Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL201684082M
Compliance #: HL201687947C

Date Concluded: August 28, 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: Brandon Martfeld, 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 the resident when the facility failed to follow the resident's plan of care. The resident received an incorrect diet and had lost weight resulting in admission to hospice.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Although the resident lost weight and was admitted to hospice, there was not a preponderance of evidence it was due to the facility failing to provide services on the resident's care plan. The resident was referred to hospice services due to the progression of Alzheimer's disease and was moved to a higher level of care.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's case manager. The investigation included review of the resident records, grievances, facility incident reports,

hospice records, staff schedules, and related facility policy and procedures. Also, the investigator observed staff to resident interactions.

The resident resided in an assisted living memory care unit. The resident's diagnoses included Alzheimer's disease and dementia. The resident's service plan included assistance with transfers, mobility, and required cues and assist with eating. The resident's assessment indicated the resident was not cognitively intact. The resident's assessment indicated the resident required foods to be broken into smaller bite sized pieces.

The resident's medical record indicated the resident had a weight loss and admitted to hospice services. Dining assistance was provided when the resident allowed.

During an interview, facility leadership stated the resident had a decline in health from Alzheimer's disease which led to weight loss. Hospice was initiated for supportive services. It was recommended by hospice that the resident's food be cut into small bite size pieces. Leadership stated staff would sit with the resident during meals and provide assistance as needed.

During an interview, the family member had concerns about the resident's food not being cut into small bite size pieces. The family member decided to move the resident to a higher level of care.

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. Resident no longer resided at the facility.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:

The facility acknowledged the resident's weight loss and dementia progression and requested hospice for additional services.

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 08/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE HIGHLAND PARK	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 August 18, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL201684082M / #HL201687947C. No correction orders are issued.	0 000		