Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL235056706M
Compliance #: HL235051146C

Date Concluded: February 11, 2025

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: Not Substantiated

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 facility neglected the resident when the facility failed to follow multiple aspects of the resident's plan of care, including eating assistance, which resulted in the resident losing a significant amount of weight.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The resident's meal intake was not consistently tracked and the amount of eating assistance provided to the resident varied between staff. However, there was no indication the resident lost weight due to neglect.

Additional concerns including lack of staff assistance with showering, grooming, dressing, and apartment cleaning were reviewed. Corresponding licensing orders were issued regarding the facility's non-compliance.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the case worker, ombudsman, and provider. The investigation included review of resident photos and video, the resident records, facility internal investigation, facility incident reports, staff schedules, and related facility policy and procedures. Also, the investigator observed eating assistance, scheduled unit activity, apartments for appearance of cleanliness, and staff providing care to the resident and other residents.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia, depression, and insomnia. The resident's service plan included assistance with activities, weekly bathing, cues, extensive eating assistance, dressing twice per day, upper denture assistance, monthly weights, and medication. The resident's assessment indicated the resident had impaired speech and verbal expression, was forgetful, wandered, and could be uncooperative with care.

Review of recent monthly facility weights over a seven-month period indicated the resident weighed 173.2 pounds, 171.2 pounds, 173 pounds, 173.6 pounds, 175.4 pounds, 179 pounds, and 178 pounds.

During an onsite observation the resident was first observed participating in a unit painting activity. During mealtime, staff were observed guiding the resident back to the dining table three separate times and handed the resident a drink while waiting for his food. The resident waved away the first plate of food, and a staff brought out a cut of sandwich and encouraged the resident to eat. The resident pushed the sandwich away and put up his hands and declined the sandwich. The resident sat at the table and another staff member brought the resident a different type of sandwich and handed the resident a piece of the sandwich, the resident declined to eat it and set the portion down. A third staff member then approached the resident, handed him a portion of the sandwich and asked him to eat. The resident ate the first half of the sandwich and the third staff member returned and sat with the resident. The third staff encouraged the resident to eat and handed food to the resident. The resident finished the sandwich, ate a cookie, and drank a glass of juice. After lunch, the resident stayed in the common area and used colored pencils to color pictures of birds.

Observation of the resident's apartment indicated the resident's floor and toilet appeared dirty. No foul odors were noted in the apartment.

During interview, several unlicensed staff stated the resident needed to be encouraged to eat and at times he would not want to eat meals. When that happened, staff would attempt to provide the resident other options to eat. The unlicensed staff stated there were times staff were able to encourage the resident to eat or get dressed, but at other times encouragement did not work.

During interview, a leadership member stated it often took five to seven attempts to get the resident to sit and eat a meal. The leadership member stated the resident was difficult to redirect at times, and the resident was very active and protective of his space which could be intimidating to staff. The leadership member stated meetings and educations sessions were held with staff to implement better ways to redirect and assist the resident.

During interview, a provider stated in the prior four months the resident was seen twice by the provider. The provider stated concerns were reported about the resident's lack of variety and amount of food the resident received. However, the resident's weights were stable and there were no specific nutritional concerns the provider was aware of.

During interview, the resident's family members stated the resident's clothing was becoming too large for him. Family also stated the facility staff did not ensure the residents cares were completed so family had to assist the resident with cares which included feeding, showering, grooming, dressing, and apartment cleaning.

In conclusion, the Minnesota Department of Health determined neglect was not substantiated.

"Not Substantiated" means:
An investigatory conclusion indicating the preponderance of evidence shows that an act meeting the definition of maltreatment 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: Yes.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility: Review of care concerns, education of care staff.

Action taken by the Minnesota Department of Health:
The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:

https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

You may also call 651-201-4200 to receive a copy via mail or email.

