Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Project: HL247183363M
Compliance Project: HL247183497C

Date Concluded: June 12, 2024

Name, Address, and County of Licensee Investigated:
New Perspective Mankato
100 Dublin Road
Mankato MN 56001
Blue Earth County

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

Evaluator's Name: Lena Gangestad, 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 abused the resident by restraining her in bed because they did not have a Hoyer lift to transfer the resident.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was not substantiated. The resident returned from a hospitalization with a change in her ability to transfer out of bed, so the facility designated her bed-bound temporarily until the proper equipment was obtained. The facility order a Hoyer lift (a total-assist lift) and it arrived in less than 24-hours. The facility updated the resident's transfer status to two-person with a Hoyer at that time.

The investigator conducted interviews with facility staff members, including administrative staff, and nursing staff. The investigator contacted the resident's family member. The investigation included review of resident's records, facility's policies and procedures, incident reports, and

the resident's external medical record. The investigation included an onsite visit, observations, and interactions between residents and facility staff.

The resident resided in an assisted living secured memory care building. The resident's diagnoses include dementia. The resident's service plan included assistance with all activities of daily living which included hygiene, dressing, toileting, medications, meals, and housekeeping. The service plan also included cueing four to six times a day. The resident's assessment indicated she was bed bound.

The progress notes indicated the resident re-admitted to the facility after rehab due to a recent fall. She broke her left finger and had a cast on her arm, making it unsafe for her to use an EZ stand (stand assist lift). The facility did not have a Hoyer lift on hand and placed an order immediately. In the meantime, they conducted an assessment and changed her status to bed-bound until the Hoyer lift arrived.

The progress notes also indicated that the Hoyer lift was delivered the next day. A new assessment was done, changing the resident's status to assist of two persons with Hoyer lift.

During an interview, Nurse #1 stated that when the resident returned to the facility, there was no Hoyer lift in the building. Therefore, the nursing staff was instructed that the resident would need to be bed-bound until a Hoyer lift arrived.

During an interview, Nurse #2 stated the resident went to transition care unit for rehab after the fall and was returned to the facility with outpatient physical therapy. She said the resident also had fractured fingers and a cast on her arm, so she could not use the EZ stand anymore. They switched her to a Hoyer lift. However, there was no Hoyer lift in the facility, so the resident was placed in a bed-bound status until the lift arrived, which took only one day. She is now assisted by two persons with the Hoyer lift.

In conclusion, the Minnesota Department of Health determined abuse 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.

Abuse: Minnesota Statutes section 626.5572, subdivision 2.
"Abuse" means:
(a) An act against a vulnerable adult that constitutes a violation of, an attempt to violate, or aiding and abetting a violation of:
(1) assault in the first through fifth degrees as defined in sections 609.221 to 609.224;
(2) the use of drugs to injure or facilitate crime as defined in section 609.235;
(3) the solicitation, inducement, and promotion of prostitution as defined in section 609.322; and

(4) criminal sexual conduct in the first through fifth degrees as defined in sections 609.342 to 609.3451.
A violation includes any action that meets the elements of the crime, regardless of whether there is a criminal proceeding or conviction.
(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;
(2) use of repeated or malicious oral, written, or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening;
(3) use of any aversive or deprivation procedure, unreasonable confinement, or involuntary seclusion, including the forced separation of the vulnerable adult from other persons against the will of the vulnerable adult or the legal representative of the vulnerable adult; and
(4) use of any aversive or deprivation procedures for persons with developmental disabilities or related conditions not authorized under section 245.825.
(c) Any sexual contact or penetration as defined in section 609.341, between a facility staff person or a person providing services in the facility and a resident, patient, or client of that facility.
(d) The act of forcing, compelling, coercing, or enticing a vulnerable adult against the vulnerable adult's will to perform services for the advantage of another.

Vulnerable Adult interviewed: Attempted but unsuccessful. The resident was confused.
Family/Responsible Party interviewed: No.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
A skin assessment was conducted when the resident was re-admitted to the facility. A Hoyer lift was ordered and arrived the next day, after which another assessment was done.

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
	24718	A. BUILDING: _____ B. WING _____	C 04/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE - MANKATO	100 DUBLIN ROAD MANKATO, MN 56001

(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 April 30, 2024, the Minnesota Department of Health initiated an investigation of complaint HL247183182M/HL247183248C and HL247183363M/HL247183497C. The following correction orders are issued for HL247183182M/HL247183248C: 2360. No correction orders are issued for complaint HL247183363M/HL247183497C	0 000		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, 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: The facility failed to ensure one of one resident reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360	No plan of correction is required for this tag.	