Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL306492503M
Compliance #: HL306494410C

Date Concluded: July 16, 2025

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

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

Evaluator's Name: Jennifer Segal 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), a facility staff, sexually abused a resident when the AP grabbed the resident's buttocks.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was substantiated. The AP was responsible for the maltreatment. The resident stated the AP applied topical gel medication to the residents back as requested then pulled the residents pants down without her consent and grabbed her bare buttocks. After the AP left the residents apartment the resident was afraid to press her call light for staff assistance. The resident left the facility for several days after the incident because she was uncomfortable and fearful staying at the facility. The AP denied the allegation.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement and family. The investigation included review of the resident's facility records including internal investigation, personnel files, staff schedules, law enforcement reports and pertinent facility policy and procedures. Also, the investigator visited the facility and observed resident and staff interactions.

The resident resided in an assisted living facility with diagnoses including lumbar degenerative disc disease and chronic back pain. The resident's service plan included assistance with monitoring and management of pain, bathing, and compression hose. The resident's assessment indicated the resident had no cognitive impairment.

An internal facility report indicated the resident pressed her call light for help to apply gel medication to her back. The AP told the resident he was a professional masseuse and offered the resident a massage, but the resident stated she did not want a massage, she wanted help to apply the gel to her low back. The AP grabbed the resident's buttocks, and the resident told the AP to stop. The AP asked what he would get in return for the massage. Additionally, the AP stated that he assumed the resident would report the incident to management. The resident told the AP that she would not report the incident to management because she was scared the AP would return during the night.

An internal interview document indicated that the facility management interviewed the AP about the incident. When management asked the AP if he had provided care to the resident, the AP reported that he had applied gel to the resident's back because she had reported that her back was hurting, and she could not reach it. The AP clarified with management that he was not a massage therapist, although he told the resident he was. When asked if the resident requested a massage, the AP replied he did not remember. The AP could not recall any other care provided or how long he was in the resident's apartment. Management offered the AP the opportunity to share additional information, but the AP stated that he had no further information.

A facility call light report confirmed the timing of the incident as reported by the resident. In addition, the report confirmed that the AP was the staff member who responded to the residents' call light and completed the request. The total time from the initial call to the completion of the response was approximately 30 minutes.

A law enforcement report indicated the resident pressed her call light to request assistance in applying a gel medication to her low back above the waistline. However, the AP pulled the resident's pants down, unnecessarily exposing both buttocks. When the resident questioned the AP about his actions, he responded that he was a massage therapist and asked what she would give the AP in return for the massage. Despite the resident informing the AP the medication would burn her buttocks and asking him not to touch that area, the AP proceeded to grope her and massage her buttocks before pulling her pants back up. He claimed he needed

to feel her buttocks to ensure everything felt right. The resident expressed that the experience left her feeling very scared, guilty, and fearful that the AP would rape her.
In addition, the law enforcement report indicated that a sample of the resident's DNA was collected, and the resident's pants were also collected for touch DNA analysis. Results of the DNA tests were not available at the time MDH concluded the investigation.

During interview, facility leadership stated the AP was placed on investigative leave the day the incident was reported. Following the facility investigation, the AP was terminated from employment based on facility findings and standards of care.

During interview, a family member stated the resident was scared and uncomfortable after the incident; therefore, the resident stayed at a family member's home and slept for three days following the incident because the resident was exhausted from the trauma.

During interview, the resident stated that when she asked the AP about school for massage therapy, the AP replied that he was kidding, stating he had not attended school for massage therapy but had wanted to. The resident stated that after the AP left, the resident locked the door and sat on the bed, scared. The resident stated that she did not dare press the call light for assistance because she was unsure if the AP would return.

The AP did not respond to multiple attempts for an interview.

In conclusion, the Minnesota Department of Health determined abuse 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.

Abuse: Minnesota Statutes section 626.5572, subdivision 2.
"Abuse" means:
(a) An act against a vulnerable adult that constitutes a violation of, an attempt to violate, or aiding and abetting a violation of:
(1) assault in the first through fifth degrees as defined in sections 609.221 to 609.224;
(2) the use of drugs to injure or facilitate crime as defined in section 609.235;
(3) the solicitation, inducement, and promotion of prostitution as defined in section 609.322; and
(4) criminal sexual conduct in the first through fifth degrees as defined in sections 609.342 to 609.3451.
A violation includes any action that meets the elements of the crime, regardless of whether there is a criminal proceeding or conviction.
(b) Conduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to, the following:

(1) hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult;
(2) use of repeated or malicious oral, written, or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening; or
(3) use of any aversive or deprivation procedure, unreasonable confinement, or involuntary seclusion, including the forced separation of the vulnerable adult from other persons against the will of the vulnerable adult or the legal representative of the vulnerable adult unless authorized under applicable licensing requirements or Minnesota Rules, chapter 9544.
(c) Any sexual contact or penetration as defined in section 609.341, between a facility staff person or a person providing services in the facility and a resident, patient, or client of that facility.
(d) The act of forcing, compelling, coercing, or enticing a vulnerable adult against the vulnerable adult's will to perform services for the advantage of another.

Vulnerable Adult interviewed: Yes
Family/Responsible Party interviewed: Not Applicable
Alleged Perpetrator interviewed: No, the AP refused to contact the investigator following multiple attempts including a subpoena

Action taken by facility:
The facility promptly investigated the incident, placed the AP on investigative leave and reported to appropriate agencies. The AP was terminated following the facility investigation.

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:

Anoka County Attorney
Anoka County Sheriff's Office
Columbia Heights City Attorney
Columbia Heights Police Department
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 06/09/2025

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: #HL306492503M, #HL306494410C On June 9, 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 68 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #HL306492503M, #HL306494410C tag identification 2360.	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.	
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical,	02360		

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02360	Continued From page 1 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 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		