

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL200228542M
Compliance #: HL200225780C

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, facility 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 facility neglected a resident who had multiple falls with injuries, when they failed to investigate to determine the root cause of the falls or make changes to the care plan to include interventions to reduce the risk of further falls. The facility also neglected to provide showers or incontinence cares which led to the resident sleeping in dirty sheets.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The resident received skin tears, bruises, rug burns, and a head wound from falls. The facility failed to update the plan of care with individualized fall prevention interventions. The facility failed to ensure staff completed showers and incontinence cares as required according to the assessed needs of the resident.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted family and hospice. The

investigation included review of the resident records, hospice records (including a photo), facility internal investigation, facility incident reports, a personnel file, staff schedules, an ambulance run report, related facility policy and procedures. Also, the investigator observed the facility, the resident's room, and staff interactions with residents.

The resident lived in an assisted living memory care unit. The resident's diagnoses included Alzheimer's Disease. The resident's service plan included assistance with medication administration, management of behaviors, completion of activities of daily living, incontinence cares seven to eight times per day, and bathing twice weekly. The resident received hospice cares from an outside company.

Facility documentation failed to identify when the resident received incontinence cares, as staff only signed off providing the cares once per shift.

Facility incident reports for the three months prior to the date of the investigation indicated the resident had eight unwitnessed falls, two that required 911 calls, and four that resulted in injury.

Review of the resident's services for the three months prior to the investigation indicated the resident received bathing four times in the first month, four times in the second month, and eight times in the third month (two provided by hospice staff).

During an interview, a hospice nurse stated recently the resident had an episode of vomiting, the staff called hospice, a hospice nurse went in and assessed the resident. The hospice nurse cleaned up the resident, determined he had fecal matter in the vomit likely due to constipation and provided medication to help him have a bowel movement. The nurse asked caregivers to change the resident's bedding, and suggested they clean the vomit off the wall. The nurse returned to the facility the next day and found the resident in the same vomit covered bedding, with dried vomit on the wall next to the bed and photographed the area with the dried vomit. The staff reported to the hospice nurse that they did not know if the resident had a bowel movement.

During an interview a facility registered nurse stated the resident had falls because he tried to self-transfer. The nurse stated staff interventions to prevent falls included staff providing more cues when he tried to get himself up, and to provide more toileting. The registered nurse stated the facility had no documentation of whether staff completed more cues or more toileting. The nurse stated she made no changes to the resident's service plan after falls. The nurse stated she provided general training to staff on falls prevention, but not individualized to the resident.

During an interview, an administrator stated the facility documentation did not show the number of times staff provided services and the facility was not able to track when residents were supposed to be toileted.

During an interview a family member stated the facility neglected her family member. The family member stated staff made no attempts to feed the resident, did not watch the resident which led to multiple “unwitnessed” falls, failed to clean him up (showers and incontinence cares), and allowed other residents to take items from his room.

During investigative interviews, multiple staff members stated the facility had a problem with staff documenting but not actually completing the services for the residents, especially in the memory care unit.

In conclusion, the Minnesota Department of Health determined neglect 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.

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: Yes.

Family/Responsible Party interviewed: Yes.

Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:

No action taken.

Action taken by the Minnesota Department of Health:

The responsible party will be notified of their right to appeal the maltreatment finding.

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

cc:

The Office of Ombudsman for Long Term Care

The Office of Ombudsman for Mental Health and Developmental Disabilities

Hennepin County Attorney

Roseville City Attorney

Roseville Police Department

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20022	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/06/2025
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0 000	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>ASSISTED LIVING PROVIDER CORRECTION ORDER</p> <p>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation.</p> <p>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.</p> <p>INITIAL COMMENTS:</p> <p>#HL200223047C/#HL200227585M; HL200225780C/#HL200228542M</p> <p>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.</p> <p>The following correction orders are issued for #HL200223047C/#HL200227585M; HL200225780C/#HL200228542M, tag identification 2310 and 2360.</p>	0 000	<p>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.</p> <p>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.</p> <p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</p> <p>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.</p>	
02310 SS=H	144G.91 Subd. 4 (a) Appropriate care and services	02310		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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02310	<p>Continued From page 1</p> <p>(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.</p> <p>This MN Requirement is not met as evidenced by: 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.</p> <p>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).</p> <p>Findings include:</p> <p>R1</p>	02310	<p>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.</p> <p>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.</p> <p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</p> <p>THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND</p>	

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02310	<p>Continued From page 2</p> <p>R1 was admitted on March 25, 2020, due to diagnoses that included stroke, diabetes, below the knee amputation of right leg, and incontinence.</p> <p>R1's service plan dated December 13, 2024, indicated R1's required services included the following:</p> <p>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".</p> <p>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".</p> <p>3) Maltreatment risk, and the service consisted of "Community proved interventions as applicable to mitigate the potential for maltreatment by others."</p> <p>4) Fall mitigation interventions. The document indicated services consisted of "Community provides environmental fall mitigation interventions", and "Community provides health-related fall mitigation interventions."</p> <p>R1's service plan did not identify the specific interventions caregivers were to implement.</p> <p>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</p>	02310	REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	

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02310	<p>Continued From page 3</p> <p>(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.</p> <p>R1's progress notes failed to include documentation of the incident or follow up with R1 regarding the incident.</p> <p>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."</p> <p>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.</p> <p>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.</p> <p>During an interview on February 10, 2025, at 2:30 p.m. family member (FM)-C stated since the</p>	02310		

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02310	<p>Continued From page 4</p> <p>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.</p> <p>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.</p> <p>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."</p> <p>R2 R2 was admitted May 28, 2024, due to diagnoses that included Alzheimer's disease.</p> <p>R2's record indicated he received hospice services from an outside provider beginning on December 3, 2024.</p> <p>R2's service plan dated December 19, 2024, indicated R2's required services included the following: 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". 2) Assist of one staff for incontinence cares "7-8 x[times] per 24 hours" and the service consisted</p>	02310		

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

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02310	<p>Continued From page 6</p> <p>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.</p> <p>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.</p> <p>8) January 17, 2025, at 8:00 p.m. witnessed fall, no injury documented.</p> <p>9) January 25, 2025, at 7:35 a.m. unwitnessed fall, no injury documented.</p> <p>10) January 26, 2025, at 11:16 p.m. unwitnessed fall, no injury documented.</p> <p>11) February 2, 2025, 1:57 p.m. witnessed fall to knees, no injury documented.</p> <p>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."</p> <p>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.</p>	02310		

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02310	<p>Continued From page 7</p> <p>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.</p> <p>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: January 2 6:00 a.m., 6:00 a.m. to 1:45 p.m. January 6, at 2:00 p.m. or 2:00 p.m. to 9:45 p.m., January 16, at 6:00 a.m. or 6:00 a.m. to 1:45 p.m. January 21, 6:00 a.m. or 6:00 a.m. to 1:45 p.m. January 30 at 6:00 a.m. or 6:00 a.m. to 1:45 p.m.</p> <p>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: 1) "Encourage resident to participate in community exercise activities, 2) "Drink fluids between meals and at mealtime, 3) "Maintain a consistent sleep schedule (including naps); 4) "Timely report to nursing any changes in condition (physical, cognitive, behavioral)." 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</p>	02310		

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02310	<p>Continued From page 8</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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</p>	02310		

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NAME OF PROVIDER OR SUPPLIER NEW PERSPECTIVE - ROSEVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 2750 NORTH VICTORIA STREET ROSEVILLE, MN 55113
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(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
02310	<p>Continued From page 9</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p>	02310		

Minnesota Department of Health

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02310	Continued From page 10 TIME PERIOD FOR CORRECTION: Seven (7) Days	02310		
02360	<p>144G.91 Subd. 8 Freedom from maltreatment</p> <p>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.</p> <p>This MN Requirement is not met as evidenced by: The facility failed to ensure two of two residents reviewed (R1, R2) was free from maltreatment.</p> <p>Findings include:</p> <p>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.</p> <p>Please refer to the public maltreatment reports for details.</p>	02360		