did not harm a resident's health or

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

safety but had the potential to have harmed a

The licensees' complaint/grievance forms

Minnesota Department of Health STATE FORM

7FS711 If continuation sheet 45 of 52

Minnesota Department of Health

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY
		24427	B. WING		03/0) 7/2023
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
DIAMON	ID WILLOW OF BAXTI	FR	AND OAKS MN 56425	DRIVE		
(V 4) ID	SLIMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	ION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	COMPLETE DATE
02480	Continued From pa	ge 45	02480			
	- On February 17, 2 had concerns regar	tered nurse (RN)- J included: 2023, Family member (FM)-F ding medication ided by unlicensed personnel				
	regarding R3's bloo	2023, FM-F had concerns do sugars and staff not blood glucose of 300.				
	- On February 17, a regarding staffing a	2023, FM-F had concerns nd staffing levels.				
	regarding a delay in ordered antibiotic a	2023, FM-F had concerns the resident receiving an nd a lack of staff arding resident information.				
	she was not aware had shared multiple also stated she sha to sharing her conc	at 10:30 a.m., FM-F stated of the grievance process but concerns with RN-J. FM-F red concerns with RN-A prior erns with RN-J and had not on any of the concerns.				
		evidence of responses to the ots to resolve the grievances.				
		ot implemented resident or ncerns or grievances could d acted upon.				
	assisted living direct should notify the LA LALD-K stated ther with concerns but sas soon as there is aware if all grievance.	at 10:45 a.m., the licensed tor (LALD)-K stated the RN LD of any grievances. e was no timeline to follow up tated they should be dealt with a concern. LALD-K was not ces were documented and regarding grievances should				

Minnesota Department of Health

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED		
		24427	B. WING		03/0°	; 7/2023
			AND OAKS	STATE, ZIP CODE DRIVE	•	
(V 4) ID	STIMMADV STA	TEMENT OF DEFICIENCIES	MN 56425	PROVIDER'S PLAN OF CORRECTION		(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	.D BE	(X5) COMPLETE DATE
02480	Continued From pa	ge 46	02480			
	be followed.					
	· · ·	at 10:50 a.m., RN-J stated s concerns on a complaint ow up with FM-F.				
	dated September 4 possible and reason resolved immediate The same documen	cy titled, Complaint/Grievance, 2022, indicated when nable, the complaint will be ly involving others as needed. In the indicated a prompt applainant will be provided ired in writing.				
	TIME PERIOD FOR	R CORRECTION: seven (7)				
03000 SS=E	626.557 Subd. 3 Tii	ming of report	03000			
	(a) A mandated repletieve that a vulnerable adult has which is not reason immediately report common entry point vulnerable adult soll admitted to a facility required to report stindividual that occurring the individual was another facility and believe the vulnerable previous facility; or (2) the reporter know that the individual is	orter who has reason to rable adult is being or has who has knowledge that a sustained a physical injury ably explained shall the information to the t. If an individual is a lely because the individual is y, a mandated reporter is not uspected maltreatment of the rred prior to admission, as admitted to the facility from the reporter has reason to be adult was maltreated in the ws or has reason to believe a vulnerable adult as defined the subdivision 21, paragraph				

Minnesota Department of Health

STATE FORM 7FS711 If continuation sheet 47 of 52

Minnesota Department of Health

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	E CONSTRUCTION	(X3) DATE : COMPL	
					С	;
		24427	B. WING		03/0	7/2023
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
DIAMON	ID WILLOW OF BAXTI	FR	AND OAKS	DRIVE		
BAXTER			MN 56425			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
03000	Continued From pa	ge 47	03000			
	(a), clause (4). (b) A person not reconstructions of this set described above. (c) Nothing in this set known or suspected knows or has reason been made to the construction of the constru	quired to report under the ection may voluntarily report as ection requires a report of dimaltreatment, if the reporter on to know that a report has ommon entry point. ection shall preclude a eporting to a law enforcement of order who knows or has eat an error under section on 17, paragraph (c), clause make a report under this eporter or a facility, at any time estigation by a lead y will determine or should reported error was not neglect teria under section 626.5572, agraph (c), clause (5), the may provide to the common by to the lead investigative explaining how the event under section 626.5572, agraph (c), clause (5). The gency shall consider this taking an initial disposition of				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			D MINIO			
		24427	B. WING		03/0	7/2023
NAME OF I	PROVIDER OR SUPPLIER		,	STATE, ZIP CODE		
DIAMON	D WILLOW OF BAXTI	FR	AND OAKS MN 56425	DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	_D BE	(X5) COMPLETE DATE
03000	violation that did no safety but had the president's health or cause serious injury was issued at a pat limited number of rethan a limited numb situation has occurr found to be pervasi. The resident list indresided on Fjord. R2 was admitted Jadiagnoses of severed disturbance and be R2's service plan in assistance with med dressing, grooming plan lacked behavior R2's individual abust assessment dated R2 was physically a other resident's who R2 would try to pus other resident room re-direction. The sawould go into other night. The IAPP lactidentified vulnerabiling R2's progress notes. - January 23, 2023,	ed in a level two violation (a tharm a resident's health or potential to have harmed a safety, but was not likely to y, impairment, or death), and tern scope (when more than a esidents are affected, more per of staff are involved, or the red repeatedly; but is not ve). Ilicated R2, R12, and R13 Inuary 19, 2023, with the dementia with psychotic havioral disturbance. Idicated R2 required dication management, and bathing. R2's service for management interventions. In the province of staff's hands are prevention plan (IAPP) frebruary 3, 2023, indicated abusive and would try and grab be elchairs out of staff's hands. The hands are document indicated R2 resident rooms during the ked interventions for the ities. In the province of the halls, tried ility multiple times and	03000			
	booaine very upset	ana nastratoa.				

