

State Rapid Response Investigative

Public Report

Office of Health Facility Complaints

Maltreatment Report : HL247182901M
Compliance : HL247181436C

Date Concluded: September 14, 2026

Name, Address, and County of Licensee

Investigated:

New Perspective Mankato
100 Dublin Road
Mankato, MN 56001
Blue Earth County

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

Evaluator's Name: Lena Gangestad, RN
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) neglected the resident when she did not follow the resident's service plan by not using the required transfer belt during ambulation and was distracted by her phone while assisting the resident resulting in a fall.

Investigative Findings and Conclusion: The Minnesota Department of Health determined neglect was substantiated. The AP was responsible for the maltreatment. The AP, an unlicensed caregiver, failed to follow the resident's service plan and did not maintain appropriate attention and supervision while assisting the resident, resulting in a fall and subsequent injury.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident's records, internal investigation documentation, incident reports, personnel files, staff schedules, policies, and procedures.

The resident resided in an assisted living secured memory care building. The resident's diagnoses include dementia and history of falling. The resident's service plan included assistance with activities of daily living including assist of one person with transfer using a gait belt. The service plan also included the residents' history of refusing services; however, it did not specify which services the resident had previously refused.

An incident report indicated the resident fell in her room with the AP present to witness the fall. The report indicated the resident was found lying partially inside the closet on her back, with a pillow underneath her head. The same document indicated the resident bumped her head and complained of pain below her left knee. The resident was transferred to the hospital.

The hospital record indicated the resident had fractures near the top of the shinbone and the smaller bone next to it, caused by a witnessed fall. The shinbone fracture was slightly out of place, and the smaller bone is broken into several pieces. Orthopedic surgery recommended nonoperative management, including immobilization with a splint extending to the foot and no weight bearing on the left leg. Following the injury, the resident required total assistance with mobility and transfers, with use of a ceiling lift and a bed alarm for safety.

During an interview, the AP stated she was going to assist the resident to breakfast and offered to use the gait belt; however, the resident refused. The AP stated she was aware the resident was required to use a gait belt according to her care plan but did not force the resident to use it because she believed the resident had the right to refuse. The AP stated she was walking with the resident when her work phone went off. The AP said she briefly looked at the phone and then placed it back in her pocket, resulting in her being approximately one step behind the resident. The AP stated she then heard the resident yell, "oh, oh, oh," and the resident subsequently fell to the floor. The AP acknowledged she should not have looked at the phone and stated the incident occurred quickly, leaving her insufficient time to catch the resident. The AP also stated she had a back injury and was unable to assist the resident from the floor, so she called for assistance.

During an interview, the manager stated there was video footage of the fall which he reviewed. He stated the video showed the AP using a phone at the time the resident fell. The manager stated AP did not use the gait belt as required by the resident's care plan and allowed the resident to walk ahead of her without adequate assistance, after which the incident occurred. The manager stated the recording did not contain audio and only captured the incident when the fall occurred. Therefore, she could not determine from the recording whether the resident had refused use of the gait belt.

During an interview, the registered nurse stated the resident was new to the facility at the time of the incident. The nurse also stated the resident had a history of refusing services at her previous facility but was not known to have refused services at this facility. The nurse stated AP was using her personal phone, and this could be observed on the recorded video of the incident.

Video surveillance reviewed at the time of the incident was no longer available for review at the time of the investigation.

During an interview, unlicensed caregiver #1 stated the resident often refused care and did not want to use the gait belt. She said the resident would say, "Don't put it on me; it is useless." However, for the resident's safety, unlicensed caregiver #1 stated most of the staff would put the gait belt on the resident anyway. She stated once the gait belt was on, the resident would not take it off.

During an interview, unlicensed caregiver #2 stated the resident required assistance of one staff person with a gait belt. She said she would walk alongside the resident while keeping one hand on the gait belt, which was secured around the resident's waist. She said when the resident went to the bathroom, staff used a gait belt in combination with a walker. For longer distances, staff provided one-person assistance using the gait belt, then assisted the resident into a wheelchair and pushed her to meals. Unlicensed caregiver #2 stated she would not describe the resident as refusing the gait belt. She said if staff asked residents in the memory care unit whether they wanted a gait belt, they would likely say no, as this was common among memory care residents. She also stated staff would still apply the gait belt because it was needed to ensure the resident's safety during ambulation. Unlicensed caregiver #2 further stated the resident did not become upset, was not aggressive, and did not attempt to remove the gait belt after it was applied.

During an interview, the family member stated she received a call from staff notifying her the resident had fallen and had been transported to the emergency department. The family member stated the resident sustained fractures as a result of the fall and now required total assistance with mobility and transfers. She also stated the resident was no longer able to ambulate.

In conclusion, the Minnesota Department of Health determined neglect 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.

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, the resident was unable to participate in an interview due to dementia.

Family/Responsible Party interviewed: Yes.

Alleged Perpetrator interviewed: Yes.

Action taken by facility:

The facility initiated an internal investigation, which included reviewing the video surveillance. The resident's care plan was updated, and AP was no longer employed by the facility.

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 the 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

Blue Earth County Attorney

Mankato City Attorney

Mankato Police Department

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 24718	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/02/2026
NAME OF PROVIDER OR SUPPLIER STORYPOINT MANKATO		STREET ADDRESS, CITY, STATE, ZIP CODE 100 DUBLIN ROAD MANKATO, MN 56001			
(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 July 2nd, 2026, the Minnesota Department of Health initiated an investigation of complaints #HL247182901M/HL247181436C. The following correction order is issued, tag identification 2360.	0 000			
02360	144G.91 Subd. 8 Freedom from maltreatment 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. This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360	No plan of correction is required for this tag.		

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE