Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL236098284M
Compliance #: HL236095463C

Date Concluded: January 23, 2024

Name, Address, and County of Licensee Investigated:

Diamond Willow Assisted Living
915 Old Highway 2
Proctor, MN 55810
St. Louis County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name:
Jana Wegener, RN, Special Investigator

Finding: Substantiated, facility and individual responsibility

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 resident was neglected when the alleged perpetrator, (AP)1, failed to safely transfer the resident as indicated in the resident's plan of care, the resident fell, and sustained a proximal right femur (hip) fracture. In addition, AP2 neglected the resident when AP2 failed to safely transfer the resident as indicated in the resident's plan of care, the resident fell again with pain in her right hip.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. AP1 and the facility were responsible for the maltreatment. AP1 failed to follow the residents plan of care which instructed staff to use a transfer belt and leg brace with transfers. The resident fell and sustained a right femur fracture requiring surgical repair and hospitalization.
AP2 failed to follow the resident's plan of care for safe transfers. The resident fell and complained of pain. However, the facility failed to ensure AP2 had completed training and competency prior to providing care independently to the resident.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident's medical records, facility communication notes, physician notes, radiology reports, AP's employment and training records, and facility policy and procedures. The investigator completed onsite observation of staff assisting residents with cares.

The resident resided in an assisted living facility with diagnoses including early onset Alzheimer's Disease, dementia, contracture of right hand, stroke, and hemiplegia (paralysis on one side of the body).

The resident's assessment indicated the resident was cognitively impaired but able to communicate her needs and was usually understood. A fall risk assessment indicated the resident was at a risk for falls related to decreased coordination, problems with balance while standing, right sided hemiplegia, impaired cognition, confusion/forgetfulness, anxiety, and poor decision-making ability. The assessment indicated the resident required assistance from one to two staff with transfers using a transfer belt for stability. The assessment instructed staff to provide toileting every two to three hours, use proper footwear, and ensure appropriate assistance was provided to the resident with transfers.

The residents service/care plan indicated the resident was unable to walk due to hemiplegia affecting the right side of her body. The residents service/care plan indicated she required assistance from one to two staff with transfers using a transfer belt and leg brace for stability. The care plan indicated the resident required one to two assistance using a transfer belt with showers and instructed staff to apply the resident's leg brace upon waking.

A fall incident report completed by AP1 at the time of the incident indicated when transferring the resident out of the bathtub the resident had bare feet and slipped on the wet floor. The report indicated the resident had pain in her right knee and the provider was notified with additional pain management ordered.

A facility report indicated the resident fell when AP1 failed to use a transfer belt or leg brace as indicated in the resident's plan of care. The report indicated the floor was wet, and the resident's wheelchair brakes were not locked at the time of the incident.

A provider communication indicated the facility notified the provider of the residents fall and knee pain. The provider ordered an X-ray of the resident's right knee to be completed onsite due to the resident's advanced dementia.

A radiology report indicated there was no fracture of the resident's right knee.

The progress notes indicated the following day the resident reported pain in her right hip, instead of the right knee as identified initially. The progress notes and provider communication

indicated the facility updated the provider with orders received for X-rays of the resident's hip and femur.

A radiology report indicated the resident sustained a proximal femur (hip) fracture. The resident record indicated the resident was transferred to the emergency department and admitted to the hospital for surgical repair. The resident was readmitted to the facility six days later.

When interviewed AP1 stated she had provided care to the resident before, knew how to apply a transfer belt, and knew how to find the resident's care plan. AP1 stated she did not look for a transfer belt or review the resident's plan of care before providing care to the resident. AP1 stated she thought she could do it on her own.

When interviewed the nurse who responded after the incident occurred stated AP1 failed to use a transfer belt, proper footwear, and did not ask for assistance with transferring the resident. The nurse indicated AP1 completed training and the nurse observed AP1 providing care to residents with no concerns of AP1's competency prior to the incident.

When interviewed another staff stated she trained AP1 prior to the incident. The staff stated she had reviewed the resident's plan of care with AP1, and instructed AP1 on using a transfer belt, and applying the resident's leg brace for transfers.

When interviewed a registered nurse stated she had completed skills and competency with AP1 prior to the incident. The nurse stated AP1 demonstrated skills and competency with safe transfer techniques using a transfer belt and accessing the resident's plan of care.

