MINNESOTA
BOARD OF EXECUTIVES FOR
LONG TERM SERVICES AND SUPPORTS

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PHONE
EMAIL:
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Tiffany Ziwicki
27564 US Highway 169
Aitkin, MN 56431

Re: Agreement for Corrective Action: Dated: April 24, 2024

Dear Ms. Ziwicki:

The Standards of Practice Committee of the Minnesota Board of Examiners for Long Term Services and Support reviewed your Agreement for Correction Action and documentation in support of satisfaction of the terms contained therein. The Committee concluded that the Agreement has been satisfied. The committee then presented this to the full board on April 24, 2024, for their approval. We wanted to inform you that the full board approved your corrective action(s). We wish you future success in providing supports and services for Minnesotans and thank you for your cooperation.

Sincerely,

BOARD OF EXAMINERS FOR NURSING HOME ADMINISTRATORS

Stephen Jobe
Executive Director

BEFORE THE MINNESOTA
BOARD OF EXECUTIVES FOR LONG-TERM SERVICES AND SUPPORTS
STANDARDS OF PRACTICE COMMITTEE

In the Matter of
Tiffany Ziwicki, LALD
License No. 3557

AGREEMENT FOR CORRECTIVE ACTION

This Agreement is entered into by and between Tiffany Ziwicki, LALD ("Licensee"), and the Standards of Practice Committee ("Committee") for the Minnesota Board of Executives for Long-Term Services and Supports ("Board") based on Minnesota Statutes section 214.103, subdivision 6(a)(2). Licensee and the Committee agree to the following:

FACTS

1. On January 9, 2023, the Board granted Licensee an Assisted Living Director ("LALD") license.

2. Beginning on October 29, 2021, Licensee was the Assisted Living Director in Residence ("ALDIR") for a facility in Aitkin, Minnesota ("Facility #1"). During that time, the following occurred:

a. On April 13, 2022, the Minnesota Department of Health ("MDH") performed a survey of Facility #1. The survey identified deficiencies including a failure to ensure sufficient staffing, failure to report maltreatment allegations for two residents, and failure to identify measures to reduce elopement risk for residents Facility #1 identified as "memory care." MDH issued 34 correction orders resulting from the survey and issued a 90-day conditional license to Facility #1.

b. On October 5, 2022, MDH performed a follow-up evaluation of Facility #1. MDH determined that not all orders from the April 13, 2022 survey had been corrected and extended the conditional license to December 16, 2022.

c. Licensee's Residency Permit expired on November 1, 2022. From November 1, 2022, to January 9, 2022, there was no Director of Record listed for Facility #1. From January 9, 2023, through April 14, 2023, Licensee was listed as the Director of Record ("DOR") for Facility #1.

d. On December 19, 2022, MDH extended Facility #1's conditional license an additional 75 days to allow for transfer of residents receiving dementia-care services to facilities licensed to provide those services.

e. On January 24, 2023, MDH completed a further follow-up evaluation of Facility #1, finding it not to be in substantial compliance with Minnesota Statutes chapter 144G and extending the conditional license to May 14, 2023.

f. On or about April 14, 2023, Licensee's employment at Facility #1 ended.

3. Beginning on April 27, 2023, Licensee was DOR of an assisted living facility in Baxter, Minnesota ("Facility #2"). During that time, the following occurred:

a. Pursuant to a Conditional Licensure agreement with MDH, Facility #2 worked with a nurse consultant. The nurse consultant observed issues including missing service plans; staff not providing privacy during cares; staff not following proper hygiene prior to care; staff not having proper physician orders in place for physical devices; staff not feeling properly supported by management; and resident concerns not properly addressed by management.

b. On July 20, 2023, MDH substantiated a report of maltreatment by neglect at Facility #2, finding that the facility lacked a system for ensuring correct administration of

medication, failed to report a medication error to the affected resident's physician and failed to monitor the resident for adverse effects, failed to identify a root cause of the error, and failed to implement preventive interventions against future occurrences. The July 20, 2023, MDH report further noted that Licensee, when interviewed about the maltreatment incident, verified that a medication error form should have been completed and was not, and that the analysis and follow-up after the error were not documented. Licensee was unable to explain why the facility had an incorrect refill date for the medication in question.

