*Protecting, Maintaining and Improving the Health of All Minnesotans*

# State Rapid Response Investigative Public Report

*Office of Health Facility Complaints*

**Maltreatment Report #:** HL253802460M
**Compliance #:** HL253801620C

**Date Concluded:** June 17, 2024

**Name, Address, and County of Licensee Investigated:**
Diamond Willow Assisted Living
1558 Randolph Road
Detroit Lakes, MN 56501
Becker County

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

**Evaluator's Name:** Barbara Axness, RN
Special Investigator

**Finding:** Substantiated, facility responsibility

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

**Initial Investigation Allegation(s):**
The facility neglected the resident when the resident sustained multiple falls and staff failed to assess and develop new interventions to prevent further falls. In addition the facility failed to ensure medication was administered as prescribed and the resident was not administered scheduled morphine and lorazepam.

**Investigative Findings and Conclusion:**
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The resident sustained multiple falls and the facility failed to investigate the cause, reassess the resident and failed to create and implement new fall interventions following each fall. The resident fell nine times in the month that he died; seven of the falls occurred in the days leading up to his death. In addition, the facility failed to ensure a system was in place to ensure medications were transcribed and administered in accordance with physician's orders and the resident did not receive scheduled pain and anxiety medications.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator also contacted the resident's family, hospice agency staff, and the facility's corporate leadership staff. The investigation included review of the resident records, death record, autopsy report, hospice records, facility incident reports, personnel files, and related facility policies and procedures. Also, the investigator observed medication administration and care and services provided in the facility.

The resident resided in an assisted living memory care unit. The resident's diagnoses included Alzheimer's dementia with anxiety and hypertension (high blood pressure.) The resident's service plan included assistance with dressing, grooming, bathing, repositioning, transfers with a mechanical lift, fall coordination ten times per day, safety checks eight times per day, and medication administration.

The resident's assessment indicated had impaired judgment, anxiety, and agitation. The RN was responsible for the resident's medication management, including ordering medications. The assessment failed to include the resident's risk of falls.

The resident's record contained an order for Morphine (an opioid pain medication) 4 mg every 4 hours around the clock and Lorazepam (an anti-anxiety medication) 1 mg every 4 hours around the clock. Due to a transcription error, the order was not processed correctly, and the medication was only scheduled to be given four times per day, not six as initially prescribed.

Approximately one month before the resident died, he fell in his room and was hospitalized for one week. After returning from the hospital, the resident admitted to hospice services. The day he returned, he fell in his room and the intervention of frequent checks was put into place the next day.

The resident's medical record lacked evidence to support that the intervention of frequent checks were completed by nursing staff.

Seven days before he died, the resident fell but interventions were not put in place until two days later, following a subsequent fall. Nursing staff implemented an intervention of a fall alarm. However, the next day, the resident fell in his room. The alarm did not go off as it was not attached properly, and the resident was observed removing the alarm. Nursing staff failed to assess if an alarm was an appropriate intervention after the resident was able to remove it himself and failed to develop new fall interventions.  Following these falls, the resident was not administered four individual doses of Morphine (for pain) and four individual doses of Lorazepam (for anxiety) over a two-day period due to a transcription error.

The week of the resident's death, the resident fell seven times. Fall incident reports were completed but not reviewed by the nurse until after the resident's death. Fall interventions

were not assessed or evaluated for appropriateness and no new interventions were created or implemented by facility staff.

Nursing staff contacted the hospice agency five days prior to the resident's death due to the resident's behaviors, frequent falls, and concern for his safety. Nursing staff informed the hospice agency that the facility had provided as much intervention as they could support, and they felt that the resident required a higher level of care. Later that evening, a hospice nurse visited the resident and discovered that the resident's pain and anxiety medications were not being administered as prescribed. The order was transcribed incorrectly, and the resident missed 10 doses of medication for pain and anxiety.

Two days before he died, the resident fell while trying to get out of bed. An incident report was created but not reviewed by the nurse until after the resident died. Staff documented that the resident's bed broke, so they placed the resident's mattress on the floor.

Staff interviewed indicated the resident was a frequent faller with behaviors that were hard to control.  Staff stated that the resident's mattress was put on the floor to keep him from falling out of bed but he continued to roll off the mattress so they were directed to get foam pads to put on the floor so the resident wouldn't be able to roll off anything. Staff stated that they used barriers to prevent him from being restless which included pillows, body pillows, blankets, and found anything they could to put underneath him.

During an interview, the resident's power of attorney (POA) stated the resident was at the facility for eight months and "he never really had any care from them as far as meeting his needs or what we were expecting him to get there." The POA stated once the resident went on hospice, it seemed like he got even less care from the facility as they expected hospice to manage his care from that point. The POA stated the resident had countless falls in the days leading up to his death. The POA stated that the night before the resident died, she was in his room when another resident fell. The staff working handed her a syringe of Morphine and told her to administer it so they could attend to the resident who fell. The POA told them she could not administer the medication and they should just give it quick and then go help the resident who fell but they left the room, leaving her with the Morphine. The POA stated staff came two days before the resident died to clean up his room so he would have less fall hazards in his room and "everything was broken. The recliner he broke, he broke a TV stand, the nightstand, a lamp, his Christmas tree, almost everything was broken in that room. How was he able to do so much damage, if they knew he did that, why did they leave him alone?" The POA stated that the resident did not have a bed in the last few days of his life and was left to sleep on a mattress on the floor. The POA stated staff told her the resident fell off the bed, rolled under the bed, and somehow got caught under the cords and pulled them and broke the hospital bed. The POA put a camera in the resident's room after that because they were concerned about what was going on at the facility. The POA stated that not even four minutes after we left the facility, he fell forward, hit his head on the floor and died less than 48 hours later. The POA stated the resident was covered in bruising and provided the investigator with photographs and videos taken two

days before his death. The photos showed the resident had significant bruising, scrapes, and abrasions in various stages of healing. During review of video footage, the resident could be heard moaning out in pain.

During an interview, the facility nurse confirmed incident reports were not reviewed per facility policy, new interventions were not implemented following each fall, and there was no root cause analysis completed. The nurse was not aware that the resident's alarms were not functioning properly and were being unclipped by the resident at the time of several of his falls. The nurse stated the resident kept falling and falling and the facility couldn't provide one on one care, so they felt it was appropriate to discharge the resident. The nurse recalled that the resident was "really uncomfortable" in the last few days of his life and kept rolling off his bed, so they eventually put his mattress on the floor. The nurse stated she bought a pillow to help keep him from rolling off the edge of the mattress and in the bed. The nurse did not consider the pillow a restraint but indicated it was for his safety, so that he wasn't falling since staff couldn't provide one on one care. The nurse did not complete an assessment to evaluate the pillow as a possible restraint.

During an interview with the facility's corporate leadership, they stated they expected nursing staff to review all incident reports within 24 hours and implement interventions to prevent future falls. Corporate leadership staff could not explain why the nurse failed to take action related to the resident's ongoing falls.

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

**Action taken by facility:**

No action taken.

**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
Becker County Attorney
Detroit Lakes City Attorney
Detroit Lakes Police Department
Minnesota Board of Executives for Long Term Services and Supports
Minnesota Board of Nursing
Medical Examiner

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 25380 | A. BUILDING: _____ B. WING _____ | C 04/09/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| DIAMOND WILLOW ASSISTED LIVING | 1558 RANDOLPH ROAD DETROIT LAKES, MN 56501 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
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| 0 000 | Initial Comments<br><br>******ATTENTION******<br><br>ASSISTED LIVING PROVIDER CORRECTION ORDER<br><br>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation.<br><br>Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance.<br><br>INITIAL COMMENTS:<br><br>#HL253802460M/#HL253801620C<br><br>On April 2, 2024, through April 9, 2024, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 27 residents receiving services under the provider's Assisted Living with Dementia Care license.<br><br>The following immediate correction order is issued for #HL253802460M/#HL253801620C, tag identification 2310.<br><br>The following correction orders are issued for #HL253802460M/#HL253801620C, tag identification 0430, 0490, 0510, 0800, 1460, 1690, 1940, 1950, 2320, 2360, 2410, 2430, 2480, and 3100 | 0 000 | Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction.<br><br>PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.<br><br>The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3. | |

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| 0 250 | Continued From page 1 | 0 250 | | |
| 0 250 SS=F | 144G.20 Subdivision 1 Conditions<br><br>(a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility:<br>(1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules;<br>(2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services;<br>(3) performs any act detrimental to the health, safety, and welfare of a resident;<br>(4) obtains the license by fraud or misrepresentation;<br>(5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter;<br>(6) denies representatives of the department access to any part of the facility's books, records, files, or employees;<br>(7) interferes with or impedes a representative of the department in contacting the facility's residents;<br>(8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4, or interferes with or impedes access by the Office of Ombudsman for Mental Health and Developmental Disabilities according to section 245.94, subdivision 1;<br>(9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; | 0 250 | | |

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| 0 250 | Continued From page 2<br><br>(10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter;<br>(11) refuses to initiate a background study under section 144.057 or 245A.04;<br>(12) fails to timely pay any fines assessed by the commissioner;<br>(13) violates any local, city, or township ordinance relating to housing or assisted living services;<br>(14) has repeated incidents of personnel performing services beyond their competency level; or<br>(15) has operated beyond the scope of the assisted living facility's license category.<br>(b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure the management officials who were in charge of the day-to-day operations and responsible for the resident's assisted living services, understood all of the assisted living facility regulations. This had the potential to affect all residents.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).<br><br>The findings include: | 0 250 | | |

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| 0 250 | Continued From page 3<br><br>The licensee's "Application for Assisted Living License", section titled "Official Verification of Owner or Authorized Agent", (page four and five of the application), identified, "I certify I have read and understand the following:" [a check mark was placed before each of the following]:<br>- I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45 (opens in a new window), my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17 (opens in a new window).<br>- I have read and fully understand Minn. Stat. sect. 144G.80 (opens in a new window), 144G.81 (opens in a new window). and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22 (opens in a new window), my building(s) must comply with these sections if applicable.<br>- Assisted Living Licensure statutes in Minn. Stat. chpt. 144G (opens in a new window).<br>- Assisted Living Licensure rules in Minnesota Rules, chpt. 4659 (proposed and not final) (opens in a new window).<br>- Reporting of Maltreatment of Vulnerable Adults (opens in a new window).<br>- Electronic Monitoring in Certain Facilities (opens in a new window)."<br>- "I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G (opens in a new window), and Minnesota Rules, chapter 4659 (proposed and not final) (opens in a new window), governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract."<br>- "I have examined this application and all attachments, and checked the above boxes | 0 250 | | |

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| 0 250 | Continued From page 4<br><br>indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct and complete. I will notify MDH, in writing, of any changes to this information as required."<br>- I attest to have all required policies and procedures of Minn. Stat. chapter 144G (opens in new window). and Minn. Rules chapter 4659 (proposed and not final) (opens in new window), in place upon licensure and to keep them current as applicable."<br><br>Page six was electronically signed by the authorized agent on October 23, 2023.<br><br>The licensee had an assisted living with dementia care license reissued, effective January 1, 2024.<br><br>The licensee failed to ensure the following policies and procedures were developed and/or implemented:<br>- orientation, training, and competency evaluations of staff, and a process for evaluating staff performance;<br>- handling complaints regarding staff or services provided by staff;<br>- conducting initial and ongoing resident evaluations and assessments of resident needs;<br>- orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; and<br>- medication and treatment management.<br><br>As a result of the survey, the following correction orders were issued, 0430, 0490, 0510, 0800, 1460, 1690, 1940, 1950, 2310, 2320, 2360, 2410, 2430, 2480, and 3100, which indicated the licensee's understanding of the Minnesota | 0 250 | | |

