Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL243152081M
Compliance #: HL243153731C

Date Concluded: April 21, 2023

Name, Address, and County of Licensee Investigated:
New Perspective Cloquet & Barn
701 Horizon Circle
Cloquet, MN 55720
Carlton County

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

Evaluator's Name: Lena Gangestad, 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 alleged perpetrator (AP) abused a resident when she slapped the resident on the arm. She also held the resident's hand up to her mouth and told her to shut up.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was inconclusive. The investigation found there was insufficient evidence to determine if abuse occurred.

The investigator attempted to interview facility staff members, including administrative staff, and unlicensed staff. The investigation included a review of resident medical records, facility records, policies, and procedures. At the time of the onsite visit, the investigator completed observations of the environment, staff interaction with residents, and the care provided at the facility.

The resident resided in an assisted living with a dementia care facility. The resident's diagnosis included dementia. The resident's service plan indicated she required assist of two caregivers for dressing and bed mobility. The same document she received behavior monitoring.

One evening two unlicensed caregivers provided bedtime care for the resident. Later, it was alleged one of the unlicensed caregivers, the AP, slapped the resident's upper arms. It was also alleged the AP covered the resident's mouth when she cried out and said "oh, shut up".

The facility conducted an internal investigation during which the AP was placed on administrative leave. The internal investigation indicated the AP the reported acts. The same documents indicated the resident did not demonstrate recall of the event.

The resident's assessment dated the day after the reported event indicated the resident had no bruises or injuries indicating harm. Additionally, the facility observed the resident for changes increases in anxiety or tearfulness, but the resident did not have a change in behavior.

The investigation included attempts to interview the other unlicensed caregiver present at the time of the reported events but without success. The investigation included attempts to interview the AP, but without success. The investigation did not identify other staff members who witnessed the reported event.

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.

Abuse: Minnesota Statutes section 626.5572, subdivision 2.
"Abuse" means:
(a) An act against a vulnerable adult that constitutes a violation of, an attempt to violate, or aiding and abetting a violation of:
(1) assault in the first through fifth degrees as defined in sections 609.221 to 609.224;
(2) the use of drugs to injure or facilitate crime as defined in section 609.235;
(3) the solicitation, inducement, and promotion of prostitution as defined in section 609.322; and
(4) criminal sexual conduct in the first through fifth degrees as defined in sections 609.342 to 609.3451.
A violation includes any action that meets the elements of the crime, regardless of whether there is a criminal proceeding or conviction.
(b) Conduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to, the following:
(1) hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult;

(2) use of repeated or malicious oral, written, or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening.

Vulnerable Adult interviewed: No
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Attempts to contact the AP were unsuccessful.

Action taken by facility:
The facility immediately suspended the AP, reported the incident, and began an internal investigation. The facility provide the unlicensed caregiver who was present with the AP education on maltreatment reporting. The AP's employment was terminated for unrelated reasons.

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
	24315	A. BUILDING: _____ B. WING _____	C 03/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE - CLOQUET & BA	**701 HORIZON CIRCLE CLOQUET, MN 55720**

(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 2, 2023, the Minnesota Department of Health initiated an investigation of complaint HL243153731C/HL243152081M. No correction orders are issued.	0 000		