Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL369029182M
Compliance #: HL369027581C

Date Concluded: March 20, 2025

Name, Address, and County of Licensee Investigated:
A Daughter's Love Inc
25184 Thunder Road
Staples, MN 56479
Todd County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Barbara Axness, RN
Special Investigator

Finding: Inconclusive

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 the registered nurse (RN) failed to assess the resident's ability to use bedrails. The resident became entrapped in a bedrail and sustained a bruise.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. While the RN failed to assess the resident's bedrail, there was insufficient evidence and conflicting information provide about the incident. It was unable to be determined if the resident was entrapped in the bedrail and/or what area of the resident's body was bruised.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the case manager. The investigation included review of the resident record, facility incident reports, staff schedules, and related facility policy and procedures. Also, the investigator observed the resident's bedrails.

The resident resided in an assisted living facility. The resident's diagnoses included dementia. The resident's service plan included assistance with activities of daily living, repositioning, transfers, and mobility. The resident's assessment indicated the resident had a standard bed frame and did not use assistive devices. The resident did not have a bedrail assessment completed. The resident transferred with assistance of two people and a gait belt, had decreased muscle coordination in his legs, and was impulsive with decision making. The resident had impaired cognition that fluctuated throughout the day and night.

An incident report indicated the resident fell and sustained a bruise on an unidentified part of his body after he fell out of bed. The incident report indicated staff had found the resident "half on the floor and half on the bed…hanging on to the side rail of the bed and his butt and legs on the floor…" Additional staff were called to help get the resident off the floor and the resident was put back in bed and assessed for injuries.

Multiple unlicensed personnel (ULP) interviewed could not recall specific details of the alleged incident and could not recall if the resident had been entrapped in the bedrail or if any part of his body was bruised.

The primary nurse stated she didn't hear of any reports regarding the resident getting entrapped in bedrails and since she hadn't completed the incident report, she wasn't aware of any other details. The primary nurse stated the resident had a history of falling out of bed and having his legs hang over the side of the bed but she wasn't sure if he had ever gotten stuck in the bedrails. The nurse who completed the incident report could not recall exact details of the incident and did not remember if the resident had been entrapped in the bedrail at all.

During an interview, the resident's responsible party stated she heard the resident's arm or hand got stuck in the bed rail so they removed one of the bedrails from his bed.

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

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.

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: Unable due to cognition.
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
No action taken.

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
	36902	A. BUILDING: _____ B. WING _____	C 02/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A DAUGHTERS LOVE INC	25184 THUNDER ROAD STAPLES, MN 56479

(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 February 19, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL369027581C/HL369029182M. No correction orders are issued.	0 000		