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| 0 250 | Continued From page 5<br><br>statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.01 to 144G.95.<br><br>On April 9, 2024, at 5:30 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A confirmed there were several systemic issues impacting operations at the facility.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 250 | | |
| 0 450 SS=F | 144G.41 Subdivision 1 Minimum requirements<br><br>All assisted living facilities shall:<br>(1) distribute to residents the assisted living bill of rights;<br>(2) provide services in a manner that complies with the Nurse Practice Act in sections 148.171 to 148.285;<br>(3) utilize a person-centered planning and service delivery process;<br>(4) have and maintain a system for delegation of health care activities to unlicensed personnel by a registered nurse, including supervision and evaluation of the delegated activities as required by the Nurse Practice Act in sections 148.171 to 148.285;<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to follow up on concerns brought forward related to resident care and the service delivery process and failed to provide services in a person-centered manner for | 0 450 | | |

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| 0 450 | Continued From page 6<br>two of three residents reviewed (R2, R6).<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>R2<br>Facility staff failed to ensure person-centered planning and service delivery when hospice orders were not implemented or included on R2's service plan.<br><br>R2's diagnoses included type two diabetes and congestive heart failure.<br><br>R2's service plan dated February 28, 2023, indicated the resident received assistance with dressing, grooming, bathing, fall coordination, and medication administration.<br><br>R2's most recent assessment dated February 18, 2024, indicated the resident could walk independently but could need an assist of one for transfers at times. The resident required assistance with toileting.<br><br>R2's hospice orders contained an order written on March 4, 2024, which read "do not administer OJ [orange juice] due to side effect of loose stools." The order sheet had a red stamper on it initialing off it was processed and noted on March 4, 2023 (sic). | 0 450 | | |

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| 0 450 | Continued From page 7<br><br>Facility staff failed to process an order written by hospice which indicated the resident was not to be served orange juice as it caused loose stools.<br><br>R2's most recent assessment dated February 18, 2024, lacked any directions on restrictions for orange juice.<br><br>R2's progress notes indicated the resident was given orange juice on April 7, 2024, due to having low blood sugar.<br><br>On April 9, 2024, at 9:30 a.m., hospice nurse (HN)-M stated she had told the facility staff on multiple occasions that the resident should not be served orange juice because it would cause loose stools. HN-M stated she would get frustrated with the facility when they would provide orange juice for low blood sugars because there are a lot of other options to help with increasing blood sugar and no one ever seemed to remember she shouldn't be served it.<br><br>On April 9, 2024, at 10:25 a.m., ULP-O stated she would give the resident orange juice and was not aware of any restrictions or reasons why the resident couldn't have orange juice.<br><br>On April 9, 2024, at 11:05 a.m., ULP-N stated she would give the resident orange juice and was not aware of any restrictions or reasons why the resident couldn't have orange juice.<br><br>On April 9, 2024, at 5:20 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A confirmed she would have been the one who signed off on the stamper for the March 4th order but did not recall seeing an order indicating the resident should not have orange | 0 450 | | |

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| 0 450 | Continued From page 8<br><br>juice. LALD/CNS-A confirmed she was not aware of the order until it was brought up by the investigator.<br><br>R6<br>Facility staff failed to honor the resident's preference of times for a bath and also failed to accommodate a request by a resident to have a bath after she reported feeling dirty.<br><br>R6's diagnoses included history of stroke, weakness, and osteoarthritis.<br><br>R6's service plan was requested, but a care plan was provided.<br><br>R6's most recent assessment dated February 23, 2024, indicated the resident needed "significant bathing assist (staff does more than resident, or more than 1 staff is required.)" On non-bath days, staff were to assure the resident got a partial bed bath with cares to include face, hands, armpits, chest, abdominal folds, legs, feet, and peri area. The resident used a mechanical lift for transfers.<br><br>R6's Service Recap Summary for March 2024, indicated the resident had a weekly bath on Wednesdays on the PM shift (2:00 p.m.-10:30 p.m.) A bath was documented as completed on March 6, refused on March 13, refused on March 20, and completed on March 27.<br><br>R6's Service Recap Summary for April 2024 lacked documentation of baths.<br><br>On April 2, 2024, at 2:20 p.m., ULP-B told another staff member that R6 did not get her bath today as they didn't have time, "but it wasn't her bath day today anyways." During that conversation, ULP-B asked another staff member who was | 0 450 | | |

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| 0 450 | Continued From page 9<br><br>across the hallway if a resident had a bowel movement that day in front of four residents and an outside service provider who was walking with another resident. The other staff member replied that the resident had not had a bowel movement.<br><br>On April 2, 2024, at 3:00 p.m., R6 stated she had wanted a bath today but "I haven't had one yet now and it's getting late, so I probably won't. I feel dirty, it's so warm in here at night, I get sweaty at night." R6 stated she had a preference of having a bath at 1:00 p.m. and that was rarely honored. R6 stated she has refused baths because staff came too late in the evening to offer a bath and she didn't want to take a bath that late. R6 stated most of the staff were helpful and tried to honor her requests but "some will just say you went to the bathroom an hour ago and are very sharp. I tell them that doesn't matter because my bladder says I have to go. Staff will tell me that I'm not the only one here and I know that but I'm here because I need help."<br><br>On April 3, 2024, at 7:35 a.m., corporate clinical director (CCD)-E confirmed the observations would not reflect person centered care.<br><br>The licensee's Bill of Rights policy last updated October 11, 2023, indicated staff would be trained on the concepts/rights contained in the Bill of Rights.<br><br>FAMILY CONCERNS<br><br>On April 8, 2024, at 9:00 a.m., family member (FM)-J stated they have brought concerns forward to the facility on a few issues. FM-J stated they've had to make their mom toast because no one brought her breakfast or they'll have to wait extended period of time for someone | 0 450 | | |

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| 0 450 | Continued From page 10<br><br>to help take her to the bathroom. FM-J stated they were visiting one day and her mom stated she had to use the bathroom so they went to go find someone. FM-J stated they found a staff member mopping the floor and they told her the resident needed to use the bathroom but "the girl said I'm busy now." FM-J stated they went to run an errand and when they came back 45 minutes later, the resident was still waiting to use the bathroom. FM-J stated, "I'm paying a lot of money for her to be here, for there to be someone to help her." FM-J stated she has brought up concerns of only one staff member working on their side or food quality of the meals and has been told "they're working on it."<br><br>On April 8, 2024, at 9:45 a.m., family member (FM)-H stated she has brought up many concerns about care at the facility and issues keep happening. FM-H stated she visits occasionally but her other siblings visit more often and they will often tell her about concerns they see while visiting. FM-H stated recently, her dad asked to go to the bathroom so someone went to go ask a caregiver for help. FM-H stated they were told, "we just changed him not that long ago, he doesn't have to go right now. He had a depend (incontinent product) on, he can just go in his depend." FM-H stated, "I'm sorry but that's called irresponsible care, it's abuse of an elderly person who needs your help." FM-H stated they saw a staff member sitting in the common area crocheting once and not paying attention to residents. FM-H stated "That's why we put them here, we thought they'd get good care." FM-H stated there are many times they're not able to locate a staff member and staff give the impression they're only there for a paycheck. FM-H stated she had some recent concerns with a urinary tract infection not being addressed | 0 450 | | |

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| 0 450 | Continued From page 11<br><br>timely for her mom. "I understand there's not a nurse on duty all the time but they have the ability to call someone to tell them what to do, they did nothing."<br><br>On April 8, 2024, at 10:10 a.m. family member (FM)-K stated she had many concerns about the facility and that she had been trying to get the resident placed elsewhere. FM-K stated she is frequently called to get supplies because they ran out and she was just called on Friday evening to see if she could go pick up a blood glucose sensor for the facility. FM-K stated the resident often gets anxious because call lights take a long time to answer and they just "don't trust that facility, there's no staff trained on what to do." FM-K stated she has come to the facility on several occasions and witnessed staff standing outside vaping, bottles of medications sitting unattended on medication carts, and had other residents approach her with concerns. FM-K stated she was told by a staff member once that she was "not the only person running into problems with the facility not getting medications delivered on time."<br><br>On April 8, 2024, R1's power of attorney (POA)-L stated the resident was at the facility for eight months and "he never really had any care from them as far as meeting his needs or what we were expecting him to get there." POA-L stated she would often come visit the resident and he would be only wearing a depends because all his clothing was missing. POA-L stated she had filed numerous complaints on missing clothing and they had to go to another resident's room and borrow clothes so he could get dressed to go out for an appointment. POA-L stated she was told it was not the facility's responsibility if he was missing clothes because the resident was | 0 450 | | |

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| 0 450 | Continued From page 12<br><br>apparently throwing them away but she told them, "This is a memory care facility, he doesn't know what he's doing." POA-L stated she went in his room one day and noticed poop smeared on the wall and the staff said he had done that today and it'd get cleaned up. POA-L stated she came back five or seven days later and the same poop was still smeared on the walls. POA-L stated she asked them about it and they'd say "we can't go in his room, he gets too agitated. So, he was living in filth the whole time he lived there. We had to throw away the brand new recliner we bought when we moved in because it was so full of fecal matter. They never cleaned it. It was brand new 8 months ago but he was sitting full of fecal matter." POA-L stated once R1 went on hospice, it seemed like he got even less care from the facility as they expected hospice to manage his care from that point. POA-L stated R1 had countless falls in the days leading up to his death and "I don't know what the truth is. It's hard for me to sort through everything. The staff gave me way different information than hospice did, versus what LALD/CNS-A said versus what Diamond Willow corporate management said. It's so hard to judge the truth over this situation." POA-L stated the night before the resident died, she was in his room when another resident fell. The staff working handed her a syringe of Morphine and told her to administer it so they could go attend to the resident who fell. POA-L stated she told them she could not administer the medication and they should just give it quick and then go help the resident who fell but they left the room, leaving her with the Morphine. POA-L stated they came on February 25, 2024, to clean up his room so he would have less fall hazards in his room and "everything was broken. The recliner her broke, he broke a TV stand, the nightstand, a lamp, his Christmas tree, almost everything was broken in | 0 450 | | |

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| 0 450 | Continued From page 13<br><br>that room. How was he able to do so much damage, if they knew he did that, why did they leave him alone?" POA-L stated she asked staff about the hospital bed and they told her he had broken that too and said "he fell off the bed, rolled under the bed, and somehow got caught under the cords and pulled them and broke the hospital bed." POA-L stated the resident did not have a bed the last few days of his life and was left to sleep on a mattress on the floor. POA-L stated they decided to go out and get a camera for the resident's room after that because they were concerned over what was going on at the facility. POA-L stated "not even four minutes after we left the facility, he fell forward, hit his head on the floor and died less than 48 hours later." POA-L stated she heard staff on camera discussing why certain falls were not reported to R1's family and they had figured the resident fell anywhere from 10-17 times over the weekend before he died.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 450 | | |
| 0 490 SS=F | 144G.41 Subd 1 (13) (ii)-(vii) Minimum requirements<br><br>(iv) upon the request of the resident, provide direct or reasonable assistance with arranging for transportation to medical and social services appointments, shopping, and other recreation, and provide the name of or other identifying information about the persons responsible for providing this assistance;<br>(v) upon the request of the resident, provide reasonable assistance with accessing community resources and social services available in the | 0 490 | | |

