Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL396088804M
Compliance #: HL396086307C

Date Concluded: December 20, 2023

Name, Address, and County of Licensee Investigated:

New Perspective
3565 Pine Tree Drive
Arden Hills, MN 55112
Ramsey County

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

Evaluator's Name: Peggy Boeck, RN
Special Investigator

Finding: Abuse-Inconclusive
Neglect- Not Substantiated

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.

Initial Investigation Allegation(s):
The Alleged Perpetrator (AP) (an unknown staff) abused a resident when the AP restrained the resident to his wheelchair in his room.
It is also alleged the facility neglected to supervise the resident, who had a fall with injury.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was inconclusive. Although a staff found the resident secured to their wheelchair, it could not be determined who placed the gait belt on the resident or if the resident had been there for any length of time.

The allegation of neglect is not substantiated. The resident had a history of falls. The care plan provided fall prevention interventions for staff. The nurse assessed the resident after each fall

and made changes to the care plan as needed. The concern of failure to provide medications in a timely manner (leading to falls) was not supported by interview or documentation.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's medical provider and a family member. The investigation included review of medical records, incident reports, facility investigation documents, training documentation, policies, and procedures related to falls, change in condition, medications, nursing services, service plans, staffing, and maltreatment of vulnerable adults. Also, the investigator observed medication administration and staff/resident interactions.

The resident lived in an assisted living memory care unit while recovering from a fall related hip fracture that occurred at a previous placement. The resident's diagnoses included Parkinson's Disease. The resident's service plan included assistance with bathing, dining, dressing, grooming, housekeeping, laundry, medication administration, transfers, falls management, toileting, and incontinence cares. The resident's assessments indicated the resident received occupational and physical therapy. Progress notes indicated the resident showed improvement in strength and balance with a goal of reducing falls.

Multiple incident reports indicated staff found the resident on the floor after what appeared to be falls. The resident's medical record indicated each incident resulted in a nursing assessment, and changes to the service plan if indicated. The resident had one injury (a bruise above his eye) which resulted in no long-term consequences and was assessed at the hospital (due to altered level of consciousness later in the day).

An incident report indicated a staff member found the resident one morning in his room, sitting in his wheelchair with a gait belt secured around his waist and the chair, allowing movement but preventing him from standing. The staff member took a photo of the restraint, released the gait belt, and made appropriate notifications. A nursing assessment indicated the resident received no injuries.

During an interview, an administrative staff indicated a facility investigation which included interviews with staff, failed to identify the AP. No staff admitted to the restraint, and no staff witnessed the restraint. The facility did not have surveillance cameras in the memory care unit. The administrative staff stated the investigation resulted in re-education to all staff regarding prohibition of restraints and the facility moved the resident to a room closer to staff.

During an interview, a staff member stated she discovered the restraint. The staff member stated she had never seen anyone restrain a resident with a gait belt but thought maybe someone did it to prevent the resident from wandering or falling. The staff member stated the resident did not appear harmed.

During investigative interviews, multiple staff members who worked the evening and night shifts denied restraining the resident or knowing who did restrain the resident. None of the evening or night shift staff admitted to seeing the resident restrained in the wheelchair. Two of the staff working with the resident gave conflicting information about whether the resident was in bed or sitting in the living room at change of shift (evening to nights) so it could not be verified who placed the resident in bed.

During an interview, a family member stated a staff member called about a fall the resident had one morning and then the next morning they found him restrained to the wheelchair. The family member worried the staff restrained the resident in the wheelchair because he had fallen, and the staff did not want to have to keep checking on him. The family member stated the resident was more likely to be unsteady/sleepy when he did not consistently get his Sinemet (a medication used to treat symptoms of Parkinson's Disease that required precisely timed administration). The family member stated the resident became very sleepy the day after the fall, unable to complete an occupational therapy session and went to the hospital. The family member stated the resident perked back up after the hospital gave him a dose of Sinemet and he returned to the facility the next day. The family member stated the facility reeducated staff on the importance of timely administration of the medication and prohibition of restraints. The family member expressed satisfaction with the facility, due to improved staffing, fewer falls, improved activities, and good food for the residents.

In conclusion, abuse is inconclusive, and neglect is not substantiated.

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or 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:
(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.

"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: Interacted, unable to interview.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Possible APs were interviewed, no specific AP identified.

Action taken by facility:
The facility investigated the incident and provided staff re-training on maltreatment and medication administration.

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
	39608	A. BUILDING: _____ B. WING _____	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE ARDEN HILLS	3565 PINE TREE DRIVE ARDEN HILLS, MN 55112

(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 December 8, 2023, the Minnesota Department of Health initiated an investigation of complaint #HL396086307C/#HL396088804M. No correction orders are issued.	0 000		