Protecting, Maintaining and Improving the Health of All Minnesotans

Office of Health Facility Complaints Investigative Public Report

Maltreatment Report #: HL24424047M

Date Concluded: September 30, 2021

Name, Address, and County of Licensee Investigated:
Twin Diamond Operator LLC
302 W Superior Street #70
Duluth, MN 55802
Saint Louis County

Name, Address and County of Housing with Services Registration:
Diamond Willow Assisted Living
921 Old Hwy 2
Proctor, MN 55810
Saint Louis County

Facility Type: Home Care Provider

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

Finding: Substantiated, facility and individual responsibility

Nature of Visit:
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.

Allegation(s):
It is alleged: The client was abused when the alleged perpetrator (AP) repeatedly called the client disparaging names including "bulldog", "bull dyke" and "ugly". The AP also put a pager on the client's lap and pressed the pendant multiple times so the client would know what it felt like when the pendant was pressed.

Investigative Findings and Conclusion:
Abuse was substantiated. The AP and the facility were responsible for the maltreatment. Three unlicensed personnel (ULP) witnessed the AP repeatedly verbally abuse the client. Two ULPs witnessed the AP place a pager on the client's lap and press it repeatedly.

The investigation included interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. In addition, the investigator reviewed the client's records and employee files.

The client's medical record identified diagnoses which included bipolar disorder and mild cognitive impairment. The client required assistance with all activities of daily living (ADLs). The client's IAPP identified the client was at risk for abuse and the facility would train staff on the vulnerable adult law upon hire and annually.

The client's electronic medical record included a message indicating ULP-G heard the AP call the client a "bulldog", "ugly", and "fat" in front of the client. The same documents indicated the AP yelled at the client for going to the bathroom in her pants and wanting to take a shower. The same documents indicated ULP-B said the AP was rude to the client, placed a pager on the client's lap and pressed the call light repeatedly for the client to experience the pager going off. The same documents indicated the AP yelled at the client for going to the bathroom in her pants and called the client names such as "lizard', "bulldog", and "ugly".

During an interview, ULP-B stated she heard the AP call the client names every time ULP-B worked with the AP. ULP-B stated most of the shifts she worked were with the AP. ULP-B stated the AP let the client sit in her wet pants for hours and refuse to change her. ULP-B also stated the AP called the client names like "lizard", "bull dyke", "bulldog", "a three-year-old" and yelled at the client to keep her tongue in her mouth. ULP-B also said she did not report this because she did not think it was abuse.

When interviewed, ULP-C stated the AP called the client names repeatedly for two to three months before the incident was reported. ULP-C stated the AP called the client a "bull dyke", "ugly", "stupid" and would completely ignore and refuse to work with the client. ULP-C stated she witnessed the AP put a pager on the client's lap and press it multiple times so the client could hear what the AP heard. ULP-C said when the AP called the client names, the client would put her head down and not make eye contact with people. ULP-C stated the client was happier when the AP was not working. ULP-C said she did not report this because she was scared, and the AP was her friend.

When interviewed, the previous executive director (ED) stated she was no longer employed by the facility but was at the time of the incident. The ED said the AP denied calling the client names but did confess to placing the pager in the client's lap and the AP did not see a problem with this. The ED was not aware of the incident until it was reported to her.

When interviewed, the AP stated she did not call the client names. The AP stated she did put the pager on the client's lap so the client could hear what it sounded like when the pager went off constantly. The AP stated she knows she should not have done that. The AP stated she was burnt out and frustrated.

When interviewed, the client's family members stated they were not aware these events occurred.

In conclusion, abuse 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.

Abuse: Minnesota Statutes section 626.5572, subdivision 2
"Abuse" means:
(b) Conduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to, the following:
(2) use of repeated or malicious oral, written, or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening;

Vulnerable Adult interviewed: No, due to memory loss.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The AP is no longer employed by this facility.

Action taken by the Minnesota Department of Health:
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

Or call 651-201-4890 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

cc:
The Office of Ombudsman for Long-Term Care
Saint Louis County Attorney
Proctor City Attorney
Proctor law enforcement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H24424	A. BUILDING: _____ B. WING _____	C 08/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWIN DIAMOND OPERATOR LLC	1411 LONDON ROAD DULUTH, MN 55805

(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 The Minnesota Department of Health conducted a maltreatment investigation, in accordance with Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minnesota Statute § 626.557. The Minnesota Department of Health issued a correction order pursuant to the investigation. INITIAL COMMENTS: On , the Minnesota Department of Health conducted a maltreatment investigation of complaint #HL24424047M. At the time of the investigation, there were #29 clients receiving services under the comprehensive license The following correction order is issued for #HL24424047M, tag identification 0325.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Home Care 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. 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. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144A.474 SUBDIVISION 11 (b)(1)(2).	
0 325	144A.44, Subd. 1(a)(14) Free From Maltreatment Subdivision 1.Statement of rights. (a) A client who	0 325		

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0 325	Continued From page 1 receives home care services in the community or in an assisted living facility licensed under chapter 144G has these rights: (14) be free from physical and verbal abuse, neglect, financial exploitation, and all forms of maltreatment covered under the Vulnerable Adults Act and the Maltreatment of Minors Act; This MN Requirement is not met as evidenced by: Based on observations, interviews, and document review, the facility failed to ensure one of 29 clients reviewed C1 was free from maltreatment. C1 was abused. Findings include: On September 30, 2021, the Minnesota Department of Health (MDH) issued a determination that abuse occurred, and that the facility and an individual staff person were responsible for the maltreatment, in connection with incidents which occurred at the facility. The MDH concluded there was a preponderance of evidence that maltreatment occurred.	0 325	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	