Protecting, Maintaining and Improving the Health of All Minnesotans

Office of Health Facility Complaints Investigative Public Report

Maltreatment Report #: HL24424049M

Date Concluded: September 16,2021

Name, Address, and County of Licensee Investigated:
Diamond Willow of Proctor
913 Old Highway 2
Proctor, MN 55810
St. Louis County

Name, Address, and County of Housing with Services location:
Twin Diamond Operator LLC
302 West Superior Street, #70
Duluth, MN 55802
St. Louis County

Facility Type: Home Care Provider

Evaluator's Name: Jill Hagen, RN,
Special Investigator

Finding: Substantiated, 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 alleged perpetrator (AP) abused the client when the AP slapped the client's face and swore at the client.

Investigative Findings and Conclusion:
Abuse was substantiated. The alleged perpetrator (AP) was responsible for the maltreatment. The AP admitted to holding down the client's arms and, in the process, slapped the client's face when providing incontinent care for the client.

The investigation included interviews with facility staff members including administrative staff and unlicensed staff. In addition, the investigation included a review of the client's medical record, the AP's personnel file, staff schedules, the facilities investigation, and facility policies and procedures.

The client had diagnoses that included Alzheimer's dementia. The client required staff to anticipate her needs and required staff assistance with all activities of daily living including

incontinence care every two to three hours. The client used a wheelchair for mobility and a sling mechanical lift for transfers.

The client had a history of physical and verbal aggression toward staff and other clients. Care planned approaches directed staff to reduce the behaviors by redirecting the client's behavior, setting limits, providing positive reinforcement for healthy and positive behaviors, notifying the nurse when needed, distracting the client with a favorite topic or activity, providing touch, music, and comfort objects. Additional interventions included ensuring the client had the necessary adaptive equipment such as glasses and hearing aids, avoiding overreacting to the behavior, assisting the client with toileting and check and change the incontinent brief, monitoring for signs and symptoms of pain, providing Tylenol as needed, administering Seroquel (antipsychotic medication) when interventions were not successful, or laying the client in bed.

The facility investigation indicated an unlicensed professional (ULP) notified management they witnessed the AP slapped the client's face with an open hand and yelled at the client to "shut the fuck up!" Management came to the facility, interviewed the staff, assessed the client for injuries, and suspended the AP. The AP denied slapping the client and raising her voice.

During interview, the ULP stated she and the AP assisted the client with evening cares. When turning the client from side to side in bed, the client began hitting at the AP. The AP, with an open palm, slapped the client in the face and stated, "All you have to do was hit [the client] and she stops." The AP grabbed the client's right arm and twisted the arm backwards. The AP held the client's hands down to finish the cares. That evening was the first time the ULP worked with the AP.

During interview, management stated the facility trained all staff regarding vulnerable adult definitions, reporting maltreatment concerns, and to follow a clients care plan.

During interview, the AP stated she held down the client's hands to prevent the client from hitting during cares. The AP knew holding down the client's hands was a restraint and not care planned for how to deal with the client's behaviors. While struggling with the client to restrain her hands, the AP slapped the client's face but said she did not hit the client hard. The client responded to the AP's actions with increased hitting. The AP stated she was frustrated with the client and should have re-directed the client or left the room and approached the client at a later time. The AP denied yelling and swearing at the client and twisting the client's arm.

In conclusion, abuse was substantiated. The AP was responsible for the maltreatment. The AP admitted to holding down the client's arms and slapping the clients face.

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:
(a) An act against a vulnerable adult that constitutes a violation of, an attempt to violate, or aiding and abetting a violation of:
(1) assault in the first through fifth degrees as defined in sections 609.221 to 609.224;
(2) the use of drugs to injure or facilitate crime as defined in section 609.235;
(3) the solicitation, inducement, and promotion of prostitution as defined in section 609.322; and
(4) criminal sexual conduct in the first through fifth degrees as defined in sections 609.342 to 609.3451. A violation includes any action that meets the elements of the crime, regardless of whether there is a criminal proceeding or conviction.
(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:
(1) hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult;
(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;
(3) use of any aversive or deprivation procedure, unreasonable confinement, or involuntary seclusion, including the forced separation of the vulnerable adult from other persons against the will of the vulnerable adult or the legal representative of the vulnerable adult; and
(4) use of any aversive or deprivation procedures for persons with developmental disabilities or related conditions not authorized under section 245.825.
(c) Any sexual contact or penetration as defined in section 609.341, between a facility staff person or a person providing services in the facility and a resident, patient, or client of that facility.
(d) The act of forcing, compelling, coercing, or enticing a vulnerable adult against the vulnerable adult's will to perform services for the advantage of another

Vulnerable Adult interviewed: No, deceased.
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility:
Management provided training regarding their vulnerable adult policy and procedures and following a client’s care plan. The facility no longer employed the AP.

Action taken by the Minnesota Department of Health:
The facility was issued a correction order regarding the vulnerable adult’s right to be free from maltreatment.

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
Proctor Police Department
City of Proctor Attorney
St. Louis County Attorney

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 08/19/2021

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 ******ATTENTION****** HOME CARE PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144A.43 to 144A.482, the Minnesota Department of Health issued a correction order pursuant to an investigation. 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. INITIAL COMMENTS: On August 19, 2021, the Minnesota Department of Health initiated an investigation of complaint #HL24424049M. At the time of the investigation, there were #29 clients receiving services under the comprehensive license. The following correction order is issued for #HL24424049M, tag identification 0325.	0 000		
0 325	144A.44, Subd. 1(a)(14) Free From Maltreatment Subdivision 1.Statement of rights. (a) A client who 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;	0 325		

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0 325	Continued From page 1 This MN Requirement is not met as evidenced by: Based on interviews and document review, the facility failed to ensure one of one clients reviewed (C1) was free from maltreatment. C1 was abused. Findings include: On September 16, 2021, the Minnesota Department of Health (MDH) issued a determination that abuse occurred, and that an individual staff person was 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.	