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 #: HL236099947M
Compliance #: HL236098144C

Date Concluded: March 12, 2024

Name, Address, and County of Licensee Investigated:
Diamond Will Assisted Living
913 Old Highway 2
Proctor, MN 55810
St. Louis County

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

Evaluator's Name: Holly German, 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) abused the resident when the AP chemically restrained the resident by giving as needed medications to the resident without permission or directive from a nurse.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was substantiated. The AP was responsible for the maltreatment. The AP provided as needed (PRN) medication, Ativan (an anti-anxiety medication) and Morphine (a pain medication), to chemically restrain the resident. The AP used the medications to make the resident sleep during her shift. Staff reported the resident rarely had behaviors that were not redirectable and managed with her scheduled doses. Video footage also showed during the night shift the AP administered Ativan and Morphine for behaviors, the resident did not exhibit behaviors.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted a family member. The investigation included review of the resident records, personnel files, staff schedules, facility complaints and incidents, and related facility policy and procedures. Also, the investigator observed medication administration and staff response and interventions to resident behaviors at the facility.

The resident resided in an assisted living facility. The resident's diagnoses included dementia. The resident's service plan included assistance with medication administration and behavior management. The resident's assessment indicated the resident required supervision of walking and usually stayed up late at night. The resident's medication administration record (MAR) indicated she had scheduled doses of Ativan three times a day at 6:00 A.M., 2:00 P.M. and 8:00 P.M. and Morphine scheduled at bedtime.

The facility's policy for administration of PRN medications required the ULP to obtain approval from a nurse prior to giving any PRN medication. The ULP could obtain approval by verbal, written or electronic communication. The nurse call log indicated the AP failed to contact the nurse for approval to administer PRN medications to the resident.

Staff work performance notes indicated a nursing supervisor noted the AP administered PRN medications to the resident and the AP had not obtained directive from the nurse to give the medications. The AP documented the resident had physically aggressive behaviors as the reason for needing to give the medications. Video footage lacked evidence the resident was aggressive or anxious.

The resident's MAR showed during a 36-day time frame, the resident received 19 doses of Ativan and 13 doses of Morphine. The AP gave 17 of the 19 doses of Ativan, and 12 of the 13 doses of Ativan to the resident. The resident's MAR showed there were no PRN doses of Ativan or Morphine medication given to the resident for the rest of the month (approximately 25 days) after the AP no longer worked at the facility.

During an interview, the nursing supervisor stated she re-educated the AP on the process of giving as needed medications once she noted the error. The supervisor stated the AP continued to give as needed medications without consulting the nurse first despite the re-education.

During an interview, ULP 1 stated the AP told to him she gives as needed medications all night long to get the resident to sleep. Additionally, ULP 1 stated he never witnessed the resident get physically aggressive.

During an interview, ULP 2 stated the resident was not physically aggressive and easily redirectable. ULP 2 stated the AP came in on the overnight shift and stated she did not expect to see or hear from any of the residents on her shift and wanted them in their rooms. ULP 2 stated the AP would give the resident medications just to make her sleep.

During an interview, a family member stated the resident was a very busy person in her life prior to dementia and felt the staff struggled with properly assessing what the resident keeping herself busy looked like versus what agitation looked like. The family member stated it was easy to distract and redirect the resident.

During an interview, the AP stated the facility process was to call the nurse and get permission to give an as needed medication before giving it. The AP stated she had given as needed medications without having permission from the nurse.

The resident could not complete an interview due to dementia.

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:
(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:
(3) use of any aversive or deprivation procedure, unreasonable confinement, or involuntary seclusion, including the forced separation of the vulnerable adult from other persons against the will of the vulnerable adult or the legal representative of the vulnerable adult; and

Vulnerable Adult interviewed: No, unable to complete due to dementia.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility conducted an internal investigation and educated the AP on PRN use. The AP was no longer employed at 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
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 02/07/2024

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: HL236099947M/HL236098144C and HL236098071C On February 7, 2024, 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 38 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for HL236099947M/HL236098144C, tag identification 2360. No correction orders are issued for #HL236098071C.	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.	
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical,	02360		

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02360	Continued From page 1 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 reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual person 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 correction is required for this tag.	