Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL24315001M
Compliance #: HL24315002C

Date Concluded: April 19, 2022

Name, Address, and County of Facility Investigated:
New Perspective Cloquet and Barnum
701 Horizon Circle
Cloquet, MN 55720
Carlton County

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

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 perpetrators (AP 1, AP 2), staff members, neglected the resident when both failed to report a change in condition. The resident had a heart attack, hospitalized, and underwent a procedure.

Investigative Findings and Conclusion:
Neglect was substantiated. The alleged perpetrators (AP 1, AP 2) were responsible for the maltreatment. AP 1 did not follow proper medication administration procedures and both AP 1 and AP 2 failed to report the residents change in condition to nursing.

The investigation included interviews with facility staff, including administrative staff, nursing staff, and unlicensed staff. The investigation included interviews with AP 1 and AP 2. The investigation included review of the resident's medical records, hospital records, the facility's

investigation notes, staff schedules, AP 1 and AP 2's personnel files, and policy and procedures related to change and condition and maltreatment.

The resident's medical record was reviewed. The resident's diagnoses included angina pectoris (chest pain) and coronary artery disease. The resident's service plan indicated the resident required assistance with bathing, dressing, grooming, toileting, two-staff assist using a mechanical lift for transfers and used an electric wheelchair. The resident's nursing assessment indicated the resident was alert, oriented, and had a history of chest pain.

The facility internal investigation indicated one night at approximately 11:15 p.m., the resident was outside smoking a cigarette with overnight staff when she experienced a period of unresponsiveness for two to three minutes. AP 1 said the resident had told him if she ever went unresponsive to give her nitroglycerin (medication used to relive chest pain) from her coin purse as chest pain caused her to do this. AP 1 said he recalled the conversation and administered nitroglycerin from the coin purse. The resident came to and said she had chest pain. The resident reported resolution from the nitroglycerin almost immediately. Fifteen minutes later, the resident requested to lay back down in bed, AP 1 and AP 2 assisted. At 12:00 a.m., AP 1 and AP 2 reported the resident used her call pendent because she was restless. At 5:00 a.m., the resident fell asleep. AP 1 and AP 2 reported to oncoming staff they monitored the resident every 15 minutes until the end of their shift. At 8:20 a.m., a staff member noticed a change in the resident since the last check and notified the registered nurse (RN 1).

A review of the resident's progress notes indicated RN 1 assessed the resident at 8:20 a.m., due to complaints of chest pain and not feeling well. The resident stated it felt like an elephant was on top of her chest and denied shortness of breath. The resident was pale, cool, and clammy. Emergency medical services were contacted and transported the resident to the hospital.

The resident's emergency room records indicated the resident arrived and was alert and oriented. The resident reported she had constant midsternal chest pain since the night before and denied radiation to neck, arms, or back. The resident did not have shortness of breath, nausea, or sweating. She diagnosed with acute coronary syndrome (reduced blood flow to the heart) with high troponin (test to diagnose heart attack) and transferred to different hospital for evaluation of a heart attack.

The resident's hospital records indicated the resident admitted to the hospital, had a stent placed (a wire mesh that holds an artery open and keeps it from closing again), and discharged back to the facility two days later.

A review of AP 1's personnel file records indicated AP 1 administered nitroglycerin without completing proper medication administration procedures. AP 1 did not call a nurse after administering the medication, did not take vital signs or document them per protocol, and did not alert the nurse of the resident's change of condition.

A review of the resident's medication administration record indicated orders for nitroglycerin 0.4 mg (milligrams). The directions indicated to take one tablet under tongue every five minutes as needed for chest pain, take vital signs, and call nursing. The same instructions indicated to call nursing immediately with any changes and vital signs after each nitroglycerin given.

A review of AP 2's personnel file records indicated the resident had a change of condition that included complaints of chest pain. AP 2 did not obtain vital signs or call the nurse to report concerns.

A review of the resident's service plan indicated instruction for caregivers to notify nursing of changes of condition per policy and document vital signs as instructed. A review of the resident's services received record indicated AP 2 was assigned those services during shift the night of the incident.

A review of the resident's vital sign records did not indicate AP 1 or AP 2 obtained vital signs during their shift.

