Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL247188622M
Compliance #: HL247186081C

Date Concluded: April 11, 2025

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: Substantiated, individual responsibility

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 resident fell while being assisted in the bathroom.

Investigative Findings and Conclusion: The Minnesota Department of Health determined neglect was substantiated. Two alleged perpetrator (AP #1 and AP #2) were responsible for the maltreatment. Both AP#1 and AP#2, who were unlicensed caregivers, were in the room and failed to follow the care plan by not using the required equipment to assist the resident to the bathroom, resulting in the resident falling on her knee and sustaining a tibial plateau fracture. A video recorded showed inconsistencies between what AP #1 and AP #2 stated occurred.

The investigator conducted interviews with facility staff members, including administrative staff, and unlicensed staff. The investigation included review of the resident's records, incident reports, personnel files, staff schedules, policies, and procedures.

The resident resided in an assisted living secured memory care building. The resident's diagnoses include Alzheimer's disease, history of falling, and restless leg syndrome. The resident's comprehensive assessment indicated that assistance from two persons and a sit-to-stand lift were required for transfers.

The resident's comprehensive assessment, conducted 11 days before the incident, indicated the resident had severe limitations in her right upper and lower extremities as well as her left lower extremity.

The resident's progress notes indicated AP #1 reported the resident slipped out of the sit-to-stand lift, twisting her left knee. The triage nurse was contacted, and interventions were initiated; however, the left knee remained painful and swollen. The same documented indicated the triage nurse instructed staff to call 911, and the resident was transferred to the emergency room for further evaluation.

During an interview, AP #1 stated that she was assigned to the resident on the day of the incident. She asked AP #2 to help her transfer the resident to the bathroom. She said that while she was trying to assist the resident, AP #2 went to another room to get something for the resident. As soon as AP #2 left, the resident told AP #1 that she could stand, so AP #1 helped her stand up. As soon as the resident stood, she slipped. AP #1 stated that she supported the resident with her leg, and AP #2 returned to help her guide the resident back to the toilet. She said the resident did not fall completely to the ground because she was holding onto the resident from behind. She said that she should have used the sit-to-stand lift and not relied on the resident's ability to stand independently.

During an interview, AP #2 stated that he helped AP #1 assist the resident to the bathroom. He left the room to retrieve something for the resident, and when he returned, AP #1 had already begun helping the resident stand. At that point, the resident was slipping, so he stepped in and assisted in getting her back to the toilet. He stated the resident did not fall to the floor or at least he did not see her fall. He stated the resident required a sit-to-stand or Easy Stand lift, and staff were supposed to use it with two-person assistance. He said that since the resident did not appear to fall, he did not report the incident to anyone.

However, a video recording device in the resident's apartment was reviewed and inconsistencies between the description provided by AP #1 and AP #2 and what the video showed. The video reviewed was divided into three segments.

At 8:04 AM, video recording segment #1 showed the resident was standing and leaning against the wall, with her left hand holding the doorknob while AP #1 was pulling up her pants. At the same time, AP #2 was seen removing the sit-to-stand lift from the bathroom and bringing in the wheelchair.

At 8:05 AM video recording segment #2 showed AP #2 walked out of the bathroom, and the resident was already on the floor, kneeling with her left hand still holding the doorknob. AP #1 was attempting to assist the resident by supporting her from behind. AP #2 tried to bring in the sit-to-stand lift, but there was not enough space, so both APs manually lifted the resident back onto the toilet without using equipment. The resident remained on her knees on the ground for over a minute.

At 8:06 AM, video recording segment #3 showed the resident was assisted back to the toilet seat.

During an interview, the manager stated that she was new at the time of the incident. She said that a staff member was attempting to assist the resident with a transfer, but the resident insisted she could stand without help. The staff member trusted the resident and proceeded without using proper equipment, which resulted in the resident falling. The manager said she was unsure if the resident actually ended up on the floor. She said that the staff reported the incident to the triage line and that, at the time, the resident did not appear to have any injuries but was later sent to the hospital due to pain. The manager also said that she did not conduct the staff interviews herself but was aware that AP#1 and AP#2 were no longer employed at the facility.

During an interview, a family member stated that the resident was in her room and needed to use the bathroom. Two unlicensed caregivers [AP #1 and AP #2] were in the room with her. The caregivers used the sit-to-stand to transfer her to the toilet but did not use it to assist her to stand. Instead, they had the resident stand and hold onto the doorknob while they pulled up her pants. However, the resident was unable to hold onto the doorknob and stand for long, causing her to fall onto her knee. In the process, she also knocked over the toilet paper holder. The family member stated the resident sustained bruises and was in significant pain. The caregivers told the manager and the family member that the resident did not fall and never touched the ground, but due to her level of pain, the family member reviewed the video and discovered what actually happened.

In conclusion, the Minnesota Department of Health determined 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 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, the resident no longer resided at the facility.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility: The facility assessed the resident and transferred her to the hospital for further evaluation. An internal investigation was initiated, and AP#1 and AP#2 ‘s employment was terminated.

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.

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

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

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
Blue Earth County Attorney
Mankato City Attorney
Mankato Police Department

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 03/13/2025

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 March 13, 2025, the Minnesota Department of Health initiated an investigation of complaint HL247188622M/HL247186081C. The following correction order is issued, tag identification 2360.	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 two individuals were responsilbe 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.	