Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL285457007M
Compliance #: HL285453317C

Date Concluded: November 21, 2023

Name, Address, and County of Facility Investigated:
Diamond Willow of Lester Park
6353 East Superior Street
Duluth, MN 55804
St. Louis County

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

Evaluator's Name: James Larson, RN
Special Investigator

Finding: Substantiated, facility 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):
A facility staff member/ alleged perpetrator (AP) sexually abused the resident by inappropriately touching her on more than one occasion, causing bruising of the thighs and vagina. In addition, the facility neglected the resident when facility staff failed to assess, investigate, and implement new interventions when multiple occurrences of inner thigh bruising were observed on the resident.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was inconclusive. Due to incomplete and conflicting accounts, the cause of the bruising was not able to be determined, and an alleged perpetrator (AP) was not able to be identified.

The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. Inner thigh bruising was observed on the resident on three separate occasions over a fifteen-week period. Neglect occurred when the facility failed to act on their awareness and knowledge of the multiple occurrences of unexplained bruising and

failed to develop and/or implement new interventions to protect the resident's health and safety.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator also contacted law enforcement and the resident's family. The investigation included review of hospital records, facility policies and procedures, incident reports, and the resident's facility medical record including nursing assessments, service plans, and progress notes. At the time of the onsite visit, the investigator observed medication administration and staff assistance with activities of daily living, including transfer techniques.

The resident resided in an assisted living memory care facility. The resident's diagnoses included dementia with behavioral disturbance, hallucinations, and anticoagulant (blood thinner) use. The resident's assessment identified the resident was cognitively impaired, able to verbally communicate her needs, had impaired decision making and was a poor historian, and had a history of progressive night terrors. The resident's service plan directed staff to provide assistance with activities of daily living including bathing, grooming, dressing, toileting, and transfers. The service plan identified one person was required to assist with all cares however, the resident required a two-person assist and the use of a mechanical lift for transfers. The resident's service plan included for staff to assist the resident weekly with bathing and a partial bed bath was to be given daily. Staff were directed to contact the nurse with any changes noted to the resident's skin.

Review of the resident's record included a nursing note from a routine skin assessment which identified "small bruise noted under belly button and scant scattered bruises to the left thigh-unknown origin." No further follow-up, monitoring, or investigation into the origin of the bruising was initiated by the facility.

Approximately two weeks later, the resident's family submitted a complaint to the facility when they observed bruises on the resident's thighs. An incident report was completed, local police were notified, and an internal investigation was initiated by the facility. The resident was interviewed and reported she was sexually assaulted on more than one occasion when an unknown individual/alleged perpetrator (AP) entered her room in the night and inserted fingers into her vagina. The family requested for the resident to have no male caregivers and for the resident to be examined by a female physician.

Five days later, after a family member questioned nursing staff about why the resident had not yet been examined by a physician, the resident was sent to the emergency room for a sexual assault examination. The sexual assault nurse examination (SANE) report identified four areas of bruising to the resident's left thigh and periuvular (around the vulva) bruising. The resident was discharged back to the facility per the family's request.

Upon the resident's return, no new interventions were developed or implemented to protect the resident's health and safety.

Three months later, a third instance of unexplained bruising on the resident's thighs was reported by facility staff. Although the facility reported the incident, no further follow-up, monitoring, or investigation into the origin of the bruising was initiated and no new interventions were developed or implemented to prevent further occurrence.

The resident's medical record was not updated to include an intervention for two staff members to be present for all cares until one month after the third report of inner thigh bruising.

During an interview with a resident's family member, they recalled assisting the resident in the bathroom when they initially saw multiple circular bruises, in a line, along the resident's inner thigh. They reported the bruising to facility staff and requested for no male staff to be assigned to care for the resident. Although no formal complaint was made, the family recalled the registered nurse made an entry in the resident's record of the unknown injury. Approximately one week later, the resident made a request to the family member that she be put to bed with pants on because she "did not want them in there and it hurts inside."

During an interview with the resident, she stated she was sexually assaulted on more than one occasion when an unknown AP entered her room in the night and inserted fingers into her vagina. There were inconsistencies provided in description of the event(s) which occurred, and no specific AP could be identified. When asked about the third and most recent event, the resident denied any assault occurred and had no knowledge of the origin of the bruises.

During an interview with a facility nurse, the nurse recalled the resident had a history of visual and auditory hallucinations and although the resident was able to follow directions, she would on occasion stiffen up when staff provided care. The nurse stated no additional interventions were placed on the resident's care plan following the incidents, only that staff were instructed to use caution with the resident during cares due to a history of bruising easily.

During an interview with the facility administrator, when asked about the delay in treatment or being transported to a hospital after the second incident, she deferred to nursing staff and denied knowledge the situation.

In conclusion, the Minnesota Department of Health determined abuse was inconclusive and neglect was substantiated.

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or did not occur.

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.

Substantiated: Minnesota Statues, section 626.5572, Subdivision 19.
“Substantiated” means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

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: N/A

Action taken by facility: The facility conducted an internal investigation into the allegations of sexual abuse.

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

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

You may also call 651-201-4200 to receive a copy via mail or email

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Duluth City Attorney
Duluth Police Department
Minnesota State Board of Nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28545	A. BUILDING: _____ B. WING _____	C 10/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAMOND WILLOW ASSISTED LIVING	6353 EAST SUPERIOR STREET DULUTH, MN 55804

(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****** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint 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: HL285453317C/HL285457007M On October 11, 2023, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction order is issued. At the time of the complaint investigation, there were 19 residents receiving services under the provider's Assisted Living license. The following correction order is issued for HL285453317C/HL285457007M, tag identification 2360.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License 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 144G.31 subd. 1, 2, and 3.	
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial	02360		

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02360	Continued From page 1 exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		