*Protecting, Maintaining and Improving the Health of All Minnesotans*

# State Rapid Response Investigative Public Report

*Office of Health Facility Complaints*

**Maltreatment Report #:** HL200227585M
**Compliance #:** HL200223047C

**Date Concluded:** February 28, 2025

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

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

**Evaluator's Name:** Peggy Boeck
Special Investigator

**Finding:** Substantiated, individual responsibility

**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 a resident when the AP (a facility staff) had unwanted physical and sexual contact with the resident. The AP kissed the resident on the cheek and fondled his genitals multiple times.

**Investigative Findings and Conclusion:**
The Minnesota Department of Health determined abuse was substantiated. The AP was responsible for the maltreatment. The AP received training from the facility on maltreatment, sexual abuse, and resident boundaries and although the AP denied the allegation, there was a preponderance of evidence that the incidents occurred based on the resident's consistent report of events and the AP's history of abusive behavior toward residents.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement and family. 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 observed the facility, the resident's room where the alleged incidents occurred, and staff interactions with residents.

The resident lived in an assisted living. The resident's diagnoses included stroke, diabetes, and incontinence. The resident's service plan included assistance with verbal cues, and incontinence cares. The resident's assessment indicated he was cognitively intact.

An internal investigation report indicated a resident reported the AP hugged and kissed the resident, asked the resident if he "loved" the AP, and on more than two occasions, fondled the residents' genitals while providing incontinence cares. The investigation indicated the facility reported to law enforcement, interviewed residents, and assessed the resident.

During an interview, a staff stated she witnessed the AP verbally abuse residents, swearing and saying degrading things about and to the residents in front of them.

During an interview, a supervisory staff stated the AP was terminated for witnessed abuse of another resident shortly before the current incident was reported. The supervisory staff stated there were additional complaints about the AP.

During an interview, the AP stated she did not provide cares, but only passed medications. The AP then stated that she did provide cares if residents needed help. The AP declined the rest of the interview, but stated she was going to have a lie detector test done so she could sue the facility. The AP's personnel file indicated the AP had received a written warning for a conduct violation two months before the incident.

During an interview, a family member stated the incidents traumatized the resident, who had difficulty sleeping, required a light on at night, and continued to ask who was working on the overnight shift for fear of the AP returning. The family member stated the resident had never made an allegation of abuse before and his recollection of events were consistent when he talked with the facility administration, police, and family.

During an interview the resident stated the AP used terms of endearment (calling him "Baby") and touched him inappropriately only when she was in his room. The resident stated the AP fondled his privates when she changed his incontinence brief on four to five occasions. The resident stated he wanted the AP to never do this to another person, but did not want her hurt.

In conclusion, the Minnesota Department of Health determined abuse was substantiated.

**Substantiated:  Minnesota Statutes, section 626.5572, Subdivision 19.**
"Substantiated" means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

**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.

**Vulnerable Adult interviewed**: Yes.
**Family/Responsible Party interviewed**: Yes.
**Alleged Perpetrator interviewed**: The AP briefly interviewed, then declined.

**Action taken by facility:**
The facility terminated the AP for a prior abuse allegation. The facility investigated the allegation by interviewing other residents.

**Action taken by the Minnesota Department of Health:**
The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:

https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html

If you are viewing this report on the MDH website, please see the attached Statement of

Deficiencies.

You may also call 651-201-4200 to receive a copy via mail or email

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

cc:

The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Ramsey County Attorney
Roseville City Attorney
Roseville Police Department

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 20022 | A. BUILDING: _____ B. WING _____ | C 02/06/2025 |

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| 0 000 | Initial Comments<br><br>******ATTENTION******<br><br>ASSISTED LIVING PROVIDER CORRECTION ORDER<br><br>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation.<br><br>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.<br><br>INITIAL COMMENTS:<br><br>#HL200223047C/#HL200227585M; HL200225780C/#HL200228542M<br><br>On February 6, 2025, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 93 residents receiving services under the provider's Assisted Living with Dementia Care license.<br><br>The following correction orders are issued for #HL200223047C/#HL200227585M; HL200225780C/#HL200228542M, tag identification 2310 and 2360. | 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.<br><br>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.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.<br><br>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. | |
| 02310 SS=H | 144G.91 Subd. 4 (a) Appropriate care and services | 02310 | | |

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| 02310 | Continued From page 1<br><br>(a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and document review, the licensee failed to provide appropriate care and services for two of two residents (R1 R2) reviewed for maltreatment. The facility failed ensure that services were individualized for each resident, failed to implement individualized interventions in response to the needs of R2 after multiple falls and R1 after reported incidents of abuse of R1, and failed to ensure staff implemented the services identified in the service plans of R1 and R2. R1 experienced emotional harm (as manifested by difficulty sleeping, requiring a night light, and fear of unlicensed personnel (ULP)-E returning to further abuse him) and R2 received physical harm from ongoing falls.<br><br>This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to 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).<br><br>Findings include:<br><br>R1 | 02310 | 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.<br><br>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.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.<br><br>THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND | |

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| 02310 | Continued From page 2<br><br>R1 was admitted on March 25, 2020, due to diagnoses that included stroke, diabetes, below the knee amputation of right leg, and incontinence.<br><br>R1's service plan dated December 13, 2024, indicated R1's required services included the following:<br>1) Cues "1-4 x [times] per 24 hours" The document indicated R1 required cueing assistance for "1-30 minutes per 24 hours" and the service consisted of "Community provides cueing support based on identified needs".<br><br>2) Assist of one staff for incontinence cares "5-6 x [times] per 24 hours" and the service consisted of "Community provides assistance with bladder continence tasks".<br><br>3) Maltreatment risk, and the service consisted of "Community proved interventions as applicable to mitigate the potential for maltreatment by others."<br><br>4) Fall mitigation interventions. The document indicated services consisted of "Community provides environmental fall mitigation interventions", and "Community provides health-related fall mitigation interventions.".<br><br>R1's service plan did not identify the specific interventions caregivers were to implement.<br><br>A facility document titled "Investigation [R1] 12.13.2024" indicated there was an allegation that a staff member sexually assaulted R1. The investigation indicated unlicensed personnel (ULP)-E reportedly hugged and kissed R1, and fondled R1's private parts while providing incontinence cares on more than one occasion. The investigation indicated assisted living director | 02310 | REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3. | |

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| 02310 | Continued From page 3<br><br>(ALD)-B asked R1 why he waited to report and R1 stated he was embarrassed. The investigation indicated the facility contacted law enforcement, interviewed R1, and interviewed all residents.<br><br>R1's progress notes failed to include documentation of the incident or follow up with R1 regarding the incident.<br><br>R1's individual abuse prevention plan dated December 13, 2024, indicated R1 had a history of abuse, and identified the following service interventions: "Team members are trained on vulnerable adult protections and mandated reporter procedures, and they will timely notify a supervisor of any signs or allegations of maltreatment."<br><br>During an interview on February 6, 2025, at 1:00 p.m. R1 stated ULP-E called him names like "baby" and kiss his cheek/mouth and touched his privates in a way that made him uncomfortable. R1 stated ULP-E only behaved that way toward him when she was alone with him in his room. R1 stated ULP-E acted that way toward him four or five times and it made him feel degraded. R1 stated he just wanted ULP-E to stop doing that to people.<br><br>During an interview on February 6, 2025, at 2:08 p.m. registered nurse, health and wellness director (HWD)-A stated after the allegations of sexual assault of R1, she conducted a skin assessment on R1 and helped interview other residents during the investigation. HWD-A stated she made no changes to R1's service plan, as she focused her assessment on R1's skin.<br><br>During an interview on February 10, 2025, at 2:30 p.m. family member (FM)-C stated since the | 02310 | | |

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| 02310 | Continued From page 4<br><br>incident R1 no longer slept well, needed to have a light on at night, and needed to know who the overnight staff was, for fear of ULP-E returning to the facility. FM-C stated no one at the facility had talked about referral to a therapist for R1 to talk about the incident.<br><br>An interview was attempted with ULP-E on February 11, 2025, at 9:57 a.m. ULP-E stated she did not work for the facility, did not know R1, and did not do cares. ULP-E stated she was going to get a lie detector test and sue the company, when she terminated the interview.<br><br>ULP-E's personnel file contained a document titles "Separation of Employment" dated December 10, 2024. It indicated the facility had terminated ULP-E due to "the second instance of a report and investigation of alleged abuse towards a resident."<br><br>R2<br>R2 was admitted May 28, 2024, due to diagnoses that included Alzheimer's disease.<br><br>R2's record indicated he received hospice services from an outside provider beginning on December 3, 2024.<br><br>R2's service plan dated December 19, 2024, indicated R2's required services included the following:<br>1) Extensive cues "15+ x [times] per 24 hours" The document indicated R2 required cueing assistance for "121+ minutes per 24 hours" and the service consisted of "Community provides cueing support based on identified needs".<br><br>2) Assist of one staff for incontinence cares "7-8 x[times] per 24 hours" and the service consisted | 02310 | | |