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| 0 490 | Continued From page 14<br><br>community, and provide the name of or other identifying information about persons responsible for providing this assistance;<br>(vi) provide culturally sensitive programs; and<br>(vii) have a daily program of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs, and that creates opportunities for active participation in the community at large; and<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to have daily programs of social and recreational activities based on individual and group interests, physical, mental, and psychosocial needs. This had the potential to affect all residents.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>On April 2, 2024, an activities calendar for the month was observed in the common areas of both of the facility's households. The activities calendar indicated there were two activities scheduled for April 2nd, a movie at 10:00 a.m. and yoga at 4:00 p.m.<br><br>The investigator walked through both sides of the facility at 10:10 a.m. and 4:15 p.m. and did not | 0 490 | | |

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| 0 490 | Continued From page 15<br><br>observe any activities or coordinated group activities being held.<br><br>The calendar for April 2024 included two activities per day which were the same each week. Monday activities included manicures and coloring, Tuesday activities were movies and yoga, Wednesday activities were ball toss and bean bag toss, Thursday activities were making cookies and one on one visits, Friday activities included music and bingo, Saturday activities were salon and cards, and Sunday activities were church and movie.<br><br>On April 8, 2024, at 10:05 a.m., family member (FM)-K stated she visits the facility often and "they have no activities you can only do so much coloring or listening to country music. Maybe they could do something more mind stimulating."<br><br>On April 9, 2024, at 5:20 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated her expectation was the house coordinator would do activities as there was a house coordinator for each side. LALD/CNS-A stated sometimes the house coordinator was pulled to the floor or one wasn't in so they would be responsible for delegating activities to the unlicensed staff.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 490 | | |
| 0 510 SS=F | 144G.41 Subd. 3 Infection control program<br><br>(a) All assisted living facilities must establish and maintain an infection control program that | 0 510 | | |

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| 0 510 | Continued From page 16<br><br>complies with accepted health care, medical, and nursing standards for infection control.<br>(b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities.<br>(c) The facility must maintain written evidence of compliance with this subdivision.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program to comply with accepted health care, medical, and nursing standards for infection control and current recommendations for hand hygiene. This had the potential to affect all the licensee's residents, staff, and visitors.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).<br><br>The findings include:<br><br>On April 2, 2024, at 11:20 a.m., ULP-B was observed using her personal cell phone to access the facility's electronic medical record to administer medications. The personal cell phone was observed to have a fabric/leather like cover on it which included a flap that when opened, | 0 510 | | |

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| 0 510 | Continued From page 17<br><br>contained several credit and debit cards. Additional attachments on the phone case included key chains and car keys. The personal cell phone or the case covering it was not sanitized at any point during ongoing observations on April 2, 2024. ULP-B set up medications and brought them to the resident to administer. At no point in the process did ULP-B perform hand hygiene.<br><br>On April 2, 2024, at 11:25 a.m., ULP-B returned to the cart and accessed the electronic record on her personal phone. ULP-B set up another resident's medications and brought them to the resident to administer. At no point in the process did ULP-B perform hand hygiene.<br><br>On April 2, 2024, at 11:35 a.m., ULP-B returned to the cart and accessed the electronic record on her personal phone, set-up another resident's medications and brought them to the resident to administer. At no point in the process did ULP-B perform hand hygiene.<br><br>On April 2, 2024, at 11:40 a.m., ULP-B was observed performing ostomy cares on R3. ULP-B failed to perform hand hygiene before beginning the process and donning gloves. After emptying out a soiled ostomy bag containing bowel movement, ULP-B failed to wash her hands and continued to provide cares, including securing a brace to the resident's leg. ULP-G was also in the room and failed to perform hand hygiene upon entering the room. ULP-B did not wash her hands until after she had brought garbage down to the laundry room.<br><br>On April 2, 2024, at 11:50 a.m., ULP-B was observed preparing medications to administer to R2. ULP-B used her personal cell phone to | 0 510 | | |

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| 0 510 | Continued From page 18<br><br>access the facility's electronic medical record. ULP-B failed to perform hand hygiene before administering insulin to R2.<br><br>On April 3, 2024, at 7:35 a.m. the corporate clinical director (CCD)-E confirmed the facility should educate staff to sanitize when entering and leaving as well as when administering medications; before med pass starts and after meds are given, unless if hands are visible soiled.<br><br>The licensee's Hand Washing policy dated February 7, 2023, indicated hand washing would be performed by all employees, as necessary, between tasks and procedures, and after bathroom use to prevent cross contamination.<br><br>The Center of Disease Control (CDC) Core Infection Prevention and Control Practices regarding hand hygiene dated November 29, 2022, recommends healthcare personnel should use an alcohol-based rub or wash with soap and water for the following clinical indications: immediately before touching a patient, before performing aseptic task or handling invasive medical devices, before moving from work on a soiled body site to a clean body site on the same patient, after touching a patient or the patient's immediate environment, after contact with blood, body fluids, or contaminated services, and immediately after glove removal.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 510 | | |
| 0 800 SS=F | 144G.45 Subd. 2 (a) (4) Fire protection and physical environment | 0 800 | | |

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| 0 800 | Continued From page 19<br><br>(4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee failed to provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>On April 2, 2024, at 10:20 a.m., the investigator observed the door connecting the Burlington unit and the common area propped open by a large exercise bike. A panel on the door indicated it was a listed fire door with a 20 minute rating. Fire doors must be installed and maintained as designed to protect the opening in which they were installed and to protect adjacent spaces. Wedging fire doors in the open position prohibits the required operation and closing feature of the | 0 800 | | |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
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| 0 800 | Continued From page 20<br>door.<br><br>On April 2, 2024, at 10:40 a.m., the investigator walked through the building with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A. LALD/CNS-A confirmed the door was a fire rated door and should not be propped open.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 800 | | |
| 01460 SS=F | 144G.63 Subdivision 1 Orientation of staff and supervisors<br><br>All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure orientation to assisted living licensing requirements and regulations was completed for one of one employees (licensed practical nurse (LPN)-D). This has the potential to affect all residents.<br><br>This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and | 01460 | | |

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| 01460 | Continued From page 21<br><br>was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>LPN-D was hired on December 18, 2023, to provide assisted living services. LPN-D resigned with a one day notice on February 27, 2024.<br><br>LPN-D's employee record contained a transcript of online learning courses completed by LPN-D as part of her orientation process. Online courses completed included training on dementia, the Bill of Rights, customer service, emergency preparedness, a guide to assisted living, dining, nutrition, and food safety, documenting, observing, and reporting, infection control, and professional boundaries.<br><br>LPN-D's employee record contained a Personnel File Turn-Around indicating the employee had completed online education videos. A section titled Competency Signature Pages was marked NA (not applicable). LPN-D's employee record lacked evidence of an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person. LPN-D's record lacked training on facility specific processes including processing medication orders.<br><br>On February 2, 2024, operations associate (OA)-F emailed LPN-D, with LALD/CNS-A copied on the message, writing "Looking into more training for you, can you give me a list of duties/items that need more training?..." LPN-D replied to the email that same day writing, "The process for medication ordering, setup, checking | 01460 | | |

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| 01460 | Continued From page 22<br><br>med carts, narc box, cycle meds, etc.; we seem to be having a lot of meds that are being missed or out; it gets missed because there is not one standard process in place...Still waiting on the official offer letter with conditions on which I accepted this position!"<br><br>On February 26, 2024, LALD/CNS-A sent a text message to LPN-D which read, "I have been up all night worrying about what the hell I am going to do. I know they [hospice provider] will be filing a report on this [a medication error] and I most likely have to. [Another resident's] cycle meds are not checked in or in cart. He missed doses, [another resident] ran out of gabapentin, it was locked up, there is traxadone 100 mg in the cart for [another resident] and rtasks says 50 [mg]. Thank God [a ULP] caught that and split the pill. When do I get to study for my test Wednesday?" LPN-D replied on February 27, 2024, writing, "Just to clarify, you are filing a report against me when I was never given proper/adequate medication training?" LALD/CNS-A replied, "I have to file a report either way. If u [you] wa t (sic) more training u [you] can have more training, I am not going to train on basic things such as processing an order. That is learned in nursing school and is a basic skill."<br><br>LPN-D's employee record contained a copy of an email dated February 27, 2024, that LPN-D sent to LALD/CNS-A, CCD-E, and another corporate staff member. The email subject was "Resignation" and read, "Due to lack of training opportunities and staffing issues, among other things; this will serve as my official letter of resignation, my last day will be tomorrow, 2/28,"<br><br>On April 3, 2024, at 7:30 a.m., corporate clinical director (CCD)-E stated she thought LPN-D had | 01460 | | |

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| 01460 | Continued From page 23<br><br>been trained on the medication order process as the facility used a stamper method and had a process in place specific to the facility for processing orders. CCD-E stated she would have expected LPN-D was trained on the facility's process for implementing orders. CCD-E stated LALD/CNS-A was "driving the training" for LPN-D and a LPN from a sister facility also helped with some training.<br><br>On April 3, 2024, at 1:20 p.m., LPN-D stated she was not provided with proper or adequate training and that was why she quit. LPN-D stated she had been scheduled for training initially but got sick so it had to be rescheduled and it never got rescheduled. LPN-D stated she had voiced concerns to LALD/CNS-A and had asked for more training but LALD/CNS-A never followed up on anything. LPN-D stated the overall medication management process "was a disaster" and she had brought up ideas on how to change the process to LALD/CNS-A a few times but nothing was implemented. LPN-D stated she was uncomfortable with having her nursing license affiliated with practices at the facility and felt she had no other option but to quit.<br><br>On April 3, 2024, at 5:33 p.m., CCD-E confirmed they were not able to locate any additional documented training for LPN-D.<br><br>On April 4, 2024, at 10:15 a.m., CCD-E stated "In hindsight, it should have been a more formal orientation." CCD-E stated she knew LPN-D reviewed policies in their electronic medical record and "she acknowledged reading them and that she understood them." CCD-E was asked if that would be sufficient training and stated, "I would have liked more training after that." | 01460 | | |

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| 01460 | Continued From page 24<br><br>On April 4, 2024, at 2:05 p.m., operations associate (OA)-F stated the individual sites handled training needs but if anyone needed help with setting up training she could help coordinate it. OA-F stated she had reached out to help get LPN-D more training early February and they got something scheduled for LPN-D to visit a sister facility on February 7th, however LPN-D got COVID-19 and was not able to make the training. OA-F stated LPN-D never contacted her again to set up a new training date and she did not take any further action to follow up. OA-F stated if there was an issue with LPN-D not being able to travel to another site, they would have had someone come to her if they knew that was an issue.<br><br>On April 4, 2024, at 2:15 p.m., director of operations (DO)-I stated he thought LPN-D had been offered training opportunities but agreed it should have been scheduled sooner than February. DO-I stated the text message response from LALD/CNS-A to LPN-D regarding not training on doing orders would not be in alignment with their process on educating and "I would hope our leaders would respond in a different manner and offer to walk through this together and here's how we do it so it would be inappropriate for that supervisor to not give training."<br><br>On April 9, 2024, at 5:20 p.m., LALD/CNS-A stated onboarding for LPN-D had been difficult because they had offered her to train at another site but "LPN-D had a lot going on and was not able to travel far away." LALD/CNS-A stated she was only provided with a checklist for training items and the rest of the training was done via online education or reading policies on the computer. | 01460 | | |

