*Protecting, Maintaining and Improving the Health of All Minnesotans*

# State Rapid Response Investigative Public Report

*Office of Health Facility Complaints*

**Maltreatment Project:** HL302256862M
**Compliance Project:** HL302256284C

**Date Concluded:** March 3, 2026

**Name, Address, and County of Licensee Investigated:**
New Perspective Faribault
828 1st St. NE
Faribault, MN 55021
Rice County

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

**Evaluator's Name:** Deb Schillinger RN BSN
Special Investigator

**Finding:** Substantiated, individual responsibility

**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) financially exploited the resident when the resident's medication was diverted for personal use.

**Investigative Findings and Conclusion:** The Minnesota Department of Health determined financial exploitation was substantiated. The AP was responsible for the maltreatment. Over a two-week period, the AP signed out tramadol (a narcotic medication) that was not requested and was not received by the resident.

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, facility internal investigation, facility incident reports, personnel files, 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 facility. The resident's diagnoses included blindness, rheumatoid arthritis and pain. The resident's service plan included assistance with medication management and administration and transfer assistance. The resident's assessment indicated the resident was alert and, although blind, is cognitively intact and able to request additional pain medication as needed.

A concern arose the AP was administering tramadol without documenting the medication in the medication administration record (EMAR). This act also raised the concern for drug diversion.

The timeline below shows the key events over a 23-day time period. Day numbers are used in lieu of dates.

**Day 1**
The resident's medical record indicated an order was received for tramadol to be given every morning before getting out of bed. The order also indicated the resident could receive an additional tramadol for pain one time per day if requested by the resident.

**Day 2**
The residents medical record indicated a tramadol was signed out of the narcotic logbook (a log that indicates when staff members remove narcotics from supply), and the AP initialed and dated the medication card next to where the dose was located.

A review of the residents EMAR or did not include documentation the medication was administered to the resident.

**Day 3**
The residents medical record indicated a tramadol was signed out of the narcotic logbook, and the AP initialed the medication card next to where the dose was located.

A review of the residents EMAR or did not include documentation the medication was administered to the resident.

**Day 4**
The residents medical record indicated a tramadol was signed out of the narcotic logbook, and the AP initialed the medication card next to where the dose was located.

A review of the residents EMAR or did not include documentation the medication was administered to the resident.

**Day 5**
The residents medical record indicated a tramadol was signed out of the narcotic logbook, documented in the EMAR and the AP initialed the medication card next to where the dose was located.

**Day 6**
Coaching completed with AP, medication administration and documentation was reviewed.

**Days 8, 11, 12, 13, 14, 16 and 18**
The resident's medical record indicated that on the days when the AP worked (Days 8, 11, 12, 13, 14, 16, and 18) the resident received an additional tramadol dose for pain.

No other unlicensed caregivers administered additional doses of tramadol on the days the AP was not working.

**Day 19**
A facility report indicated the nurse manager spoke with the resident and the resident reported she did not receive an additional tramadol dose over the weekend, nor did the AP ask her if an additional tramadol dose was needed. [Day 19 was a Monday.]

During an interview, the nurse manager stated she implemented a new policy on day 19 where the unlicensed caregivers needed to notify a nurse before administering PRN medications.

The AP was not working on day 19; a review of the resident's EMAR, narcotic logbook and medication card indicated no additional doses of tramadol were documented as given.

**Day 20**
The AP worked on this day. A review of the resident's EMAR, narcotic logbook and medication card indicated no additional doses of tramadol were documented as given.

**Day 21 and 22**
The AP was not working on day 21 or 22; a review of the resident's EMAR, narcotic logbook and medication card indicated no additional doses of tramadol were documented as given.

**Day 23**
During an interview, the nurse manager stated on day 23 the unlicensed caregivers were notified she would be out of the building for a period of time during that day. The AP asked what she should do if the resident needed an additional tramadol dose, due to the new process. The nurse manager stated instructions were given to the AP and unlicensed caregiver #1 to administer the dose together.

