

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL200225921M
Compliance #: HL200228414C

Date Concluded: November 6, 2024

Name, Address, and County of Licensee

Investigated:

New Perspective Roseville
2750 North Victoria Street
Roseville, MN 55113
Ramsey County

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

Evaluator's Name: Brandon Martfeld, RN BSN
Special Investigator

Finding: Inconclusive

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), a facility staff member, abused the resident when the AP forced the resident to sit in a chair.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined abuse was inconclusive. Due to conflicting information provided by witnesses and the AP, it could not be determined whether abuse occurred.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's family member. The investigation included review of the resident records, facility internal investigation, facility incident reports, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator observed staff and resident interactions.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia and anxiety. The resident's service plan indicated the resident became anxious, restless, sad, and cried multiple times a day. The resident's assessment indicated the resident had impaired cognition and was able transfer and ambulate independently. The resident's assessment indicated staff were to offer food, snack and/or something to drink if the resident became compulsive, agitated, or resistive to cares. The resident was at risk for abuse.

The facility investigation indicated one day the resident approached the AP and struck the AP with a boot. The AP took the resident by her arms and pushed her down into a chair. The facility investigation indicated the resident began to cry and yelled out "you hurt me."

During an interview, unlicensed personnel stated she was cleaning tables in the dining room and the AP was passing medications. The resident attempted to grab the medications from the AP. The AP told the resident she needed to eat breakfast and had the resident sit in a chair in the dining room. Unlicensed personnel stated the AP was not forceful with the resident, did not grab the resident with both hands, and did not yell at the resident.

During an interview, another unlicensed personnel stated the AP was assisting the resident from the living room to the dining room. The unlicensed personnel stated the AP became frustrated with the resident, placed one hand on each of the resident's upper arms, above the elbow and below the shoulder and forcefully sat the resident down in a chair in the dining room. The unlicensed personnel stated the resident became "scared" and started to cry. The unlicensed staff stated she told the AP not to grab the resident that way and asked the resident if she was okay and checked the resident's arms for bruises. The unlicensed staff stated the resident had no injury following the incident. The unlicensed personnel stated she did not report the incident to leadership right away.

During an interview, leadership stated once they became aware of the incident about two days later, they began an investigation. Leadership stated when they interviewed the AP, the AP said he had to pivot the resident near a chair and admitted to forcefully putting the resident in a chair but denied hitting or pushing the resident. Leadership stated the resident frequently cried but could be redirected easily. Leadership stated they assessed the resident and found no injury. Leadership stated the AP had no other work issues or disciplinary actions.

During an interview, the AP stated the day of the allegation while passing medications, the resident approached him and attempted to grab an insulin pen and a medication cup that had medications in it for another resident. The AP stated the resident started yelling and the AP took the resident by the hand/wrist to prevent her from grabbing the insulin pen and medication cup. The AP stated he pulled a chair close to the resident by using his foot and leg and asked the resident to sit down and have breakfast. The AP denied pushing, hitting, or having both of his hands on the resident.

During an interview, the resident's family member stated there was no concerns with abuse and that the resident can be challenging for the staff members.

In conclusion, the Minnesota Department of Health determined abuse was inconclusive.

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.

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; or

(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 unless authorized under applicable licensing requirements or Minnesota Rules, chapter 9544.

(c) Any sexual contact or penetration as defined in section [609.341](#), between a facility staff person or a person providing services in the facility and a resident, patient, or client of that facility.

(d) The act of forcing, compelling, coercing, or enticing a vulnerable adult against the vulnerable adult's will to perform services for the advantage of another.

Vulnerable Adult interviewed: No. Resident no longer resided at the facility.

Family/Responsible Party interviewed: Yes.

Alleged Perpetrator interviewed: Yes.

Action taken by facility:

The facility suspended the AP while completing an internal investigation. In addition, the facility completed education with staff on reporting suspected abuse.

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20022	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/21/2024
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NAME OF PROVIDER OR SUPPLIER NEW PERSPECTIVE - ROSEVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 2750 NORTH VICTORIA STREET ROSEVILLE, MN 55113
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(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	<p>Initial Comments</p> <p>On October 21, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL200225921M/#HL200228414C. No correction orders are issued.</p>	0 000		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____