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| 01460 | Continued From page 25<br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) days | 01460 | | |
| 01690 SS=F | 144G.71 Subdivision 1 Medication management services<br><br>(a) This section applies only to assisted living facilities that provide medication management services.<br>(b) An assisted living facility that provides medication management services must develop, implement, and maintain current written medication management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse, licensed health professional, or pharmacist consistent with current practice standards and guidelines.<br>(c) The written policies and procedures must address requesting and receiving prescriptions for medications; preparing and giving medications; verifying that prescription drugs are administered as prescribed; documenting medication management activities; controlling and storing medications; monitoring and evaluating medication use; resolving medication errors; communicating with the prescriber, pharmacist, and resident and legal and designated representatives; disposing of unused medications; and educating residents and legal and designated representatives about medications. When controlled substances are being managed, the policies and procedures must also identify how the provider will ensure security and accountability for the overall management, control, and disposition of those substances in compliance with state and federal | 01690 | | |

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| 01690 | Continued From page 26<br>regulations and with subdivision 23.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to implement and maintain current medication management policies and procedures that were developed under the supervision and direction of a registered nurse (RN) consistent with current practice standards and guidelines. The licensee failed to follow their policy related to medication errors and failed to take action after identifying an issue with the process to receive orders.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>RECEIVING ORDERS<br>R5's diagnoses included stroke and hypothyroidism (a condition that causes decreased production of thyroid hormones)<br><br>R5's service plan was requested, but a care plan was provided instead.<br><br>R5's most recent assessment dated February 23, 2024, indicated the resident had hypothyroidism and took Levothyroxine (a medication to treat hypothyroidism), labs were monitored and ordered by primary care provider. Nursing staff | 01690 | | |

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| 01690 | Continued From page 27<br><br>were responsible for monitoring medications and fulfilling provider orders.<br><br>Clinic records indicated R5 was seen in the office on February 7, 2024, for health concerns including a rash and R5's thyroid. Documentation indicated family was concerned because facility staff put the thyroid medication with her other morning medications mixed in applesauce. A TSH lab (thyroid stimulating hormone, a test that shows the functioning of the thyroid gland) was drawn and was elevated at 9.37 (normal is 0.4-4.0) New orders for an increase in Levothyroxine were written to increase it to 112 mcg. The clinic provider recommended following up with the facility's rounding provider since they worked for the same health system and the resident would not need to leave the facility to be seen.<br><br>R5's record contained a progress note dated February 26, 2024, but backdated to February 16, 2024, indicating the licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A "found an order that family had dropped off on the desk without notifying nurse of taking resident to an outside provider. She was seen on 2/7/2024 and found this order when returned. New orders for antibiotic ointment, systane gel nightly to both eyes, increase in Levothyroxine to 112 mcg (micrograms) daily and repeat TSH in 6 weeks. Notified pharmacy and they will fill the medications and send out."<br><br>Clinic records indicated the facility's rounding provider saw the resident in the facility on February 21, 2024, but the provider was not updated of the elevated TSH or the need for follow up labs. The resident's TSH was rechecked on March 29, 2024, and was back in normal ranges. | 01690 | | |

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| 01690 | Continued From page 28<br><br>R5's medication administration record (MAR) for February 2024, included Levothyroxine 88 mcg to be given daily at 7:30 a.m. Directions indicated the medication should be given at least 30 minutes before other medications or food. The MAR indicated Levoythyroxine was consistently given with other medications, sometimes as late as 10:00 a.m. R5's MAR indicated the resident received 88 mcg of Levothyroxine until February 19, 2024. The order was discontinued and the medication was on hold for February 20, 2024, however an administration note indicated 112 mcg was given with other morning medications at 7:20 a.m. on February 20th. The Levothyroxine 88 mcg order was restarted on February 20, 2023, through February 23, 2024, when it was discontinued. The Levothyroxine 112 mcg order was initiated on February 24, 2024.<br><br>On April 3, 2024, at 10:00 a.m., one of R5's family members (FM)-L stated she had voiced concerns about LALD/CNS-A and not following through on things but she didn't see any changes improved responsiveness from LALD/CNS-A.<br><br>On April 3, 2024, at 10:20 a.m., FM-L stated she had brought R5 to an appointment and brought the paperwork back to the facility. LALD/CNS-A was not in the office and she was directed to leave the orders on LALD/CNS-A's desk as that was the usual process for communicating orders to her. FM-L stated she was not aware LALD/CNS-A never saw the orders and there was a delay in implementing them.<br><br>On April 3, 2024, at 1:25 p.m., licensed practical nurse (LPN)-D stated she quit due to how disorganized things were and over her concerns with the facility's process for managing | 01690 | | |

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| 01690 | Continued From page 29<br><br>medications. LPN-D stated LALD/CNS-A wanted any new orders placed on her desk but "it's stuff everywhere. I don't know how she functions even with papers everywhere. At one point she wanted to switch offices every other week and I said no, it was too unorganized and cluttered. I'm sure that's what happened, it got shoved under some paperwork. I talked to her about having a specific place for things like that like a mail slot. But she wanted it on her desk which is what they've been doing with empty meds, they'd just throw it on her desk." LPN-D stated LALD/CNS-A never implemented her ideas for changing the process of communicating new orders and wasn't sure why she didn't do anything to fix the process.<br><br>On April 3, 2024, at 3:02 p.m., corporate clinical director (CCD)-E replied via email to the investigators question on what action LALD/CNS-A took after identifying an order had been missed on February 26, 2024. CCD-E wrote the issue was related to the family going to an outside provider and not communicating it to the nurse. CCD-E wrote the provider who saw the resident at the facility "had a discussion with the family after this incident on the importance of communication between providers." CCD-E added they would be "putting a document box outside of the nursing office for family members to leave information for nursing."<br><br>On April 4, 2024, at 10:10 a.m., CCD-E was asked if she was aware of the family being directed to leave orders on LALD/CNS-A's desk and that was the preference of LALD/CNS-A and if she'd still consider it to be an issue of family not updating the provider about the new orders. CCD-E stated it would not be the family's fault and "there's ownership on the nursing and leadership side of it." CCD-E stated she was not | 01690 | | |

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| 01690 | Continued From page 30<br><br>sure why LALD/CNS-A failed to take action to improve the order communication process after LALD/CNS-A identified it on February 26, 2024. CCD-E stated she would consider the failure to implement the order when written to be a medication error and was not sure why there was no documentation to show the error and how it was resolved.<br><br>On April 9, 2024, at 5:15 p.m., LALD/CNS-A was asked if it would be a medication error if the order to increase the Levothyroxine was not implemented within 24 hours. LALD/CNS-A stated she was not able to complete a medication error report because it was a pharmacy issue and their software didn't have an option to attribute the error to the pharmacy. The investigator asked how it would be a pharmacy issue if the order was not processed or noticed by her. LALD/CNS-A stated, "So you're saying it's my error if I'm not in my office and not present to do an order?" LALD/CNS-A confirmed that in hindsight, she should have contacted the provider to update them that the order was not implemented for several weeks and a medication error form should have been completed. LALD/CNS-A stated she had been out of the office and "other people are allowed in my office and they had moved my stuff around and I found it when I got back..." LALD/CNS-A stated she addressed the issue of communicating orders to the nurse by "putting out an RTask (online medical record) message that no staff was to be in my office and if anything is on the fax or on the desk it needs to stay where it is. Things were being taken off the fax and put wherever and if anyone hands staff an order, a phone call should be made." LALD/CNS-A was asked if sending one electronic message was sufficient for correcting the root cause of the issue related to communicating | 01690 | | |

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| 01690 | Continued From page 31<br>orders and she felt it was sufficient.<br><br>The licensee's Order Processing policy dated December 25, 2023, indicated the LPN would be the primary person to process orders as they are received. If the RN was onsite, they would be responsible to process the order and the LPN would be responsible to sign off as a second person verifying that the order was processed correctly. The RN was responsible to sign off on all orders and double check all steps of the order to assure accuracy of the order process. The policy failed to identify a timeframe for processing orders.<br><br>MEDICATION ERRORS/PROCESS FOR ADMINISTERING INSULIN<br><br>R2's diagnoses included type two diabetes and congestive heart failure.<br><br>R2's service plan dated February 28, 2023, indicated the resident received assistance with dressing, grooming, bathing, fall coordination, and medication administration.<br><br>R2's most recent assessment dated February 18, 2024, indicated<br><br>R2's Medication Administration Summary indicated the resident received Humalog KwikPen (a fast acting insulin) 12 units at lunch, Humalog KwikPen 15 units at 5:00 p.m. with supper daily, and received Lantus SoloStar (a long acting insulin) 25 units at bedtime at 8:00 p.m.<br><br>On April 2, 2024, at 11:50 a.m., ULP-B was observed preparing medications to administer to R2. ULP-B used her personal cell phone to access the facility's electronic medical record and | 01690 | | |

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| DIAMOND WILLOW ASSISTED LIVING | 1558 RANDOLPH ROAD DETROIT LAKES, MN 56501 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
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| 01690 | Continued From page 32<br><br>was observed writing 12 units on a post it note. ULP-B left her phone at the medication cart and walked down to R2's room. After checking a blood sugar, which was 157, ULP-B opened a locked cabinet in R2's room to obtain an insulin pen, two pens were in the cabinet, one Humalog and one Lantus. ULP-B stated she was not sure why they were not kept in the medication cart. ULP-B did not verify the insulin dose with another staff member.<br><br>A medication error report dated February 9, 2024, at 5:20 p.m. indicated R2 was given the wrong medication when she received 15 units of Lantus instead of "Himalayan/Lispro" (sic). The resident was supposed to receive Humalog 15 units at supper instead. The reason for the med error was listed as "Staff did not double check with other staff member to verify." The incident report indicated the resident's physician was not updated of the error.<br><br>On April 3, 2024, at 6:16 p.m., corporate clinical director (CCD)-E replied via email to the investigator's question regarding if the physician was updated and what additional monitoring was completed. CCD-E wrote, "we cannot find information as to why the provider was not notified. A second blood sugar was taken at 7:55pm and recorded as 238. Our policy that was updated as of 01/25/2024 does not require 2 staff to verify an insulin dose."<br><br>On April 9, 2024, at 5:15 p.m., LALD/CNS-A stated the facility's current policy as of April 9th was to have two staff verify an insulin dose and she was not aware that corporate had changed the policy in January. LALD/CNS-A stated she educates staff on using two people to verify an insulin dose. LALD/CNS-A was asked if a root | 01690 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| 01690 | Continued From page 33<br><br>cause analysis was done for the February 9th medication error and if they had considered storing the insulin pens in the room versus the medication cart might be a contributing factor. LALD/CNS-A stated she had reviewed the med error with the staff member responsible and didn't think there were any systems issues that contributed to the medication error.<br><br>The licensee's Medication Errors policy dated indicated any preventable event that may cause or lead to inappropriate medicaition use or resident harm while the medication is in control of the assisted living facility. An incident report from the staff person who reported the error was to be completed.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01690 | | |
| 01940 SS=D | 144G.72 Subd. 3 Individualized treatment or therapy managemen<br><br>For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following:<br>(1) a statement of the type of services that will be provided;<br>(2) documentation of specific resident instructions relating to the treatments or therapy | 01940 | | |

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| 01940 | Continued From page 34<br><br>administration;<br>(3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel;<br>(4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and<br>(5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for one of one resident (R3) who had treatments managed by the facility.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).<br><br>The findings include:<br><br>R3's diagnoses included CVA with right hemiparesis (a stroke resulting in weakness to | 01940 | | |

