Protecting, Maintaining and Improving the Health of All Minnesotans

Office of Health Facility Complaints Investigative Public Report

Maltreatment Report #: HL21672016M **Date Concluded:** November 17, 2021

Name, Address, and County of Licensee Investigated:
New Perspective-Cloquet & Barnum
702 Horizon Circle
Cloquet, MN, 55720
Carlton County

Facility Type: Home Care Provider

Evaluator's Name: Angela Vatalaro, RN
Special Investigator

Finding: Substantiated, individual responsibility

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.

Allegation(s):
It is alleged: The alleged perpetrator (AP) abused the client when the AP grabbed and twisted the client's wrist and pushed her onto the couch.

Investigative Findings and Conclusion:
Abuse was substantiated. The alleged perpetrator was responsible for the maltreatment. A witness saw the AP push the client. During the push, the client held onto the AP. The witness stated the AP then grabbed and squeezed the client's wrist causing a bruise. The client's records indicated a right wrist bruise measured 2 centimeters (cm) x 3.5 cm and a skin tear inside the bruise measured 0.5 cm x 0.5 cm.

The investigation included interviews with facility staff members, including administrative staff, nursing staff, unlicensed staff, the client's family, and the AP. The investigation included review of the client's medical records, incident report, internal investigation, photograph of injury, client voice recording, staff text messages, the AP's personnel file, and policy and procedures related to maltreatment.

The client's diagnoses included dementia, diabetes, and macular degeneration. The clients service plan included assistance with medication administration and bathing. The client's nursing assessment indicated she was alert, forgetful, required frequent prompts throughout the day, and used a walker independently.

A review of a text message sent to the executive director on the day of the incident indicated unlicensed personnel (ULP)-A reported the AP was abusive, unprofessional, and fought with the client. A second text message sent to the executive director indicated ULP-B observed a bruise on the client's arm after the AP's altercation.

A review of the facility's internal investigation indicated the facility initiated an investigation for alleged abuse. The facility's internal interview with ULP-A indicated the client asked the AP for food and the AP told her she had just ate. The client went over to the AP's medication cart, and the AP continued to yell and argue with the client. The AP twisted the client's wrist and pushed her onto the couch. The client held onto the AP as she fell backwards onto the couch and scratched the AP during the fall. The facility's internal interview with the AP indicated the AP said the client had behaviors during her shift and was upset because she thought she had not eaten yet. The AP said the client was at her medication cart, upset about food, and scratched her. The AP said she grabbed the client's hand to get her away and denied she pushed her. The AP said she did not have time to deal with the client's behaviors, needed to pass medications, and was sick of dealing with behaviors daily stating "it's ridiculous."

A review of the client's progress notes, and incident report indicated a right wrist bruise measured 2 cm x 3.5 cm and a skin tear inside the bruise measured 0.5 cm x 0.5 cm.

A review of the internal investigation findings indicated the facility substantiated the allegation due to the AP's admission she grabbed the client's wrist to "get her away" resulting in a bruise and skin tear. The internal investigation finding's also indicated evidence of a voice recording of the client. The findings indicated the client's tone was distraught, scared having had an altercation, and feared the AP would harm someone else due to her "temper."

During an interview, ULP-A stated both her and the AP worked the same shift the day of the incident. They worked in the memory care unit where the client resided. She saw the AP yell and argue with the client about food and meals. She said the client went to the AP's medication cart. At the medication cart the incident turned physical. ULP-A said it looked like two people fighting on the street. The AP pushed the client. During the push the client held onto the AP causing scratches. The AP grabbed and squeezed the client's wrist, and shoved the clients arm away causing a bruise. After the incident ULP-A spoke to the client and said the client appeared nervous, restless, and scared to have anyone near her. ULP-A said she voice recorded the client speaking. She said she wanted to make sure facility leadership heard what the client said in case the client forgot due to her memory.

During an interview, ULP-B said the day of the incident she worked the overnights. When she arrived to work the AP and ULP-A were working. The AP told her, she and the client got into a fight. ULP-A told her the AP grabbed and twisted the client's wrist and pushed her onto the couch earlier in the shift. ULP-B went to see the client. She said the client was anxious and told her someone had hurt her. ULP-B rolled up the client's sleeve and seen a bruise. She took a photo and reported the bruise to the facility's leadership.

During an interview, the district director of clinical services stated she interviewed the AP. The AP said the client was hard to handle, had behaviors, and was upset about food. The AP did not attempt to diffuse the situation, did not assist the client to a safer place mentally, or offer the client something to eat. The AP said the client kicked and scratched her, so she grabbed the client's wrist to get the client away. The AP denied she pushed the client. The facility substantiated the allegation due to the AP's admission she grabbed the client's wrist resulting in a bruise and skin tear as well as the client's voice recorded evidence. She said she listened to the client's voice recording. The client was upset, mentioned the AP's temper and was afraid something would happen to other people due to the AP's temper.

During an interview, the executive director stated the facility substantiated the allegation due to the AP's admission she grabbed the client's wrist, caused a bruise and skin tear, as well as voice recorded evidence the client was scared and distraught.

During an interview, the AP said the client was at her medication cart attempting to grab something off it, so she blocked her hand. The AP said she did not push the client. The AP said she did not grab the client's wrist or hand.

In conclusion, 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:
(1) hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult;

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

Action taken by facility:

The facility placed the AP on suspension pending internal investigation. The AP was 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.

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
Carlton County Attorney
Cloquet City Attorney
Cloquet Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H21672	A. BUILDING: _____ B. WING _____	C 09/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE - CLOQUET & BARNUM	702 HORIZON CIRCLE CLOQUET, MN 55720

(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 The Minnesota Department of Health conducted a maltreatment investigation, in accordance with Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minnesota Statute § 626.557. The Minnesota Department of Health issued a correction order pursuant to the investigation. INITIAL COMMENTS: On September 1, 2021, the Minnesota Department of Health conducted a maltreatment investigation of complaint HL21672016M. At the time of the investigation, there were #69 clients receiving services under the comprehensive license The following correction order is issued for HL21672016M, tag identification 325.	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. The assigned tag number appears in the far left column entitled "ID Prefix Tag. " The state statute/rule number and the corresponding text of the state statute/rule number out of compliance are listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings, which are in violation of the state statute after the statement, "This Rule is not met as evidenced by. " Following the investigators ' 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/RULES.	
0 325	144A.44, Subd. 1(a)(14) Free From Maltreatment Subdivision 1.Statement of rights. (a) A client who receives home care services in the community or in an assisted living facility licensed under chapter 144G has these rights: (14) be free from physical and verbal abuse, neglect, financial exploitation, and all forms of maltreatment covered under the Vulnerable	0 325		

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0 325	Continued From page 1 Adults Act and the Maltreatment of Minors Act; This MN Requirement is not met as evidenced by: Based on observations, interviews, and document review, the facility failed to ensure one of one clients reviewed (C1) was free from maltreatment. C1 was abused. Findings include: On November 17, 2021, the Minnesota Department of Health (MDH) issued a determination that abuse occurred, and that an individual staff person was responsible for the maltreatment, in connection with incidents which occurred at the facility. The MDH concluded there was a preponderance of evidence that maltreatment occurred.	0 325	There is no plan of correction required for tag 325. Please refer to the public maltreatment report (sent separately) for details.	