Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL302252563M
Compliance #: HL302254449C

Date Concluded: June 12, 2025

Name, Address, and County of Licensee Investigated:
New Perspective Faribault
828 First Street Northeast
Faribault, MN Zip 55021
Rice County

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

Evaluator's Name: Danyell Eccleston, RN
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 facility neglected Resident #1 and Resident #2 when the facility failed to provide appropriate supervision. Resident #1 and Resident #2 were cognitively impaired and were unable to make personal decisions without family oversight. Resident #1 and Resident #2 had a sexual relationship.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. Due to conflicting information, it could not be determined if Resident #1 and Resident #2 had a sexual relationship.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of resident records, staff schedules, and related facility policy and procedures. Also, the investigator observed the residents and staff providing care to residents.

Observation of the memory care unit indicated Resident #1's and Resident #2's apartments were directly across from each other at the end of a hallway.

Resident #1 resided in an assisted living memory care unit. The resident's diagnoses included dementia, history of stroke, and anxiety. The resident's service plan included assistance with cueing, behavioral expressions, escorts to meals, grooming, dressing, and bathing. The resident's assessment indicated the resident wandered and had delusional and aggressive behaviors.

Review of approximately five months of Resident #1's behavioral monitoring logs indicated two instances of "resident to resident contact" occurred that were resolved with interventions of redirection and rest, no further documentation regarding instances noted.

Review of six months of Resident #1's progress notes indicated staff found Resident #1 unclothed in another resident's apartment. Staff did not believe Resident #1 and the other resident had any physical contact. The other resident was not Resident #2.

Resident #2 resided in an assisted living memory care unit. The resident's diagnoses included cognitive impairment and amnesia. The resident's service plan included assistance with cueing, behavioral expressions, redirection, dining assistance, and bathing. The resident's assessment indicated the resident wandered, needed redirection and encouragement, and made sexual gestures.

Review of approximately five months of Resident #2's behavioral monitoring logs indicated three instances of "sexual gestures" occurred that were resolved with interventions of redirection and reproaching later, no further documentation regarding instances noted.

Review of Resident #2's progress notes for the previous six months were reviewed. There was no documentation regarding a relationship or sexual contact between Resident #1 and Resident #2.

Review of a document from outside of the facility indicated a staff member reported Resident #1 and Resident #2 were in a sexual relationship. The identity of the staff member was not included.

During separate interviews, six unlicensed staff members denied being aware of or witnessing any sexual relationship or contact between Resident #1 and Resident #2.

During interview, an unlicensed staff member stated Resident #2 could be "touchy feely" with staff and touch staff members' waists or lower backs. The unlicensed staff member stated she had not seen Resident #2 touch fellow residents in a sexual way.

During interview, a family member of Resident #1 stated while visiting the facility, the family member witnessed Resident #2 entering Resident #1’s apartment multiple times and the family member directed Resident #2 to leave Resident #1’s apartment.

During separate interviews, family members of Resident #1 and Resident #2 stated the facility had not discussed any sexual relationship between Resident #1 and Resident #2 with family members.

In conclusion, the Minnesota Department of Health determined neglect 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.

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 Adults interviewed: Yes.
Family/Responsible Parties interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
No action taken.

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
	30225	A. BUILDING: _____ B. WING _____	C 05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE - FARIBAULT	828 1ST STREET NE FARIBAULT, MN 55021

(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 May 21, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL302254449C/#HL302252563M. No correction orders are issued.	0 000		