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| 01940 | Continued From page 35<br>the right side) and type two diabetes.<br><br>R3's service plan dated February 29, 2024, indicated the resident received ostomy care two days per week from unlicensed personnel.<br><br>R3's most recent assessment dated March 18, 2024, indicated the resident had a colostomy and staff were to "assist with maintaining colostomy per service chart."<br><br>R3's treatment management plan was requested and the service plan was provided.<br><br>R3's record contained a Treatment Recap Summary for March and April 2024. A task for ADL Ostomy Care on Tuesdays and Fridays was listed. No other additional details on the ostomy care were listed. Written instructions on how staff should perform ADL ostomy care was requested, but not provided.<br><br>R3's record lacked an individualized treatment plan to include:<br>-a statement of the type of services that will be provided;<br>-documentation of specific resident instructions relating to the treatments or therapy administration;<br>-identification of treatment or therapy tasks that will be delegated to unlicensed personnel;<br>-procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and<br>-any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible | 01940 | | |

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| 01940 | Continued From page 36<br>complications or adverse reactions.<br><br>On April 2, 2024, at 11:40 a.m., unlicensed personnel (ULP)-B was observed performing ostomy cares on R3. ULP-B stated she had watched other staff perform the ostomy cares but was still uncomfortable with the process. ULP-B did not check R3's chart for instructions specific for performing cares on the ostomy site. Written instructions were not observed with the resident's supplies or in his room. ULP-B wiped the stoma with a paper towel as directed by ULP-G and stated, "Is that supposed to be a little bloody? I'm new at this." R3 advised ULP-B to "not touch the pink area." ULP-B used a wipe to clean the area around the stoma and asked, "How will I know when I've wiped enough?" R3 advised her that was probably enough. ULP-B asked R3 how to apply the foam barrier and how much powder to apply to the site. ULP-B verified with R3 that she was using the right supplies as she was "just nervous as all heck."<br><br>On April 4, 2024, at 10:20 a.m., corporate clinical director (CCD)-E was asked if she was familiar with the requirements of a treatment management plan and if it was part of the resident's record. CCD-E stated she had not worked in assisted living settings for a number of years and was not sure if there was a treatment management plan developed for R3.<br><br>On April 9, 2024, at 5:30 p.m. licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated she was aware of the requirements for the contents of a treatment management plan and "it's obviously lacking some stuff."<br><br>No further information was provided. | 01940 | | |

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| 01940 | Continued From page 37<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01940 | | |
| 01950 SS=D | 144G.72 Subd. 4 Administration of treatments and therapy<br><br>Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has:<br>(1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures;<br>(2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) specified, in writing, specific treatment instructions for each resident, and documented those instructions in the resident record one of one residents (R3). In addition, the licensee failed to ensure the RN instructed unlicensed personnel in the proper methods with respect to each resident and that unlicensed personnel demonstrated the ability to competently | 01950 | | |

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| 01950 | Continued From page 38<br><br>follow the procedures. Unlicensed personnel (ULP)-B did not have training from the RN on how to perform ostomy cares for R3.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).<br><br>The findings include:<br><br>ULP-B was hired on March 12, 2024, to provide care and services to the licensee's residents.<br><br>ULP-B's record contained a skills competency (return demonstration) checklist which indicated she was trained on general colostomy and urostomy cares. ULP-B's record lacked evidence of orientation to R3 or training related to the specific steps of the resident's colostomy cares.<br><br>R3's diagnoses included CVA with right hemiparesis (a stroke resulting in weakness to the right side) and type two diabetes.<br><br>R3's service plan dated February 29, 2024, indicated the resident received ostomy care two days per week from unlicensed personnel. The ostomy cares included removing a foam dressing around the stoma, cleaning the site, and applying a new seal and bag.<br><br>R3's most recent assessment dated March 18, 2024, indicated the resident had a colostomy and staff were to "assist with maintaining colostomy | 01950 | | |

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| 01950 | Continued From page 39<br>per service chart."<br><br>R3's treatment management plan was requested and the service plan was provided.<br><br>R3's record contained a Treatment Recap Summary for March and April 2024. A task for ADL Ostomy Care on Tuesdays and Fridays was listed. No other additional details on the ostomy care were listed. Written instructions on how staff should perform ADL ostomy care was requested, but not provided.<br><br>On April 2, 2024, at 11:40 a.m., unlicensed personnel (ULP)-B was observed performing ostomy cares on R3. ULP-B stated she had watched other staff perform the ostomy cares but was still uncomfortable with the process. ULP-B did not check R3's chart for instructions specific for performing cares on the ostomy site. Written instructions were not observed with the resident's supplies or in his room. ULP-B wiped the stoma with a paper towel as directed by ULP-G and stated, "Is that supposed to be a little bloody? I'm new at this." R3 advised ULP-B to "not touch the pink area." ULP-B used a wipe to clean the area around the stoma and asked, "How will I know when I've wiped enough?" R3 advised her that was probably enough. ULP-B asked R3 how to apply the foam barrier and how much powder to apply to the site. ULP-B verified with R3 that she was using the right supplies as she was "just nervous as all heck."<br><br>On April 3, 2024, at 7:45 a.m., corporate clinical director (CCD)-E stated ostomy training should be resident specific since there are multiple different brands of supplies and the cares are so specific to the resident. CCD-E stated there should have been resident specific training with a | 01950 | | |

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| 01950 | Continued From page 40<br><br>hands on demonstration and return demonstration based off the orders for the resident's ostomy bag.<br><br>On April 9, 2024, at 5:30 p.m. licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated they had provided general training on ostomy cares so they did not provide more individualized training on resident specific ostomy cares. LALD/CNS-A stated they should have written out instructions on the resident's ostomy and had staff complete a return demonstration on it.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01950 | | |
| 02310 SS=G | 144G.91 Subd. 4 (a) Appropriate care and services<br><br>(a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care standards, and medical or nursing standards for one of one residents (R2) who utilized consumer bed rails. This resulted in an immediate correction order issued on April 2, 2024, at 2:00 p.m. | 02310 | | |

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| 02310 | Continued From page 41<br><br>This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).<br><br>The findings include:<br><br>R2's diagnoses included type two diabetes and congestive heart failure.<br><br>R2's service plan dated February 28, 2023, indicated the resident received assistance with dressing, grooming, bathing, fall coordination, and medication administration.<br><br>R2's most recent assessment dated February 18, 2024, indicated the resident was independent with bed mobility and used a bed rail for repositioning and transfers. The section for bed safety indicated the resident used an "adult hand bed rail installed on both sides of the bed." The assessment further indicated the bed rail was used per manufacturer instructions and maintained. The assessment indicated education on bed rails was provided to the responsible party and they understood the risks related to bed rail use.<br><br>On April 2, 2024, at 11:15 a.m., the investigator observed R2 sleeping in her bed. Consumer grade U shaped bed rails were on each side of the bed. The investigator observed pillows wedged under the mattress, which created a several inch gap between the rail and the box spring. | 02310 | | |

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| 02310 | Continued From page 42<br><br>On April 2, 2024, at 1:00 p.m., the investigator was provided with a copy of the manufacturer guidelines for the bed rail used by R2. The manufacturer guidelines indicated use of only one rail on the bed at a time, not two, as was being used. The manufacturer guidelines included a picture which showed a U shaped bed rail with two bars going across the length of the bed rail.<br><br>On April 2, 2024, at 1:20 p.m., LALD/CNS-A observed R2's bed rails with the investigator present. Since R2 was in the bed, it was not able to be determined if the rail was one piece or two separate rails. LALD/CNS-A confirmed the picture of the bed rail shown on the manufacturer guidelines did not match the ones on the resident's bed. LALD/CNS-A confirmed pillows were positioned under the rails on each side and removed a total of three pillows that had been placed under the mattress by the head of the bed. LALD/CNS-A confirmed putting pillows under the mattress would not be part of the manufacturer guidelines.<br><br>On April 2, 2024, at 1:30 p.m., LALD/CNS-A informed the investigator she had removed the bed rails from R2's bed. LALD/CNS-A confirmed she had not assessed if there were any risks related to removing the bed rails since they were used for bed mobility and that she had not notified the resident's responsible party prior to removing the bed rails. LALD/CNS-A stated she would be getting the resident a hospice bed and walked away. As she walked away, LALD/CNS-A stated, "Now I'm in trouble for removing them [bed rails]."<br><br>A policy on bed rails was requested, along with documentation of when the responsible party was | 02310 | | |

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| 02310 | Continued From page 43<br>updated of risks related to side rail use.<br><br>On April 24, 2024, at 1:54 p.m., LALD/CNS-A emailed, "They are in her chart. I have to run to an appointment. Corporate office is helping and [a registered nurse] from corporate will be on her way down soon. I will be back in an hour or so."<br><br>The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently Asked Questions (FAQs), last updated February 20, 2024, indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, "Documentation about a resident's bed rails includes, but is not limited to:<br>- Purpose and intention of the bed rail.<br>- Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail.<br>- The resident's bed rail use/need assessment:<br>- Risk vs. benefits discussion (individualized to each resident's risks):<br>- The resident's preferences:<br>- Installation and use according to manufacturer's guidelines:<br>- Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and<br>- Any necessary information related to interventions to mitigate safety risk or negotiated | 02310 | | |

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| 02310 | Continued From page 44<br><br>risk agreements".<br>Additionally, the MDH website indicated for "consumer beds", the licensees should refer to individual manufacturer's guidelines for appropriate installation, maintenance, and use. In addition, licensees should refer to the CSPC for the most up-to-date information related to portable bed side rail recall information.<br><br>No further information was provided.<br><br>Time Period for Correction: IMMEDIATE | 02310 | | |
| 02320 SS=H | 144G.91 Subd. 4 (b) Appropriate care and services<br><br>(b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards related to falls and medication errors. The licensee failed to have a fall management system that ensured staff provided the resident with supervision and implemented interventions after falls for one of one resident (R1) reviewed. R1 had a known history of falls, however, the registered nurse (RN) failed to assess the resident's risk for falls and failed to implement interventions to prevent falls or reduce the risk of serious injury from falls. In addition, a | 02320 | | |

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| DIAMOND WILLOW ASSISTED LIVING | 1558 RANDOLPH ROAD DETROIT LAKES, MN 56501 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
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| 02320 | Continued From page 45<br><br>transcription error occurred, resulting in the resident not receiving prescribed Morphine and Lorazepam as ordered. The licensee also failed to ensure reporting of resident condition to the appropriate supervisor or health care professional for one of one residents (R2).<br><br>This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).<br><br>The findings include:<br><br>R1<br>R1's diagnoses included severe Alzheimer's dementia with anxiety and hypertension (high blood pressure.)<br><br>R1's service plan dated February 26, 2024, indicated the resident received assistance with dressing, grooming, bathing, repositioning, transfers with a mechanical lift, fall coordination ten times per day, safety checks eight times per day, and medication administration.<br><br>R1's most recent assessment completed by corporate clinical director (CCD)-E, dated February 8, 2024, the day he admitted to hospice services, indicated the resident had impaired judgment, anxiety, and agitation The RN was responsible for the resident's medication management, including ordering medications. The assessment failed to include the resident's | 02320 | | |

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| 02320 | Continued From page 46<br>risk of falls.<br><br>R1's record contained an order from hospice dated February 21, 2024, for Morphine (an opioid pain medication) 4 mg every 4 hours around the clock and Lorazepam (an anti anxiety medication) 1 mg every 4 hours around the clock.<br><br>R1 admitted to the facility on July 6, 2023. R1 admitted to hospice services for end of life care on February 8, 2024. R1 died on February 27, 2024.<br><br>R1's record contained progress notes and incident reports which included the following:<br><br>February 1, 2024, R1 fell at 9:00 p.m. in his room. The resident "appeared dizzy and exhausted and fell." 911 was called and the resident was admitted to the hospital. The RN did not review the incident report until February 8, 2024. Interventions were "resident remained at hospital and admitted. Will assess when returns." The assessment completed on February 8, 2024, when the resident returned failed to assess for fall interventions.<br><br>February 8, 2024, R1 fell at 11:50 p.m. in his room. No alarms or fall prevention aides were in use at the time of the fall. "Frequent checks, staff notified" were interventions put in place for fall prevention on February 9, 2024.<br><br>February 20, 2024, R1 fell at 3:56 a.m. in his room. No alarms were in use at that time. TABs alarms were put in place as an intervention two days later on February 22, 2024.<br><br>February 21, 2024, R1 fell at 4:15 p.m. in his room. TABs alarms were put in place as an | 02320 | | |