When interviewed facility leadership stated when she talked to AP1 after the incident occurred, AP1 knew the resident should have had a transfer belt on at the time of the incident.

When interviewed another registered nurse stated she provided re-education to AP1 after the incident occurred. The nurse stated AP1 verbalized feeling comfortable with the training she had received prior to the incident and expressed feeling comfortable with her duties. The nurse stated AP1 knew the resident should have had on proper footwear, leg brace, and a transfer belt at the time of the incident.

AP1's training records indicated she had completed training, competency, and online training modules which included safe transfers using a transfer belt, falls prevention, and bathing/showering skills prior to the incident.

Approximately three months later, a fall incident report indicated the resident fell when AP2 assisted the resident to the toilet without a transfer belt, proper footwear, or the resident's leg brace.

A review of AP2's personnel files indicated she was newly hired at the time of the incident.

When interviewed AP2 stated she was training at the time of the incident. AP2 stated staff instructed her to go help the resident to the bathroom alone. AP2 stated she had not reviewed the residents plan of care, and did not use a transfer belt, proper footwear, or leg brace at the time of the incident.

When interviewed a registered nurse stated she went to the facility after the fall incident with AP2. The nurse stated the residents plan of care was not followed at the time of the incident and AP2 did not use a transfer belt, proper footwear, or the resident's leg brace. The nurse stated AP2 was in training at the time of the incident and had not yet completed skills and competency. The nurse stated after the incident occurred AP2 was removed from her duties and completed the skills and competencies checklist including safe transfers and toileting at that time. The nurse stated when she talked to staff after the incident occurred, staff stated they were busy and instructed AP2 to go help the resident to the bathroom alone. The nurse stated AP2 should not have been working independently at any point prior to her training and competency sign off. The nurse stated the resident had pain after the incident and was evaluated in the emergency department with no injury noted.

When interviewed the resident's family member stated the facility failed to ensure the resident's plan of care was consistently followed. The family member stated they had reported their concerns to the facility but continued to witness the resident without her leg brace on numerous occasions.

In conclusion, the Minnesota Department of Health determined neglect 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.

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: No, unable.
Family/Responsible Party interviewed: Yes
Alleged Perpetrators interviewed: Yes

Action taken by facility:
The resident was assessed for injures after the incident's occurred, and the facility communicated with the resident's provider and family. The facility provided re-education to staff on safe transfer techniques after the incidents occurred.

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

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
The Office of Ombudsman for Mental Health and Developmental Disabilities
MN Department of Human Services
St. Louis County Attorney
Proctor City Attorney
Proctor Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23609	A. BUILDING: _____ B. WING _____	C 12/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAMOND WILLOW ASSISTED LIVING	913 OLD HIGHWAY 2 PROCTOR, MN 55810

(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: #HL236095463C/#HL236098284M On December 14, 2023, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 41 residents receiving services under the provider's Assisted Living license. The following correction orders are issued for #HL236095463C/#HL236098284M, tag identification 0730, and 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.	
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident:	0 730		

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0 730	Continued From page 1 (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service	0 730		

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0 730	Continued From page 2 termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of one resident, (R1), medical records contained the required documentation of a thorough investigation of incidents, and complaints/grievances involving the resident and actions taken in response, when suspected maltreatment of R1 a resident occurred including interviews/statements of staff and potential witnesses involved for one of one resident (R1) reviewed. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety) and was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). Findings include: The licensee failed to ensure contents of a resident record included the following for R1: Documentation of incidents involving the resident and actions taken in response to the needs of the resident. Documentation of complaints received and any resolution. R1 was admitted to the facility on May 28, 2019, with diagnoses including early onset Alzheimer's	0 730		

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0 730	Continued From page 3 Disease, dementia, contractures of right hand, stroke, and hemiplegia (paralysis on one side of the body). R1's 90 day assessment dated May 31, 2023, indicated R1 was cognitively impaired but able to communicate her needs and was usually understood. A fall risk assessment indicated R1 was at a risk for falls related to decreased coordination, problems with balance while standing, right sided hemiplegia, impaired cognition, confusion/forgetfulness, anxiety, and poor decision-making ability. The assessment indicated R1 required assistance from one to two staff with transfers using a transfer belt for stability. The assessment instructed staff to provide toileting every two to three hours, use proper footwear, and ensure appropriate assistance was provided to R1 with transfers. R1's care plan updated November 21, 2023, indicated R1 was unable to walk due to hemiplegia affecting the right side of her body. R1's care plan indicated she required assistance from one to two staff with transfers using a transfer belt and leg brace for stability. The care plan indicated R1 required one to two assistance using a transfer belt with showers and instructed staff to apply R1's leg brace upon waking. On August 30, 2023, at 1:30 p.m. unlicensed personnel (ULP)-A completed a fall incident report. The incident indicated ULP-A transferred R1 out of the tub with bare feet and the resident slipped on the wet floor. The report was reviewed by licensed practical nurse (LPN)-C and indicated R1 had pain in her right knee, and the provider was notified with pain management ordered. The incident report failed to include details of the incident including R1's care plan was not followed	0 730		

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0 730	Continued From page 4 at the time of the incident, or actions taken to prevent recurrence. A facility complaint grievance form dated August 30, 2023, indicated R1's family filed a complaint regarding the fall incident. The complaint indicated ULP-A failed to use proper footwear after a bath. A complaint response dated September 2, 2023, indicated X-rays and pain medication were ordered, and R1 was sent to the hospital. The form indicated on August 30, 2023, all staff were re-educated. The form indicated an investigation of the incident was completed by cooperate registered nurse (RN)-G. A document titled "Record of Complaint and Investigative Process" dated August 30, 2023, indicated R1's family filed a complaint that R1 had a fallen due to staff not using proper equipment. The report indicated a MAARC report would need to be filed for known/suspected maltreatment of a vulnerable adult. The form indicated the licensed assisted living director (LALD)-F and RN-G had completed an investigation. The document included instructions to interview staff and get staff statements of the incident and attach them with the investigators notes to the form. The documentation lacked details of the incident including ULP-1 had not followed R1's care plan at the time of the incident to use a transfer belt, foot brace, and proper footwear. The investigation failed to include information including ULP-A transferred R1 with bare feet on a wet floor, and the wheelchair brakes were not locked at the time of the incident. The documentation lacked interviews and statements from staff involved including ULP-A at the time of the incident, and the staff who responded to assist R1, assessed R1 for injuries, and what the staff involved witnessed/heard at the time of the incident, and	0 730		

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0 730	Continued From page 5 after the incident occurred. Facility investigation documentation including staff statements at the time of the incident were requested, none were provided. A facility Minnesota Adult Abuse Reporting Center (MAARC) report dated August 31, 2023, indicated R1 fell when ULP-A failed to use a transfer belt or leg brace as indicated in the resident's plan of care. The report indicated the floor was wet, and the resident's wheelchair brakes were not locked at the time of the incident. An undated facility document titled root cause analysis (RCA) indicated ULP-A was properly trained and aware of the proper procedure/technique at the time of the incident. The RCA indicated ULP-A was signed off on competencies prior to providing care to R1. The RCA indicated R1 was a one assist and indicated no transfer belt was used with R1 typically. The RCA indicated non-slip footwear was not used, R1 was bare foot, and the wheelchair brake was not functioning on the right side. The RCA indicated no adjustment to R1's plan of care was needed. The RCA indicated maintenance looked at the wheelchair brake but did not identify if there was any dysfunction needing repair. The RCA failed to identify the floor was wet at the time of the incident and R1 required one to two assist with a transfer belt, foot brace, and proper footwear for all transfers. On December 8, 2023, at 9:00 a.m. a fall incident report indicated the resident fell when ULP-B assisted the resident to the toilet without a transfer belt, proper footwear, or the resident's leg brace. A document titled "Record of Complaint and	0 730		

