Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL247183183M
Compliance #: HL247183249C

Date Concluded: June 11, 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 numerous falls but the facility did not put interventions in place to address the risk of falls.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. During the course of approximately nine weeks, the resident fell on multiple occasions, but the facility did not implement interventions to reduce the risk of increased falls.

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 memory care unit. The resident’s diagnoses included dementia. The resident's service plan indicated the resident required cues to stay seated in a wheelchair due to imbalance. The resident’s assessment indicated the resident was confused at times and did not respond to cues. The assessment also indicated she had a history of falls and would receive toileting assistance up to three times a day.

Week One
The progress notes indicated the resident was sent to the hospital due to a fifth fall within 36 hours. The same document indicated the resident would require "1:1" supervision if she returned to the facility. The same document indicated the family stated they would not be providing one-on-one care.

Week Two
The progress notes indicated the facility went to the hospital, conducted an assessment, and accepted the resident back to the facility.

The resident’s medical record included a note from the medical provider who wrote "Unable to prevent falls related to resident having a diagnosis of dementia; resident will continue to fall." The same document did not include how the medical provider made this determination.

Week Four
The resident’s progress notes indicated the resident had an unwitnessed fall in the dining room in the evening around 6:30 p.m.

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

Week Six
The resident’s progress notes indicated these falls occurred:

- The resident was found lying on her back in her apartment around 5:00 p.m.
- The resident fell in the dining room while using her wheelchair around noon.

Under Falls Management, a review of the resident’s service plan did not identify an intervention after these falls.

Week Seven
The resident’s progress notes indicated these falls occurred:

- The resident was found lying on her back at approximately 2:20 a.m.
- The resident was found on the floor with a "positive head strike" at approximately 1:20 p.m.

During this same week, the progress notes indicated the resident was sent to the hospital after a fall and came back the same day with diagnosis of T11-T12 compression fracture.

Later that same evening the progress notes indicated this fall occurred:

- The resident fell while attempting to get from her wheelchair and walk at approximately 7:00 p.m.

Later that same week the progress notes indicated the facility consulted with "therapy" and determined R2 required "long term care" placement due to ongoing falls.

Later that same week the progress notes indicated:

- The resident had an unwitnessed fall in her room at approximately 12:30 a.m.

Under Falls Management, a review of the resident's service plan did not identify an intervention after these falls.

During week seven the progress notes indicated a care conference was held with the resident's family to address the frequent falls and therapy recommendations for "direct supervision with close proximity at all times". The same document indicated neither the family nor the facility would provide "1:1" supervision and "there will continue to be falls". The same document indicated the care plan will be increased to a "custom level".

During interviews, multiple employees stated the resident fell frequently during a period covering about two months and that a care conference was held with the family with the recommendation that the resident transfer to a nursing home setting. Multiple employees stated that during the care conference a member of the management team presented a different perspective, and that the resident did not need such extensive care, which conflicted with the understanding of the caregivers. Multiple employees stated the facility management decided the resident could stay at the facility with increased services.

Later during week seven the progress notes indicated the following occurred:

- The resident had an unwitnessed fall next to her bed at 12:12 a.m., 2:13 a.m. and 4:58 a.m. for one night shift.
- The resident had an unwitnessed fall with a "head strike" one evening.

Under Falls Management, a review of the resident's service plan did not identify an intervention after these falls.

Week Eight

The resident's progress notes indicated these falls occurred:

- The resident was found on the floor in her bathroom around 7 p.m.
- The resident was found on the floor in her room around 11:00 p.m.

- A fellow resident reported to a caregiver that R2 had fallen in the dining room around 11:30 a.m.

Under Falls Management, a review of the resident's service plan did not identify an intervention after these falls.

Week Nine
The resident's progress notes indicated this fall occurred:

- The resident was found sitting on the floor, leaning against her bed 12:50 a.m.

Under Falls Management, a review of the resident's service plan did not identify an intervention after these falls.

Interviews
During an interview, an employee stated the facility only had two staff members for the entire building during the overnight shift covering more than 120 residents and that no one was stationed in the memory care unit.

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

During an interview, the resident's family member stated the staff kept resident out in the common area all the time and just left her sitting there without anything to do. The family member stated that even with that the resident still fell more than 20 times, mostly unwitnessed in the last two months. The family member said the facility suggested family member to sit with the resident all day to prevent the resident from falling because they were short staffed. Additionally, the family member said that the facility would put the resident to bed at 6 p.m. each evening and only checked on her 2-3 times throughout the night. The family member said the facility's claim that they could not prevent the resident from falling, yet they were raising their prices. The family member stated that as a result of these falls the resident fractured her T11 and T12. She also said there were only two staffs working at night and it was very hard to find help.

The resident's family decided to move her to a different facility.

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 un-successful. The resident was confused.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
Care conference was held to increase the level of care.

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 HL247183183M/HL247183249C. The following correction orders is issued 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. 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.	