Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL243159483M
Compliance #: HL243153741C

Date Concluded: April 8, 2026

Name, Address, and County of Licensee Investigated:
New Perspective Assisted Living
701 Horizon Circle
Cloquet, MN 55720
Carlton County

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

Evaluator's Name:
Katherine Barnhardt RN, 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 alleged perpetrator (AP), a facility staff member, abused the resident when the AP used a gait belt (secures around waist to assist with transfers and ambulation) to restrain the resident.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was not substantiated. The resident was seen in her wheelchair with a gait belt on; however, the AP was redirected after cares were started for the resident and the gait belt was not intentionally used as a restraint. The resident was able to move freely with her wheelchair if she chose. The error was an isolated incident, and no harm occurred to the resident. The incident did not rise to the level of abuse.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted family. The investigation included review of the resident record(s), death record, hospital records, facility internal investigation,

facility incident reports, personnel files, staff schedules, related facility policy and procedures. Also, the investigator observed facility staff provide direct cares.

The resident resided in an assisted living memory care unit. The resident's diagnoses included stroke, repeated falls and a recent hip fracture. The resident's service plan included assistance with mobility, transfers and fall management. The resident's assessment indicated the resident was confused, required two-person transfers with a gait belt and used a wheelchair for mobility.

The resident record indicated the resident was seen sitting in her wheelchair with a transfer belt around the resident's waist and through a bar on the wheelchair. The resident record indicated licensed staff, a provider and family were notified. Licensed staff completed an assessment and no harm was noted.

An internal investigation indicated the AP reported the resident was next for cares and she placed the gait belt "loosely" on the resident in preparation of cares while she briefly assisted a coworker with a second resident's cares. During the internal investigation the AP reported she had forgotten the gait belt was still on and didn't realize it was around the resident's wheelchair.

During an interview, leadership stated the resident was observed with a transfer belt around her waist and wheelchair. Leadership stated when the AP was asked about it, the AP reported she had put it on the resident, went to assist a second resident, and didn't realize it was around the resident's wheelchair. Leadership stated the AP was "really upset" and reported it was not intentional. Leadership stated the transfer belt was on the resident for a few minutes, and the resident did not experience harm from the one-time error.

During an interview, a staff member stated the AP was in and out of another resident's room assisting with transfers and when they were done both staff went to the living room to chart. When in the living room, the staff member observed the resident sitting in her wheelchair with a transfer belt around her waist and the wheelchair. A staff member stated she asked the AP about it, the AP quickly jumped up, removed the transfer belt and stated they had to do that, but she had forgotten to remove it.

During an interview, the AP stated she was getting the resident ready for bed and a second staff member requested her assistance. The AP stated she had loosely placed the gait belt on the resident and didn't realize it was around the bar of the wheelchair. The AP stated she was away from the resident for two to three minutes and had no intention of restricting the resident's movement. The AP stated the gait belt was removed as soon as she realized it was still on.

During an interview, a family member stated she was notified of the error and had no concerns with the cares provided by the AP. A family member stated she hoped the AP stayed in the profession because of the level of care shown to residents.

In conclusion, the Minnesota Department of Health determined abuse 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.

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: Deceased
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility:
The facility licensed staff assessed the resident and conducted an internal 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
	24315	A. BUILDING: _____ B. WING _____	C 03/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE - CLOQUET & BA	701 HORIZON CIRCLE CLOQUET, MN 55720

(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 March 2, 2026, the Minnesota Department of Health initiated an investigation of complaint #HL243159483M/#HL243153741C. No correction orders are issued.	0 000		