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| 02320 | Continued From page 47<br><br>intervention one day later on February 22, 2024.<br><br>February 22, 2024, R1 fell at 11:30 p.m. in his room. The incident report indicated "alarms or fall prevention aides in use at time of fall: "they did not have the alarm on for PM. It was attached to his shirt and pulled off the machine. The machine did not go off."<br><br>A progress note entered by LALD/CNS-A on February 22, 2024, at 7:49 p.m. indicated the resident had two falls in the last two days and "he is mentally and physically declining...Reviewed falls and safety checks in place. I placed a tab alarm for when he is in bed and in wheelchair. Notified staff and educated them on fall prevention. Encouraged staff to use PRN (as needed) medications for noted pain, agitation, and anxiety as ordered by hospice."<br><br>A medication error occurred on February 22, 2024, at midnight and due to a transcription error, Morphine 4 mg was not administered.<br><br>A medication error occurred on February 22, 2024, at midnight and due to a transcription error, Lorazepam 1 mg was not administered.<br><br>A medication error occurred on February 22, 2024, at 4:00 a.m. and due to a transcription error, Morphine 4 mg was not administered.<br><br>A medication error occurred on February 22, 2024, at 4:00 a.m. and due to a transcription error, Lorazepam 1 mg was not administered.<br><br>A medication error occurred on February 23, 2024, at midnight and due to a transcription error, Morphine 4 mg was not administered. | 02320 | | |

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| 02320 | Continued From page 48<br><br>A medication error occurred on February 23, 2024, at midnight and due to a transcription error, Lorazepam 1 mg was not administered.<br><br>A medication error occurred on February 23, 2024, at 4:00 a.m. and due to a transcription error, Morphine 4 mg was not administered.<br><br>A medication error occurred on February 23, 2024, at 4:00 a.m. and due to a transcription error, Lorazepam 1 mg was not administered.<br><br>February 23, 2024, R1 fell at 6:00 a.m. in another resident's room. The incident report indicated "alarms or fall prevention aides in use at time of fall: bed alarm." The report further indicated the resident was not at his normal baseline due to "end of life restlessness." Details of the fall included "bed alarm wet off, found in another room and he fell." The resident was placed on every 30 minute checks as an intervention, however the intervention had an effective date of March 4, 2024, after the resident had passed away. The RN failed to review the incident report and implement interventions until March 4, 2024. The RN failed to reassess if a fall alarm was an appropriate intervention given the resident's ability to remove it.<br><br>R1's Service Recap Summary for February 2024 lacked evidence of 30 minute checks being completed.<br><br>February 23, 2024, R1 fell at 11:50 p.m. The incident report indicated "alarms or fall prevention aides in use at time of fall: yes, it didn't go off some reason." The RN failed to review the incident report and implement interventions. The RN failed to reassess if a fall alarm was an appropriate intervention given the resident's | 02320 | | |

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| 02320 | Continued From page 49<br><br>ability to remove it. The incident report was never reviewed by the RN.<br><br>A progress note entered by LALD/CNS-A on February 23, 2024, at 9:28 p.m., indicated she had placed a "call to hospice and asked to speak to RN manager regarding resident high care needs and inability to meet his needs in keeping him safe. Transferred to [social worker] as RN is off. Conversation regarding resident needing higher level of care due to multiple falls with as much interventions and support we can provide but continues to pose a safety issue to self and other. She stated she is aware and guardian and hospice are actively looking for placement in a nursing home. There are currently no local openings and she will be discussing the urgency with guardian and see if they can expand search out of area. I told her we would be calling them over the weekend with every noted issue or inability to control his behaviors and falls. She agreed and stated to call in call. Safety checks in place, toileting schedule, tab alarm all in place. Staff instructed of this and voiced understanding."<br><br>A medication error occurred on February 24, 2024, at midnight and due to a transcription error, Morphine 4 mg was not administered.<br><br>A medication error occurred on February 24, 2024, at midnight and due to a transcription error, Lorazepam 1 mg was not administered.<br><br>A progress note entered by LALD/CNS-A on February 24, 2024, at 1:24 a.m. indicated, "Staff called to report that the hospice nurse was on site and that orders for morphine and lorazepam were not matching what his MAR is. He verbalized that orders should be Morphine 4mg every 4 hours around the clock and Lorazepam 0.5mg every 4 | 02320 | | |

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| 02320 | Continued From page 50<br><br>hours around the clock. on line rtask record indicates every 4 hours but with only 8 am, 12 pm, 4 pm and 8 pm for both medications. I notified him that I did not process these orders but that I would change it with his verbal order and on Monday I would see if we had communication or orders in his chart at the facility for Feb 21st as he stated they were from..."<br><br>February 24, 2024 at 4:49 p.m., staff called the on-call RN to report the resident fell and was on the floor beside his bed. The progress note from the on-call RN indicated hospice came to the facility and administered 1 mg of Lorazepam and 10 mg of Morphine to "help settle the resident."<br><br>February 24, 2024, R1 fell at 4:50 p.m. The incident report indicated "alarms or fall prevention aides in use at time of fall: ripped tab alarm, so none available." The RN failed to review the incident report and implement interventions. The RN failed to reassess if a fall alarm was an appropriate intervention given the resident's ability to remove it. The incident report was not reviewed by the RN until March 27, 2024, after the resident had passed away.<br><br>Documentation from ULP on February 24, 2024, at 10:00 p.m., indicated R1's behaviors were "impossible to control."<br><br>February 25, 2024, R1 fell at 1:00 p.m. while trying to get out of bed. The RN failed to review the incident report and implement interventions. The RN failed to reassess if a fall alarm was an appropriate intervention given the resident's ability to remove it. The incident report was not reviewed by the RN until March 8, 2024, after the resident had passed away. | 02320 | | |

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| 02320 | Continued From page 51<br><br>February 25, 2024, at 8:45 p.m., LALD/CNS-A documented she "came to site to check on resident and bring in a body pillow to assist in positioning in bed and fall prevention. Resident now has his mattress on the floor and I added a fall mat beside it. Assisted staff in getting him changed with another staff member and positioned well in bed as he was beside his mattress due to moving around. Resident continues to display agitation and pain with anger and yelling out as well as grimacing...tab alarms in place. Noted per staff that resident's guardian placed cameras in the room without notifying this writer. Staff stated they told her she needs to sign proper paperwork and she stated she won't be here this week.<br><br>February 26, 2024, LALD/CNS-A documented hospice changed the resident's scheduled Morphine to 10 mg every four hours and every 1 hour as needed. Seroquel 25 mg was started and Zyprexa was discontinued. LALD/CNS-A "asked her [hospice] to order a new bed as his is broken and mattress is now on floor. RN and family are ok with this. I did also call [family member] and discussed the cameras set up in the room and that she needs to fill out the consent forms. She stated she would and that she has them up to help alert her to any falls. She stated she would send me the link as well if I wanted to use the monitoring. She is ok with plan of care and I did tell her about the medication errors and the plan going forward. We went over service plan updates...we talked about the higher level of care and that hospice social worker and her her or working on it. I did mention private caregiver or sitter if she wanted to check into the availability of that and the affordability.<br><br>On April 3, 2024, at 7:30 a.m., corporate clinical | 02320 | | |

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| 02320 | Continued From page 52<br><br>director (CCD)-E stated it would be expected the clinical nurse supervisor review incident reports within 24 hours and each fall should have a unique intervention implemented. CCD-E stated she was not sure why LALD/CNS-A failed to review the incident reports timely.<br><br>On April 4, 2024, at 2:15 p.m., director of operations (DO)-I stated all incident reports should be reviewed in a 24 hour period and interventions should be in place after each fall. DO-I stated he was not sure why LALD/CNS-A failed to review incident reports timely.<br><br>On April 8, 2024, R1's power of attorney (POA)-L stated the resident was at the facility for eight months and "he never really had any care from them as far as meeting his needs or what we were expecting him to get there." POA-L stated once R1 went on hospice, it seemed like he got even less care from the facility as they expected hospice to manage his care from that point. POA-L stated R1 had countless falls in the days leading up to his death and "I don't know what the truth is. It's hard for me to sort through everything. The staff gave me way different information than hospice did, versus what LALD/CNS-A said versus what Diamond Willow corporate management said. It's so hard to judge the truth over this situation." POA-L stated the night before the resident died, she was in his room when another resident fell. The staff working handed her a syringe of Morphine and told her to administer it so they could go attend to the resident who fell. POA-L stated she told them she could not administer the medication and they should just give it quick and then go help the resident who fell but they left the room, leaving her with the Morphine. POA-L stated they came on February 25, 2024, to clean up his room so he | 02320 | | |

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| 02320 | Continued From page 53<br><br>would have less fall hazards in his room and "everything was broken. The recliner her broke, he broke a TV stand, the nightstand, a lamp, his Christmas tree, almost everything was broken in that room. How was he able to do so much damage, if they knew he did that, why did they leave him alone?" POA-L stated she asked staff about the hospital bed and they told her he had broken that too and said "he fell off the bed, rolled under the bed, and somehow got caught under the cords and pulled them and broke the hospital bed." POA-L stated the resident did not have a bed the last few days of his life and was left to sleep on a mattress on the floor. POA-L stated they decided to go out and get a camera for the resident's room after that because they were concerned over what was going on at the facility. POA-L stated "not even four minutes after we left the facility, he fell forward, hit his head on the floor and died less than 48 hours later." POA-L stated she heard staff on camera discussing why certain falls were not reported to R1's family and they had figured the resident fell anywhere from 10-17 times over the weekend before he died. POA-L stated she was surprised LALD/CNS-A kept pushing the idea of discharging the resident on February 26, 2024, because "he's on hospice and at end of life, at that point he was unconscious and not responding." POA-L stated they had just planned to bring R1 home because "at that point I didn't feel like he was in a safe place" and they knew he was "on a downhill slide and he'd pass within the next week. We were just going to keep him dosed up so he didn't feel any pain." POA-L stated R1 was covered in bruising in various stages of healing and provided the investigator with photographs and videos taken February 25, 2024. The photos showed the resident had significant bruising, scrapes, and abrasions in various stages of healing. The | 02320 | | |

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| 02320 | Continued From page 54<br>resident could be heard moaning out in pain.<br><br>On April 9, 2024, at 11:05 a.m., ULP-N stated R1 was a frequent faller and over the last weekend of his life, he was having behaviors that were more difficult to control. ULP-N stated they had put R1's mattress on the floor to keep him from falling out of bed but he was still rolling off the mattress so they were directed by LALD/CNS-A to get some foam pads to put on the floor so the resident wouldn't be able to roll of anything. ULP-N stated they would also use barriers to "prevent him from being restless" which included pillows, body pillows, blankets "anything we could find to put underneath him." ULP-N was asked what other interventions had been put in place by LALD/CNS-A and stated they would use as needed medications and try have someone sit one on one with the resident "but he would still try roll out of bed with someone in there."<br><br>On April 9, 2024, at 4:50 p.m., LALD/CNS-A confirmed incident reports should have been reviewed within 24 hours and that did not occur with several for R1. LALD/CNS-A stated "I was out on the floor more than I was in the office documenting, I don't know how else to put it, it's been so crazy and busy." LALD/CNS-A stated around the time R1 admitted to hospice, she was out with COVID-19 for ten days and working remotely and the licensed practical nurse was also out with COVID-19 and not in the building. LALD/CNS-A stated she was not aware the tab alarms were not functioning properly and were being unclipped by the resident for several of his falls. LALD/CNS-A stated the resident kept falling and falling and they weren't able to provide one on one care so they felt it was appropriate to discharge the resident. LALD/CNS-A stated the resident was "really uncomfortable" the last few | 02320 | | |

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| 02320 | Continued From page 55<br><br>days of his life and kept rolling off his bed so they eventually put his mattress on the floor. "I came on my time off and bought a pillow to help keep him in the bed from rolling off the edge of the mattress and we kinda just did everything on the floor." LALD/CNS-A stated she would not consider that a restraint but did not document an assessment to show it was not a restraint. LALD/CNS-A stated "As a nurse, it didn't look to me as a restraint it looked more like safety so he wasn't falling from a long distance since you can't do one on one with him." LALD/CNS-A was asked what other interventions were done or if there was any root cause analysis to determine why the resident was so restless. LALD/CNS-A stated there was not but "hospice came in and gave Morphine and Lorazepam and she found his bladder was distended and she got 400 of urine out of him and he was a lot more comfortable then."<br><br>R2<br>R2's diagnoses included type two diabetes and congestive heart failure.<br><br>R2's service plan dated February 28, 2023, indicated the resident received assistance with dressing, grooming, bathing, fall coordination, and medication administration.<br><br>R2's most recent assessment dated February 18, 2024, indicated the resident wanted to be as independent as possible and needed an assist of one for toileting and transfers. R2 had a history of UTIs and staff were to monitor for changes in urine, flank pain, fever, increased confusion and report any symptoms to the nurse.<br><br>Documentation from R2's progress notes indicated: | 02320 | | |

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| DIAMOND WILLOW ASSISTED LIVING | 1558 RANDOLPH ROAD DETROIT LAKES, MN 56501 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
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| 02320 | Continued From page 56<br><br>-April 6, 2024, at 10:29 a.m., the on-call RN was contacted for concerns with the resident's blood sugar. The resident was reported to have some shakiness which ULP reported "happens when she gets a UTI." Hospice was informed about the blood sugar and ULP "also report there is someone there now from hospice who will evaluate the resident."<br>-April 8, 2024, at 4:00 p.m., CCD-E documented "hospice nursing saw [R2] on 4/8/24 for suspected UTI. Sample collected by hospice staff and sent for analysis...called antibiotic order into [pharmacy.]<br><br>R2's April 2024 medication administration record (MAR) included the following:<br>-April 6, 2024, the resident refused her 8:00 a.m. medications including pantoprazole, gabapentin, lactulose, metoprolol, rifaximin, spironolactone, and her noon lactulose.<br>-April 7, 2024, the resident refused her 8:00 a.m. medications including pantoprazole, gabapentin, lactulose, metoprolol, rifaximin, spironolactone, and her noon lactulose.<br>-April 7, 2024, at 4:42 p.m., the resident was given PRN oxycodone for "crying out in pain."<br>-April 7, 2024, at 8:27 p.m., the resident was given PRN oxycodone for "general pain, cried out ouch when changing her, won't tell us where the pain is."<br><br>Documentation from hospice included the following notes:<br>-April 6, 2024, at 10:21 a.m., the hospice RN was called by the on-call RN to report a blood sugar of 167, 48 units of insulin was administered and the resident declined breakfast. A follow up blood sugar was 84. The hospice RN advised staff to continue to monitor, offer sweets/carbs. The hospice RN attempted to call the facility later that | 02320 | | |

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| 02320 | Continued From page 57<br><br>day at 3:42 p.m. to check up on the resident but no one answered the phone at the facility.<br>-April 6, 2024, the resident refused lunch and supper due to not feeling well. Activities were not offered as the resident was "in bed the whole shift."<br>-April 7, 2024, the resident was "repositioned and changed throughout the shift" and was noted to have "been sleeping all day due to her not feeling well."<br>-April 7, 2024, at 3:28 p.m., R2's daughter called the hospice RN to "request a visit for [R2] as she has not ate or taken her medication in the past 24 hours and she would like a visit to assess what is going on with this patient as the staff has not notified either family or hospice of this change."<br>-April 8, 2024, at 8:42 a.m., hospice received a urinalysis and at 8:55 a.m., an order was placed for an antibiotic. A ULP called hospice at 11:26 a.m. to report the resident had not been out of bed yet that day and was refusing to eat or drink and was wondering if they should still give her insulin. At 3:50 p.m., a hospice RN left the new order for an antibiotic with CCD-E.<br><br>On April 8, 2024, at 9:45 a.m., family member (FM)-H stated family came in to visit R2 on Sunday, April 7, 2024, and were very concerned to see the condition she was in and she was upset no one from the facility had called to tell her their concerns. FM-H stated she called hospice to have someone come and assess her because she didn't think the facility was going to manage it.<br><br>On April 9, 2024, at 9:30 a.m., hospice nurse (HN)-P stated they had ongoing concerns with the quality of care R2 was receiving at the facility and "it's hit or miss on when they'll feel like reporting" any changes of condition. HN-P stated hospice | 02320 | | |

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| 02320 | Continued From page 58<br><br>had not been updated of the resident's potential UTI over the weekend and "it was the daughter who called and requested a visit." HN-P stated they were not previously aware the resident refused most of her medications on Saturday and Sunday and had only been updated on the insulin and blood sugar concerns. HN-P stated they would have expected staff notified them on Saturday April 6th to report concerns of UTIs.<br><br>On April 9, 2024, at 9:45 a.m., CCD-E was asked if there would be documentation to show hospice was updated on concerns with the resident having a UTI on April 6th or April 7th. CCD-E was in an office with a ULP who could be heard telling CCD-E that they had notified hospice when they were in the building on April 6, 2024. CCD-E was asked who the hospice person they updated was and confirmed the person updated was a certified nursing assistant with hospice, not the RN.<br><br>On April 9, 2024, at 10:25 a.m., ULP-O stated she had called the on-call RN to notify her of some concerns with the resident's blood sugar on April 6, but also mentioned to her some of the behaviors the resident had were consistent with how she acted the last time she had a UTI. ULP-O stated the resident's change in condition over the weekend was "definitely concerning" and seemed to get worse on Sunday, April 7th.<br><br>On April 9, 2024, at 11:05 a.m., ULP-N stated she had worked on April 7, 2024, and R2 was normally able to be up on her own and toilet herself and "my coworkers and I were changing her in bed, she wasn't really responding to us, we'd ask if she was in pain and she wouldn't say anything to us and would just look at us, it was out of the ordinary." ULP-N stated she had called the on-call RN and in the voicemail she left the | 02320 | | |

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| 02320 | Continued From page 59<br><br>on-call she mentioned concerns for a UTI but didn't think she had mentioned it again when the on-call RN called back. ULP-N stated hospice came to the facility on April 7, so they had been updated of the concerns for the UTI at that point.<br><br>On April 9, 2024, at 4:15 p.m., the on-call RN (RN)-Q stated she remembered the phone call from April 6, 2024, at 10 a.m. and reviewed her notes from the encounter. RN-Q stated she updated hospice on the blood sugar issues but did not pass on the concern about the UTI because staff had told her that someone from hospice was at the facility currently and would be assessing the resident. RN-Q stated she was not aware the hospice person at the facility was a CNA and not a nurse and stated the CNA would not be able to assess the resident and if she was told that she would have updated hospice about the UTI issue as well.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 02320 | | |
| 02360 | 144G.91 Subd. 8 Freedom from maltreatment<br><br>Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act.<br><br>This MN Requirement is not met as evidenced by:<br>The facility failed to ensure one of one residents reviewed (R1) was free from maltreatment.<br><br>Findings include: | 02360 | No plan of correction is required for this tag. | |

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| 02360 | Continued From page 60<br><br>The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details. | 02360 | | |
| 02410 SS=E | 144G.91 Subd. 13 Personal and treatment privacy<br><br>(a) Residents have the right to consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being. Staff must respect the privacy of a resident's space by knocking on the door and seeking consent before entering, except in an emergency or unless otherwise documented in the resident's service plan.<br>(b) Residents have the right to have and use a lockable door to the resident's unit. The facility shall provide locks on the resident's unit. Only a staff member with a specific need to enter the unit shall have keys. This right may be restricted in certain circumstances if necessary for a resident's health and safety and documented in the resident's service plan.<br>(c) Residents have the right to respect and privacy regarding the resident's service plan. Case discussion, consultation, examination, and treatment are confidential and must be conducted discreetly. Privacy must be respected during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and document | 02410 | | |

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| 02410 | Continued From page 61<br><br>review, the licensee failed to ensure the resident's right to privacy was respected during toileting and other activities of personal hygiene for two of two residents (R2, R3) reviewed.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).<br><br>The findings include:<br><br>R2<br>Facility staff failed to provide privacy while changing an incontinent product and failed to remove a soiled soaker pad from a recliner in the resident's room.<br><br>R2's diagnoses included type two diabetes and congestive heart failure.<br><br>R2's service plan dated February 28, 2023, indicated the resident received assistance with dressing, grooming, bathing, fall coordination, and medication administration.<br><br>R2's most recent assessment dated February 18, 2024, indicated the resident could walk independently but could need an assist of one for transfers at times. The resident required assistance with toileting.<br><br>On April 2, 2024, at 1:10 p.m., unlicensed personnel (ULP)-B entered R2's room and | 02410 | | |

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| 02410 | Continued From page 62<br><br>checked her brief (incontinent product), which was wet. R2 was laying in bed and a hospice aide was in the room attending to R2's husband. ULP-B began to change R2's brief with the door open. The hospice aide got up and shut the door to provide privacy for the resident. The investigator observed a recliner with a disposable pad on it that was saturated with urine and appeared to have been sitting there for an extended period of time. As ULP-B exited R2's room, she stated, "I'm too old for this shit."<br><br>R3<br>Facility staff failed to provide privacy while performing a dressing and bag change on the resident's colostomy.<br><br>R3's diagnoses included CVA with right hemiparesis (a stroke resulting in weakness to the right side) and type two diabetes.<br><br>R3's service plan dated February 29, 2024, indicated the resident received ostomy care two days per week from unlicensed personnel. The ostomy cares included removing a foam dressing around the stoma, cleaning the site, and applying a new seal and bag.<br><br>R3's most recent assessment dated March 18, 2024, indicated the resident had a colostomy bag and staff were to "assist with maintaining colostomy per service chart."<br><br>On April 2, 2024, at 11:40 a.m., ULP-B was observed performing ostomy cares on R3. ULP-B began to gather supplies to perform the ostomy bag change and failed to shut the door or provide privacy for the resident who shared a room with another resident. Another ULP entered the room to provide assistance and failed to shut the door | 02410 | | |

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| 02410 | Continued From page 63<br><br>or provide privacy for R3. The ULP began to change the ostomy bag. Licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A walked up to the door during this time and noticed staff were busy with cares and walked away. LALD/CNS-A failed to shut the door or provide privacy for the resident. A few minutes later while staff were still assisting with the ostomy cares, a case manager entered the room to visit with the resident's roommate. The case manager noticed cares being provided and helped escort the roommate out of the room.<br><br>On April 3, 2024, at 7:35 a.m., corporate clinical director (CCD)-E confirmed cares should be done in private with doors closed.<br><br>The licensee's Bill of Rights policy last updated October 11, 2023, indicated staff would be trained on the concepts/rights contained in the Bill of Rights. | 02410 | | |
| 02430 SS=F | 144G.91 Subd. 15 Confidentiality of records<br><br>(a) Residents have the right to have personal, financial, health, and medical information kept private, to approve or refuse release of information to any outside party, and to be advised of the assisted living facility's policies and procedures regarding disclosure of the information. Residents must be notified when personal records are requested by any outside party.<br>(b) Residents have the right to access their own records.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview the licensee | 02430 | | |

