Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL201681845M
Compliance #: HL201683176C

Date Concluded: September 2, 2025

Name, Address, and County of Licensee Investigated:
New Perspectives Highland Park
750 Mississippi River Blvd S
St Paul, MN 55116
Ramsey 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 two residents when resident #2 hit resident #1.

Investigative Findings and Conclusion: The Minnesota Department of Health determined neglect was not substantiated. The facility could not have reasonably anticipated resident #2 would strike out at resident #1 and separated the residents quickly after the altercation. Resident #1was not seriously injured and returned to her baseline health condition.

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

Resident #1 resided in an assisted living secured dementia care unit. The resident's diagnoses included dementia and anxiety. The resident's service plan included assistance with medication management and administration, transferring and mobility assistance. The resident's assessment indicated the resident was cognitively impaired, ambulated using a walker but needed the assistance of one person for safety, had incontinence, and frequent falls due to poor safety awareness.

Resident #2 resided in an assisted living memory care unit. Resident #2's diagnoses included dementia and had a history of pain due to arthritis. The service plan included assistance with prompts and cueing due to confusion in new situations. Resident #2's assessment indicated he was able to communicate needs but did not follow directions or respond well to cues provided.

A facility report indicated resident #1 inadvertently rolled over resident #2's toes with her wheelchair. Resident #2 then struck resident #1 in the face. The facility caregivers immediately separated the two residents, and facility managers were notified.

During an interview, the nurse stated the facility works to prevent resident-to-resident altercations, however this arose unexpectedly. Once it occurred the two residents were separated quickly, and this remained an isolated event between them.

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: No, residents are cognitively impaired
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility: Resident #1 and resident #2 were separated and no further altercations occurred between this incident and the onsite visit for the investigation. The facility updated resident #2's care plan to reduce the risk of recurrence.

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
	20168	A. BUILDING: _____ B. WING _____	C 06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE HIGHLAND PARK	750 MISSISSIPPI RIVER BLVD SAINT PAUL, MN 55116

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0 000	Initial Comments ******ATTENTION****** HOME CARE PROVIDER/ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: On June 3, 2025 through June 4, 2025, the Minnesota Department of Health conducted a complaint investigation at the above provider: #HL201683174C/#HL201681843M; #HL201683175C/#HL201681844M; #HL201683176C/#HL201681845M; and #HL201683229C. At the time of the complaint investigation, there were 84 residents receiving services under the provider ' s Assisted Living with Dementia Care license. There are no correction orders issued for #HL201683176C/#HL201681845M; and #HL201683229C. The following correction orders are issued for #HL201683175C/#HL201681844M: 1760 and 2360. The following correction orders is issued for #HL201683174C/#HL201681843M: 0450 and	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	

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0 000	Continued From page 1 2360.	0 000		
0 450 SS=E	144G.41 Subdivision 1 Minimum requirements All assisted living facilities shall: (1) distribute to residents the assisted living bill of rights; (2) provide services in a manner that complies with the Nurse Practice Act in sections 148.171 to 148.285; (3) utilize a person-centered planning and service delivery process; (4) have and maintain a system for delegation of health care activities to unlicensed personnel by a registered nurse, including supervision and evaluation of the delegated activities as required by the Nurse Practice Act in sections 148.171 to 148.285; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed have and maintain a person-centered service delivery process for four of four residents reviewed (R1, R2, R3 and R4). Additionally, the licensee failed to have and maintain a system for delegation of health care activities to unlicensed personnel by a registered nurse, including supervision and evaluation of the delegated activities as required by the Nurse Practice Act. The residents' plan of care indicated unlicensed caregivers were to check on the residents a number of times a day. However, the delegation to the unlicensed caregivers did not include timeframes to carry out the tasks nor did the documentation system allow for unlicensed caregivers to document when nor how many times the services were provided on any given shift.	0 450		

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0 450	Continued From page 2 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: The Nurse Practice Act indicated the definition of "delegation" means the transfer of authority to another nurse or competent, unlicensed assistive person to perform a specific nursing task or activity in a specific situation. The National Guidelines for Nursing Delegation, developed by the American Nurses Association (ANA) effective April 29, 2019, indicated the licensed nurse cannot delegate nursing judgement or any activity that will involve nursing judgement or critical decision making. R1 R1's diagnoses include dementia and anxiety. R1's service plan dated June 4, 2025, indicated R1 received assistance with medication management, bathing, dressing, grooming, toileting, transferring and mobility assistance. R1 used a walker for ambulation and required the use of a transfer belt for transfers. R1 was also receiving hospice care. The Service Plan indicated a task titled "Bladder Cont: Assist 8+ x/24 hr" with the times for the	0 450		

