Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL247183182M
Compliance #: HL247183248C

Date Concluded: June 12, 2024

Name, Address, and County of Licensee Investigated:

New Perspective Mankato
100 Dublin Road
Mankato MN 56001
Blue Earth County

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

Evaluator's Name: Lena Gangestad, 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 the resident had a fall resulting in a laceration. The resident was seen on camera by a family member yelling for help for 40 minutes before a staff member came to assist.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The resident has multiple falls over the course of approximately seven weeks during which the facility did not put interventions in place to prevent future falls. Additionally, on one occasion the facility did not perform safety checks per the service agreement and the resident fell on the floor yelling for help. The resident sustained a laceration and a broken finger.

The investigator conducted interviews with facility staff members, including administrative staff, and nursing staff. The investigator contacted the resident's family member. The investigation

included review of resident's records, facility's policies and procedures, incident reports, and the resident's external medical record. The investigation included an onsite visit, observations, and interactions between residents and facility staff.

The resident resided in an assisted living but moved to the secured memory care building during the events described below. The resident's diagnoses include dementia. The resident's service plan included assistance with all activities of daily living which included hygiene, dressing, toileting, medications, meals, and housekeeping. The service plan also included cueing four to six times a day. The resident's assessment indicated the resident was assisted of one person with stand-assist (EZ) lift for transfers.

Week One:
One day the progress notes indicated the resident had an unwitnessed fall. 911 was called, and she was sent to the hospital where a hip fracture was identified. The hip fracture was deemed non-operative. The facility notified the resident's medical provider of the fall by fax.

Three days later the progress notes indicated the resident returned to the facility and was moved to the secured memory care unit. Later that same evening she had an unwitnessed fall.

Week Two:
A week later the progress notes indicated the resident was found on the floor.

Under Falls Management, a review the resident's service plan did not identify an intervention after this fall.

Three days later the progress notes indicated there was a note in the 24 hour shift log that the resident called 911 herself and was transported to the emergency room. The same document indicated the resident sustained a left hip fracture and the resident's family had stated the resident required surgery.

Week Three:
Five days later the progress notes indicated the resident returned to the facility and needed assistance from two persons with an EZ stand.

Two days later the progress notes indicated the resident was found sitting on the floor in her living room with her back against the couch by a caregiver.

Under Falls Management, a review the resident's service plan did not identify an intervention after this fall.

Week Six:
One night two weeks later, the resident was found on the floor by the door in her room. She had a cut on her left middle finger and had pulled out her catheter. The resident had a

laceration, a fracture of her left middle finger, and a left femur fracture. She was admitted to the hospital.

Under Falls Management, a review the resident's service plan did not identify an intervention after this fall.

Interviews:
During an interview, nurse #1 stated the resident was moved to memory care after the fall. The staff members tried to keep the resident in the common area as long as she tolerated it to keep an eye on her. She also said the staff did not document how often they checked on the resident even though she claimed they did do it.

During an interview, nurse #2 stated the resident had a couple more falls and re-fractured her hip in the memory care unit. She said the family was pretty upset because the call light took so long to answer, and they ended up having to come and help her. She said the facility had one medication passer and one caregiver. She said the resident started using a standing (EZ) lift when she moved to memory care, and the staff tried to keep her out in a day room and offered activities to keep her busy. At shift change, she said the staffs were supposed to verbalize about the last check, but there was never any specific check scheduled or documented.

During an interview, family member #1 stated the resident was living on the assisted living side and had a couple of falls. She broke her hip, had surgery, and returned to the memory care side. She was placed in memory care unit and within one or two days, she fell again post-hip surgery. The family had installed a ring camera, so they knew whether staff came to help her or not. No one had come to assist the resident. She was yelling, and the family ended up driving to the facility to help her to the bathroom. Within 24 hours, the resident was sitting on the edge of the bed and scooting on the floor for two hours at 3:00 a.m., and no one had come to help her. She ended up ripping her catheter out. The family talked to the director, and their only response was that they were short-staffed.

During an interview, family member #2 stated the camera they installed showed that at night, the resident would yell for help, and no one came to assist her. There was a button to push, but the resident had dementia and did not know how to use it. She fell, broke her finger, and pulled out her catheter. At night, the facility did not have enough staff to check on people, and the night staff did not check on the resident as often as they said they would. The facility told her that they were short-staffed. She said the resident often fell either at night or early in the morning.

During an interview, an employee stated the facility only had two staff members: a caregiver and one medication passer at night for the entire building, and no one was stationed in the memory care unit.

During an interview, manager #1 stated at night the facility only had one med passer and one care giver working for the whole building.

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: Attempted but unsuccessful. The resident was confused.
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:
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
Blue Earth County Attorney

Mankato City Attorney
Mankato Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24718	A. BUILDING: _____ B. WING _____	C 04/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE - MANKATO	100 DUBLIN ROAD MANKATO, MN 56001

(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 April 30, 2024, the Minnesota Department of Health initiated an investigation of complaint HL247183182M/HL247183248C and HL247183363M/HL247183497C. The following correction orders are issued for HL247183182M/HL247183248C: 2360. No correction orders are issued for complaint HL247183363M/HL247183497C	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. This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident 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.	