Electronically Delivered

June 1, 2023

Licensee
New Perspective - Mahtomedi
111 East Avenue
Mahtomedi, MN 55115

RE: Project Number(s) SL20051015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on May 4, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS
The enclosed State Form documents the state correction orders. The MDH documents state licensing correction orders using federal software. Tag numbers are 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 are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines and enforcement actions based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility**.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with

the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS
In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by the MDH within 15 calendar days of the correction order receipt date.

A state correction order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

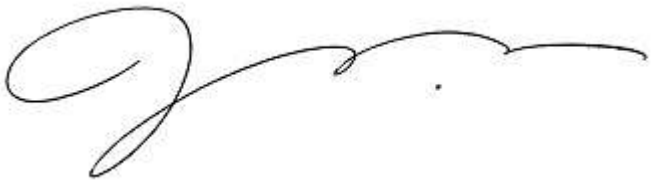
Please address your cover letter for reconsideration requests to:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter and state form with your organization's Governing Body.

If you have any questions, please contact me.

Sincerely,



Jess Schoenecker, Supervisor
State Evaluation Team
Email: jess.schoenecker@state.mn.us
Telephone: 651-201-3789 Fax:651-281-9796

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20051	A. BUILDING: _____ B. WING _____	05/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE - MAHTOMEDI	111 EAST AVENUE MAHTOMEDI, MN 55115

(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 LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL20051015-0 On May 1, 2023, through May 4, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were thirteen (13) active residents receiving services under the Assisted Living with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. 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 surveyors' 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 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	0 480		

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0 480	Continued From page 1 following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated May 5, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the	0 510		

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0 510	Continued From page 2 national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program that complied with accepted health care, medical and nursing standards for infection control related to personal protective equipment (PPE) and clean surfaces for one of two unlicensed personnel ((ULP)-B). 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 a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On May 2, 2023, at 8:38 a.m., the surveyor observed ULP-B during medication set up, use bare hands to grab capsules out of the medication cup to crush the tablets and open the capsules to pour content into jelly for administration. ULP-B donned (applied) gloves to check R2's blood glucose by a needle stick to a finger. ULP-B wiped the first drop of blood with a tissue and placed that tissue on the countertop in	0 510		

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0 510	Continued From page 3	0 510		

front of R2. After medication administration to R2, ULP-B picked up the supplies and put them back into the medication cart. Surveyor did not observe the countertop being disinfected which surveyor observed residents eating breakfast at. For R3's medication set up, ULP-B used bare hands to remove capsules from the medication cup to separate the tablets to be crushed and capsules to be opened and poured into jelly.

During observation and interview on May 2, 2023, at 9:10 a.m., ULP-B performed morning cares to R2 within the apartment and noted blood on sheets. ULP-B donned gloves and removed the soiled sheets and brought them directly to the laundry room and placed them on the floor. ULP-B with the same gloves, removed clean items out of the dryer and placed those on top of the dryer then moved the wet items from the wash machine into the dryer. ULP-B then doffed (removed) the gloves. Surveyor asked ULP-B when gloves are required to be changed, and ULP-B stated, "Shoot, I should have changed them before touching the clean items."

ULP-B's training record indicated ULP-B received hand washing and PPE training on August 9, 2022.

During interview on May 2, 2023, at 9:30 a.m., ULP-B stated he/she was not aware they had to wear gloves for medication set up. ULP-B stated no one wore gloves during medication set up.

During interview on May 2, 2023, at 10:00 a.m., registered nurse (RN)-A stated staff were trained to wear gloves when touching any medication a week prior, staff were expected to remove dirty gloves right away after a task, and disinfect countertops when it became dirty.

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0 510	Continued From page 4 The licensee's Medication Administration policy dated March 21, 2023, indicated medication passers would not touch pills with ungloved hands. The licensee's Standard Precautions policy dated November 5, 2021, indicated staff would use infection control practices to reduce the transmission of infectious microorganisms. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment of the facility in a continuous state of good repair and operation. This has the potential to directly affect the health, safety, and well-being of all residents, visitors, and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 800		

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0 800	Continued From page 5 safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On May 3, 2023, approximately from 10:40 a.m. to 12:50 p.m., survey staff toured the facility with the environmental services director (ESD)-E. During the tour, survey staff observed the following: 1. In the open kitchens/dining common areas of cottage 113, the commercial hot water dispenser and coffee brewing unit with pots and hot plates were located within reaching distance immediately adjacent to the memory care resident counter sitting areas. The readily accessible commercial hot coffee and hot water dispenser pose safety concerns for the hot surfaces and burns to memory care residents. 2. The laundry room of cottage 113, was not secured from memory care residents as the door to the laundry room was unlocked without staff in the area to prevent access to unsafe detergent and chemical products. The ESD-E verified the finding and stated that it should be locked. 3. The exit discharge from the courtyard gate to the walkway had landscape shrubs that obstructed the passageway connecting to the adjacent sidewalk and roadway. The finding was evident as the exit doors inside cottages 111 and 113 showed signs to exit or evacuate into the courtyard. Survey staff discussed with the ESD-E that all exit discharge walks and exterior walkways serving marked exit doors through the courtyards and the discharge walks to the public	0 800		