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0 730	Continued From page 6 Investigative Process" dated December 12, 2023, indicated R1's family removed R1 from the facility due to a fall with no injury. The document indicated a MAARC report was needed for known/suspected maltreatment of a vulnerable adult. The document lacked details of the incident including ULP-B had not followed R1's plan of care at the time of the incident to use a transfer belt, foot brace, or proper footwear. The form indicated LALD-F and RN-I had completed an investigation of the incident. The document included instructions to interview staff and get staff statements of the incident and attach the investigators notes to the form. Staff interviews/statements were requested, none were provided. ULP-B's personnel files indicated she was recently hired on November 17, 2023. ULP-B's skills and competency checklist included transferring a resident, toileting assistance, completed on December 7, 2023, the day before the incident with R1 occurred, signed off by RN-I on December 7, 2023. On January 5, 2024, at 10:54 a.m. ULP-B stated she was training at the time of the incident. ULP-B stated the staff she was working/training with that day instructed her to go help R1 to the bathroom alone. ULP-B stated she had not reviewed the residents plan of care, and did not use a transfer belt, proper footwear, or leg brace at the time of the incident. On January 5, 2024, at 9:36 a.m. RN-I stated she went to the facility after the fall incident with ULP-B. The nurse stated R1's plan of care was not followed at the time of the incident and ULP-B did not use a transfer belt, proper footwear, or	0 730		

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0 730	Continued From page 7 R1's leg brace. RN-I stated ULP-B was in training at the time of the incident and had not completed skills and competency. RN-I stated after the incident occurred ULP-B was removed from her duties and completed the skills and competencies checklist including safe transfers and toileting at that time. RN-I stated the date on ULP-B's skills and competency forms were incorrect and they were completed on December 8, 2023. RN-I stated she talked to staff working with ULP-B after the incident occurred, and they stated they were busy and instructed ULP-B to go help R1 to the bathroom alone. RN-I stated ULP-B was in training and should not have been working independently at any point prior to her training being completed weather staff were busy or not. RN-I stated she did not document interviews with ULP-B or staff involved who directed her to assist R1 independently. RN-I indicated she thought that was the roll of the LALD. A date correction on ULP-B's skills competency form was requested but not provided. On January 5, 2024, at 10:18 a.m. RN-H stated when suspected/known maltreatment of a resident occurred an investigation would be completed, and a report submitted to MAARC. RN-H stated video footage should be viewed, interviews of staff working at the time of the incident should be documented, written statement from staff of what happened in their own words, and any other pertinent incident investigation documents like provider communication or records reviewed should be attached to the investigation document and put into the investigation binder. On January 3, 2023, at 3:18 p.m. email communication with LALD-F indicated she had to cross reference timecards to determine which	0 730		

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0 730	Continued From page 8 staff were working the days the incidents occurred. The email communication indicated the facility investigation lacked information including key staff and witnesses involved when the incident's occurred. On January 4, 2023, at 12:14 p.m. email communication with LALD-F indicated after the day the incident occurred ULP-B did not respond to phone calls and indicated she was unable to be interviewed. LALD-F indicated RN-I had a conversation with ULP-B after the incident. Documentation of RN-I's conversations with ULP-B and staff working the day of the incident were requested, none were provided. As a result, the facility failed to identify issues with ensuring new staff were properly trained and competent prior to providing care to resident's independently. On December 14, 2023, at 10:21 a.m. LALD-F stated after the incident occurred ULP-A stated she was supposed to use a transfer belt with R1. LALD-F stated she was not sure what kind of training was provided to staff after the incident occurred with safe transfers with bathing and wet floors. A facility policy and procedure titled "Vulnerable Adults (VA) and Maltreatment Communication, Prevention, and Reporting" revised August 17, 2023, indicated if alleged or suspected maltreatment occurred, the facility would take corrective action to protect the health and safety of the VA's. An internal investigation would be completed by the RN and LALD or their designee to interview persons in the event in question. During an investigation the facility would obtain a list of staff members and contact information, the RN would complete a summary of the investigation including information on the alleged	0 730		

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(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
0 730	Continued From page 9 perpetrator including date of hire, address phone number and summary of any other disciplinary actions. The policy indicated written statements from all staff involved with date and signature of staff, and a summary of communication with family members would be obtained. The policy indicated a corporate RN would review information to ensure completion of an investigation and an internal review would be completed to determine if policies and procedures were followed, need for additional training, corrective action taken, and a MAARC report would be filed within 24 hours of knowledge of the concern. No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	0 730		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial 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(s) reviewed, (R1) was free from maltreatment, R1 was neglected. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred. The facility and an individual person were	02360		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23609	A. BUILDING: _____ B. WING _____	C 12/14/2023

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02360	Continued From page 10 responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		