Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL369028962M
Compliance #: HL369027101C

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: Substantiated, facility 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 facility neglected the resident when it failed to provide adequate supervision to a resident who smoked. The resident was outside when it was 45 degrees below zero and sustained frostbite to his fingers.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. Facility staff brought the resident outside to smoke in subzero weather dressed only in sweatpants and a long-sleeved shirt. It was unable to be determined how long the resident was outside but when he came back in, his hands appeared red. The resident's fingers had various blisters and turned blue shortly after. The resident was later diagnosed with frostbite. The facility lacked a process or system to ensure residents who smoked would remain safe when going outside during extreme temperatures.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the primary care provider. The investigation included review of the resident record, hospital records, facility incident reports, staff schedules, and facility policy and procedures. Also, the investigator observed the area where the resident smoked and the resident's frostbite.

The resident resided in an assisted living facility. The resident's diagnoses included traumatic brain injury and left sided weakness. The resident's service plan included assistance with behavior management and smoking assistance. The resident's assessment indicated staff were to assist the resident outside to smoke as he desired, and the resident could smoke independently once outside. The resident had left sided weakness and was only able to use his right hand. The assessment failed to identify how the resident would be kept safe while outside smoking during temperature extremes.

Weather data for the date the frostbite occurred indicated high temperatures were forecasted to be negative 7 degrees Fahrenheit and a low temperature of negative 13 degrees Fahrenheit, with windchills nearing negative 47 degrees Fahrenheit.

The resident's record lacked documentation to indicate how long he had been outside, what type of clothing he was wearing, or how many times per day he went out to smoke. An incident report attributed the "bruise" on his hand to being "outside too long." The incident report indicated "staff said they had him come in after being outside for too long in the negative weather and that no frost bite was visible at that point and time." The resident's record lacked consistent progress notes. A progress note entered on the day the frostbite was first noted indicated facility staff notified the RN the resident's right hand was red/swollen and had blisters, but the cause was "unknown." The note indicated the resident smoked outside and temperatures were extremely cold, but the resident also had a space heater in his room. The resident's primary care provider was updated and new orders for wound care were obtained. The next day, staff notified the RN that some of the resident's fingertips appeared blue and were painful. The resident's provider was updated again and as needed ibuprofen for pain relief was ordered. Two days after the blisters were observed, staff notified the RN again that his fingertips appeared blue, and his blisters were still intact. The provider was updated. Three days after the incident, the resident was seen in person by his provider, who decided the resident needed to be evaluated in the emergency room. Documentation from the provider's visit indicated the resident was "outdoors Saturday morning and afternoon per reports for longer period. Sunday staff noticed blistering of digits to right hand, had increased swelling with blistering and mild discoloration tips of fingers…"

Photographs of the blisters taken around the time they were first observed were reviewed. The pictures showed the middle finger on the resident's left hand had a very large, fluid filled blister that went from the knuckle to the base of the fingernail. Another photograph of the finger showed it after the blister had been popped. The resident's right-hand pointer, middle, and ring

finger had several smaller, fluid filled blisters between the knuckle and base of the fingernail. The fingertips appeared discolored.

Hospital records indicated the resident was evaluated in the emergency room with bilateral hand frostbite. The resident was in “the elements for an extended time yesterday…” The resident reported significant pain and received new orders for narcotic pain medication and instructions to follow up with his primary care provider.

During an interview, a staff member stated she thought staff on Friday weren’t paying attention and watching to make sure the resident came inside so he was left outside too long for what she assumed was at least 30 minutes. The staff member stated when she came to work on Saturday morning, the resident’s hands had blisters. The staff member stated she thought it was frostbite as she had looked up what pictures of frostbite looked like, and it looked similar so they called the nurse. The staff member stated the nurse thought since there were blisters, it was from heat exposure possibly from the space heater in his room, so they were initially treating the blisters as a burn. The staff member stated the nurse had asked them all kind of questions on what they thought had happened to the resident and she had reported to the nurse it was frostbite and that he should be seen, but the nurse kept saying it was burns and that she would come look at it but she didn’t come in until Tuesday. The staff member stated when she came to work on Sunday, the resident’s fingers had started to turn purple. The staff member stated she wanted to send the resident in to the hospital on Saturday, but he wasn’t sent in.

During an interview, the staff member working the evening of the incident stated she helped the resident outside around 6 or 7 p.m. to smoke and the resident was wearing his usual clothes of sweatpants and a long-sleeved flannel shirt. The staff member stated she had never been told the resident should have a hat, mittens, or should limit his time outside when it was extremely cold. The staff member stated the resident was only outside about five or ten minutes and when she brought him back inside, his fingers seemed red. The next day, the resident developed a large blister on his left hand and the RN asked staff to pop it to relieve pressure. The staff member stated they refused to pop it because they thought it was frostbite and didn’t’ think it should be popped, but the RN eventually came in and popped the blister herself. The staff member stated she told the RN the resident had been outside in negative 40-degree weather and she thought his hands had frostbite but the RN kept thinking it was a burn.

During an interview, another staff member working the evening of the incident stated she thought the resident had only been outside for 10 to 15 minutes and when he came back inside, his hands were really red, so they were trying to warm them up. The staff member stated when she left her shift that evening, the resident’s fingertips had started to turn white and the next couple of days, people had told her it was starting to look like he had frostbite. The staff member stated a few days after the incident, the resident’s fingers started to get black like

frostbite. The staff member stated she didn't think the resident got stuck outside but they had looked out the window and saw him and thought he needed to come back inside.

During an interview, the nurse stated staff had sent her pictures of the resident's hand and she text the provider right away and that the resident's fingertips were slightly blue but the resident had "profound" blisters so she got orders for bacitracin and band-aids on the blisters and if they opened, she was supposed to notify the provider. When the blisters became painful, she updated the provider and got an order for ibuprofen. The nurse stated when the provider rounded on that Wednesday, she felt he should be seen so he was sent to the emergency room. The nurse confirmed the resident should have been sent in sooner. The nurse stated she wasn't sure how the resident got stuck outside as he was normally able to get in and out on his own and she wasn't sure how long he was left outside.

During an interview, the resident stated he had gone outside to smoke wearing clothes similar to what he was currently wearing, sweatpants, a t-shirt, and a long-sleeved flannel shirt. The resident stated he had not been educated on safe smoking during temperature extremes. The resident stated he had been brought outside to smoke and when he tried to get back inside, the door was locked. The resident stated he "banged on the door so hard I almost broke the glass." The resident stated he had been left outside and couldn't get back in and "was outside too damn long."

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: Yes
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:

The facility sent the resident in for evaluation of his frostbite and the resident had follow up appointments with a wound care clinic.

Action taken by the Minnesota Department of Health:
The responsible party will be notified of their right to appeal the maltreatment finding.

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
Todd County Attorney
Staples City Attorney
Staples Police Department
Minnesota Board of Nursing
Minnesota Board of Executives for Long Term Services and Supports

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 ******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: #HL369028962M/ #HL369027101C On February 19, 2025, 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 14 residents receiving services under the provider's Assisted Living license. The following correction order is issued for #HL369028962M/ #HL369027101C, tag identification 2360.	0 000		
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.	02360		

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02360	Continued From page 1 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, and 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	No plan of correctio required for this tag.	