Protecting, Maintaining and Improving the Health of All Minnesotans

Office of Health Facility Complaints Investigative Public Report

Maltreatment Report #: HL24424051M **Date Concluded:** November 12, 2021

Name, Address, and County of Licensee Investigated:
Diamond Willow
1558 Randolph Road
Detroit Lakes, MN 56501
Becker County

Facility Type: Home Care Provider **Evaluator's Name:** Laura duCharme, 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) neglected the client when the AP failed to provide cares overnight. The client fell and sustained a cut on his head. The client was transported and admitted to the hospital.

Investigative Findings and Conclusion:
Neglect of care was substantiated. The AP was responsible for the maltreatment. The client required staff assistance overnight for both toileting and safety checks, however the AP did neither. When staff members working the next shift entered the client's room, they found the client on the floor with a cut and dried blood on his head. The client required hospitalization.

The investigation included interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. In addition, the investigator reviewed the client's medical records, facility policies and procedures, and staff personnel records.

The client's diagnoses included hemiplegia (right sided paralysis), aphasia (impairment in speech and language), and macular degeneration (visual impairment). The client received staff assistance with toileting, transferring, dressing, and bed mobility. The client's medical record indicated the client received an anticoagulant (a medication slowing the clotting of blood).

The client's most recent assessment indicated he was forgetful, disoriented, and at a high risk for falling. The care planned indicated the client required assistance of one staff with dressing and hygiene at bedtime. The same document indicated the client required safety checks and offer toileting every two-to-three hours including overnight.

The client's medical record indicated the facility nurse transferred the resident to emergency room (ER) for medical evaluation resulting in hospital admission. The same document indicated the ER identified a hematoma (a solid swelling of clotted blood within the tissues) on the back of his head.

The facility internal investigation indicated the AP was the unlicensed personnel (ULP) working on the unit overnight and did not provide cares or check on the resident during the shift. The same document indicated when the resident was found on the floor, he was still wearing the same shirt from the day before and with no pants but a soiled incontinence brief. The same document indicated the client was found with a cut on the back of his head with dried blood on both the client and on the floor. The same document indicated the client's call light was not within reach to him on the floor. The same document indicated the AP said she did not do anything with the resident all night long because she was not feeling well.

The AP's employment record indicated she had been employed for two to three months prior to the incident. The same documents indicated the AP received training and signed a document indicating she was aware of the facility safety check policy and the resident's care plan. The AP did receive additional training to her job duties one month after hire.

During an interview, the AP, stated she was not feeling well and tried to find a replacement for work but was not successful. The AP stated she was aware of the facility's safety check policy and resident's care plan of every two-hour toileting but does not remember if she helped the resident with his clothing or if she saw him at all during her shift. The AP stated she did not do every resident check because she did not feel well. The AP stated she sat on the couch and watched movies during her shift.

During an interview, registered nurse (RN)-B stated the client required safety checks and toileting every two hours "around the clock". RN-B stated the client refused a lot of the time, but staff were still supposed to go in and offer services. RN-B stated she assessed the client when he was found on the floor and found he had a cut on his head, which was not no longer bleeding when staff members found him. She also stated the client wore the same shirt from the previous day and an incontinence brief. RN-B stated the client said he could not remember when he fell but he was trying to get into his pajamas in the dark.

During an interview, ULP-D stated she worked primarily night shifts and was familiar with the client's nighttime routine. ULP-D stated the night staffing plan has two staff members present working two different units separated by a door. ULP-D stated staff members can ask each other for help if needed. ULP-D stated the client required assistance to change his incontinence brief and pajamas. ULP-D stated the client also required assistance to the bathroom every two hours at night.

During an interview, RN-C, who is the director of operations, stated it is the facility policy and expectation of staff to complete a visual check of clients a minimum of every two hours.

In conclusion, neglect occurred.

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:
(a) 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.
(b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.

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

Action taken by facility: The AP is no longer employed by the facility.

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

Or call 651-201-4890 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

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
Becker County Attorney
Detroit Lakes City Attorney
Detroit Lakes Police Department

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 08/30/2021

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 The Minnesota Department of Health investigated an allegation of maltreatment, complaint #HL24424051M, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557. The following correction order is issued/orders are issued for #HL24424051M, 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; This MN Requirement is not met as evidenced by: Based on interviews and document review, the facility failed to ensure one of one client (C1) reviewed was free from maltreatment. C1 was neglected. Findings include: On November 12, 2021, the Minnesota Department of Health (MDH) issued a determination that neglect occurred, and that the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. The MDH concluded there was a	0 325	Based on interviews and document review, the facility failed to ensure one of one client reviewed (C1) was free from maltreatment. C1 was neglected. Findings include: On November 12, 2021, the Minnesota Department of Health (MDH) issued a determination that neglect occurred, and that the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. The MDH	

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0 325	Continued From page 1 preponderance of evidence that maltreatment occurred.	0 325	concluded there was a preponderance of evidence that maltreatment occurred.	