Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL260247122M
Compliance #: HL260241880C

Date Concluded: April 18, 2025

Name, Address, and County of Licensee Investigated:
New Challenges, Inc
Rosemount Court
3710 145th Street West
Rosemount, MN 55068
Dakota County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Christine Bluhm, 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: The facility neglected the resident when the facility staff did not provide the resident's inhaler when she asked for it.

Investigative Findings and Conclusion: The Minnesota Department of Health determined neglect was not substantiated. The facility staff contacted the on-call nurse appropriately who instructed them to have the resident call 911 when she complained of chest pain. Emergency medical services (EMS) arrived, the resident was transported to the emergency room and returned to the facility the same day.

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, hospital records, facility incident reports, law enforcement report, police body camera video, and related facility policy and procedures.

The resident resided in an assisted living facility. The resident's diagnoses included anxiety, depression, and diabetes. The resident's service plan included assistance with medications and blood glucose monitoring. The resident's assessment indicated she used a walker for mobility, was alert and oriented and able to make her needs known.

The resident's medication administration record (MAR) indicated the resident had a Ventolin aerosol inhaler (medication to help with breathing) every six hours, as needed, for shortness of breath. The inhaler had not been signed out as given per the MARs reviewed.

The facility incident report indicated the resident called staff member(s) to report she was in pain and could not breathe. The same document indicated staff told her to call 911 and she tried her an inhaler. When paramedics arrived, she was transported to the hospital.

The emergency room visit summary indicated the resident was seen that day for musculoskeletal chest pain and back pain and given a narcotic prescription for pain and returned to the facility the same day.

Police body cam footage showed an officer obtained an inhaler from a caregiver who stated she was preparing dinner in the lower-level kitchen area. The officer returned to the resident's apartment on the second floor and gave the inhaler to the resident to self-administer. A second officer questioned the caregiver as to when did the resident ask for the inhaler and the caregiver stated, "five minutes ago." The caregiver then attempted to explain to the officer that it was the officer who came down to ask for the inhaler approximately five minutes prior. The caregiver then told the officer that the resident complained of chest pain and trouble breathing and the nurse advised her to call 911.

During interview, the resident stated she called a staff member and told them she couldn't breathe. When EMS arrived, she said they asked her if she had asthma, and she told them that she did. She said a police officer brought her the inhaler, and she used it, but she stated it did not really work. The resident said she was transported to the emergency room and came back that same night.

The facility Emergency Response policy indicated residents at the facility have access to 24-hour emergency response from staff.

In conclusion, the Minnesota Department of Health determined 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: Yes.
Family/Responsible Party interviewed: No.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility: The facility reviewed its emergency policy and procedures.

Action taken by the Minnesota Department of Health: No further action 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
	26024	A. BUILDING: _____ B. WING _____	C 04/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEMOUNT COURT	3710 145TH STREET WEST ROSEMOUNT, MN 55068

(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 April 2, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL260241880C/#HL260247122M. No correction orders are issued.	0 000		