Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL306493882M
Compliance #: HL306497468C

Date Concluded: October 15, 2025

Name, Address, and County of Licensee Investigated:
New Perspective Columbia Heights
3801 Hart Boulevard Northeast
Columbia Heights, MN 55421
Anoka County

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

Evaluator's Name: Willette Shafer, 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) neglected the resident when the AP failed to respond to the resident's call light timely, the resident tried transferring herself and fell. The resident's health quickly declined because of the fall.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The resident was independent with toileting at the time of the fall. Although the pendent log indicated the resident's call light was on for 101 minutes, it was an isolated error of the AP. The AP responded to the resident, called for help and the on-call nurse. The nurse assessed the resident after the fall and no injuries were noted. Additionally, the resident had a recent health decline from chronic conditions a few days prior to the fall, continued to decline afterwards and admitted to hospice services.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's family. The investigation included review of the resident's record, death record, hospital records, facility incident reports, personnel files, staff schedules, and related facility policy and procedures Also, the investigator toured the facility and observed resident cares and call light response time.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia with visual hallucinations, osteoarthritis, and radiculopathy (nerves in the spine that are compressed or irritated causing pain weakness, and pain). The resident's service plan included assistance with medication management, grooming, and housekeeping. The resident was not at risk for falling before the incident and she walked independently with a walker.

The resident's progress notes indicated several days before the fall the resident reported not "feeling good." A nurse assessed the resident, her vitals were stable, and directed staff to encourage fluids, rest and notify nurse if no improvement.

Two days later, progress notes indicated the resident was found slumped over in her recliner and she was sent to the hospital. The resident reported discomfort in her neck but otherwise denied significant pain of neurological symptoms. After several tests were negative the hospital reported she appeared to be suffering from torticollis (a condition from muscle spasms that persistently turn the head to one side).

Three days later, the resident retuned from the hospital. She denied pain or any other symptoms. After dinner the resident was found on the floor in her apartment. The resident reported she attempted to walk to the bathroom. Her vitals were stable, range of motion at baseline for resident, she denied hitting her head. Staff assisted the resident off the floor with direction to call the nurse if any complaint of pain or change in condition.

The resident's pendant push log report indicated the resident's call light was on for 101 minutes shortly after dinner.

The incident report indicated the resident was found on the floor. An assessment was completed and within normal limits for the resident. The incident was reported to the nurse and family. The incident follow-up note completed the morning after the fall indicated the resident was up and walking. The resident was assessed "at baseline for mobility and transfers" with walker.

Progress notes indicated the day after the fall, nursing staff discussed with family the resident recent health decline and on-going weight loss. The physician ordered a hospice referral and evaluation.

During an interview, the family member said the resident was recently transferred to memory care because her physical and mental health were declining. She stopped interacting with

others and began hallucinating. She was independent with toileting and walked with her walker. The resident's primary care provider recently told the family the resident was "progressing," and she was entering the final end stage of her life. A couple days before the incident, the resident was found slumped to one side in her recliner and she was sent to the hospital. The hospital diagnosed the resident with torticollis. The hospital planned to discharge the resident, but family requested the resident stay for observation. The family wanted the resident walking independently before discharge. The following day the resident "walked several laps around the nursing station." The evening the resident returned from the hospital; she pressed her call pendant for assistance to the toilet. The resident reported to the family member, staff took too long so she transferred herself and fell. At the time of the incident, the resident was independent with toileting and walked independently with a walker although at the hospital staff assisted her. The family member came to the facility the evening of the fall and spend a couple hours with the resident.

During an interview, the AP said she found the resident on the floor sometime after supper. She called another staff member for help and then they called the nurse. She thought the resident was trying to walk to the bathroom but was unable to recall if the resident's call light was on. She was trained to answer call lights as soon as possible. The alert was through text only, no constant or intermittent alerts sound on the phone or in the building.

During an interview, an unlicensed personnel (ULP) said she remembered the resident fell during her shift but was unable to recall specific details about the incident. When a resident pressed their call pendent, staff received an alert on their phone but the there was no noise. It was possible the AP forgot to deactivate the alarm when she entered the resident's room because she was busy calling for help and assisting the resident. The call pendent may have been on during the entire incident and only was deactivated once the resident was back in her chair. The ULP said the AP was new at the time but answered resident calls quickly and provided good care.

During an interview, a member of management, who was also a nurse, said a staff member called and reported the incident to the triage nurse. The resident's range of motion, vitals, skin, and mobility were all at baseline after the fall. The resident stated she was on her way to the bathroom and fell. At the time of the incident, she was unaware if the resident used her call light to request assistance. No injuries were observed after the incident and the resident's family member came to visit right after the incident. The member of management completed the incident follow-up assessment the following morning.

The resident's death record indicated the resident died from natural causes related to heart disease and no injury contributed to her death.

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, she was deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility completed an incident report, assessed the resident, and provided follow-up care following the event.

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
	30649	A. BUILDING: _____ B. WING _____	C 09/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE - COLUMBIA HEIGHTS	3801 HART BOULEVARD NE COLUMBIA HEIGHTS, MN 55421

(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 September 18, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL306497468C/#HL306493882M. No correction orders are issued.	0 000		