Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL243156462M
Compliance #: HL243159701C

Date Concluded: January 14, 2025

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

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

Evaluator's Name: Angela Vatalaro, 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 alleged perpetrator (AP), a staff member, emotionally abused the resident when the AP made a threatening statement that the facility was trying to remove the resident from the facility. In addition, the AP threw wipes at the resident during toileting services while making a derogatory statement. The AP also rushed the resident when the resident walked. The resident felt frightened.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined emotional abuse was not substantiated. Although the AP's comments and actions were disrespectful and inappropriate, they did not meet the definition of abuse. The resident denied feeling frightened.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff. The AP did not respond to a subpoena. The investigation included review of the resident record, facility internal investigation, personnel file, staff schedules, related facility

policy and procedures. Also, the investigator observed the resident, staff interactions with the resident, and staff interactions with other residents.

The resident resided in an assisted living memory care unit. The resident's diagnoses included mild cognitive impairment, and anxiety. The resident's service plan included assistance with anxiousness. Interventions included redirection, distraction, providing calming music, lighting, and environment. Staff were to offer support and reassurance when the resident was anxious. The resident required assist of one using a walker on daily walks and assistance with bowel and bladder continence to ensure proper cleansing. The resident was alert, able to understand others, and able to communicate her needs.

Records indicated one day the AP entered the resident's room with the resident and the resident's family member present. The AP told the resident's family member that the resident was "not the only one who lives here." "This house is full, people are dying, we can't do this anymore. We can't' take care of her, we are looking to move her out of here." The AP's anger frightened the resident.

Leadership spoke to the resident. The resident said the AP was "gruff," always in a hurry, and told the resident to "hurry up."

Records indicated it was also reported that the AP had thrown wipes at the resident when family was visiting and said, "she knows how to wipe herself and acts like she can't do anything when you're in town."

Records indicated the AP told leadership she did blow up in front of the resident and resident's family member. The AP admitted she was in the wrong. The AP stated when she said "we were trying to get her to move out of here" she meant she wanted to get her out of here not the company. The AP said she realized what she said was wrong, and admitted what was reported was what the AP said.

During an interview, leadership stated the AP admitted she made inappropriate comments towards the resident and had hurried the resident to the bathroom. The resident resided at one of the houses on the campus. When leadership spoke to the resident, the resident asked leadership if she was going to be kicked out of the facility. Leadership provided the resident reassurance that she was not being removed from her current location. The resident said she felt the AP hurried and rushed her when providing her services. The resident required assist of one staff to the bathroom and staff assistance with cleansing. Leadership stated it was not reported to the facility that the AP threw wipes at the resident. There were no prior concerns raised regarding the AP's interactions with the resident, or the AP's interactions with other residents. Leadership stated she previously visited with the resident during the same shift the AP worked and did not notice any changes, reactions, or responses with the resident during the AP's shift. The resident was happy and pleasant whenever leadership spoke with her.

During an interview, the resident denied feeling scared or fearful of any staff members.

In conclusion, the Minnesota Department of Health determined abuse 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.

Abuse: Minnesota Statutes section 626.5572, subdivision 2.
"Abuse" means: …
(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: Yes.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: No. Did not respond to subpoena.

Action taken by facility:
The facility conducted an internal investigation. The AP is no longer employed by the facility.

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 12/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE - CLOQUET & BARNUM	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 December 9, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL243159701C/#HL243156462M. No correction orders are issued.	0 000		