Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Project: HL201681601M
Compliance Project: HL201682526C

Date Concluded: July 16, 2025

Name, Address, and County of Licensee Investigated:
New Perspective Highland Park
750 Mississippi River Boulevard
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: Inconclusive

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), a facility staff member, abused the resident when the AP coerced the resident to perform oral sex.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was inconclusive. The incident was not reported for approximately 10 days, thus no evidence was available. There were no witnesses to the incident. The AP, who was an unlicensed caregiver denied the allegation of abuse.

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

The resident resided in an assisted living facility. The resident's diagnoses included chronic pain, osteoarthritis, and generalized weakness. The resident's service plan included assistance with dressing and bathing. The resident's assessment indicated the resident was alert and walked short distances with a walker and used a wheelchair for longer distances.

A facility internal investigation indicated a facility manager was notified by a friend of the resident about an incident where the resident confided she was coerced to perform oral sex for the AP while the event was being recorded. The report indicated the friend identified a weekend when the incident occurred and provided a description of the AP. The facility immediately suspended the AP, who matched the description provided, notified law enforcement and began an internal investigation.

The staffing schedule provided indicated the AP worked every day of the weekend identified by the resident.

During an interview, the resident stated she had a relationship with the AP that developed over several months when the AP was assigned to provide her care while employed in the facility. The resident stated the AP asked the resident to perform sex and she complied two times because she wanted to please him and enjoyed his company. The resident stated the AP took pictures and video of the sexual encounters.

During correspondence with law enforcement, the officer indicated no picture or video evidence was found in the AP's possession, however a charging packet was sent to the county attorney for processing.

During an interview, the manager stated upon notification of the incident, law enforcement was notified, and the AP was suspended pending the outcome of the investigation. The manager indicated a rape exam completed after the report was negative, however the resident did not report the incident for approximately 10 days.

The AP declined the allegation of sexual abuse and declined to be interviewed.

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

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or 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: Yes.
Family/Responsible Party interviewed: Not Applicable.
Alleged Perpetrator interviewed: No, Declined interview.

Action taken by facility:
The facility completed an internal investigation and suspended the AP pending law enforcement investigation.

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 06/03/2025

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

(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 June 3, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL201682526C/#HL201681601M. No correction orders are issued.	0 000		