During an interview regarding day 23, unlicensed caregiver #1 stated she was working with the AP and received instructions from the nurse manager to administer any additional doses of tramadol with both caregivers present. Unlicensed caregiver #1 stated she was in the laundry room and when she came out, the AP stated she forgot and gave an additional tramadol dose to the resident. The AP then told unlicensed caregiver #1 if anyone asked to tell them she saw the

AP give the resident the tramadol dose. Unlicensed caregiver #1 later reported the incident to her supervisor and later to the nurse manager.

A facility internal investigation report indicated the AP failed to follow instructions given by the nurse manager to have two caregivers present when administering the tramadol. The AP administered the pain medication alone then told the unlicensed caregiver working with her, "if anyone asks, tell them you saw me give it [the narcotic medication]". The form indicated the resident stated she had not requested the narcotic pain medication, nor did she receive the narcotic medication.

During an interview with the caregiver manager, it was reported that on day 6, coaching was completed when tramadol was signed out of narcotic logbook and the AP's initials were on the medication card, but no documentation was found in the EMAR. The AP was re-educated on proper procedure of medication administration and documentation. The caregiver manager stated after learning on day 23 the AP had another incident regarding the resident, The AP was suspended to investigate. The caregiver manager thought it was strange that when the AP was notified of the suspension, she did not question the reason she was suspended.

A review of the resident's narcotic logbook and EMAR documentation indicated the AP was the only caregiver between day 1 and day 23 to document giving additional tramadol dose.

A review of the AP's employee file indicated the AP received training regarding medication administration, medication administration records, and narcotic control books on day 6 and during her orientation period less than one year prior to the incident.

During an interview, the resident stated she only takes her pain medication once per day before she gets out of bed in the morning and can take an additional pill once per day but does not like to take it.

Attempts to contact the AP were not successful.

In conclusion, the Minnesota Department of Health determined financial exploitation was substantiated.

**Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.**
"Substantiated" means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

**Financial exploitation: Minnesota Statutes, section 626.5572, subdivision 9**
"Financial exploitation" means:
(b) In the absence of legal authority a person:
(1) willfully uses, withholds, or disposes of funds or property of a vulnerable adult;

(2) obtains for the actor or another the performance of services by a third person for the wrongful profit or advantage of the actor or another to the detriment of the vulnerable adult;
(3) acquires possession or control of, or an interest in, funds or property of a vulnerable adult through the use of undue influence, harassment, duress, deception, or fraud; or
(4) forces, compels, coerces, or entices a vulnerable adult against the vulnerable adult's will to perform services for the profit or advantage of another.

**Vulnerable Adult interviewed**: Yes
**Family/Responsible Party interviewed**: Not applicable; the resident was independent with decision-making
**Alleged Perpetrator interviewed**: Attempts to contact AP were not successful.

**Action taken by facility:** Facility conducted an internal investigation, notified law enforcement and ended employment with AP.

**Action taken by the Minnesota Department of Health:** The facility was issued a correction order regarding the vulnerable adult's right to be free from maltreatment.

To view a copy of the Statement of Deficiencies and/or correction orders, please visit:

https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html

You may also call 651-201-4200 to receive a copy via mail or email.

The responsible party will be notified of their right to appeal the maltreatment finding. If maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Rice County Attorney
Faribault City Attorney
Faribault Police Department
Department of Human Services (DHS) Background Study Unit
MN Department of Human Services

| 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 12/03/2025 |

| 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<br><br>******ATTENTION******<br><br>ASSISTED LIVING PROVIDER CORRECTION ORDER<br><br>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation.<br><br>Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance.<br><br>INITIAL COMMENTS:<br><br>#HL302256284C/#HL302256862M<br><br>On December 3, 2025, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 49 residents receiving services under the provider's Assisted Living with Dementia Care license.<br><br>The following correction order is issued/orders are issued for #HL302256284C/#HL302256862M, tag identification 2360. | 0 000 | | |
| 02360 | 144G.91 Subd. 8 Freedom from maltreatment<br><br>Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. | 02360 | | |

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|---|---|---|---|---|
| 02360 | Continued From page 1<br><br>This MN Requirement is not met as evidenced by:<br>The facility failed to ensure one of one resident reviewed (R1) was free from maltreatment.<br><br>Findings include:<br><br>The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual person was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details. | 02360 | | |