*Protecting, Maintaining and Improving the Health of All Minnesotans*

# State Rapid Response Investigative Public Report

*Office of Health Facility Complaints*

**Maltreatment Report #:** HL246646807M
**Compliance #:** HL246642820C

**Date Concluded:** July 24, 2023

**Name, Address, and County of Licensee Investigated:**
Diamond Willow of Mountain Iron
8585 Unity Drive
Mountain Iron, MN 55768
St. Louis County

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

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

**Finding:** Substantiated, 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 alleged perpetrator (AP), facility staff, abused a resident when the AP yelled at the resident and repeatedly acted in an intimidating, threatening, manner while the AP stomped and swung their arms around and threatened to slash the resident's throat.

**Investigative Findings and Conclusion:**
The Minnesota Department of Health determined abuse was substantiated. The AP was responsible for the maltreatment. The AP was witnessed slamming her fists on the table, stomping her feet, and swinging her arms around while yelling in the resident's face, "Fuck you, you want to see mad, now I am fucking mad!" "You just couldn't leave me alone"! The AP continued to yell at the resident despite staff intervening twice. The AP stated she would, "slash [residents] throat from ear to ear."

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of AP personnel files,

training records, resident records, progress notes, incident report, facility investigation documentation, and witness statements.

The resident resided in an assisted living facility memory care unit with diagnoses including early onset Alzheimer's Disease, moderate depressive disorder, and anxiety. The resident's assessment indicated the resident was cognitively impaired and could be disoriented and anxious at times.

The resident's care plan and individual abuse prevention plan identified the resident was at risk for abuse and mental abuse related to impaired judgment. The resident required 24-hour supervision and staff assistance, with ques and reassurance to protect the resident from abuse.

One day the resident's progress note indicated the resident was having agitation and behaviors with repetitive questions.

A short time later a facility incident report indicated the resident told the AP she was being rude and mean, and the resident did not like how the AP was treating people. The incident report indicated the resident and AP argued and the AP walked away, however the resident followed the AP and they continued to argue. The AP then got up and started yelling and swearing at the resident. Staff intervened and separated the AP from the resident, and the AP left the facility. The report indicated the resident attempted to follow the AP, and the AP continued to yell and swear at the resident. The progress note indicated when the AP returned to the facility she began yelling and swearing at the resident again, staff separated the AP from the resident, and instructed the AP to leave the building.

When interviewed a facility nursing staff stated the AP and resident argued back and forth for approximately 10 to 15 minutes. The resident followed the AP and continued asking the AP why she was acting that way. Suddenly, the AP yelled at the resident, "Fuck you, you want to see mad! You want to see fucking mad; now this is mad! You just could not leave me alone!" The nurse stated the AP slammed her fists on the table, stomped her feet, and swung her arms around while yelling in the resident's face in a threatening intimidating manor. The nurse stated she intervened and sent the AP outside two separate times, but the AP returned and continued to yell and swear at the resident and blamed the resident for making her angry. The nurse stated the incident was frightening, shocking, and the AP's response toward the resident was pure anger and rage.

When interviewed two unlicensed staff stated they witnessed the incident between the AP and the resident. The staff stated the AP and resident were arguing, and suddenly the AP threw her hands up, slammed her fists on the table, started to "storm" and stomp around in a threatening manner, and repeatedly yelled at and swore in the resident's face. One staff stated she heard the AP tell the resident she would, "slash her throat from ear to ear".

When interviewed the AP stated she had personal issues going on in her life and was having a bad day when the resident accused her of being rude to another resident. The AP stated she initially walked away, but the resident followed her and continued to ask repetitive questions. The AP stated she “blew up” at the resident and yelled at the resident in anger, but stated she never touched the resident. The AP indicated she went outside a couple of times to cool off, but when she came back in the facility the resident continued to accuse her of doing something wrong. The AP stated she yelled at the resident repeatedly over 20-30 minutes but denied swearing at or threatening to harm the resident. When the AP was asked what she said to the resident the AP did not recall.

In conclusion, the Minnesota Department of Health determined abuse 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.

**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.
(b) Conduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to, the following:
(1) hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult;
(2) use of repeated or malicious oral, written, or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening.

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

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

**Action taken by the Minnesota Department of Health:**
The facility was issued a correction order regarding the vulnerable adult's right to be free from maltreatment.
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
St. Louis County Attorney
Mountain Iron City Attorney
Mountain Iron Police Department

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 24664 | A. BUILDING: _____ B. WING _____ | C 07/12/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| DIAMOND WILLOW OF MOUNTAIN IRON | 8583 UNITY DRIVE MOUNTAIN IRON, MN 55768 |

| (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<br><br>******ATTENTION******<br><br>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER<br><br>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation.<br><br>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.<br><br>INITIAL COMMENTS:<br><br>#HL246646807M, and #HL246642820C<br><br>On July 12, 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 26 residents receiving services under the provider's Assisted Living with Dementia Care license.<br><br>The following correction order is issued for #HL246646807M and HL246642820C, 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.<br><br>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.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.<br><br>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<br><br>Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial | 02360 | | |

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| DIAMOND WILLOW OF MOUNTAIN IRO | 8583 UNITY DRIVE MOUNTAIN IRON, MN 55768 |

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|---|---|---|---|---|
| 02360 | Continued From page 1<br>exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the facility failed to ensure one of one of one residents (R1) was free from maltreatment.<br><br>Findings include:<br><br>The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual was responsible for the maltreatment, in connection with incidents which occurred at the facility.<br><br>Please refer to the public maltreatment report for details. | 02360 | No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag. | |