Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL306495742M
Compliance #: HL306493623C

Date Concluded: November 3, 2025

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

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

Evaluator's Name: Brandon Martfeld, RN, BSN, 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 the resident when the facility staff failed to follow the resident's plan of care, resulting in insufficient incontinent (being unable to control the body's natural excretions of urine or feces) care and bathing.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. There were conflicting information from interviews regarding the resident's care, the services received and the resident's reported history of refusal of incontinence care with facility records. The facility had insufficient documentation to demonstrate incontinence care services were provided at the frequency the resident required per their assessment. There was no evidence of skin breakdown or other negative effects related to an allegation of a lack of incontinence care.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted an outside agency physical

therapist, occupational therapist and nurse. The investigation included review of the resident records, staff schedules, and related facility policy and procedures. Also, the investigator observed staff and resident interactions.

The resident resided in an assisted living facility. The resident's diagnoses included stroke and bipolar disorder. The resident's service plan included assistance with bathing once a week, and incontinence care. The resident's assessment indicated the resident required assistance up to eight or more times in 24 hours for incontinence care. The resident's assessment indicated the resident had impaired cognition, required a mechanical lift and two staff for transfers and was at risk for skin breakdown due to impaired mobility, incontinence, and diabetes.

Three months of resident's service delivery records reviewed indicated instructions for facility staff were to provide incontinence care eight times in a 24-hour period with two staff members, however the facility's documentation did not match the frequency of those services were provided. The service delivery records indicated facility staff would initial incontinence care was completed one time for the day shift, one time for the evening shift and one time for the overnight shift. The facility had several days and shift were no staff documented incontinence care services were provided. Additionally, the record lacked documentation of refusal of services.

During an interview, unlicensed staff member stated staff would assist the resident with incontinence care three times during the day shift. Staff assist with incontinence care when the resident woke up in the morning, again around lunch time, and then in the afternoon just prior to the day shift ending.

During an interview, the nurse stated the resident's plan of care for incontinence care directed staff to assist the resident eight times in a 24-hour period. The expectation was that staff would assist the resident with incontinence cares three times on day shift and three times on evening shift and as needed on the overnight shift. The resident required a mechanical lift from her wheelchair and into her bed for cares to be provided. The resident had a history of refusing cares.

During an interview, a homecare nurse stated the resident refused to allow staff to provide incontinence cares. The resident had been educated on the importance of allowing staff to provide incontinence cares to prevent skin breakdown and wound healing.

During an interview, the resident stated staff would not help with incontinence cares. The resident stated she received a weekly bath.

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 Adult interviewed: Yes.
Family/Responsible Party interviewed: No. Attempted but did not reach.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility requested a homecare agency for additional resources for resident cares.

Action taken by the Minnesota Department of Health:
The facility was found to be in noncompliance. 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

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

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

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 10/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE - COLUMBIA HEI	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 ******ATTENTION****** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. 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. INITIAL COMMENTS: HL306495742M/HL306493623C On October 20, 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 69 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for HL306495742M/HL306493623C, tag identification 1650.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
01650 SS=D	144G.70 Subd. 4 (f) Service plan, implementation and revisions to	01650		

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01650	Continued From page 1 (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on record review and interview the licensee failed to ensure one of one resident's (R1) service plan included the frequency of service delivered and documentation services were provided according to R1's assessed needs for staff to implement.	01650		

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01650	Continued From page 2 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's diagnoses included stroke and bipolar disorder. R1's assessment dated July 15, 2025, indicated R1 was incontinent of urine and required assistance from two staff. R1's assessment indicated R1 required incontinence care up to eight or more times in a 24-hour period and that frequency would be specified on R1's service plan. R1's service plan dated July 15, 2025, indicated R1 needed assistance with bladder incontinence care from two staff eight plus times in a 24-hour period. R1's service plan indicated times for assistance was morning, evening and overnight. During an interview on October 20, 2025, at 11:47 a.m., unlicensed personnel (ULP)-B stated staff attempted to provide incontinence care to R1 three times during the day shift. ULP-B stated R1's incontinence care would be completed in the morning when R1 wakes up, completed around lunch time, and then completed for a third time in the afternoon just prior to the day shift ending.	01650		

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01650	Continued From page 3 During an interview on October 20, 2025, at 12:07 p.m., registered nurse (RN)-C stated R1 received incontinence care eight plus times in a 24-hour period. RN-C stated the expectation was staff would assist R1 with incontinence care three times during day shift, three times during the evening shift and as needed on the overnight shift. RN-C stated R1 had a history of refusing services. R1's service check off list for the of months of June, July and August 2025, indicated R1 received bladder incontinence care from two staff eight plus times in a 24-hour period. However, R1's service check off list indicated day shift, evening shift and overnight each initialed one time per shift for incontinence care that was completed and failed to include the eight scheduled incontinence care times. R1's service check off list lacked evidence that services for incontinence care were provided 8 plus times in 24-hour period for the months of June, July and August. R1's service check off list for the month of June indicated R1's day shift incontinence care was completed 19 out of 30 days. All other days did not have initials and documentation to indicate why R1's incontinence care was not completed on day shift. R1's evening shift incontinence care was completed 22 out of 30 days. All other days on evening shift did not have initials and documentation to indicate why R1's incontinence care was not completed. R1's overnight shift incontinence care was completed 30 out of 30 days. R1's service check off list for the month of July indicated R1's day shift incontinence care was	01650		

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01650	Continued From page 4 completed 21 out of 31 days. On July 14, 2025, day shift staff indicated R1's incontinence care was not completed due to being out in the community. All other days did not have initials and documentation to indicate why R1's incontinence care was not completed on day shift. R1's evening shift incontinence care was completed 18 out of 31 days. On July 12, 2025, and July 13, 2025, staff indicated R1's incontinence care was not completed due to being out in the community. All other days on evening shift did not have initials and documentation to indicate why R1's incontinence care was not completed. R1's overnight shift incontinence care was completed 25 of 31 days. All other days on the overnight shift did not have initials and documentation to indicate why R1's incontinence care was not completed. R1's service check off list for the month of August indicated R1's day shift incontinence care was completed 28 out of 31 days. All other days did not have initials and documentation to indicate why R1's incontinence care was not completed on day shift. R1's evening shift incontinence care was completed 22 out of 31. All other days on evening shift did not have initials and documentation to indicate why R1's incontinence care was not completed. R1's overnight incontinence care was completed 27 out of 31 days. All other days on the overnight shift did not have initials and documentation to indicate why R1's incontinence care was not completed. The licensee's policy titled Resident Service Plan dated December 30, 2024, indicated a service plan addressing the individualized needs of the resident will be developed during the initial assessment and completed for each resident	01650		

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01650	Continued From page 5 before nursing services are initiated. Reassessments will allow the licensee to verify that it can continue to meet the needs of the resident. The licensee's policy indicated the service plan will identify the programs services and frequency. Team members responsible for the delivery of care will physically or electronically (for electronic health record systems) sign to attest that the care was completed, and if necessary, any exceptions to care will be documented and communicated immediately to the nurse on duty. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650		