DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL28545001M
Compliance #: HL28545002C

Date Concluded: September 20, 2022

Name, Address, and County of Licensee Investigated:
Diamond Willow Assisted Living of Lester Park
6353 East Superior Street
Duluth, MN 55805
St Louis County

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

Evaluator's Name: Carol Moroney RN, Special Investigator

Finding: Inconclusive

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.

Initial Investigation Allegation(s):
The facility neglected the resident when the resident did not receive a prescribed antiseizure medication. The resident had a seizure and was hospitalized. In addition, the facility failed to implement interventions to prevent the VA from falling.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. Although the resident missed five doses of an antiseizure medication, the medication was restarted three days prior to the seizure. It could not be determined if the missed doses of the antiseizure

medication resulted in the seizure. In addition, there was no documentation the resident had any history of falls at the facility.

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 record, medication administration record (MAR), physician orders, hospital and ambulance records, employee records, and facility policy and procedures.

The resident resided in an assisted living facility and had diagnoses including seizures, vascular disease, anxiety with depression, and stroke. The resident's service plan included assistance with dressing, grooming, bathing, oral care, toileting, transfer assistance, medication administration, and walking twice daily. The resident's assessment indicated decreased strength from a past stroke, history of seizures, history of dizziness related to seizures, and sometimes had difficulty finding words.

The resident's medication record indicated staff had not administered one of the resident's antiseizure medications for five days. The facility noted the missed medication and began to administer the medication as prescribed. Three days later the resident had a seizure.

The residents progress notes indicated facility staff observed the resident having a seizure and notified the nurse. The family called emergency services and the resident went to the hospital for evaluation and in-patient monitoring.

The resident's hospital records indicated, while in the emergency room, the provider admitted the resident for evaluation of seizures and altered mental status. That evening, the resident had a seizure followed by a confused period. The physician note indicated other providers noted difficulty finding seizure medications which were effective for the resident.

During an interview, the facility staff stated the resident's antiseizure medication was out of stock for several days. The facility staff interviewed had not seen any seizures from the resident during the time period she did not receive the medication.

The resident's record did not contain documentation of any recent resident falls.

The resident's death certificate indicated the resident died from natural causes.

In conclusion, it is inconclusive whether neglect occurred.

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

Action taken by facility:
The facility implemented medication systems to prevent missed medications.

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
	28545	A. BUILDING: _____ B. WING _____	C 07/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAMOND WILLOW OF LESTER PARK	6353 EAST SUPERIOR STREET DULUTH, MN 55804

(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 Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.10 to 144G.93, the Minnesota Department of Health issued a correction order(s) pursuant to an 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: On July 27, 2022, the Minnesota Department of Health initiated an investigation of complaint #HL28545004C/#HL28545003M, HL28545002C/HL28545001M. At the time of the investigation, there were #18 residents receiving services under the Assisted Living with Dementia Care license. . The following correction orders are issued for #.HL28545004C/#HL28545003M, tag identification 0630, 1640.	0 000	The Minnesota Department of Health documents the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. 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 are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that 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. Per Minnesota Statute §144G.30, Subd. 5 (c), the assisted living facilities must document any action taken to comply with the correction order. A copy of the provider ' s records documenting those actions may be requested for follow-up surveys. The home care provider is not required to submit a plan of correction for approval; please disregard the heading of the fourth column, which states "Provider ' s Plan of Correction." The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to Minn. Stat. § 144G.31, Subd. 2 and 3.	
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma	0 630		

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0 630	Continued From page 1 (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement an updated individual abuse prevention plan (IAPP) for two of two residents (R1, and R2) with records reviewed. The facility did not update R1's IAAP after an allegation R1 inappropriately touched R2. R2 lacked an IAPP until a month after the allegation was made. The IAPP did not identify the reported concern or developed interventions regarding the reported concern. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). Findings include: R1's medical record included diagnoses of post ischemic stroke, vascular disease, and	0 630		

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0 630	Continued From page 2 depression. On July 28, 2022,at 10:00 a.m., R1's family (F)-E member stated on February 26, 2022, she reported to registered nurse (RN)-B that R2 came into R1's room and put his hands down R1's pants. F-E stated RN-B told her she reviewed all camera footage for that night and spoke with the staff who we're working and R2 was not observed in R1's room. R1's nursing assessment, dated March 22, 2022, indicated R1 required assistance of two staff and a mechanical sit to stand lift to transfer. R1 required staff assistance with meal setup, grooming, and bed mobility. R1 was able to communicate with difficulty but could be understood. The assessment indicated R1 was at risk for being abused. R1's Individual Abuse Prevention Plan (IAPP) dated December 28, 2021, indicated R1 was at risk for abuse. However, the IAPP did not indicate specific, individualized interventions regarding R1's risk for abuse. The IAPP indicated a Vulnerable Adult Assessment would be completed on admission and annually thereafter to assure that the resident vulnerabilities were identified. R1's IAPP dated May 24, 2022, listed the same vulnerability's as the prior IAPP assessment dated December 28, 2021, with no specific interventions to reduce the risk of abuse. There were no changes or updates made to the IAPP after the allegation of R2 inappropriately touching R1 three months prior. R2's IAPP dated March 29, 2022, indicated R2	0 630		

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0 630	Continued From page 3 had impaired judgement and had difficulty communicating. R2 was vulnerable and was at risk for abuse. R2's IAPP did not identify any specific, individualized interventions regarding R2's risk for abuse. R2's Planned Services (document for unlicensed personnel instruction of care) dated August 10, 2022, and July 26, 2022, indicated if the resident was inappropriate with another resident staff were to remove the resident from area and notify the RN immediately. During interview on August 15, 2022, at 10:40 a.m., registered nurse (RN)-C stated the facility had no updated IAPP's for R1 and R2 which identified the alleged incident and/ or specific interventions to prevent potential abuse. A policy regarding IAPP's was requested but not provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	0 630		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident	01640		

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01640	Continued From page 4 about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure two of two residents (R1, and R2) service plans were developed and implemented. with records reviewed This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted on November 24, 2021, with diagnoses including post ischemic stroke, vascular disease, and depression. R1's record lacked a current service plan; however, R1's Individual abuse prevention plan (IAPP) and nursing assessment dated May 24, 2022, and December 23, 2021, indicated the	01640		

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01640	Continued From page 5 resident received services including assistance with medication administration, transferring, mobility, and grooming. R2 was admitted on December 2, 2021, with diagnoses including Parkinson's disease and diabetes mellitus with diabetic neuropathy. R2's record lacked a current service plan; however, R1's Individual abuse prevention plan (IAPP) and nursing assessment dated May 24, 2022, and December 23, 2021, indicated the resident received services including assistance with medication, transferring, mobility, and grooming. During interview on August 15, 2022, at 10:40 a.m., registered nurse (RN)-C stated the facility had no service plans for R1 and R2. The facility Service Plan policy dated June 20, 2022, indicated all residents receiving assisted living services would have a service plan in place. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	01640		