Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL244255842M
Compliance #: HL244253822C

Date Concluded: October 21, 2025

Name, Address, and County of Licensee Investigated:
Diamond Willow Memory Care and Assisted Living
132 W North Rd ST 6B
Cloquet, MN 55720
Carlton County

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

Evaluator's Name:
Katherine Barnhardt RN, 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 alleged perpetrator (AP) neglected the resident when the AP transported the resident on the seat of a four-wheel walker while outside. The walker hit a rock, tipped over, and the resident was injured.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The resident was outside, became short of breath, and was directed by the AP to sit on her four-wheeled walker. The AP pushed the resident on the four-wheeled walker back to the facility and hit a bump on the sidewalk. The resident was sent to the emergency room and returned to the facility later that evening. The AP was acting in the resident's best interest to provide medical care, and the incident does not rise to the level of neglect.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted a medical facility. The investigation included review of the resident record(s), hospital records, rounding provider records, pharmacy records, facility internal investigation, facility incident reports, personnel files, staff schedules, related facility policy and procedures. Also, the investigator observed facility staff interact with the resident.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia and an anxiety disorder. The resident's service plan included assistance with pendant checks, fall coordination and behavior management for anxiety. The resident's assessment indicated the resident required assistance from one staff and a gait belt for walker ambulation. The resident's assessment indicated the resident utilized as needed oxygen at two liters per minute (LPM) for shortness of breath and facility staff were directed to contact a nurse if the resident experienced respiratory distress.

The resident record indicated the resident seen a rounding provider and had a history of anxiety. The resident's record indicated distractions, redirection, and activities were used to comfort the resident when the resident experienced anxiety.

Rounding provider notes indicated the resident had a history of falls and the resident's strength had decreased over the prior week. The rounding provider notes indicated the resident was seen three days prior to the incident and the provider ordered a physical therapy evaluation and a standard wheelchair.

The resident's progress notes indicated the AP, and the resident walked outside with the resident's four-wheel walker. The resident became anxious and reported shortness of breath and weakness. Progress notes indicated the AP instructed the resident to sit on the walker and the AP attempted to push the resident back into the facility with the resident seated on the walker. Progress notes indicated when the AP pushed the resident back to the facility the walker hit a rock and tipped over. Progress notes indicated the resident struck her head when the walker tipped over and the AP was instructed by licensed triage staff to call emergency medical services. Progress notes indicated the resident was transported to the hospital and an incident report was completed.

An incident report indicated the resident went outside for a walk with the AP when the resident was anxious. When outside, the resident became weak, and the AP utilized the resident's walker to return the resident to the facility. The incident report indicated a walker wheel had gone off the sidewalk and the resident fell backwards and struck her head. The incident report indicated licensed staff, 911 and the family were notified. The incident report indicated the resident was transported to a hospital emergency room for evaluation.

The resident's hospital records indicated the resident was seated on her walker and being pushed when the walker hit a crack in the sidewalk ejecting the resident and the resident hit

her head. Hospital records indicated the resident reported back pain and CT scans (non-invasive imaging tests) were completed. Hospital records indicated a compression fracture was found at the T12 (vertebra bone in spine) level; however, it could not be determined if it was an old or new injury.

During an interview, licensed staff stated the resident required an assist of one staff with ambulation. Licensed staff stated she was contacted by the AP when the resident fell, however her workday had ended, and she directed the AP to call triage on-call to maintain continuity of care for the resident. Licensed staff stated she was updated of the details of the fall when she returned to work. Licensed staff stated it was reported to her the AP was outside with the resident and the resident reported shortness of breath and was directed by the AP to sit on the seat of the walker. Licensed staff stated while the resident was seated on the walker, the AP attempted to push the resident back to the facility, the walker hit a stone and tipped over and the resident hit her head. Licensed staff stated the resident returned from the emergency room the same night with pain medication orders. Licensed staff stated the on-call followed the resident throughout the weekend assisted with orders and notified the resident's family. Licensed staff stated there were no changes to the resident's services until the resident was seen by the rounding provider the next week.

During an interview, the resident stated she did not recall the walker tipping over or the fall. The resident stated she went to the emergency room and returned to the facility. The resident stated she was "almost" at baseline.

During an interview, a family member stated they were notified of the fall and taking the resident outside was one of the interventions used to manage the resident's anxiety. A family member stated there were no concerns with cares the resident received at the facility and the AP acted appropriately for the situation when she pushed the resident on her walker.

During an interview, the AP stated the resident had become anxious and the AP took the resident outside for a walk with the resident's walker. The AP stated while outside the resident became weak and the AP feared for the resident's safety and didn't want the resident to fall. The AP stated she had the resident sit on the seat of the walker and was pushing the resident back towards the building when the front wheel of the walker went off the uneven sidewalk and the resident and the AP fell. The AP stated the resident had fallen backward and hit her head. The AP stated she called for assistance from a co-worker, notified licensed facility staff, on-call licensed staff. and emergency services. The AP stated emergency services transported the resident to the hospital for evaluation and the resident returned that night.

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: Yes.

Action taken by facility:
The facility summoned emergency services.

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
	24425	A. BUILDING: _____ B. WING _____	C 09/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAMOND WILLOW ASSISTED LIVING	130 WEST NORTH ROAD CLOQUET, MN 55720

(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 September 29, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL244255842M/ #HL244253822C. No correction orders are issued.	0 000		