4. In letters dated April 7, 2023 and June 22, 2023, Licensee responded to the Board's inquiries about the issues at Facility #1 and Facility #2 with statements including the following:

a. Facility #1's compliance issues were a result of confusion over whether the facility was licensed for Assisted Living with Dementia Care and the statute under which the surveys were performed;

b. Facility #1 began working with a nurse consultant, implemented monthly Quality Assurance and Performance Improvement ("QAPI") meetings and monthly department head meetings to address the compliance issues, and Licensee implemented a weekly manager's meeting;

c. Facility #1 worked with an outside firm to reassess the residents, with Licensee available to answer the firm's questions and concerns and communicate recommendations to the nurse at Facility #1;

d. Facility #1's owners were not supportive of or helpful with her efforts, and the nurse consultant did not provide guidance or suggestions;

e. Facility #2 provides more support than Facility #1, has appropriate staffing levels, audits staff cares and services and infection control, and holds biweekly quality meetings; and

f. Residents and families expressed satisfaction with the care they receive at Facility #1 and Facility #2.

CORRECTIVE ACTION

5. The Committee determined that the conduct described in paragraphs 2 through 4 above does not comply with Minnesota Rules 6400.7095, subpart 1.E., and necessitates the following corrective action as described below.

a. ***Completion of Coursework.*** Licensee shall arrange to enroll in and complete no less than six (6) total hours of education on the topics of leadership, QAPI and use of data points, and conflict resolution. Licensee must obtain preapproval from the Committee for the courses that Licensee selects. To secure preapproval, Licensee shall submit to the Committee a course description, including course objectives and the instructor's name and applicable credentials. The approved course or courses must not be the same courses as, and must be in addition to, any coursework Licensee completes as part of any training or onboarding required by her employer. Licensee shall complete the courses within sixty (60) days of the date of the Agreement for Corrective Action ("Agreement"). Successful completion of the courses shall be determined at the sole discretion of the Committee and verified by Licensee's submission of official certificates indicating completion of the preapproved courses. Licensee shall be responsible for any expenses associated with this coursework.

b. ***Written Report.*** Within 60 days of this Agreement becoming effective, Licensee shall submit a written report on Licensee's understanding of how she will demonstrate

improved leadership skills. Licensee shall submit or cause to be submitted to the Board verification that her employer has received a copy of the report. The Board's mailing address is Minnesota Board of Executives for Long-Term Services and Supports, c/o Stephen Jobe, Executive Director, 335 Randolph Avenue, Suite 210-B, St. Paul, Minnesota 55102. Final determination regarding successful completion of this requirement shall be at the discretion of the Committee.

OTHER INFORMATION

6. Upon Licensee's satisfactory completion of the corrective action referenced in paragraph 5 above, the Committee agrees to dismiss the complaint(s) concerning the matters referenced in paragraphs 2 through 4 above. The Committee shall be the sole judge of satisfactory completion. The Committee may reopen this complaint if it receives newly discovered information that was not available to the Committee during the initial investigation or if the Committee receives a new complaint that indicates a pattern of behavior or conduct.

7. If Licensee fails to complete the corrective action satisfactorily, the Committee may, at its discretion, reopen the investigation and proceed according to Minnesota Statutes sections 144A.19 to 144A.37 (the Board's Practice Act) and chapters 214 and 14. Licensee agrees that failure to complete the corrective action satisfactorily is failure to cooperate under Minnesota Rules 6400.7905, subpart 1.U. and may subject Licensee to disciplinary action by the Board.

8. Licensee was advised that she may be represented by legal counsel in this matter. Licensee chose to represent herself. The Committee was represented by Erin Farmer, Assistant Attorney General.

9. This agreement shall become effective upon execution by the Board's Executive Director and shall remain in effect until the Committee dismisses the complaint, unless the

Committee receives additional information that renders correct ive action inappropriate. Upon receiving such information, the Committee may, at its discretion, proceed according to Minnesota Statutes sections 144A.19 to 144A.37 (the Board's Practice Act) and chapters 214 and 14.

10. This agreement is not disciplinary action. *See* Minnesota Statutes section 214.103, subdivision 6. However, this agreement is classified as public data pursuant to Minnesota Statutes section 13.41, subdivision 5.

11. Licensee hereby acknowledges having read and understood this agreement and having voluntarily entered into it. This agreement contains the entire agreement between the Committee and Licensee, there being no other agreement of any kind, verbal or otherwise, which varies the terms of this agreement.

LICENSEE	STANDARDS OF PRACTICE COMMITTEE
TIFFANY ZIWICKI, LALD	STEPHEN JOBE Executive Director
Dated: 1/2/24	Dated: 1/5/2024

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