

# State Rapid Response Investigative Public Report

*Office of Health Facility Complaints*

**Maltreatment Report #:** HL396085428M  
**Compliance #:** HL396087760C

**Date Concluded:** November 8, 2024

**Name, Address, and County of Licensee**

**Investigated:**

New Perspective of Arden Hills  
3565 Pine Tree Drive  
Arden Hills MN 55112  
Ramsey County

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

**Evaluator's Name:** Maggie Regnier  
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 facility neglected the resident when they failed to notice the residents weight gain over a month-long time period.

**Investigative Findings and Conclusion:**

The Minnesota Department of Health determined neglect was not substantiated. The resident did experience shortness of breath related to the weight gain, however the facility acted appropriately, and the resident was sent to the hospital for care.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of facility records, policies, resident records and hospital records. Also, the investigator observed staff interactions with residents, other staff and visitors.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia, stroke, cardiac pacemaker and cardiomyopathy (heart disease which makes it more difficult for the heart pump blood). The resident's service plan included assistance with all personal care, ambulation, and medication administration. The resident's assessment indicated the resident was receiving services from a home care agency that included nursing, physical therapy, occupational therapy, and speech therapy.

The resident's service agreement indicated the resident would have monthly weights with a directive to notify the supervisor if the resident declines to be weighed or if unable to weigh the resident.

The resident's medical record indicated demonstrated the resident was weighed on admission. The next weight was one month later, which documented at 18 pounds higher than the admission weight. The next weight was documented 2 days later that documented the weight at 4 pounds less than the admission weight.

During an interview, the nurse stated the electronic medical record (EMR) triggered the second weight as out of range, so the nurse reweighed the resident and this weight was then less than the admission weight. The nurse stated that it was assumed the high weight was an error.

The home care documents indicated the homecare agency was also monitoring the resident's weight but on more frequent basis and were to the resident's medical provider notified.

During an interview, a family member stated the facility was responsible for weighing the resident monthly and the home care agency would weigh the resident weekly or more if needed and would report changes to the provider.

In conclusion, the Minnesota Department of Health determined neglect was 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, attempt to interview not successful

**Family/Responsible Party interviewed:** Yes

**Alleged Perpetrator interviewed:** Not Applicable

**Action taken by facility:** No action required.

**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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>39608</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/03/2024</b>
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NAME OF PROVIDER OR SUPPLIER  <b>NEW PERSPECTIVE ARDEN HILLS</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3565 PINE TREE DRIVE ARDEN HILLS, MN 55112</b>
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(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	<p><b>Initial Comments</b></p> <p>On October 3, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL396087760C/#HL396085428M. No correction orders are issued.</p>	0 000		

Minnesota Department of Health  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_