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0 450	Continued From page 3 service: NOC2, AM, PM, NOC1 and NOC. Notes included within the task included: offer toileting when resident first wakes up for the day, before and after meals, and before going to bed. A review of the Service checkoff List indicated the description note was the same instructions for all 3 shifts and times for the task listed were AM, PM, NOC and NOC1. R1's service plan dated June 4, 2025, indicated a task for "Cues" ten plus times per day with the note indicating "caregivers to provide interventions as described and report changes in need for cues to nursing" with the times for the task listed were AM, PM, and NOC. A review of the service plan and service checkoff list did not contain specific interventions unlicensed caregivers should provide in regard to "Cues" or what changes would indicate nursing should be notified. The Service Plan indicated R1 received "Falls Management" every shift. The Notes section included orders (or actions) that but were nonspecific delegations for R1. A facility incident report indicated R1 fell one early morning when ambulating out of the bathroom without her walker. R1 did not use a pendent, however, was able to obtain her cell phone and call the family member almost two hours after the fall. The family member was not able to reach the facility caregivers by phone for approximately an hour, so the family member texted administration as directed in the after-hours phone process. Facility unlicensed caregivers were seen on camera entering R1's room to provide assistance at approximately 5:00 am.	0 450		

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0 450	Continued From page 4 During an interview on June 17, 2025, at 6:00 p.m. with unlicensed caregiver (ULP) C, she stated during orientation she was taught that all residents in the memory care unit should be checked every two hours. ULP-C stated there was only one place to sign in the facility's documentation system to sign for the instructed every two hour checks. ULP-C stated R1 had a sheet in her room provided by the family where unlicensed caregivers were to sign after those checks and note whether R1 was continent, or sleeping, etc. During the same interview, ULP-C was unable to describe the meaning of the tasks on the Service Checkoff List for Cues, Bladder Cont., or Falls management. ULP-C stated the meaning for the task Cues, "I'm guessing that's how many times we help her". During an interview on June 4, 2025, at 2:10 p.m., nurse-A states unlicensed caregivers should be checking on R1 "every couple of hours" as directed by the number of items on the Service Checkoff List, and by signing off once per shift on the Service Checkoff List, the unlicensed caregiver is signing that they checked on the resident every two hours. Nurse-A stated they have added NOC 1 and NOC2 on R1's Service Checkoff List to assure R1 is checked on at least two times throughout the overnight shift. A review of R1's Service Checkoff List did not indicate NOC1 and NOC2 contained individualized instructions for the tasks to be completed at different times during the overnight shift. A review of R1's Service Checkoff Lists dated for April, May and June 2025 did not include a time task entry for NOC2 as listed in R1's Service Plan.	0 450		

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0 450	Continued From page 5 A review of R1's Service Checkoff List dated for April 2025, indicated unlicensed caregivers only signed off for NOC1 as completed on April 4-April 30, 2025. The NOC task was signed as completed April 1 through April 3, 2025, then had an X indicating the task was not completed April 4 through April 30, 2025. A second task entered as NOC contained an X indicating the task was not completed April 1 through April 3, 2025, then the remaining days of April 4 through April 30, 2025, were blank. The same document included no indication of what time during the shifts the service was provided. A review of R1's Service Checkoff List dated for May 2025, indicated unlicensed caregivers only signed off for NOC1 and the NOC task was blank for May 1 through May 31, 2025. The same document included no indication of what time during the shifts the service was provided. A review of R1's Service Checkoff List dated for June 2025 provided on June 3, 2025, indicated unlicensed caregivers only signed off for NOC1 task and the NOC task was blank for June 1 through June 3, 2025. The same document included no indication of what time during the shifts the service was provided. R2 R2's diagnoses included a history of cerebral infarction and hypertension. R2's service plan dated June 18, 2025, indicated R2 received assistance with cueing, bathing, dressing, grooming, toileting, transferring and mobility assistance. A review of the service plan and service checkoff list failed to provide unlicensed caregivers with	0 450		