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| 02430 | Continued From page 64<br><br>failed to ensure resident's personal health and medical information was kept private. This had the potential to affect all residents residing in the facility.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>On April 2, 2024, at 11:10 a.m., the investigator observed various devices charging on a ledge in the common area of the building. An iPad displaying resident health information was left open and visible to anyone who walked by. Three unlicensed personnel (ULP) were observed walking by the open iPad. A resident walked up to the iPad and looked at it, then tried to plug her personal cell phone into one of the chargers. A staff member walked up to the resident and told her she did not need to charge her phone, but failed to secure the open iPad.<br><br>On April 2, 2024, at 11:20 a.m., ULP-B was observed using her personal cell phone to access the facility's electronic medical record to administer medications. ULP-B dished up medications and then left her cell phone open on the cart, displaying resident's private health information.<br><br>On April 2, 2024, at 11:25 a.m., ULP-B returned to the cart and accessed the electronic record on her personal phone and dished up another | 02430 | | |

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| 02430 | Continued From page 65<br><br>resident's medications. ULP-B left her cell phone open on the cart, displaying resident's private health information. The iPad on the ledge remained open and displaying private health information.<br><br>On April 2, 2024, at 11:35 a.m., ULP-B returned to the cart and accessed the electronic record on her personal phone and dished up another resident's medications. ULP-B left her cell phone open on the cart, displaying resident's private health information. Throughout the remainder of the medication pass, ULP-B repeatedly left her cell phone open on the cart, displaying resident's private health information.<br><br>On April 2, 2024, at 12:10 p.m., the investigator observed an iPad on a medication cart on the Burlington side displaying resident health information. The two ULP working on that side were in the kitchen assisting other residents with lunch.<br><br>On April 2, 2024, at 2:20 p.m., the investigator observed an iPad on a medication cart displaying resident health information.<br><br>On April 2, 2024, at 2:55 p.m., the investigator reviewed the facility's narcotic count book. Page 73 included a count for a resident's Gabapentin (a pain medication). The page indicated the count was zero, but underneath the zero were four partial entries. ULP-C was asked what the markings were and she stated they "used to have a resident who was a pharmacist and he'd write in the narcotic books if we left them out."<br>Throughout observations on April 2, 2024, narcotic books on both sides of the building were observed sitting unsecured on top of the medication carts. | 02430 | | |

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| 02430 | Continued From page 66<br><br>On April 2, 2024, at 4:25 p.m., the investigator observed an iPad on a medication cart on the Burlington side displaying resident health information.<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 02430 | | |
| 02480 SS=D | 144G.91 Subd. 20 Grievances and inquiries<br><br>Residents have the right to make and receive a timely response to a complaint or inquiry, without limitation. Residents have the right to know, and every facility must provide the name and contact information of the person representing the facility who is designated to handle and resolve complaints and inquiries.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to respond to grievances of one of resident (R5) reviewed for grievances.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).<br><br>The findings include:<br><br>On April 2, 2024, the investigator requested the | 02480 | | |

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| 02480 | Continued From page 67<br><br>licensee's grievances for the past three months. Three individual concerns were recorded, however no grievance forms were initiated for any of the concerns. Three pages of documentation of concerns related to R5 were provided. Information included a police report and a list of concerns dated February 16, 2024, written by corporate clinical director (CCD)-E.<br><br>The February 16, 2024, documentation completed by CCD-E included 14 bullet points of concerns brought forward by R5's family member. Concerns ranged from nebulizers not being given, physical therapy recommendations not being followed, food safety concerns, adherence to toileting plans, wound cares not being done, and a concern from the resident's provider that she is not getting her thyroid medications because her levels were elevated. The grievance record lacked evidence of what follow up was completed and if any of the concerns had been investigated.<br><br>On February 14, 2024, licensed practical nurse (LPN)-D sent an email to CCD-E and another corporate nurse letting them know a family member of R5 came to speak with her regarding some concerns. "We had a lengthy conversation and I wrote everything down so I wanted to pass this along to the correct people. She made it very clear that she did not want me to bring this to [licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A] because she thinks [LALD/CNS-A] lies and doesn't take care of the problems that arise - so she is not on this email..." The email also included that LPN-D was made aware of a resident concern about "not getting her baths when she is supposed to and then she sits in urine soiled pads/briefs because staff doesn't answer the pager when she calls for | 02480 | | |

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| DIAMOND WILLOW ASSISTED LIVING | 1558 RANDOLPH ROAD DETROIT LAKES, MN 56501 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
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| 02480 | Continued From page 68<br>help."<br><br>On April 3, 2024, at 10:00 a.m., one of R5's family members (FM)-L stated she had voiced concerns about LALD/CNS-A and not following through on things but she didn't see any changes improved responsiveness from LALD/CNS-A.<br><br>On April 3, 2024, at 10:20 a.m., FM-L stated she had brought concerns forward but did not get many of her questions answered and did not notice much follow through from the LALD/CNS.<br><br>On April 3, 2024, at 1:25 p.m., LPN-D stated she had brought concerns to LALD/CNS-A in the past and they did not get followed up on or addressed so she had lost confidence that LALD/CNS-A would handle concerns appropriately. LPN-D stated she notified their corporate nursing staff to assist with managing the grievance and assumed it would be taken care of.<br><br>On April 4, 2024, at 10:10 a.m., corporate clinical director (CCD)-E stated she had received some concerns regarding R5 and she sent a list of concerns to LALD/CNS-A to investigate. CCD-E stated she was not sure what follow up was done but would have expected LALD/CNS-A to address and investigate the concerns.<br><br>On April 4, 2024, at 2:15 p.m., director of operations (DO)-I stated the concerns brought up related to R5 should have been put on a grievance form and follow the facility's process for investigating and resolving the concerns. DO-I stated, "I don't care if it's missing laundry, it should go through the grievance procedure."<br><br>On April 9, 2024, at 5:00 p.m., LALD/CNS-A stated she was aware of the February 16th | 02480 | | |

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| | 25380 | A. BUILDING: _____ B. WING _____ | C 04/09/2024 |

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| 02480 | Continued From page 69<br><br>grievance and "[CCD-E] and I were supposed to have a meeting about that so I was kinda waiting for that meeting." LALD/CNS-A was asked if it would be appropriate to take this long to schedule a meeting regarding a concern from February and confirmed it should have been scheduled sooner and one had not yet been scheduled. LALD/CNS-A stated she had not taken any formal steps to resolve the concerns or documented any follow up realted to it but she did "take care of the concern about apple sauce and got additional people trained on safe serve." LALD/CNS-A stated a grievance form should be filled out for all concerns and sometimes concerns go to her othertimes "sometimes grievances go right to corporate, they bypass me a lot and sometimes I'll get an email that [CCD-E] has spoken to a couple of people about grievances and I get them and do what I can."<br><br>The licensee's Complaints and Grievance policy, indicated if a resident, resident representative, or employee cannot, for any reason, fill out a complaint form one will be completed on their behalf by the supervisor or Assisted Living Director. When possible and reasonable, the complaint will be resolved immediately involving others as needed. If needed, an investigation surrounding the facts of the complaint shall be initiated. After an investigation is complete, a prompt response to the resident, resident representative, or employee complaint or concern will be provided verbally and, if desired, in writing. Residents or employees will be given a reasonable explanation for the action taken on their behalf.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) | 02480 | | |

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| 02480 | Continued From page 70<br>days | 02480 | | |
| 03100 SS=D | 144.6502, Subd. 9 Obstruction of Electronic Monitoring Devices<br><br>(a) A person must not knowingly hamper, obstruct, tamper with, or destroy an electronic monitoring device placed in a resident's room or private living unit without the permission of the resident or resident representative. Checking the electronic monitoring device by facility staff for the make and model number does not constitute tampering under this subdivision.<br><br>(b) It is not a violation of paragraph (a) if a person turns off the electronic monitoring device or blocks the visual recording component of the electronic monitoring device at the direction of the resident or resident representative, or if consent has been withdrawn.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee knowingly hampered with an electronic monitoring device placed in the resident's room after facility staff requested the camera be removed.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). | 03100 | | |

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| 03100 | Continued From page 71<br>The findings include:<br><br>R1's diagnoses included severe Alzheimer's dementia with anxiety and hypertension (high blood pressure.)<br><br>R1's service plan dated February 26, 2024, indicated the resident received assistance with dressing, grooming, bathing, repositioning, transfers with a mechanical lift, fall coordination ten times per day, safety checks eight times per day, and medication administration.<br><br>R1's most recent assessment completed by corporate clinical director (CCD)-E, dated February 8, 2024, the day he admitted to hospice services, indicated the resident had impaired judgment, anxiety, and agitation  The RN was responsible for the resident's medication management, including ordering medications. The assessment failed to include the resident's risk of falls.<br><br>R1 admitted to the facility on July 6, 2023. R1 admitted to hospice services for end of life care on February 8, 2024. R1 died on February 27, 2024.<br><br>R1's record contained the following progress notes:<br>February 25, 2024, at 8:45 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A documented she "...Noted per staff that resident's guardian placed cameras in the room without notifying this writer. Staff stated they told her she needs to sign proper paperwork and she stated she won't be here this week."<br><br>February 26, 2024, LALD/CNS-A documented "...I did also call [power of attorney] and discussed the | 03100 | | |

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| 03100 | Continued From page 72<br><br>cameras set up in the room and that she needs to fill out the consent forms. She stated she would and that she has them up to help alert her to any falls. She stated she would send me the link as well if I wanted to use the monitoring..."<br><br>On April 8, 2024, R1's power of attorney (POA)-L stated she had placed the cameras in the resident's room because of ongoing falls and not feeling like he was getting adequate supervision. POA-L stated she knew from her admission contract she had the right to place a camera and did not have to disclose it for up to 14 days so she was surprised when facility staff called her and told her they needed to be removed immediately and "they told me legally, I don't have access to put cameras in unless everyone on staff signed off. I told her not according to the contract I signed, I can put a camera up...I told her the camera is staying. Then they tried to tell me I couldn't record sound and after 14 days, the camera had to be removed." POA-L stated she knew she was in her rights to have a camera placed in the resident's room and kept it up until the resident passed away approximately two days later.<br><br>On April 9, 2024, at 9:45 a.m., corporate clinical director (CCD)-E stated it would be against their policy to tell a family member they must remove a camera in the room and that facility staff would not have to sign off on it.<br><br>On April 9, 2024, at 5:00 p.m., LALD/CNS-A stated she wasn't aware POA-L was told she could not have a camera and she was aware family had the right to place a camera if they choose.<br><br>The licensee's Electronic Monitoring policy last | 03100 | | |

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| 03100 | Continued From page 73<br><br>updated November 15, 2023, indicated staff wound not knowingly hamper, obstruct, tamper with, or destroy a resident's electronic monitoring device installed as permitted under 144.6502. If the resident provides the required consent form to the Office of Ombudsman for Long Term Care, the facility expects the resident to provide the consent form to the facility 14 days after the consent was given.<br><br>No further information was provided.<br><br>TIME PERIOD TO CORRECT: Seven (7) Days | 03100 | | |