Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL200226362M
Compliance #: HL200225063C

Date Concluded: January 12, 2026

Name, Address, and County of Licensee Investigated:
New Perspective Roseville
2750 North Victoria Street
Roseville, MN, 55113
Ramsey County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Kris Detsch, 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) financially exploited three residents (resident #1, resident #2, and resident #3) when he stole money and cigarettes.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined financial exploitation was not substantiated. Although the residents reported they had money and items stolen from them, there was not a preponderance of evidence to indicate the AP stole these items. After the AP's employment ended, other residents continued to report theft of their money and property. Multiple staff members had keys to unlock resident rooms.

The investigator conducted interviews with facility staff members, including administrative staff and unlicensed staff. The investigator contacted law enforcement. The investigation included review of the resident records, facility internal investigation, facility incident reports, personnel files, staff schedules, law enforcement report, related facility policy and procedures. Also, the

investigator toured the facility and observed staffing levels, documentation processes, resident locations.

The residents resided in an assisted living facility.

Resident #1's diagnoses included Parkinson disease. Resident #1's service plan included assistance with medications, trash removal, bed making, and weekly assistance with laundry and housekeeping. Resident #1's nursing assessment indicated she was alert and her memory was intact.

Resident #2's diagnoses included heart failure. Resident #2's service plan included assistance with medications, dressing, grooming, transfers (with the use of a mechanical lift and two staff), trash removal and bed making, and weekly assistance with laundry and housekeeping. Resident #2's nursing assessment indicated he was alert and his memory was intact.

Resident #3's diagnoses included chronic pulmonary obstructive disease (COPD). Resident #3's service plan included assistance with medications, trash removal, bed making, and weekly assistance with laundry and housekeeping. Resident #3's nursing assessment indicated she was alert and her memory was intact.

The facility's internal investigation lacked any information regarding resident #2 but contained statements from resident #1 and #3 shortly after the incident. The investigation indicated resident #1 told the manger the AP was the only one she showed the pictures to from the drawer where she kept her money and the money went missing later that same day, so she suspected the AP took it. The investigation indicated resident #3 also suspected the AP because resident #1 believed it was him.

Service delivery records indicated the AP did not provide services to resident #2. The records indicated the AP provided services to resident #1 and resident #3 during the morning shifts over the time frame when the thefts occurred, however so did at least three other caregivers. Additionally, the facility also had other caregivers who worked during the evenings and nights. The AP only worked in the mornings.

During an interview, a manager said the residents reported these thefts within a three-day time frame. The manager said resident #1 suspected the AP took her money because she kept the money in a drawer and opened it to get a picture to show him. The manager said resident #1 had $80 in the drawer. The manager said resident #1 was uncertain when the money went missing. The manager said resident #2 said he had $48 dollars stolen from the table in his room, but resident #2 was uncertain who had been in his room. The manager said resident #3 said kept her money on top of her bookshelf and discovered it was gone. The manager said resident #3 reported missing $620 dollars. The manager said resident #3 was aware resident #1 thought it was the AP who took the money, and resident #3 believed resident #1 because the AP was a new staff member. The manager said the AP worked during the time frame when the thefts

occurred, so he suspended the AP's employment. The manager said months after the AP no longer worked at the facility, other residents continued to report theft of money and property. The manager said some of the caregiver's "float" (move around) to help in different units. The manager said the facility was installing video cameras, but did not have them at the time of these incidences.

During an interview, resident #1 said the last time she saw the money was when the AP was in her room with her. Resident #1 said she opened a drawer and got a card to show him and under the card was her money. Resident #1 said there was about $80 dollars in the drawer. Resident #1 said she also had $25 dollars taken from her wallet. Resident #1 said two days later she discovered the money was no longer there. Resident #1 said she was not trying to accuse the AP of taking the money, but she was suspicious of him because he had just started working there. Resident #1 said she locked her door when she left her room, however all the caregivers had a key to unlock her door.

Resident #2 was not available for interview due to illness.

During an interview, resident #3 said she had $227 dollars in a drawer and $400 dollars on top of a bookshelf in her room. Resident #3 said she noticed the money was missing from her purse, then called her son to come check for the money on top of her bookshelf and he discovered the money was gone. Resident #3 said the last time she saw the money was two days prior. When asked who she thought took the money, she said she thought was a worker from the kitchen, but she could not be certain. Resident #3 said she would probably never know.

During an interview, the AP said he did not take any money resident #1, resident #2 or resident #3, and he did not work with resident #2. The AP said the manager suspended his employment but then had him return to work. The AP said when he returned to work, he continued to provide care and services to resident #1 and resident #3.

There was no law enforcement reports for resident #1, resident #2 and resident #3's report of missing money. Law enforcement records indicated resident #3 had an item stolen (missing bowl) from her apartment after the AP's employment ended.

In conclusion, the Minnesota Department of Health determined financial exploitation 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.

Financial exploitation: Minnesota Statutes, section 626.5572, subdivision 9
"Financial exploitation" means:
(b) In the absence of legal authority a person:

(1) willfully uses, withholds, or disposes of funds or property of a vulnerable adult;
(2) obtains for the actor or another the performance of services by a third person for the wrongful profit or advantage of the actor or another to the detriment of the vulnerable adult;
(3) acquires possession or control of, or an interest in, funds or property of a vulnerable adult through the use of undue influence, harassment, duress, deception, or fraud; or
(4) forces, compels, coerces, or entices a vulnerable adult against the vulnerable adult's will to perform services for the profit or advantage of another.

Vulnerable Adult interviewed: Yes, resident #1 and resident #3. No, resident #2 due to illness.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility investigated the incident and installed video cameras.

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
	20022	A. BUILDING: _____ B. WING _____	C 12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE - ROSEVILLE	2750 NORTH VICTORIA STREET ROSEVILLE, MN 55113

(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 18, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL200225063C/#HL200226362M. No correction orders are issued.	0 000		