Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL243157562M
Compliance #: HL243153022C

Date Concluded: March 12, 2025

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

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

Evaluator's Name:
Katherine Barnhardt 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 facility staff failed to administer the resident's ordered medications for management of an infectious condition.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The resident was seen by a clinic provider for an abscess (infection that builds up within tissue in a single location on the body) when the resident denied receiving a new antibiotic. The provider alerted licensed staff at the facility that a new antibiotic was ordered two days prior. When alerted, licensed staff reached out to pharmacy for information about the order and requested a copy. Licensed staff entered the antibiotic order into the resident's electronic medication record and staff administered the antibiotic. There was a two-day delay in the implementation of the new antibiotic order, however, the two missed doses did not cause harm.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident record, hospital records, pharmacy records, facility internal investigation, facility incident reports, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator observed facility staff provide residents with medication administration and direct cares.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia and parasitic diseases. The resident's service plan included assistance with medication administration and cueing. The resident's assessment indicated the resident had emergency room visits, hospitalizations and a skilled nursing stay in the prior 12 months. The resident was seen by a clinic provider regularly. The resident was independent with visual and hearing devices, communicated clearly with staff, was independent with most activities of daily living, and independently utilized a four-wheel walker for ambulation.

The resident's record indicated the resident had a history of long-term antibiotic use when admitted to the facility in 2023. The resident worked with an infectious disease specialist. In mid-November 2024 a licensed staff assessed the resident when it was noted the resident displayed excessive fatigue and declined meals. When the resident reported pain in the abdomen and had intermittent bouts of loose stools licensed staff recommended the resident be seen at an emergency room for an evaluation.

The resident's progress notes indicated the resident's family was notified the resident had declined meals and reported abdominal pain 10/10 on a pain scale. Licensed staff assessed the resident and recommended the resident be evaluated at an emergency room. The family transported the resident to a hospital and the resident was hospitalized six days for Clostridioides difficile colitis (C. difficile, a bacterial inflammation of the digestive tract often triggered by antibiotic use). One week after the hospital discharge the resident was seen by a provider for a facial/neck abscess and the provider ordered clindamycin, another type of oral antibiotic. The resident reported to the provider that she had not begun to take the new antibiotic, and the provider reached out to the facility. The facility had not received the provider's new order for clindamycin, however, the order was electronically sent to the pharmacy, delivered and placed into the medication cart by unlicensed staff. The clindamycin was entered into the resident's electronic medication record and was scheduled for administration when the facility was alerted. A few weeks later, the resident was reported to have a significant increase in loose stools and was readmitted to the hospital a second time with recurring C. difficile.

Hospital discharge records from the first hospitalization indicated the resident was hospitalized for six days, treated with intravenous antibiotics and the C. difficile resolved. The resident was discharged back to the facility with an oral antibiotic specifically designed to fight intestinal bacteria, vancomycin. The vancomycin was to be taken over a period of several weeks and used a tapered process starting with a higher dose for several days and the dose gradually reduced over days until the medication was stopped.

Hospital discharge records from the second hospitalization indicated the resident was hospitalized for five days with recurring C. difficile and acute diverticulitis (inflamed pockets in intestines), treated and discharged back to the facility with a second round of tapered vancomycin. The resident returned to baseline after each hospitalization with physical therapy support.

During an interview, a licensed staff member stated the facility had not received the resident's clindamycin order which was typically faxed to the facility after the resident was seen by a provider at a clinic. Licensed staff stated a provider reached out to the facility when the resident reported not receiving the clindamycin and the licensed staff started an internal investigation to determine what had happened to the new order. Licensed staff stated it was determined the facility had not received the order. Licensed staff stated the pharmacy had received the order electronically, delivered the antibiotic to the facility, and unlicensed staff had placed the antibiotic into a medication cart. Licensed staff stated unlicensed staff had not followed protocol and had not notified an after-hours triage nurse for direction when the medication was delivered, however, licensed staff took action to resolve the medication process error as soon as it was aware. Licensed staff stated the resident missed two doses and the missed doses did not cause harm to the resident.

During an interview, the resident stated she had been sick for a long time with several infections in her stomach that required hospitalizations and antibiotic use in the past. The resident stated the staff provided "very good" help, met all her needs and she was "very happy" living at the facility.

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: Attempted

Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
When the facility became aware of the medication order, licensed staff started an internal investigation to review why the order had not been received and processed into the resident's electronic medication record. Licensed staff immediately entered the order into the resident's medication record, administered the first dose and provided re-education and medication process training for unlicensed staff.

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
	24315	A. BUILDING: _____ B. WING _____	C 02/24/2025

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 ******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: #HL243157562M/#HL243153022C On February 24, 2025, 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 45 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #HL243157562M/#HL243153022C, tag identification 1760.	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.	
01760 SS=F	144G.71 Subd. 8 Documentation of administration of medication	01760		

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01760	Continued From page 1 Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to transcribe physician orders on the electronic medication administration record (EMAR) to ensure medication was administered as prescribed for one of one resident (R1). This failure had the potential to affect all residents that resided at the licensee. 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 potential to affect a large portion or all of the residents). The findings include: Review of R's medical record indicated R1's diagnoses included dementia and parasitic	01760		

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01760	Continued From page 2 diseases. R1's Change of Condition assessment dated November 25, 2024, indicated R1's services included medication administration. R1's hospital discharge records dated November 25, 2024, indicated R1 was hospitalized for C. difficile colitis (bacterial inflammation of the colon) and discharged with antibiotic orders. The discharge orders included Vancomycin 125 milligrams (mg) by mouth four times per day for six days starting November 25, 2024, at 4:00 p.m. R1's electronic medication administration record (EMAR) dated November 2024, indicated R1 was not administered the first dose of Vancomycin 125 mg antibiotic until 8:00 p.m. on November 25, 2024, missing one dose on November 25, 2024, at 4:00 p.m. and administration should have continued through December 1, 2024, however, ended on November 30, 2024. R1 missed 5 doses of the ordered Vancomycin. R1's hospital discharge records dated December 27, 2024, indicated R1 was hospitalized for colitis due to C. diff, diverticulitis (inflammation of the digestive tract), acute kidney injury and dehydration. The discharge orders included: Vancomycin 125 mg orally four times daily through January 4, 2025, then lower to twice daily from January 5, 2025, through January 11, 2025, then daily from January 12, 2025, for 10 days. R1's EMAR dated December 2024, indicated Vancomycin 125 mg four times daily started on December 27, 2024, and was to be administered four times daily through January 4, 2025, however, the 12:00 p.m. dose on December 27, 2024, and two doses on December 28, 2024,	01760		

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01760	Continued From page 3 were documented unavailable by unlicensed personnel (ULP). On the same two days the Vancomycin was documented unavailable, two other ULP's documented the Vancomycin was administered. The December 2024 EMAR indicated R1 received the medication as ordered on December 29, 30, 31, 2024. R1's EMAR dated January 2025, indicated R1 received Vancomycin 125 mg four times daily on January 1, 2, 3, 2025. The ordered Vancomycin twice daily from January 5, 2025, through January 11, 2025, did not start until January 8, 2025. R1 did not receive ordered Vancomycin on January 4, 5, 6, 7, 2025. The twice daily Vancomycin was administered until January 14, 2025, and R1 was not administered any Vancomycin on January 15, 2025. The daily dose was started on January 16, 2025, and ended on January 25, 2025. During interview on February 26, 2025, at 10:00 a.m., clinical nurse supervisor (CNS)-B stated ULP's had not notified licensed staff R1's Vancomycin was in the medication cart and not on the EMAR. CNS-B stated the Vancomycin was restarted when nursing learned it was not administered. CNS-B stated licensed staff thought pharmacy entered tapered medication orders into R1's EMAR, however, learned later from pharmacy that licensed staff at the facility needed to enter tapered orders for it to populate correctly into the facility's EMAR system. The licensee's Medication Documentation policy dated November 18, 2024, indicated the health and wellness director (HWD) is responsible for ensuring that documentation is completed for all medication communication and medications administered to a resident. Regarding medication incidents and negative consequences, med	01760		

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01760	Continued From page 4 passers would also document in accordance with the medication incident policy. The licensee's Medication Administration policy dated November 21, 2024, indicated team members who are appropriately licensed or who, where allowable by law, have been trained , evaluated for competency, and delegated authorized by a licensed nurse will administer medication to residents receiving medication and treatment management services in accordance with provider orders. No additional information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	01760		