During an interview, RN 1 said she looked in the resident's coin purse to verify what medication AP 1 gave to the resident, it was nitroglycerin. The nitroglycerin was expired when AP 1 administered it. AP 1 told her he did not report the residents change because this was not new, she came to, he knew she had nitroglycerin on her, and said she got better after taking it. RN 1 said she had not heard of the resident having unresponsive episodes prior to this incident. She said she was not aware of any other instances of AP 1 not reporting a change of condition. AP 1 had called nursing in the past and knew when to call. RN 1 said when she spoke to AP 2, he told her the resident was restless throughout the night. She said nursing did not receive a phone call from AP 1 or AP 2 regarding the resident's condition. She said staff received education and training on when to report changes to nursing during orientation and during medication administration class.

During an interview, AP 1 said he was the medication passer the night of the incident. He said the procedure for administering medication included removing medication off the medication cart, check to see the medication matched the orders, administer, and document after administration. AP 1 said the night of incident the resident appeared hot and anxious. AP 1 said he went outside with the resident to smoke to help her calm down. While outside the resident rubbed her chest, was pale, and clammy. He said the resident told him if she ever appeared "out of it," unresponsive, anxious, complained of chest pain, or upon request, to administer the medication she had in her coin purse. He said he retrieved the bottle of medication. AP 1 said he did not look at the medication label to see what the medication was and administered it. AP 1 said he knew the medication was nitroglycerin because the resident told him it was and told him it was in her coin purse. AP 1 said he did not know if nitroglycerin listed on the resident's medication administration record when he administered it. After the resident received the nitroglycerin, AP 1 and AP 2 assisted the resident to bed. While in the resident's room, the resident said she felt like throwing up, so he put something beside her to throw up in. He said

he told the caregiver to check on her throughout the shift. AP 1 said a residents change of condition was when something was different with a resident then what it was normally. AP 1 said he did not call a nurse to report the resident's changes because he did not think he needed to.

During an interview, AP 2 said he was the caregiver the night of the incident. He said while the resident was out smoking, he received a phone call from AP 1 the resident did not look good. AP 2 said he went outside; the resident sat in her electric wheelchair. AP 2 said the resident stared up into space, seemed unresponsive, and was sweaty. AP 2 said the resident talked and complained of chest pain. AP 1 worked as the medication passer the night of the incident retrieved nitroglycerin and administered. The resident requested to go back to bed and AP 1 and AP 2 assisted. AP 2 said after the resident received the nitroglycerin, she did not complain of chest pain the rest of the night. AP 2 said he checked on the resident throughout the shift. The resident had cold sweats, was "kind of out of it," and slept on and off. AP 2 said if a resident had a change of condition the procedure was to call a nurse to report. He said he did not call nursing to report the resident's symptoms because he was a newer employee and AP 1 told him he would take care of it. AP 2 said leadership spoke to him after the incident about the need to report changes of conditions.

In conclusion, neglect 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.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
"Neglect" means:
(a) 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.
(b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.

Vulnerable Adult interviewed: No, resident was deceased.
Family/Responsible Party interviewed: No, declined to interview.
Alleged Perpetrator interviewed: Yes, AP 1 and AP 2.

Action taken by facility:
The RN conducted an assessment when alerted of the resident's change of condition and sent the resident into the emergency room for evaluation. The facility conducted an internal investigation. The facility chose not to continue employment with AP 1 and retrained AP 2.

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
The Office of Ombudsman for Mental Health and Developmental Disabilities
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
	24315	A. BUILDING: _____ B. WING _____	C 02/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE - CLOQUET & BA	**701 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 Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING 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: #HL24315002C/#HL24315001M On February 24, 2022, 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 44 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #HL24315002C/#HL24315001M, tag identification 2360.	0 000	Minnesota Department of Health is documenting the State Licensing 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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24315	A. BUILDING: _____ B. WING _____	C 02/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE - CLOQUET & BA	**701 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
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: Based on interviews and document review, the facility failed to ensure one of one residents reviewed (R1) was free from maltreatment. R1 was neglected. Findings include: On April 19, 2022, the Minnesota Department of Health (MDH) issued a determination that neglect occurred, and individual staff persons were 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.	02360	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	