Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL239828062M
Compliance #: HL239828722C

Date Concluded: April 17, 2026

Name, Address, and County of Licensee Investigated:
New Perspective Golden Valley
4950 Olson Memorial Hwy
Golden Valley, MN 55422
Hennepin County

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

Evaluator's Name: James Larson, 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) abused the resident when the AP tied the resident's wheelchair to another dining chair restraining the resident from moving about the unit.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was not substantiated. Although the incident occurred, the incident did not meet the definition of abuse. No physical restraint was utilized on the resident, there was no evidence of harm to the resident and the resident was not aware the incident occurred.

The investigator conducted interviews with facility staff members, including administrative staff, and nursing staff. The investigator also contacted the hospice agency. The investigation included review of the resident record, death record, staff records, facility policy and procedures. The investigator also toured the facility, observed staff members interacting with residents and completing scheduled care activities.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia, and anxiety. The resident's service plan included assistance with medication management, activities of daily living and ambulation. The resident's assessment indicated the resident was independent in repositioning while in a chair, although had a history of falls. Staff were directed to provide standby assistance while the resident was out of her apartment.

During a scheduled visit to the facility, an outside agency staff member observed the resident asleep, seated in the main living area in her Broda chair (a type of wheelchair). The resident was seated in a reclined position as a dining room chair was positioned in front of the resident's Broda chair to elevate her legs and feet. Upon closer inspection, the agency staff member noticed the dining room chair was tied to the resident's chair, preventing them from moving apart. The outside agency staff member was concerned that the chairs were being used as a restraint and asked a facility staff member to assist with untying the dining room chair and reported the findings to the nurse.

The facility nurse assessed the resident and found no evidence of injury. The resident was asleep at the time the agency staff member arrived and was not aware of the incident.

The facility completed an investigation into the incident. The staff member/alleged perpetrator (AP) who worked the night shift stated the resident had been restless that night and acknowledged she tied the chairs together to try to keep the resident from falling. There were no witnesses to the incident, and no photos were taken of the way the chairs were positioned or tied. The resident was assessed and had no evidence of harm or recollection of the incident. The AP was terminated following the investigation and all staff were reeducated.

During an interview, the AP stated she was familiar with the resident's baseline behaviors. The AP stated the resident was restless and had come out into the common area. The AP stated that around 5:00 a.m. she positioned a dining room chair in front of the resident who was seated in her wheelchair. The AP positioned the resident's legs out in front of her, so her feet were resting on the padded seat of the dining hall chair. She then took plastic garbage bags from the kitchen and used them to bind the two chairs together. The AP then gave the resident a snack and the resident fell asleep. The AP could not recall how long the resident was in this position prior to falling asleep. The AP stated she tied the chairs together for safety and better monitoring of the resident's behavior and was not aware that this was a restraint.

During an interview, the outside agency staff member stated that upon entering the facility at approximately 7:00 a.m. she observed the resident asleep in her Broda chair in the common area of the memory care unit. The resident's legs were extended out in front of her and resting on a dinning room chair that was tied with plastic garbage bags to the front of the Broda chair. The caregiver untied the restraints and wheeled the resident into her room to complete her assigned cares. She stated that the resident showed no signs of distress. After she finished with

her assigned cares, she reported the incident to the facility nurse. She stated that multiple staff and administrators questioned her over the incident.

During an interview, the nurse stated that the resident's behavior of independently getting out of her wheelchair and lowering herself onto the floor was well known by the resident's care team as well as the facility staff and documented in the resident's plan of care. During a recent care conference, the family, as well as the resident's primary care provider had agreed to alternate safety measures including monitoring, redirection techniques, and allowing the resident to continue to get out of her chair independently if done safely. The nurse stated that she was first made aware of the incident when the hospice caregiver came to her office later that morning. The nurse then notified the facility administrators, and an internal investigation was completed.

During an interview, an administrator stated that during a follow up phone conversation with the AP, she admitted to securing the chairs together to keep the resident from crawling out of the chair and onto the floor. Upon review of the incident, multiple staff members including the AP were suspended and their employment was terminated for failing to follow facility policies during that shift.

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.

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; or
(3) use of any aversive or deprivation procedure, unreasonable confinement, or involuntary seclusion, including the forced separation of the vulnerable adult from other persons against the will of the vulnerable adult or the legal representative of the vulnerable adult unless authorized under applicable licensing requirements or Minnesota Rules, chapter 9544.
(c) Any sexual contact or penetration as defined in section 609.341, between a facility staff person or a person providing services in the facility and a resident, patient, or client of that facility.
(d) The act of forcing, compelling, coercing, or enticing a vulnerable adult against the vulnerable adult's will to perform services for the advantage of another.

Vulnerable Adult interviewed: No. Deceased
Family/Responsible Party interviewed: N/A
Alleged Perpetrator interviewed: Yes

Action taken by facility:
The AP and other staff members were suspended and terminated. The facility provided refresher training to all staff regarding resident rights.

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
	23982	A. BUILDING: _____ B. WING _____	C 01/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE GOLDEN VALLEY	4950 OLSON MEMORIAL HIGHWAY GOLDEN VALLEY, MN 55422

(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 January 12, 2026, the Minnesota Department of Health initiated an investigation of complaint #HL239828722C/#HL239828062M. No correction orders are issued.	0 000		