State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL201687742M
Compliance #: HL201687902C

Date Concluded: March 10, 2026

Name, Address, and County of Licensee Investigated:
New Perspective Highland Park
750 Mississippi River Blvd
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: 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 a stranger got into the facility memory care unit and exposed himself to the resident.

Investigative Findings and Conclusion: The Minnesota Department of Health determined neglect was not substantiated. The unknown male had entered through an entrance door and may have pried it open and was subsequently spotted by caregiver(s) who began to search the building for him. He was found in the resident's room and removed from the facility. The resident had no identifiable injuries caused by the unknown male.

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

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia.

The resident's service plan included assistance with medication management, cueing, bathing and toileting. The resident's assessment indicated the resident was disoriented to person, place and time but was able to walk independently.

A concern arose early one morning during the night shift when an unknown male was found in the resident's room.

A facility report indicated an unknown male was found in the resident's bed, while the resident was standing in the corner of the room. Two unlicensed caregivers removed the resident from the room and called 911.

A law enforcement report indicated the unknown male had broken into the facility, was arrested, and booked into jail.

The resident's medical record indicated the resident was transported to the hospital for evaluation. The records indicated no visible injuries were found, however the resident was not cooperative which prohibited an extensive exam.

During an interview, a manager stated unlicensed caregiver #1 told her the unknown male was seen first in the hallway then ran. The manager stated the unknown male was found sitting on the end of the resident's bed with his pants down, and the resident was standing in the room fully clothed. The report received by the manager from unlicensed caregiver #1 was the unknown male was in the resident's room less than 5 minutes. The manager stated a back door which led into the memory care unit looked like something was used to try to pry the door open.

During an interview, unlicensed caregiver #2 stated he was alerted by unlicensed caregiver #1 there was an unknown male in the building. Upon searching the unit, the unknown male was found in the resident's room, sitting on the end of the bed with his pants down. Unlicensed caregiver #2 stated the resident was standing in front of the unknown male but was fully dressed. He then stated the two caregivers pulled the resident out of the room and called 911. Unlicensed caregiver #2 did not know how long the unknown male was in the resident's room or how he was able to get into the memory care unit. He estimated the time could have been 10-15 minutes.

Unlicensed caregiver #1 declined to be interviewed.

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, due to cognitive impairment
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility: The facility completed an investigation, law enforcement was notified, and the resident was evaluated at the hospital. The facility installed cameras on entrance doors and provided education to all staff.

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 12/16/2025

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 December 16, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL201687902C/#HL201687742M. No correction orders are issued.	0 000		