Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #HL30225001M
Compliance #HL30225002C

Date Concluded: September 14, 2022

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

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

Evaluator's Name: Erin Johnson-Crosby, 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 the resident when facility staff did not fix a heater vent with metal exposed. The resident fell out of bed landing on the metal area which caused multiple lacerations and bruising.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. It is unable to be determined if the heating vent was intact at the time of the resident's fall or if it was displaced as a result of the fall. There was no documentation of complaints made prior to the incident regarding the heating vent and the facility had no system in place to record or document required or completed maintenance. In addition, there was limited documentation of the fall, facility staff were unable to recall specifics of the incident and no measurements or description of the injuries were documented.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator also contacted hospice. The investigation included review of the resident records, pictures of the resident's injuries and conducted an onsite visit to observe the facility environment.

A Minnesota Adult Abuse Reporting Center (MAARC) report indicated the resident fell out of bed on to an uncovered heating vent with metal exposed which caused extensive lacerations to his right forearm, left elbow, and upper forearm and left knee, with multiple bruised areas to right eyebrow, bilateral arms, and knees. The report also indicated the facility was aware the heating vent had metal exposed prior to the fall.

The resident resided in an assisted living memory care unit. The resident's diagnoses included Alzheimer's disease, frequent falls, restlessness, and agitation. The resident's service plan included assistance with all activities of daily living (ADLs), transfers with a mechanical lift and a fall prevention plan which included frequent checks each shift. Resident assessments indicated the resident had cognitive impairment and was at risk for falls. Due to the resident's frequent falls, the resident's bed was to be kept in the lowest position when occupied. A comprehensive assessment completed by the facility indicated the resident had alterations in skin integrity and the resident had fragile, thin skin and bruising. Notes in the resident chart further indicated the resident had a history of peeling skin on his upper extremities and had treatment orders which included Vaseline gauze and kerlix to dress the upper extremities. In addition, the resident received hospice services.

The day the resident fell, facility staff found the resident on the floor between the bed and the heating vent. Staff reported the resident did not hit his head, but noted the resident was bleeding and had bruising and lacerations on his arms. The on-call RN was contacted and directed staff to cleanse and dress the wounds and take the resident's vital signs. Unlicensed facility staff addressed the resident's bleeding, dressed the wounds to the resident's upper extremities and provided pain medication to the resident as directed by the nurse. The resident's medical record lacked evidence of an assessment, measurements or description of the resident's skin tears, bruises, lacerations, and abrasions.

The resident's hospice notes indicated facility staff notified hospice the resident rolled out of bed on to an uncovered wall heat vent. The next day the hospice nurse assessed the resident and indicated the fall caused extensive lacerations to the right medial forearm, left elbow, and upper forearm, left knee and multiple bruised area to the right eyebrow, bilateral arms, and knees. Pictures were taken of the left arm only; no measurements were obtained of the injuries and no descriptions or measurements were provided in the resident's hospice record.

The hospice nurse was concerned with the amount of bruising and lacerations the resident obtained during the fall. The hospice nurse notified the resident's family who expressed further concern regarding the heating vent cover being exposed. The family indicated they had made a

previous request for facility staff to repair the vent as they feared the resident would fall and be injured.

The resident's progress notes indicated the facility nurse also assessed the resident the day after the fall. The nurse documented the resident had a bruise on the left side of his forehead and wounds to the left elbow and forearm which were bleeding. The notes indicated the dressing was removed, wounds were cleansed, and new dressings were applied. No measurements or description of the wounds or bruise were documented in the resident's medical record.

Review of facility documentation indicated no fall report, incident report or internal investigation completed following the incident. The resident's facility medical record and hospice record provided no documentation of the description or measurements of the resident's injuries.

Interview with the hospice nurse indicated she became aware of the fall the night it occurred, however was not told of the extent of the resident's injuries. The hospice nurse was concerned on what information was provided to the on-call facility nurse at the time of the fall as the on-call nurse did not provide her with any information regarding the resident's injuries. The hospice nurse stated she offered to go into the facility to assess the resident. The on-call nurse declined and indicated facility staff had addressed the resident's injuries. When the hospice nurse visited the next day, she noted the fall caused extensive lacerations to the right medial forearm, left elbow, and upper forearm, left knee and multiple bruised area to the right eyebrow, bilateral arms, and knees. Pictures were taken by the nurse of the resident's left arm to demonstrate the new injury. The nurse noted the resident's right arm injuries were more significant but did not take a picture of the right arm. The picture of the resident's left arm showed large skin tears with the top few layers of skin removed. The nurse stated the multiple bruises to the resident's left arm were new and the resident complained of pain during the dressing change. The hospice nurse confirmed she did not take measurements of the resident's lacerations or bruising. The hospice nurse indicated she had previously informed the facility of concerns with the heating vent cover but could not recall the date she spoke with the administration. When the hospice nurse was at the facility the day after the fall, she noticed the heating vent cover was not intact, but the resident's bed had been moved to the other side of the wall away from the heater.

During an interview with the unlicensed personnel (ULP) who worked the night of the fall, the ULP stated the staff working in memory care called her because the resident fell. The ULP stated the resident had frequent falls out of bed and chair. The ULP stated that night the resident fell between the bed and wall and the heating vent cover came off when he fell on it. The bed had been moved prior to the ULP's arrival to the resident room so it is unknown where the bed was positioned at the time the fall occurred. The ULP stated she told the on-call nurse that the resident had sustained multiple cuts and bruising, was bleeding and blood was on the floor. The ULP stated there was a lot of blood and the resident was shaky. The ULP bandaged

the resident's wounds and assisted him back to bed. The ULP stated the resident appeared to be in pain when she put on the dressings and the resident was provided pain medication. The ULP stated she was unaware of any family concerns related to the heating vent cover however indicated the resident's bed was supposed to be next to the adjacent wall and not by the heating vent. The ULP mentioned that staff kept moving the resident's bed next to the heating vent, but she was unsure what staff were responsible for moving the bed. The ULP later stated she did not see a cover for the resident's heating vent on the day of the incident but when she explained that to her supervisors, the supervisors told her the heating vent was put on before the incident and the cover must have slid underneath the heating coil.

During an interview with another ULP, they indicated the cover for the residents heating vent would occasionally come off when staff had to move the resident's bed. The ULP stated she would put the vent cover back on if it had fallen off.

During an interview, the facility nurse stated the resident had a history of falls, falling out of bed and the resident's upper extremities often had bruising and lacerations due to the resident's fragile skin and bumping into objects while self-propelling his wheelchair. The nurse stated she went to the facility the day after the fall because the resident's family member had concerns about the fall. The nurse re-dressed the resident wounds and made a phone call to the family to set-up a care conference regarding the resident's falls and declining condition. The nurse stated it was hard to tell what injuries were old or new as the resident had a history of multiple bruises to his arms. The nurse confirmed there were no measurements or descriptions documented of the bruises or lacerations. The nurse acknowledged she was aware of concerns about the placement of the bed and uncovered heating vent prior to the incident but she was not aware of the exact date. The nurse further stated there were numerous times the heating vent cover came off and staff would put the cover back in place. The nurse indicated the management team talked about moving the resident's bed but there was nowhere to move the bed because it would block the bathroom door. The nurse stated when she saw the resident the day following the fall, the heating vent covers were in place. The nurse indicated a fall report and investigation should have been completed, however she no longer worked at the facility at the time of interview and could not confirm if this was completed or not.

During an interview, the maintenance director stated he was not aware of the resident's fall and was not aware of the concerns with the heating registers until after the investigator's onsite visit. The maintenance director stated he had no record of any concern or repair in the resident's room to fix the heating register cover, however indicated prior to this incident, he took many verbal orders from staff so documentation may not have been completed on maintenance concerns or repairs.

During an interview with facility administration, they stated the front plates of the heating vents fall off easily and should be reattached immediately so there is no exposed metal. Administration indicated they had never been directly informed of any concern related to the heating vent by a family member but acknowledge the resident's heating vent cover had been

replaced multiple times as the resident would often remove it or hit it with his wheelchair causing it to fall off.

During an interview, the resident's family stated the resident would always fall out of bed. The family member stated she told facility staff to move the resident's bed and fix the heating vent multiple times before the fall occurred. The family member stated she would come into the facility and would notice the bed was not moved with the heating vent still not fixed, and she would tell staff again. The family member indicated she was initially informed of the fall, but not of the injuries sustained from the heating vent. The family member indicated she was informed the bed was 6-8 inches away from the heating vent at the time of the fall. The family member was concerned there was no follow up of her complaints regarding the vent and was discouraged by the facility's breakdown in communication and response to her concerns.

Conflicting information was provided regarding staff's awareness of concerns with the resident's heating vent, location of the resident's bed and if the heating vent cover was intact or not at the time of the fall. In addition, there is no documentation detailing the injuries sustained from the fall.

During the onsite investigation, three occupied resident rooms and locations in the dining room and day room were observed to have heating vent covers removed with metal exposed. As a result of this investigation, state licensing orders were issued related to the maintenance of the facility's physical environment to be in a continuous state of good repair and operation.

In conclusion, it was inconclusive whether neglect occurred.

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:
(a) 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.
(b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.

Vulnerable Adult interviewed: No.
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 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.