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0 800	Continued From page 6 roadway must be maintained at all times for safe means of egress during an emergency. 4. In cottage 113 resident rooms 218 and 221, survey staff observed that shower compartments were used as storage. Survey staff explained that the shower fixtures if not used for showering, the plumbing traps would be completely dried out which would pose health risks from sewer gas to residents, 5. In cottage 111 (currently no residents), the laundry room had a sewer gas odor when entered. Further investigation with the ESD-E, the standpipe traps for receiving clothes washers discharges were completely dried out. Survey staff discussed routine running water to these fixtures to prevent dried-out traps of plumbing fixtures and also adopting a water management plan for the building plumbing system before any resident move-in. The ESD-E agreed with the findings. 6. Replacements of incorrect size doorknobs for the maintenance rooms allowing penetration holes between the corridor and the rooms. The ESD-E stated they intend on replacing them with the correct knobs. All findings were visually and/or verbally verified by the ESD-E accompanying the tour. On May 3, 2023, at approximately 2:15 p.m., during the exit interview, the district director of operations-C and the ESD-E acknowledged the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		

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0 970	Continued From page 7	0 970		
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the licensee's liability for health, safety, or personal property of a resident. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On May 1, 2023, at 3:10 p.m., district director of operations (DDO)-C indicated the blank contract provided was used for all residents. The licensee's blank Residency Agreement had two dates of April 10, 2023, and May 1, 2023 (used as licensee's contract), indicated under 5. Insurance: "Resident is responsible ... for any	0 970		

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0 970	Continued From page 8 personal injury caused or permitted by Resident... If more than one (1) Resident occupies the Leased Premises, each Resident is jointly and severally liable for any such damage or personal injury." On May 3, 2023, at 10:05 a.m., DDO-C provided surveyor a screenshot of the Minnesota Department of Health's Resources and Frequently Asked Questions (FAQs) under assisted living contract which limits the licensee's liability regarding the actions of third parties. Once the surveyor explained the difference, DDO-C stated, "I guess we will have to get that changed." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 970		
01420 SS=F	144G.62 Subd. 2 Delegation of assisted living services (b) When the registered nurse or licensed health professional delegates tasks to unlicensed personnel, that person must ensure that prior to the delegation the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each resident and is able to demonstrate the ability to competently follow the procedures and perform the tasks. If the unlicensed personnel has not regularly performed the delegated assisted living task for a period of 24 consecutive months, the unlicensed personnel must demonstrate competency in the task to the registered nurse or appropriate licensed health professional. The registered nurse or licensed health professional must document instructions	01420		

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01420	Continued From page 9 for the delegated tasks in the resident's record. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the registered nurse (RN) failed to ensure the unlicensed personnel (ULP) received training in the proper methods to perform the task or procedure for each resident and were able to demonstrate the ability to competently follow the procedure to perform the tasks for two of two ULPs (ULP-B, ULP-H) for the use of a mechanical lift and a Broda chair (reclining wheelchair). 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 a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On May 2, 2023, at 12:55 p.m., surveyor observed ULP-B and ULP-G complete Hoyer (mechanical lift) transfers from both wheelchair and Broda chair for two residents. ULP-B and ULP-H were hired on August 9, 2022, and October 11, 2022, respectively. Both ULP-B and ULP-H's personnel files lacked evidence of demonstrated competency for the use of a mechanical lift and a Broda chair. During interview on May 2, 2023, at 9:15 a.m.,	01420		

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01420	Continued From page 10 ULP-B stated upon hire, there were residents using Hoyers and that she/he did not get checked off on Hoyer competency. During interview on May 2, 2023, at 1:32 p.m., RN-A stated there was a company-wide issue with the Care Skills Assessment where certain skills were "blocked out," including the Hoyer and Broda chair. RN-A indicated there were three residents that require Hoyer transfers. RN-A indicated the licensee was aware of the issue and was working on fixing the training form. The licensee's Mobility Assistance/Mechanical Lifts policy dated January 10, 2023, indicated the licensee would train staff and the training would be documented in the personnel file. No staff would assist a resident with any device without proper training. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01420		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services	01640		

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01640	Continued From page 11 and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to implement and provide all services within the service plan for one of two residents (R4). 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: On May 2, 2023, at 12:55 p.m., unlicensed personnel (ULP)-B and ULP-G transferred R4 from the manual wheelchair to bed using the manual Hoyer lift (full body lift with sling). ULP-B and ULP-G then provided peri-care after a bowel movement and wet brief and positioned R4 in bed for rest. Surveyor observed reddened bottom with indentations from sitting on the Hoyer sling while in the wheelchair.	01640		

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	20051	A. BUILDING: _____ B. WING _____	05/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE - MAHTOMEDI	111 EAST AVENUE MAHTOMEDI, MN 55115

