Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL317336101M
Compliance #: HL317338795C

Date Concluded: January 2, 2025

Name, Address, and County of Licensee Investigated:
New Perspectives of Woodbury
2195 Century Ave So
Woodbury, MN 55125
Washington County

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

Evaluator's Name: Deb Schillinger, RN BSN
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 bowel medications were not given, and the resident went several days without a bowel movement and experienced increased pain.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The facility coordinated care with and followed the orders and plan of care developed by the hospice provider responsible for the resident's symptom management.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the hospice provider, and family members. The investigation included review of the resident record, death record, facility incident reports, staff schedules, and related facility policy and procedures. Also, the investigator observed interactions between residents and facility staff members during an onsite visit.

The resident resided in an assisted living memory care unit. The resident's diagnoses included end stage heart disease and dementia. The resident's service plan included assistance with medication administration. The resident's assessment indicated the resident's condition was declining and receiving end of life care from hospice. The hospice plan of care indicated the hospice team was responsible for the resident's symptom management and care needs.

A concern arose regarding care not addressed by facility caregivers indicating the resident had not had a bowel movement for several days.

The hospice nurse visit notes indicated the resident's family members notified the hospice nurse of the lack of bowel movement in last 7 days. The same note indicated the hospice nurse collaborated with the facility nurse and hospice made order changes for additional medications to address possible constipation including a suppository to "have on hand".

A review of the medical record did not identify further instruction or direction to administer bowel suppository medication.

A review of the hospice visit notes following did not indicate gastrointestinal distress was identified by the hospice team.

During an interview, the hospice nurse stated it is normal practice for hospice to document effectiveness of orders written, however the hospice nurse found no follow up on effectiveness of the bowel medication orders. The hospice nurse stated the hospice nurse would monitor for other symptoms to determine the comfort level for the resident, such as abdominal discomfort. The hospice nurse stated the lack of follow up documentation would indicate the resident did not exhibit symptoms of discomfort related to a lack of bowel movement.

During an interview, the facility nurse stated services to track bowel movements or meal intake are not provided per the facility's Uniform Disclosure of Assisted Living Services & Amenities (UDALSA), and if the residents assessment indicated this was required, the recommendation would have been given as an order from the hospice team.

A review of the resident's medical record did not identify an order or recommendation from hospice to the facility to monitor bowel tracking.

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.
(5) an individual makes an error in the provision of therapeutic conduct to a vulnerable adult that results in injury or harm, which reasonably requires the care of a physician, and:
(i) the necessary care is provided in a timely fashion as dictated by the condition of the vulnerable adult;
(ii) if after receiving care, the health status of the vulnerable adult can be reasonably expected, as determined by the attending physician, to be restored to the vulnerable adult's preexisting condition;
(iii) the error is not part of a pattern of errors by the individual;
(iv) if in a facility, the error is immediately reported as required under section 626.557, and recorded internally in the facility;
(v) if in a facility, the facility identifies and takes corrective action and implements measures designed to reduce the risk of further occurrence of this error and similar errors; and
(vi) if in a facility, the actions required under items (iv) and (v) are sufficiently documented for review and evaluation by the facility and any applicable licensing, certification, and ombudsman agency.

Vulnerable Adult interviewed: No, the resident expired
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
The facility notified the hospice provider of resident updates and changes in condition.

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 12/17/2024

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 17, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL317338795C /#HL317336101M. No correction orders are issued.	0 000		