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0 450	Continued From page 6 individualized instructions how to provide individualized care to R2. R3 R3's diagnoses included dementia and agitation. R3's service plan dated June 18, 2025, indicated R3 received assistance with cueing, bathing, dressing, grooming, toileting, transferring and mobility assistance. The service plan indicated R3 had a history of abuse, aggression and refusing services. A review of the service plan and service checkoff list failed to provide unlicensed caregivers with individualized instructions how to provide individualized care to R3. The facility resident Incident/Accident log indicated on February 8, 2025, at 1:30 a.m. R3 had a slip/fall. The same report indicated on March 13, 2025, and April 4, 2025, R3 had resident to resident altercations. A review of R3's Service Plan and Service Checkoff List did not indicate updates were made or individualized interventions for unlicensed caregivers were provided. R4 R4's diagnoses included cerebral infarction and frontotemporal neurocognitive disorder. R4 was also receiving hospice care. R4's service plan dated June 18, 2025, indicated R4 received assistance with cueing, bathing, dressing, grooming, toileting, transferring and mobility assistance. The facility Incident/Accident log indicated on	0 450		

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0 450	Continued From page 7 April 4, 2025, R4 had a resident-to-resident altercation. A review of R4's Service Plan and Service Checkoff List did not indicate updates were made or individualized interventions for unlicensed caregivers were provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 450		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure medications were administered as prescribed; failed to ensure prescribed medications were available for use and failed to ensure prescribed medications were administered according to manufacturer recommendations for one of one resident (R1).	01760		

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01760	Continued From page 8 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1's diagnoses include dementia and anxiety. R1's service plan dated June 4, 2025, indicated R1 received assistance with medication management, bathing, dressing, grooming, toileting, transferring and mobility assistance. R1 required assistance to transfer and used a walker for ambulation. R1 was also receiving hospice care. R1's Medication Administration Record (MAR), dated May 2025 indicated an order for Morphine Sulfate 15 Milligram (mg) with the effective date of March 26, 2025. The instructions were to give one half tab (7.5 mg) at bedtime for restlessness and agitation. R1's MAR indicated the medication was not administered May 10-May 12, 2025, with documentation on the MAR indicating the medication as not available. A review of the MAR indicated 14 days later, on May 27-May 31, 2025, the medication was not given again, with documentation on MAR indicating the medication was not available for May 27-May 29, 2025 and May 31, 2025. No documentation was present for May 30, 2025. R1's MAR dated June 2025, indicated the medication was signed off as given on June 1	01760		

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01760	Continued From page 9 and June 7, 2025, but June 2 - 6, 2025, and June 8-18, 2025, the dates were circled, indicating the medication was not given and documentation on MAR reported medication not available. R1's narcotic record indicated on May 26, 2025, the amount remaining for morphine sulfate tabs (7.5 mg) was 0. R1's progress notes indicated on June 19, 2025, the medication error was identified, and the morphine sulfate was reordered and delivered by hospice. A review of the Medication Error log provided by facility administration did not indicate a medication error was made for R1 for the previous 6 months. During an interview on June 4, 2025, at 2:25 p.m., the nurse manager stated the medication passer should have completed a medication error report for the doses not available for administration. During the same interview the nurse manager was notified of medication doses not being available in May for 3 doses (May 10-12, 2025) and again 14 days later on May 27, 2025. The nurse manager stated she would look into the issue at that time. During an interview on June 4, 2025, at 4:20 p.m. with unlicensed caregiver (ULP)- E, the medication passer, when asked what she is to do if a medication is not available, stated she would notify the RN, reorder and make a note in the MAR. when asked if she would complete a medication error report she stated "no". During an interview on June 17, 2025, at 4:55 p.m. with the hospice nurse she stated she was	01760		

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01760	Continued From page 10 unaware of the medication not being available for administration. The hospice nurse stated the medication was provided as a 14-day supply from the pharmacy and she was responsible for reordering the medication. The licensee-provided policy titled "Medication Documentation", dated November 18, 2024, indicated the health and wellness director is responsible for ensuring that documentation is completed for all medication communication and medications administered to the resident. Documentation in the MAR includes all medications administered, or when medications were not administered, to include any reasons for non-administration, and any follow-up procedures (e.g., nurse on-call notified). The nurse will document: a. Any nurse request to refill a medication or communication with a prescriber, pharmacy, resident, or legal representative about a medication. The licensee-provided policy titled "Medication Incidents", dated October 27, 2023, indicates a medication error occurs when the resident does not receive a medication as prescribed/ordered by the practitioner. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced	02360		

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02360	Continued From page 11 by: The facility failed to ensure one of one resident reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued two determinations maltreatment occurred for two separate investigations (#HL201683174C/#HL201681843M and #HL201683175C/#HL201681844M) regarding R1 and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		