Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL235053708M
Compliance #: HL235056092C

Date Concluded: September 5, 2023

Name, Address, and County of Licensee Investigated:

New Perspective Eagan
3810 Alder Lane
Eagan, MN 55112
Dakota County

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

Evaluator's Name: Danyell Eccleston, 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 alleged perpetrator (AP), a nurse, neglected a resident when the AP readmitted the resident to the facility with the use of a sit-to-stand device for transferring that the resident was not able to physically use properly. The resident experienced a fall and was sent to the hospital.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The resident's physician wrote an order for the sit-to-stand device and the incident was not related to use of the device.

The investigator conducted interviews with facility staff members, including administrative staff and nursing staff. The investigation included review of medical records and policy and procedure. Also, the investigator observed staff providing care to residents.

The resident resided in an assisted living facility. The resident's diagnoses included heart disease and kidney failure. The resident's service plan included assistance with transfers and mobility. The resident's assessment indicated the resident needed the assistance of two staff for transfers with the use of a sit-to-stand device.

Review of documentation indicated the resident readmitted to the assisted living facility from a transitional care facility the day before the incident. Correspondence between the facilities indicated the resident used a four wheeled walker and the assistance of one to two staff to walk at the transitional care facility. The assisted living facility indicated it would not have variable transfer assistance and would need to plan for the highest need for transferring the resident, which would be an assist of two staff members. The assisted living facility correspondence also indicated that all two staff member transfers required a mechanical lift, such as a sit-to-stand device, to safely meet the resident's varying abilities to transfer.

Review of transitional care facility discharge orders written by a physician indicated the resident was approved to admit to the assisted living facility and use a sit-to-stand device for mobility.

During an interview, the AP stated she conducted an admission assessment for the resident the day he arrived back to the assisted living facility. The AP stated she transferred the resident with another staff member using a sit-to-stand device and did not have concerns at the time of the resident's readmission.

During an interview, a nurse stated she went to the resident's apartment the day after he was readmitted to assist with an emergency. The nurse stated staff reported the resident began to lose consciousness and was not able to bare weight on his legs while transferring in the sit-to-stand device. The nurse stated when she arrived at the resident's apartment, the resident was able to talk and was sitting down with his legs still on the sit-to-stand device. The nurse stated emergency services came and took the resident to the hospital for further evaluation due to his loss of consciousness.

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: No, vulnerable adult deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
No action taken.

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
	23505	A. BUILDING: _____ B. WING _____	C 08/09/2023

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 On August 9, 2023, the Minnesota Department of Health initiated an investigation of complaint #HL235056092C/#HL235053708M. No correction orders are issued.	0 000		