Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL201683923M
Compliance #: HL201686547C

Date Concluded: August 29, 2023

Name, Address, and County of Licensee Investigated:
New Perspective Senior Living – Highland Park
750 Mississippi River Blvd S.
Saint Paul, MN 55116
Ramsey County

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

Evaluator's Name: James P. Larson, 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 provide catheter care in accordance with the service plan and failed to complete an assessment of the resident after the resident sustained multiple falls.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Care was provided in accordance with the resident's service plan and facility policies and procedures were followed. Although catheter care was not completed on one occasion, the error was an isolated incident and there was no evidence of harm to the resident.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator also interviewed the resident's family. An onsite visit was conducted which included review of facility policies, procedures, resident

medical records, and personnel records. In addition, the investigator observed care provided to the residents.

The resident resided in an assisted living memory care unit. The resident’s diagnoses included Alzheimer's disease, spondylolysis (degeneration of the spine), recurrent urinary tract infections (UTIs) and a history of falls. The resident's service plan included assistance with medication management, assistance with activities of daily living, and catheter care three times per day.

Complaint documents identified concerns with the resident’s catheter care, frequent falls, and failure to assess the resident after each fall. Review of the resident’s medical record indicated services were provided as directed by the service plan. Progress notes and incident reports indicated the resident experienced frequent falls, but each fall was documented, the resident was assessed, and fall prevention interventions were implemented to prevent further falls. Review of fall documentation indicated the falls did not result in significant injury.

During investigative interviews, multiple staff reiterated knowledge of the resident and his frequent falls. Facility nursing staff indicated most of the resident’s falls occurred during self-transfer attempts from the bed to the wheelchair.

During interview with the resident, the resident indicated staff provided catheter care, he felt safe residing at the facility, and had no complaints with the care provided by facility staff. The resident denied falling.

The resident's family was interviewed and indicated they had no current concerns with the care provided 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: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
None.

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
	20168	A. BUILDING: _____ B. WING _____	C 07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE - HIGHLAND PARK	750 MISSISSIPPI RIVER BLVD SAINT PAUL, MN 55116

(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 14, 2023, the Minnesota Department of Health initiated an investigation of complaint #HL201686547C/ HL201683923M. No correction orders are issued.	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	

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0 000	Continued From page 1	0 000	ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	