DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL302259927M
Compliance #: HL302258053C

Date Concluded: March 27, 2024

Name, Address, and County of Licensee Investigated:
New Perspectives
828 1st St NE
Faribault, MN 55021
Rice County

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

Evaluator's Name: Deb Schillinger 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 facility neglected the resident when Torsemide (a medication used to treat extra fluid buildup in the body) was not given to the resident for a week causing rehospitalization.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Although the resident's medication was not administered as prescribed, the error was an isolated incident. When the error was discovered, the facility acted promptly to refill the medication, updated the resident's provider, and monitored the resident's condition. When a change in condition was identified the facility transferred the resident to the hospital for further evaluation and treatment.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's family member. The investigation included review of the resident record, hospital records, facility

internal investigation, facility incident reports, staff schedules, related facility policy and procedures. Also, the investigator completed an onsite visit, and observed interactions between residents and facility staff.

The resident resided in an assisted living facility. The resident's diagnoses included congestive heart failure (CHF) and hypertension. The resident's service plan included medication management. The resident's assessment indicated she was alert, oriented and independent with walking and most cares.

The resident's medical record included a progress note that indicated a refill request was made because the facility ran out of evening dose of Torsemide (a medication used to treat excess fluid in the body). The next day a progress note indicated the provider was notified of pharmacy's need for a new prescription and that the resident had some increased ankle swelling. On the following day, a progress note indicated the resident was experiencing symptoms of shortness of breath and nausea and the resident was transferred to the hospital for evaluation.

A review of the resident's electronic medication administration record (EMAR) indicated the resident had not received the medication for four days because the medication was not available.

During an interview, the nurse stated when she was notified the resident did not have the medication available, she sent a request to the pharmacy to refill through the pharmacy portal, an action which simultaneously sends a notification to the provider that the medication needs a new prescription. The provider was notified the next day by the pharmacy and the nurse stated she also emailed the information to the providers work email to assure the provider was notified. The nurse stated she gave direction to the nursing team and unlicensed caregivers to monitor the resident for symptoms of fluid retention.

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, resident was deceased.
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
The facility provided reasonable care when made aware of error, notifying the provider, and monitoring the resident's condition.

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
	30225	A. BUILDING: _____ B. WING _____	C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE - FARIBAULT	**828 1ST STREET NE FARIBAULT, MN 55021**

(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 6, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL302258053C/#HL302259927M. No correction orders are issued.	0 000		