Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL317332662M
Compliance #: HL317334480C

Date Concluded: January 23, 2023

Name, Address, and County of Licensee Investigated:
New Perspective-Woodbury
2195 Century Avenue South
Woodbury, MN 55125
Washington County

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

Evaluator's Name:
Katie Germann, RN, Special Investigator

Finding: Inconclusive

Nature of Visit:
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 a resident when the resident fell in his room after slipping on wet carpet caused by a leaking air conditioning unit. The resident subsequently suffered spinal nerve damage requiring surgery.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. The resident had a fall in his room which resulted in injury. However, it could not be determined if the residents fall was directly related to the water leaking from the resident's air conditioning unit. The resident had a history of falls and documentation indicated the residents individualized plan of care was in place at the time of the fall.

The investigator conducted interviews with facility staff members, including administrative staff and unlicensed staff. The investigation included review of medical records, hospital records, pictures of the resident's room, facility policies regarding falls and vulnerable adult incidents,

maintenance records, the facility internal investigation of the incident, training records, and call light reports. In addition, the investigator observed staff assisting residents with cares.

The resident resided in an assisted living facility with diagnoses including Parkinson's disease and a history of falling. The resident's service plan included assistance with activities of daily living, assistance with transferring and ambulation, medication management and administration, housekeeping, laundry, and meals.

The residents medical record indicated the resident lived in a studio apartment and slept in the recliner at night. One morning the resident was standing up to transfer from his recliner to his wheelchair and fell, hitting his head on his wheelchair on the way to the floor. The resident put on his call light for staff assistance and then called 911. The resident was transferred to the hospital by ambulance. The resident was evaluated at the hospital, and it was determined the resident had nerve damage in his cervical spine and required spinal fusion surgery. The resident stated he fell because the carpet in his room was wet, and he slipped.

Pictures of the resident's room showed the carpet appeared to be discolored in the area around the air conditioning unit and in front of the recliner.

The facility internal investigation indicated the carpet in front of the air conditioner was wet, but not saturated, and the air conditioning unit was leaking and needed to be replaced. Maintenance records showed a couple hours prior to the residents fall; a work order was submitted to the facility maintenance worker to look at the resident's air conditioner. The maintenance worker first responded to the call two hours after the initial work order was placed.

During an interview the resident stated his air conditioning unit had been leaking for some time and he had mentioned it to different staff members. The leaking became worse, and his carpet became saturated. The resident stated the night prior to his fall a staff member noticed his wet carpet and told the resident they would have maintenance look at it the next day. The resident stated the next morning he told the front desk concierge about the leaking air conditioner. Shortly after, the resident stood up from his recliner to transfer to his wheelchair, and the resident stated he slipped on the wet carpet which caused him to fall and hit his head on the wheelchair. The resident stated he turned on his call light to call for staff help and also called 911.

During interview the resident's family member stated the night prior to the fall the resident told them the air conditioning unit was leaking onto the carpet. The resident told her he slipped on the wet carpet and fell. Following the fall, the resident required spinal fusion surgery.

When interviewed a facility administrator stated the resident reported the air conditioning unit was leaking to the front desk concierge on the morning, he had a fall. The administrator overheard the resident and reported the leaking air conditioner to the maintenance person

right away via text message. When the maintenance worker went to the resident's room, the paramedics were there. The administrator reported the air conditioner was subsequently replaced.

In conclusion, the Minnesota Department of Health determined neglect was inconclusive.

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or 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: Yes
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
The facility replaced the broken air conditioning unit.

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
	31733	A. BUILDING: _____ B. WING _____	C 12/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE - WOODBURY	2195 CENTURY AVENUE SOUTH WOODBURY, MN 55125

(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 December 28, 2022, the Minnesota Department of Health initiated an investigation of complaint #HL317332662M/ #HL317334480C. No correction orders are issued.	0 000		