Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL235051140M
Compliance #: HL235058542C

Date Concluded: April 4, 2024

Name, Address, and County of Licensee Investigated:

New Perspectives Eagan
3810 Alder Lane
Eagan, MN 55337
Dakota County

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

Evaluator's Name: Danyell Eccleston, RN, Special Investigator

Finding: Substantiated, facility 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 staff failed to check on the resident or enter his apartment for multiple days. The resident was found on the floor and taken to the hospital.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The facility failed to ensure staff were directed on the residents individualized plan of care. Staff failed to check on the resident or enter his apartment for three days. The resident was found lying on the floor in his apartment. The resident was transferred to the hospital and diagnosed with traumatic rhabdomyolysis (a serious condition resulting from the death of muscle fibers releasing their contents into the blood stream after a traumatic event), closed head injury, facial skin infection, right arm weakness, head and right elbow wounds, and multiple scrapes.

The resident's medical record indicated the resident resided in an assisted living facility with diagnoses including a mental disorder that caused the resident to isolate and at times self-barricade in his apartment, weakness that required the resident to use a cane or walker when walking, eye disease that affected the resident's central vision causing lack of ability to see things directly in front of him, and foot numbness.

The facility internal investigation indicated a physical therapist found the resident on the floor of his bedroom in the early afternoon. Staff could not enter the resident's bedroom because his body was blocking access. The resident indicated a toolbox fell on his head and he was on the floor for a few days. The resident had a cut to the back of his head, was incontinent, and had bruises to his right knee, elbow, and toes. The facility contacted emergency services and the resident was taken to the hospital. A staff member recalled interacting with the resident approximately three days prior to him being found on the floor. Staff assigned to the resident during the three days in question indicated they had not seen the resident or gone into the resident's apartment, but had documented cares as completed.

Hospital documentation indicated the resident was admitted to the hospital for seven days and treated for traumatic rhabdomyolysis, closed head injury, facial skin infection, right arm weakness, head and right elbow wounds, and multiple scrapes. The resident discharged to a transitional are center to improve weakness.

The resident's service plan consisted of individualized services with a description of the service and an assigned frequency for each service. The service plan included assistance with weekly skin checks and daily room refreshes and bedrail checks. Three times daily falls management services instructing staff, "Resident is at risk for falls. Encourage resident to wear properly fitting foot ware or non-slip socks, keep walkways within the apartment free of clutter, participate in community exercise activities to support physical endurance and strength, keep call pendant, if in use, within reach, place pull cord, if available, within reach when in their bedroom; and drink fluids in-between meals and at mealtime." Three times daily risk for self-harm services instructing staff, "Notify nurse of signs of self-harm or self-neglect." Four to six times daily cueing services that did not describe needed interventions. Once weekly skin checks instructing staff, "Promptly report to a nurse any observed skin issues or changes in skin condition."

Individual abuse prevention plan documentation indicated the resident was at risk of harm to self, had visual and hearing deficits, and was unable to ambulate safely with or without a device and was at risk for falls. The document indicated, "caregivers are trained to follow the care plan and ensure that resident is safe went [when] ambulating." The document indicated "resident requires assistant to maintain safe and clean environments. Caregivers perform room refresh daily and resident receives housekeeping services from the facility."

In written communication, a leadership member indicated services of “cues/prompts” would typically contain verbiage regarding the resident’s cueing needs and this was not present on the resident’s service during the time in question.

During separate interviews, two leadership members and two nurses had differing responses concerning actions unlicensed personnel needed to take to document the resident’s services as completed.

During separate interviews, three unlicensed staff stated services of bedrail checks and room refreshes required staff to enter the resident’s apartment. Services of cues, falls management, risk of self-harm, and skin checks required staff to see the resident. The unlicensed personnel stated they were assigned to the resident during the time in question and documented providing services to the resident, however, they did not see the resident or enter his apartment.

During interview, a leadership staff stated the resident’s fall incident brought to light issues that caregivers did not have a good understanding of the services a resident needed and how to complete those services. The leader also stated the resident had a history of barricading himself in his apartment and needed staff cues, which create a financial charge to the resident, as a reminder to not dig through the garbage for items that could be used to block doorways.

During interview a family member stated the resident had very high social anxiety and did not like people in his apartment and had a history of barricading himself in his apartment with boards and a toolbox. The family member stated the resident’s tendency to self-isolate created further risk and detriment to himself.

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: Yes.

Family interviewed: Yes.
Alleged Perpetrators interviewed: Yes.

Action taken by facility:
Facility conducted an internal investigation, conducted service education with care staff, and coached staff that had erroneously documented completing services.

Action taken by the Minnesota Department of Health:
The responsible party will be notified of their right to appeal the maltreatment finding.

The facility was found to be in noncompliance. 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

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

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

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Dakota County Attorney
Eagan City Attorney
Eagan Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23505	A. BUILDING: _____ B. WING _____	C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE - EAGAN	3810 ALDER LANE EAGAN, MN 55122

(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 ******ATTENTION****** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 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: #HL235058542C/#HL235051140M On March 6, 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 81 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for tag identification #HL235058542C/#HL235051140M, 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.	02360		

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02360	Continued From page 1 This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident(s) reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible 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.	