Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL235056344M
Compliance #: HL235052066C

Date Concluded: December 4, 2023

Name, Address, and County of Licensee Investigated:

New Perspective Eagan
3810 Alder Lane
Eagan, MN 55122
Dakota County

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

Evaluator's Name: Danyell Eccleston, RN, 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) neglected a resident when the AP failed to place foot pedals on the resident's wheelchair before pushing the resident's wheelchair. The resident sustained a neck fracture when his foot caught under the wheelchair, and he fell.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. There was inconsistent information as to if the resident's foot pedals were in place on the wheelchair at the time of the incident.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of medical records, employee files, and policy and procedure. Also, the investigator observed staff providing assistance to residents in wheelchairs.

The resident resided in an assisted living memory care unit. The resident's diagnoses included Parkinson's disease (a condition affecting the brain, nerves, and body parts controlled by nerves that causes issues with movement, balance, and coordination) and a history of bone fractures. The resident's care plan included assistance with mobility and transfers. and the resident used an assistive device for mobility. The resident's assessment indicated the resident required an assist of one person for transfers and used a wheelchair.

Progress notes approximately two weeks before the fall indicated the resident was a high fall risk and used a wheelchair with assistance of one person.

Progress notes from the day of the fall indicated the resident was lying on the floor, bleeding from the nose with visible injuries to his face and reported pain when the nurse arrived at the incident. The resident reported he fell because his foot hit the wheelchair wheel while he was being pushed and the wheelchair flipped. The nurse contacted emergency services and the resident went to the hospital. Progress notes also indicated the hospital updated the facility later the same day and reported the resident had a neck fracture.

During interviews, three unlicensed staff members who assisted the resident directly after the incident could not recall if the resident's foot pedals were on his wheelchair.

During interview, a nurse stated staff members called her to come assist after the resident fell from his wheelchair. The nurse stated after reviewing the scene she noted foot pedals were not on the resident's wheelchair.

During an interview, the AP stated she received training foot pedals should always be in place when assisting residents in wheelchairs. The AP stated she always made sure foot pedals were in place before assisting a resident in a wheelchair but did not recall if the resident had foot pedals on his wheelchair at the time of the incident. The AP stated the resident was in the common area when she went to assist him to wheel him to the dining room for lunch. When the AP began moving the resident's wheelchair, the resident toppled out of the wheelchair. The AP stated she did not know why the resident fell.

Review of the AP's file indicated she completed education regarding wheelchair use and residents.

During interview a family member stated the resident usually had foot pedals on his wheelchair and that the resident needed assistance positioning his feet on the pedals.

In conclusion, the Minnesota Department of Health determined neglect 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.

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

Action taken by facility:
Care staff re-educated regarding the use of foot pedals when assisting residents in wheelchairs.

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
	23505	A. BUILDING: _____ B. WING _____	C 10/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE - EAGAN	3810 ALDER LANE EAGAN, MN 55122

(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 On October 30, 2023, the Minnesota Department of Health initiated an investigation of complaint #HL235052066C/#HL235056344M. No correction orders are issued.	0 000		