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 06/29/2022

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 Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: HL30225001M/HL30225002C On June 29, 2022, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 51 residents receiving services under the Assisted Living with Dementia Care license. The following correction order is issued for #HL30225002C/HL30225001M, tag identification 0800.	0 000	The Minnesota Department of Health documents the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors ' findings is the Time Period for Correction. Per Minnesota Statute §144G.30, Subd. 5 (c), the assisted living facilities must document any action taken to comply with the correction order. A copy of the provider ' s records documenting those actions may be requested for follow-up surveys. The home care provider is not required to submit a plan of correction for approval; please disregard the heading of the fourth column, which states "Provider ' s Plan of Correction." The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to Minn. Stat. § 144G.31, Subd. 2 and 3.	
0 800 SS=E	144G.45 Subd. 2 (a) (4) Fire protection and physical environment	0 800		

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0 800	Continued From page 1 (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment of the facility in a continuous state of good repair and operation with a maintenance and repair program as required by MN Statute 144G.45, subd.2(a)(4). This had the potential to affect 33 out of 51 residents that resided in the memory care unit. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: A Minnesota Adult Abuse Reporting Center (MAARC) report dated January 28, 2022, indicated R1 fell out of bed onto an uncovered heating vent with metal exposed which caused extensive lacerations to R1's right forearm, left elbow, and upper forearm and left knee, with multiple bruised areas to right eyebrow, bilateral arms and knees. The report also indicated facility staff were aware the heating vent had metal	0 800	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.	

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0 800	Continued From page 2 exposed. R1's face sheet indicated R1 resided in the memory care unit with diagnoses including Alzheimer's disease, frequent falls, restlessness and agitation. R1 also received hospice services. R1's resident agreement dated October 21, 2021, indicated maintenance of needed repairs within a resident's apartment would be completed as a result of normal wear and tear. R1's service plan dated January, 18, 2021, indicated R2 required assistance with activities of daily living (ADLs) including bathing, eating, grooming, toileting and fall prevention plan which indicated frequent checks each shift. R1's change of condition assessment dated December 14, 2022, indicated R1 was at risk for falls and had cognitive impairment. R1's licensee progress notes indicated: - On January 13, 2022, R1 had an unwitnessed fall from bed with no injuries. - On January 28, 2022, R1 had an unwitnessed fall from bed to floor with abrasions to both upper extremities. The RN instructed staff to give morphine and lorazepam and check vital signs every two hours for 24 hours. - On January 31, 2022, staff contacted R1's power of attorney to discuss concerns of resident fall and set up a care conference. - On January 31, 2022, a late entry written for January 29, 2022, indicated the registered nurse (RN) observed a bruise to the left side of R1's forehead and wounds to the left elbow and forearm was bleeding, mild pressure was applied	0 800	The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	

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0 800	Continued From page 3 until the bleeding slowed. Dressings to the left elbow and forearm were removed and cleansed and secured with Kerlex. R1's hospice notes on January 29, 2022, indicated licensee staff notified hospice to inform them R1 rolled out of bed onto an uncovered wall heat vent on the evening of January 28, 2022. The hospice registered nurse (RN) assessed R1 on January 29, 2022, and indicated the fall caused extensive lacerations to right medial forearm, left elbow, and upper forearm, left knee and multiple bruised areas to the right eyebrow, bilateral arms and knees. The hospice RN called R1's family member (FM). R1's FM was extremely upset and stated that she had asked the facility to fix the heater in R1's room and to move R1's bed away from the heater weeks ago as she was afraid a fall like this would happen. The hospice notes also indicated dressing changes were completed to R1's bilateral arms and R1 cried out in pain during the dressing change. R1's incident report for the fall on January 28, 2022, was requested, however not provided by the licensee. During an observation and interview on June 29, 2022, at 10:33 a.m., with unlicensed personnel (ULP)-A in the garden memory care unit where 18 residents resided, there were three occupied resident rooms where the heating vents were not attached and metal was exposed. There were also heating vents not attached correctly with the metal exposed in the dining room and in the day room. ULP-A confirmed R1 fell on an uncovered heating vent and sustained injuries. The investigator took pictures of the exposed	0 800		

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0 800	Continued From page 4 metal areas of the uncovered vents in resident rooms and common areas. On June 29, 2022, at 10:05 a.m., the environmental service director (ESD)-B stated when something needs to be fixed, staff will write up a work order or verbally inform him of the problem. ESD-B stated the front plates on the vent cover come off easily and are frequently knocked off of the vent. ESD-B then showed the investigator how to take off and put on the front plate of the heating vents and stated, "it's a pretty simple fix." On June 29, 2022, at 11:21 a.m., the executive director (ED)-C stated the front plates of the heating vents fall off easily and memory care residents play with them causing them to fall off. ED-C stated the vent covers should be reattached immediately so there is not exposed metal. ED-C also stated there was no training after the incident. ED-C instructed ESD-B to put the cover back on heating vent in R1's room after R1 fell out of bed. An email with ED-C dated July 12, 2022, indicated there were no documented maintenance records for R1's room regarding the vent or vent covers. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		