Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL236097003M
Compliance #: HL236091621C

Date Concluded: January 23, 2025

Name, Address, and County of Licensee Investigated:
Diamond Willow Assisted Living
915 Old Hwy 2,
Proctor, MN 55810
St. Louis County

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

Evaluator's Name: Brandon Martfeld, RN, BSN, Special Investigator

Finding: Not Substantiated

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 facility staff failed to supervise the resident causing a fall with a wrist fracture. In addition, the facility failed to provide appropriate care and services to maintain the resident's hygiene and prevent skin breakdown.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Although the resident fell and sustained a right wrist fracture, staff were following the resident's plan of care at the time of the fall. In addition, the resident records indicated the resident was independent with toileting and was provided bathing twice a week as the resident allowed.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident records,

facility incident reports, staff schedules, and related facility policy and procedures. Also, the investigator observed the facility, the resident, and the resident's room.

The resident resided in an assisted living memory care unit. The resident's diagnoses included alcohol induced dementia, and depression. The resident's service plan included assistance with bathing, dressing, and housekeeping. The resident's assessment indicated the resident had cognitive impairment, walked independently, and used the bathroom independently. Staff provided verbal ques for bathing and the resident was independent with dressing, however staff were to ensure the resident was wearing clothes appropriate for the weather.

The resident's record indicated one day the resident was outside walking in the grass while holding the hand of a staff member. The resident lost her balance and fell. The following day, the resident's right wrist was observed to be "slightly" swollen and the resident reported a "little" pain in the wrist. The facility contacted the physician, and an x-ray of the resident's wrist was ordered. Three days later the x-ray results confirmed the resident's right wrist was fractured. The resident's physician ordered a brace, and an appointment was scheduled for the resident to be seen at an orthopedic (branch of medicine dealing with the correction of deformities of bones or muscles) clinic. The resident saw an orthopedic doctor two days later and a cast was applied to the resident's right wrist.

The resident's record indicated over a two-month period, the resident's skin was clean, dry, and intact.

During an interview, facility leadership stated staff assisted the resident with grooming, bathing and encouraged the resident to change her clothes. At times, the resident refused to bathe and change her clothes, however, the resident would not wear the same clothes longer than two days. Leadership stated the resident had two falls in the last six months and leadership was not aware the resident had any skin breakdown.

During an interview, the resident stated she was independent with walking and did not need staff assistance. Staff did help with showers to ensure the resident did not fall. The resident stated her latest fall occurred several weeks ago when she was outside of the facility and fractured her wrist that required a cast. The resident had no concerns with staff providing cares and housekeeping services.

Other concerns investigated was a concern the facility and the resident smelled of urine and feces and the environment was filthy. During an onsite visit, the investigator observed the facility, the resident, and the resident's room. The resident was dressed appropriately and was wearing clean clothes. The resident's appeared well groomed and clean. The facility and the resident's room were clean and without odors.

In conclusion, the Minnesota Department of Health determined neglect was not substantiated.

“Not Substantiated” means:
An investigatory conclusion indicating the preponderance of evidence shows that an act meeting the definition of maltreatment did not occur.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
“Neglect” means neglect by a caregiver or self-neglect.
(a) "Caregiver neglect" means the failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:
(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
(2) which is not the result of an accident or therapeutic conduct.

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

Action taken by facility:
The facility staff were present with the resident outside of the facility when the resident fell. The resident physician and a family member were notified of the fall. The facility scheduled an appointment for the resident and a cast was applied to her right wrist.

Action taken by the Minnesota Department of Health:
No further action taken at this time.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23609	A. BUILDING: _____ B. WING _____	C 01/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAMOND WILLOW ASSISTED LIVING	913 OLD HIGHWAY 2 PROCTOR, MN 55810

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments On January 13, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL236097003M/#HL236091621C. No correction orders are issued.	0 000		