Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL200224141M
Compliance #: HL200224728C

Date Concluded: July 30, 2024

Name, Address, and County of Licensee Investigated:
New Perspective Roseville
2750 North Victoria Street
Roseville, MN 55113
Ramsey County

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

Evaluator's Name: Danyell Eccleston, 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 the facility failed to implement appropriate interventions to ensure the residents safety when smoking cigarettes. The resident was found to have smoked in her apartment where an oxygen supply is kept.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The facility assessed the resident to be able to safely smoke and provided an outside location for smoking. The resident understood the risk of smoking indoors and close to an oxygen supply, however, the resident had experienced a loss the day of the incident and was in a state of grief.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of resident medical records, facility internal investigation, facility incident reports, staff schedules, and related

facility policy and procedures. Also, the investigator observed staff members interacting and providing care to residents.

The resident resided in an assisted living facility. The resident's diagnoses included depression and cancer. The resident's service plan included assistance with medication management. The resident's assessment indicated the resident was capable of smoking independently and understood smoking was only permitted in designated locations.

The resident's medical orders indicated a provider ordered independent management of oxygen for the resident.

Progress notes the day of the incident indicated the resident experienced an unexpected loss and was very distraught. Staff members sat with the resident to help console her. That same day, a leadership member became aware the resident smoked in her apartment and spoke with the resident regarding the facility's smoke free policy and risks of smoking with oxygen use. The resident verbalized understanding.

During interview, a leadership member stated she visited the resident to provide support the day in question and noted a tray with cigarettes in the resident's apartment along with a cigarette smoke smell. The resident stated she smoked in her bathroom. The leadership member and the resident discussed why the resident could not smoke in her apartment or with oxygen and the resident verbalized understanding. The leadership member stated there had been no concerns with the resident's safety while smoking, and she has not been made aware of smoking issues since the incident.

During interview, the resident stated she was under great distress during the time in question and did smoke in her apartment that day. The resident expressed knowledge of designated smoking areas and knew it was unsafe to smoke with oxygen. The resident stated she smokes in the designated smoking area or goes to other outdoor areas.

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: Yes.
Family/Responsible Party interviewed: No, vulnerable adult is her own decision maker.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
Facility leadership followed up with resident regarding incident and conducted a risk assessment of the resident.

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
	20022	A. BUILDING: _____ B. WING _____	C 07/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE - ROSEVILLE	2750 NORTH VICTORIA STREET ROSEVILLE, MN 55113

(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 July 1, 2024, , the Minnesota Department of Health initiated an investigation of complaint #HL200224728C/#HL200224141M. No correction orders are issued.	0 000		