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| 02310 | Continued From page 5<br><br>of "Community provides assistance with bladder continence tasks".<br><br>3) Maltreatment risk, and the service consisted of "Community proved interventions as applicable to mitigate the potential for maltreatment by others."<br><br>4) Fall mitigation interventions. The document indicated services consisted of "Community provides environmental fall mitigation interventions", and "Community provides health-related fall mitigation interventions."<br><br>R2's service plan did not identify the specific interventions caregivers were to implement.<br><br>R2's incident documentation dated November 1, 2024, through February 6, 2025, indicated R2 had eight unwitnessed falls, and three witnessed falls as follows:<br><br>1) November 7, 2024, at 7:50 p.m. unwitnessed fall, transported to emergency department; December 31, 2024, at 1:54 am unwitnessed fall.<br><br>2) January 2, 2025, at 5:45 a.m. unwitnessed fall with abrasion and bruising on his forehead.<br><br>3) January 6, 2025, at 2:56 p.m. witnessed fall, no injury documented.<br><br>4) January 8, 2025, at 7:20 p.m. unwitnessed fall and identified as second fall of day (no documentation found of first fall) no injury documented.<br><br>5) January 9, 2025, at 8:00 a.m., unwitnessed fall with reported head strike.<br><br>6) January 11, 20225, at 6:31 p.m. unwitnessed | 02310 | | |

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| 02310 | Continued From page 6<br><br>fall with abrasion to back of the head. The note indicated emergency services contacted but not sent to emergency department due to resident enrollment in hospice.<br><br>7) January 14, 2025, at 4:18 a.m. unwitnessed fall with left elbow skin tear, reinjury of wound to back of head, skin tear on right upper arm, bruise on right knee, and purple bruise on right hip.<br><br>8) January 17, 2025, at 8:00 p.m. witnessed fall, no injury documented.<br><br>9) January 25, 2025, at 7:35 a.m. unwitnessed fall, no injury documented.<br><br>10) January 26, 2025, at 11:16 p.m. unwitnessed fall, no injury documented.<br><br>11) February 2, 2025, 1:57 p.m. witnessed fall to knees, no injury documented.<br><br>R2's service plan updated January 21, 2025, listed the following fall mitigation interventions: "Community provides environmental fall mitigation interventions." "Community provides health-related fall mitigation interventions."<br><br>R2's completed services document (titled Resident Monthly Assignment Report) dated January 2024, indicated staff provided incontinence cares. The report indicated staff signed off completion of the cares at the following times: 6:00 a.m., 6:00 a.m. to 1:45 p.m., 2:00 p.m., 2:00 p.m. to 9:45 p.m., 10:00 p.m., and 10:00 p.m. to 5:45 a.m. The electronic health record did not allow staff to enter times of completion or make multiple entries during the times listed. | 02310 | | |

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| 02310 | Continued From page 7<br><br>R2's completed services document (titled Resident Monthly Assignment Report) dated January 1, 2025, through January 31, 2025, indicated staff interventions related to fall risk included removing trip hazards in apartment and common areas, encouraging resident to remove rugs and mats not adhered to the floor, verifying the call pendant worked, encouraging resident to wear properly fitting footwear or non-slip socks, and keeping resident call pendant on resident's body or within reach.<br><br>R2's completed services document (titled Resident Monthly Assignment Report) dated January 2024, indicated staff failed to document or verify completion of toileting cares on the following dates:<br>January 2 6:00 a.m., 6:00 a.m. to 1:45 p.m.<br>January 6, at 2:00 p.m. or 2:00 p.m. to 9:45 p.m.,<br>January 16, at 6:00 a.m. or 6:00 a.m. to 1:45 p.m.<br>January 21, 6:00 a.m. or 6:00 a.m. to 1:45 p.m.<br>January 30 at 6:00 a.m. or 6:00 a.m. to 1:45 p.m.<br><br>R2's completed services document (titled Resident Monthly Assignment Report) dated January 2024, directed staff to complete the following four services and document as one task:<br>1) "Encourage resident to participate in community exercise activities,<br>2) "Drink fluids between meals and at mealtime,<br>3) "Maintain a consistent sleep schedule (including naps);<br>4) "Timely report to nursing any changes in condition (physical, cognitive, behavioral)."<br>The report indicated staff sign off completion at the following six times: 6:00 a.m., 6:00 a.m. to 1:45 p.m., 2:00 p.m., 2:00 p.m. to 9:45 p.m., 10:00 p.m., and 10:00 p.m. to 5:45 a.m. The electronic health record did not allow staff to enter | 02310 | | |

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| 02310 | Continued From page 8<br><br>times of completion of any of the four services, did not allow documentation of which of the four services staff completed, and did not allow multiple entries during a period.<br><br>During an interview on February 6, 2025, at 2:55 p.m. registered nurse health and wellness director (HWD)-A stated the root cause for R2's falls was R2 attempting to self-transfer. HWD-A stated she directed staff to give R2 "cues and take him to the toilet more often". HWD-A stated the facility electronic health record did not allow staff to document specific times when they toileted R2, so the facility had no way to track if R2 was toileted more often. HWD-A stated R2's service plan did not contain individualized interventions, as none of the residents' plans did.<br><br>During an interview on February 10, 2025, at 3:10 p.m. family member (FM)-D stated when R2 started having falls nearly daily, she asked the facility why so many were unwitnessed and what the facility was doing to prevent falls. FM-D stated the facility did not ensure staff kept their eyes on R2 in the memory care unit and did not identify ways to prevent his falls.<br><br>During an interview on February 12, 2025, at 8:53 a.m. unlicensed personnel (ULP)-F stated the electronic health record system used by the licensee did not allow for documentation of all required services. ULP-F stated if a resident required toileting/incontinence cares 7-8 times in a day, there was no way of documenting how many times staff provided that service. ULP-F stated the facility also had a problem with staff signing off on services but not completing them in the memory care unit, such as toileting and showers. ULP-F stated some of the services listed had several tasks (such as participate in | 02310 | | |

| 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 02/06/2025 |

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

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|---|---|---|---|---|
| 02310 | Continued From page 9<br><br>exercise activities, ensure drinking fluids, and maintaining a sleep schedule) and there was no way of knowing which task the staff completed when the staff signed off as completed.<br><br>During an interview on February 12, 2025, at 10:09 a.m. care team manager (CTM)-G stated the facility had a problem in memory care, with staff documenting but not providing services. CTM-G stated the problem was more prevalent in memory care because those residents "cannot tell us" when they do not receive a service. CTM-G stated she supervised the unlicensed personnel who provided cares to the residents. CTM-G stated she could think of interventions for R2 like talking about the Vikings football team or turning on music but acknowledged the service plan did not have that information for staff.<br><br>The assessments and evaluations policy dated September 21, 2022, indicated assessments, reassessments, and evaluations would be thorough and timely to ensure that a resident's care needs were identified, and an individualized service plan was maintained.<br><br>The resident service plan policy dated June 22, 2023, indicated team members responsible for the delivery of care would sign to attest that the care was completed.<br><br>The fall mitigation and management policy dated November 5, 2024, indicated based on re-assessment after a fall the licensed nurse would conduct a falls evaluation. The licensed nurse would document interventions to reduce the risk of falls in the resident's service plan and communicate the interventions to staff providing services to the resident. | 02310 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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|---|---|---|---|---|
| 02310 | Continued From page 10<br>TIME PERIOD FOR CORRECTION: Seven (7) Days | 02310 | | |
| 02360 | 144G.91 Subd. 8 Freedom from maltreatment<br><br>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.<br><br>This MN Requirement is not met as evidenced by:<br>The facility failed to ensure two of two residents reviewed (R1, R2) was free from maltreatment.<br><br>Findings include:<br><br>The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual person was responsible for maltreatment of R1 (#HL200223047C/HL200227585M) and the facility was responsible for maltreatment of R2 (#HL200225780C/HL200228542M),in connection with incidents which occurred at the facility.<br><br>Please refer to the public maltreatment reports for details. | 02360 | | |