DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL200224723M
Compliance #: HL200228045C

Date Concluded: August 10, 2023

Name, Address, and County of Licensee Investigated:
New Perspective Senior Living-Roseville
2750 Victoria Street North
Roseville, MN 55113
Ramsey County

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

Evaluator's Name:
Maerin Renee, 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 staff failed to supervise the resident. The resident left the facility for an undetermined amount of time and was found lying outside in the snow. The resident developed frostbite on her hands, knees, and chin.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The resident had been assessed as independent with most activities, and her plan of care was followed. The resident had never left the facility by herself, so staff would not have predicted she would walk out of the building alone. Staff had performed safety checks in accordance with the resident's service plan. The resident was transported to the hospital for further treatment.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement and family members. The investigation included review of the resident's medical records, facility policies

and procedures, and personnel files. Also, the investigator observed cares and staff interactions with residents.

The resident resided in an assisted living facility. The resident's diagnoses included dementia and chronic obstructive pulmonary disease. The resident's service plan included assistance with bathing, housekeeping, and laundry. The resident's assessment indicated she was independent with most activities.

The facility incident report indicated a staff member entered the facility parking lot at around 9:00 p.m. to leave for the day and saw the resident sitting near a car. The resident was visibly cold with reddened hands and appeared to have fallen with abrasions to her left hand and nose. The resident was taken inside the facility, where staff called the on-call nurse and 911. The resident told staff her brother was going to pick her up, so she went out to get into his car. The resident stated she fell and crawled to the car. Emergency Medical Services (EMS) transported the resident to the hospital via ambulance. There was no facility video available.

When interviewed, facility staff stated a staff member left the facility to go home around 9:00 p.m. and saw the resident sitting on the ground in the snow. Staff did not know how long the resident had been outside, but reported the resident was last seen in the facility around 6:00 p.m. The entrance to the facility had been locked at 8:00 p.m. as usual, so the resident would have been unable to exit the building after that without staff knowledge. The resident was brought into the building, staff assessed the resident and called 911. The resident was taken to the hospital via ambulance and was treated for frostbite.

The resident's hospital record indicated the resident was diagnosed with frostbite on both her hands. The tips of most of the resident's fingers were eventually amputated, due to the extent of the damage to those fingers.

The resident's service plan indicated the resident was independent with most activities, and staff would perform a face-to-face safety check every day. The resident's service list indicated the resident received routine safety checks during the morning and evening shifts on the day she was discovered outside in the parking lot.

When interviewed, the resident stated she fell on a patch of ice and was not outside very long.

When interviewed, a family member stated the resident had never left the facility before this incident. The family member stated they were thankful the staff member found the resident and credited a staff member for saving the resident's life.

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: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility completed an internal investigation. After the resident returned from the hospital, she was transferred to the facility’s locked memory care unit.

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20022	A. BUILDING: ______ B. WING ______	C **07/25/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE - ROSEVILLE	**2750 NORTH VICTORIA STREET ROSEVILLE, MN 55113**

(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 July 25, 2023, the Minnesota Department of Health initiated an investigation of complaint #HL200228045C/#HL200224723M. No correction orders are issued.	0 000		

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE