State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL220949245M
Compliance #: HL220946772C

Date Concluded: April 11, 2024

Name, Address, and County of Licensee Investigated:
New Perspective Prior Lake
4685 Park Nicollet Ave
Prior Lake, MN 55372
Scott County

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

Evaluator's Name: Julie Serbus, RN
Special Investigator

Finding: Inconclusive

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 alleged perpetrator (AP) abused the resident when the AP pushed the resident while trying to take the resident to her room for cares.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was inconclusive. While the AP, who was an unlicensed caregiver, was witnessed interacting with the resident in a discourteous manner, there was insufficient evidence to demonstrate abuse occurred.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed caregivers. The investigator contacted the resident's family member. The investigation included review of the resident records, incident report, service plan, assessments, related facility policy and procedures, hospital records, and the AP's file. During an onsite visit, the investigator observed the resident along with staff interactions with the resident.

The resident resided in an assisted living memory care unit. The resident's diagnosis included dementia. The resident's service plan included assistance with bathing, dressing when needed, medication administration, assistance with toileting, and reminders to go to meals. The resident at times refused cares and caregivers were directed to reattempt or reapproach to complete the services. The individual abuse prevention plan (IAPP) indicated the resident is unable to make her needs known, could not report abuse, and was susceptible to abuse by others. The resident's assessment indicated the resident was alert and orientated to self with severe short-term memory and uncooperative with cares.

One day the AP was directed by another unlicensed caregiver to toilet the resident as she appeared to be incontinent. The AP followed the direction and was witnessed to have pushed and pulled the resident forcefully when directing the resident to her room for cares. The resident was observed to be visibly shaken and crying so someone else took over her cares.

Review of the resident's progress notes indicated resident is at baseline and did not require a change in her care plan. The resident did not receive any injuries related to the incident.

During an interview, unlicensed caregiver #1 stated she was busy at the medication cart and noticed the resident needed incontinence cares because she smelled of urine and the resident had refused to be changed overnight. Caregiver #1 asked AP to take the resident to the bathroom. Caregiver #1 stated she was aware the resident did not particularly care for the AP, but still requested AP to assist the resident. The AP approached the resident, but she refused saying "no, no, no" and the AP began to "push" her down the hallway.

During an interview, unlicensed caregiver #2 stated she was near the medication cart, and she heard the AP trying to get the resident to her room, but the resident refused. Caregiver #2 stated both the AP and the resident were becoming upset, so she approached them to intervene. At first the AP wanted to keep trying and pulled the resident by her arm to coax her down the hallway. Caregiver #2 stated the resident looked scared. Caregiver #2 took over the cares and the AP did not provide cares.

During an interview, AP stated unlicensed caregiver #1 was working on the medication cart and asked AP to assist resident to her room for toileting because she was incontinent. The AP stated she was aware the resident's skin was at risk due to frequent incontinence and refusal of cares. AP stated the resident did say no and so she tried to encourage her to come down the hallway verbally. The AP stated she took her by the hand and tried to guide down the hallway, but the resident became upset. Caregiver #2 approached the resident and took over the cares.

During an interview, a manager stated caregivers do have a challenging time completing the resident's activities of daily living and caregivers are trained to either reapproach or ask another staff to attempt to assist the resident. The manager stated unlicensed caregiver #2 did report the concerns along with taking over care of the resident. The manager stated they did not have

camera footage of the incident in question. The manager stated formal retraining had not been provided after this incident or prior incidents involving the AP.

During an interview, a family member stated when they would visit the resident, she was frequently incontinent. The family member stated they were aware the resident often refused cares, only accepts help when she is ready, and has been this way all her life.

In conclusion, the Minnesota Department of Health determined abuse was inconclusive.

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:
(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.

Vulnerable Adult interviewed: NA due to cognitive status
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility:
AP no longer is employed at the facility.

Action taken by the Minnesota Department of Health:
No further action required.

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
	22094	A. BUILDING: _____ B. WING _____	C 03/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE - PRIOR LAKE	4685 PARK NICOLLET AVENUE PRIOR LAKE, MN 55372

(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 18, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL220946772C/#HL220949245M. No correction orders are issued. ******ATTENTION****** HOME CARE PROVIDER/ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144A.43 to 144A.482/144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #HL220946772C/#HL220949245M On March 18, 2024, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 84 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued/orders are issued for#HL220946772C/#HL220949245M, tag identification 2350. Minnesota Department of Health is documenting	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 License Providers. 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 surveyors' 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 issued pursuant to 144G.31 subd. 1, 2, and 3.	

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0 000	Continued From page 1 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.	0 000		
02350 SS=D	144G.91 Subd. 7 Courteous treatment Residents have the right to be treated with courtesy and respect, and to have the resident's property treated with respect This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to ensure a resident (R1) was treated with courtesy and respect for one out of one resident reviewed. While the facility disciplined an unlicensed personnel (ULP)-E for	02350		

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02350	Continued From page 2 discourteous cares, no retraining for improvement was provided though the concern arose with ULP-E multiple times. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1 was admitted to the facility on December 29, 2021. R1's diagnosis included dementia. R1's service plan dated September 13, 2023, included R1 required assistance with bathing, toileting, meal reminders, cues for dressing, grooming set up, and medication management. This same plan indicated resident can be resistant to cares. R1's Individual Abuse Prevention Plan (IAPP) dated September 14, 2023, indicated R1 was at risk of abuse by others. R1 required cues and prompts for her daily living and staff were to provide interventions as needed. R1 was unable to make her needs known. Caregivers had been trained on signs of abuse/neglect and to report any concerns to the supervisor immediately. The facility's summary of investigation dated October 22, 2023, indicated unlicensed personnel (ULP)-E was directed by another ULP to toilet R1 as she appeared to be incontinent. ULP-E followed the direction and was witnessed to have	02350		

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02350	Continued From page 3 pushed and pulled R1 forcefully when directing R1 to her room for cares. ULP-E's personnel file indicated a corrective action dated September 9, 2023, and again on September 12, 2023, where ULP-E was given written corrective actions. The same documents did not indicate the facility documented re-training regarding how ULP-E could change how she provided cares. ULP-E's file indicated the last documented training was dated August 23, 2023; no documented re-training completed after the two September incidents. The facility terminated ULP-E's employment. During an interview on March 18, 2024, at 2:37 p.m., administration (ADM)-A stated she received a report of an incident where staff members had witnessed ULP-E pulling and pushing R1 while trying to provide cares. ADM-A stated R1 had a history of resisting cares and staff are trained to either reapproach R1 after a period or try other interventions. The manager stated formal retraining had not been provided after this incident or prior incidents involving the ULP-E. During an interview on March 27, 2024, at 2:51 p.m., ULP-E stated ULP-G was working on the medication cart and asked ULP-E to assist resident to her room for toileting because she was incontinent. ULP-E stated she was aware R1 was frequently incontinence and refused cares. ULP-E stated R1 did say no and so she tried to encourage her to come down the hallway verbally. ULP-E stated she took R1 by the hand and tried to her guide down the hallway, but R1 became upset. A third ULP, ULP-F, approached and took over the cares. ULP-E stated after two prior corrective actions no re-training was	02350		

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02350	Continued From page 4 completed by the facility. The licensee provided Minnesota Bill of Rights Policy, not dated, indicated a person who resides in an assisted living community has the right to refuse care or assisted living services. Residents have the right to be treated with courtesy and respect. The licensee provided Maltreatment of a Resident policy, dated February 28, 2023, indicated mandatory team member in-service training on abuse and neglect following an incident of substantiated resident abuse, team members, as applicable will receive mandatory in-service training on abuse and neglect policies and procedures. TIME PERIOD OF CORRECTION: SEVEN (7) days.	02350		