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 12/18/2024

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 ******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: #HL235051146C/#HL235056706M On December 18, 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 134 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for #HL235051146C/#HL235056706M, tag identification 0450, 0500, and 2350	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 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 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 evaluators' 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 SUBDIVISION 1-3.	
0 450 SS=D	144G.41 Subdivision 1 Minimum requirements All assisted living facilities shall:	0 450		

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0 450	Continued From page 1 (1) distribute to residents the assisted living bill of rights; (2) provide services in a manner that complies with the Nurse Practice Act in sections 148.171 to 148.285; (3) utilize a person-centered planning and service delivery process; (4) have and maintain a system for delegation of health care activities to unlicensed personnel by a registered nurse, including supervision and evaluation of the delegated activities as required by the Nurse Practice Act in sections 148.171 to 148.285; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure utilization of person-centered planning and service delivery process for one of one resident (R1) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a client'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's diagnoses included, dementia, depression, and insomnia. R1's service agreement dated July 10, 2024, indicated the resident's apartment was equipped with a door lock that could be unlocked with a	0 450		

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0 450	Continued From page 2 key, however, the resident was not issued a key for safety reasons. The service agreement also indicated R1 received cues ten plus times per day across all shifts and that caregivers would provide interventions as described and report changes in need for cues to nursing. The service plan did not describe or list the interventions for cues. R1 apartment video footage from family member (FM)-C dated, per FM-C, as January 11, 2025, showed R1 leaving his apartment with staff members and before the door closed, a staff member appeared to lock R1's apartment door handle. Email communication on January 11, 2025, from FM-C indicated R1 contacted FM-C to report "it was broken" and "no one could fix it." FM-C indicated she reviewed video from R1's apartment that day and noted R1 was not in his apartment all day. FM-C indicated video footage showed a staff member locking R1's door in the morning. FM-C indicated she spoke with a staff member at 5:31 P.M. and R1's door was still locked. Email communication on January 23, 2025, from leadership member (LM)-B indicated she spoke with a staff member who confirmed the staff locked R1's door on the day in question and stated she locked R1's door to help R1 eat because R1 often leaves the dining area during meals. The staff member believed if R1 could not get into his room, R1 would return to the dining area to eat. LM-B indicated the staff member was informed locking R1's door was not an appropriate intervention. No further information provided.	0 450		

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0 450	Continued From page 3 TIME PERIOD FOR CORRECTION: Fourteen (14) days	0 450		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the licensee failed to maintain an infection control program which complied with accepted health care standards, when the licensee failed to implement their policy for cleaning and disinfecting apartments. This had the potential to affect all residents residing in the facility. 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 a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	0 510		

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0 510	Continued From page 4 Findings included: On December 18, 2024, from 12:05 P.M. until 12:33 P.M., observations were completed of room 11, 4, 5, 6, and 10. The resident rooms and bathrooms had stains and debris, and toilets appeared to have dried urine and feces on them. Review of video from R1's apartment from family member (FM)-C indicated video was from December 5, 2024. Video footage showed a staff member speaking with a leadership member. The housekeeper asked the leadership member, "Do they clean the floors in people's rooms or is that not a thing anymore." The staff member also stated, "It seems like multiple rooms are dirty, very dirty." During interview on December 18, 2024, at 2:57 P.M., leadership member (LM)-A stated apartment floors should be washed weekly and toilets should be cleaned weekly. LM-A stated the facility was short housekeeping staff and the facility was attempting to hire more housekeeping staff. During interview on December 30, 2024, at 1:32 P.M., LM-B stated there was a goal of weekly main hallway cleaning and housekeeping of floors and bathrooms for all dementia care residents. LM-B stated the facility had staffing issues regarding housekeeping staff and agreed there could have been challenges completing housekeeping on the dementia care unit. Review of policy titled Cleaning and Disinfecting Apartments, reviewed on September 2, 2024, indicated frequency and duration of housekeeping services in apartments will be done in accordance with resident agreements and	0 510		

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0 510	Continued From page 5 housekeeping services will be developed to accommodate resident needs and preferences as well as team members' availability. The policy indicated in the bathroom the toilet would be scrubbed, hard surface floors would be swept and mopped. The policy also indicated living spaces would have hard surfaces swept and mopped and carpeted areas would have spot removal and vacuum services. No further information was provided. TIME PERIOD FOR CORRECTION: Seven days	0 510		
02350 SS=D	144G.91 Subd. 7 Courteous treatment Residents have the right to be treated with courtesy and respect, and to have the resident's property treated with respect This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure 1 of 1 residents (R1), was treated with dignity and respect when receiving services. 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:	02350		

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02350	Continued From page 6 R1's diagnoses included dementia, depression, and insomnia. R1's service agreement dated July 10, 2024, indicated R1's services included cues ten plus times per day across AM, PM, and NOC shifts and caregivers would provide interventions as described and report changes in need for cues to nursing. The service agreement did not describe or list the interventions for cues. R1's service agreement included communication assistance daily across AM, PM, and NOC shifts and instructions to use R1's body language and tone to best understand what R1 was attempting to say. R1's service agreement included activity assistance during AM and PM shifts, dressing assistance during AM and PM shifts, and grooming assistance during AM, PM, and NOC shifts. Review of video from R1's apartment provided by family member (FM)-C who indicated video was from the evening of October 30, 2024. Video footage showed three staff members enter R1's apartment and attempt to get R1 to change clothes, a staff member is heard telling R1 he needs to change his clothes to, "get ready to be on the set of the movie," "we got to change our clothes for the next set, for part two." Then staff left R1's apartment and R1 continued to try to put on his belt. Review of video from R1's apartment from family member (FM)-C who indicated video was from the morning of October 28, 2024. Video footage showed a housekeeper debating with R1 regarding cleaning of the floor. R1 verbalized inaudibly to housekeeper and housekeeper replied, "Oh whatever, go, go, go." The housekeeper was also heard stating "Call the	02350		

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02350	Continued From page 7 police, do it, I love it." During the video the housekeeper walks out of bathroom with R1 behind her and then housekeeper attempts to re-enter bathroom holding a mop, housekeeper heard stating, "watch out, let go of me." R1 grabbed mop and housekeeper pulled the mop away. Review of video from R1's apartment from family member (FM)-C who indicated video was from the evening of January 1, 2025. Video footage showed two staff members in R1's apartment. R1 carried a zippered bag and R1 refused to give it to staff members. R1 walked away from staff, set the bag on his bed away from staff. Staff member then walked over and picked up the bag. R1 appeared upset and attempted to block the staff member from taking the bag and told staff member, "Seriously ...give it to me now," staff member blocked R1 and attempted to prevent R1 from taking the bag. R1 took the bag back, and the staff member stated "do not open that, okay, that's ours .... give it to us" R1 set the bag down on the side of his bed, staff members left R1's apartment. Review of video from R1's apartment from family member (FM)-C who indicated the video was from the evening of January 2, 2025. Video footage showed R1 laying on the couch and a staff member came into R1's apartment asking the resident to try pudding. The staff member stood over R1 and placed a spoon of pudding in front of R1, and R1 put up his hands and declined the pudding. R1 continued to declined pudding for over two minutes. Then the staff member told the resident the pudding was for his medicine. The staff member continued to stand over R1 holding the spoon in front of him for approximately another two minutes before leaving	02350		

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02350	Continued From page 8 R1's apartment. During interview on January 6, 2025, at 11:10 A.M., leadership member (LM)-F stated R1 was a very physically able resident with dementia who "almost all the time" needed cueing for cares. LM-F stated the facility has been working to re-train staff members about how to approach and reapproach, to break down directions when it comes to working with dementia residents. During interview on January 13, 2025, at 2:31 P.M., FM-D and FM-E indicated R1 did not receive the cares he needed at the facility and family members often provided cares when visiting. They stated staff members approached R1 with questions and asked him to do things, however, R1 needed to be lead when receiving cares. FM-D and FM-E indicated cares, such as showering, required staff to tell R1 it was time to take a shower and provide the resident guided steps to take. R1 did not know what to do when staff approached him with questions or asked if he would like to do something. No further information was provided. TIME PERIOD FOR CORRECTION: Seven days.	02350		