Minnesota Department of Health

NAME OF PROVIDER OR SUPPLIER DIAMOND WILLOW OF BAXTER SITEMET ADDRESS, CITY, STATE, ZIP CODE 14396 GRAND OAKS DRIVE BAXTER, MN 56425 DAY, MS 56425 DAY, MS 56425 SAMAMAY STATEMENT OF DEPOSITIONS AND ASTER MN 56426 EACH DEPOSITION WILST BE RECEDED BY PILL EACH DEPOSITION WILST BE RECEDED BY THE PREFIX TAG. COOKIETE COMMENT STATEMENT OF DEPOSITIONS AND ASTER MN 56425 CROSS-REFERENCED TO THE APPROPRIATE DEPOSITION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEPOSITION OF SHOULD BE CRO	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
DIAMOND WILLOW OF BAXTER 14396 GRAND OAKS DRIVE BAXTER, MN 58428 SUMMARY STATEMENT OF DEFICIENCIES. CRACH DEFICIENCY MUST BE PRECEDED BY FULL TAGE CRACH CORRECTIVE ACTION HADUL DE COMPLETE TAGE CROSS-REFERENCED TO THE APPROPRIATE CAPITAL TAGE CAP			24427	B. WING			
PRÉFIX TAG REQUIATORY OR LSC (DENTIFYING INFORMATION) O3000 Continued From page 49 - January 25, 2023, R2 was sigliated 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 vame back in while staff were assisting R12 with toileting. - 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	DIAMOND WILLOW OF BAXTER		AND OAKS I				
- 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	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	OULD BE	COMPLETE
- February 5, 2023, R2 wandered the halls most of the day looking for R12 and went into other	03000	- January 25, 2023, wanted to go outside sundowning and an around 3:00 p.m February 26, 2023, from the front door go to the door anytic staff. R2 then left R while staff were assess. - February 2, 2023, to pull his wheelched called to transfer R2 threatened to he into R12's room. - February 4, 2023, removing her from R2 threatened to he into R12's room. - February 5, 2023, frightened of her rowas rummaging thr R13 in the room with (RN)-A felt scared to want to make R2 m them alone. - February 5, 2023, removing her from R2 threatened to he into R12's room.	R2 was agitated twice and le. R2 was showing signs of xiety starting in the afternoon R2's behaviors the last few d, leading up to R2 pushing 12). R2 was sent to the revaluation and sent back to re was no reason for R2 paced back and forth was exit seeking, and would me the door would open. staff went to R12's room; the d staff could hear R2 talking. It door and found R2 standing started yelling and swearing at 12's room and came back in sisting R12 with toileting. R2 was fixated on R12 trying hir out of staff's hand. 911 was 2 to the emergency room. R2 was upset at staff for R12's room and yelled at staff. Lift staff if they did not allow her R13 stated she was formate R2. R13 stated R2 ough her things and locked th R2. Registered nurse of open it because she did not and but also felt scared leaving R2 wandered the halls most				

Minnesota Department of Health

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	COMPI	LETED
		24427	B. WING		03/0	; 7/2023
		24421			03/0	1/2023
NAME OF	PROVIDER OR SUPPLIER		,	STATE, ZIP CODE		
DIAMOND WILLOW OF BAXTER			AND OAKS MN 56425	DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
03000	Continued From pa	ge 50	03000			
	resident rooms look	ring for R12.				
	another resident (R	R2 became angry with 12), and went to hit him. Staff sidents and separated them.				
	started to yell at him respond to her in th	RR2 was upset with R12 and because he was unable to e way that she wanted and cannot get into his room. R2 R12.				
	resident and kissed attempted to re-dire R2 was outside of F	R2 went up to another him without approval. Staff ect and she laughed at staff. R12's room and yelling it's her significant other and faking his identity.				
	staff's hands and tri	s, - R2 grabbed a hold of led pulling another resident's eir hand. R2 started yelling at be re-directed.				
		was yelling at R12 and told lrive her somewhere.				
	a black strap going asked unlicensed p	at 9:53 a.m., R12's room had across the door. The surveyor ersonnel (ULP)-E what the JLP-E stated it was to keep m.				
		at 10:00 a.m., the investigator nd R13 continued to share a				
	R2 was fixated on F	at 11:05 a.m., RN-A stated R12 and thought he was her nd. RN-A stated R2 tried				

Minnesota Department of Health

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	. BUILDING: _	CONSTRUCTION	COMPLETED	
24427 B	WING		C	
24427 B.	. •••••		03/0	7/2023
NAME OF PROVIDER OR SUPPLIER STREET ADDRES				
DIAMOND WILLOW OF BAXTER BAXTER, MN		DRIVE		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL F TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROPED DEFICIENCY)	D BE	(X5) COMPLETE DATE
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			