(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
01640	Continued From page 12 R4's diagnoses included but limited to Alzheimer's Disease, dementia with behavioral disturbance, heart failure, and anxiety disorder. R4's Resident Service Agreement (Includes IAPP) signed on April 20, 2023, by legal representative, indicated R4 received the following services: assistance with dressing, transfers with a Hoyer, toileting eight or more times in a 24-hour period (upon rising, before and after meals, and before going to bed), bathing, and behavioral redirection. R4's Comprehensive Assessment (MN) dated April 6, 2023, specified R4 needed toileting assistance due to incontinence (inability to hold bowel and bladder) up to 8 or more times in a 24-hour period and the frequency would be specified on the service plan. Under the skin assessment, it was assessed R4 was at risk for skin breakdown due to fragile, thin skin. During interview on May 2, 2023, at approximately 9:15 a.m., ULP-B indicated R4 got up into the wheelchair for the day around 6:30 a.m. Surveyor asked to observe toileting and a Hoyer transfer before lunch and ULP-B stated they don't do it before lunch but do it after lunch around 1:00 p.m. and that surveyor could observe then. During interview on May 2, 2023, at 12:55 p.m., ULP-B stated R4 is toileted two to four times a day during the morning (6:00 a.m. to 2:30 p.m.) and evening (2:15 p.m. to 10:45 p.m.) shift then every two hours during the overnight (10:30 p.m. to 6:15 a.m.) shift. ULP-B stated R4 was last toileted that morning upon rising.	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20051	A. BUILDING: _____ B. WING _____	05/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE - MAHTOMEDI	111 EAST AVENUE MAHTOMEDI, MN 55115

(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
01640	Continued From page 13 During interview on May 4, 2023, at 3:37 p.m., registered nurse (RN)-A expected toileting to be done before and after meals and indicated he/she updated R4's toileting schedule recently due to her/his observations. The licensee's Point of Care-Documenting Service Delivery policy dated October 6, 2022, indicated the licensee would follow all instructions as written on the resident's service plan and are responsible for delivery of services as instructed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01640		
01650 SS=D	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (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	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20051	A. BUILDING: _____ B. WING _____	05/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE - MAHTOMEDI	111 EAST AVENUE MAHTOMEDI, MN 55115

(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
01650	Continued From page 14 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 observation, interview, and record review, the licensee failed to ensure the service plan included the required content for one of two residents (R5). 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: On May 2, 2023, at 1:05 p.m., unlicensed personnel (ULP)-B and ULP-G transferred R5 from the Broda chair (reclining wheelchair) to bed using the manual Hoyer lift (full body lift with sling). ULP-B and ULP-G then provided peri-care after a wet brief and positioned R5 in bed for rest. R5's diagnoses included Alzheimer's Disease, anxiety disorder, generalized muscle weakness, functional urinary incontinence (unable to hold urine), and osteoarthritis (degenerative joint	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20051	A. BUILDING: _____ B. WING _____	05/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE - MAHTOMEDI	111 EAST AVENUE MAHTOMEDI, MN 55115

(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
01650	Continued From page 15 disease) of hip and knees. R5's Comprehensive Assessment (MN) signed by a registered nurse (RN) on April 18, 2023, indicated R5 was incontinent of bowel and bladder function and required toileting assistance up to eight or more time in a 24-hour period and would specify the frequency on the service plan. R5's Resident Service Agreement signed on April 19, 2023, indicated R5's toileting times would be "AM, NOON, PM, HS, NOC," and indicated R5 would receive toileting assistance "4-7x/day." During interview on May 4, 2023, at 11:31 a.m., registered nurse (RN)-A stated R5 was assessed to receive toileting assistance eight or more times a day and the service plan did not get updated to reflect the assessment. The licensee's Resident Service Plan policy dated March 16, 2023, indicated the service plan would be updated to reflect changes to the services provided to the resident due to change in the resident's condition. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650		
01950 SS=F	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20051	A. BUILDING: _____ B. WING _____	05/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE - MAHTOMEDI	111 EAST AVENUE MAHTOMEDI, MN 55115

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01950	Continued From page 16 the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure prior to delegating nursing tasks of prescribed treatment administration, the unlicensed personnel (ULP) were trained in the proper methods to perform the task or procedure for each resident, and were able to demonstrate, to the registered nurse (RN), the ability to competently follow the procedure for two of two unlicensed personnel ((ULP)-B and ULP-H). 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 a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include:	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20051	A. BUILDING: _____ B. WING _____	05/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE - MAHTOMEDI	111 EAST AVENUE MAHTOMEDI, MN 55115

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01950	Continued From page 17 On May 2, 2023, from 8:38 a.m. to approximately 1:20 p.m., surveyor observed ULP-B perform various personal cares, meal assistance, mobility assistance, toileting/transfer assistance, room tidy and laundry. On May 2, 2023, at 11:45 a.m., surveyor observed R6's lunch to include cut up kielbasa, mashed potatoes with gravy and cut up steamed vegetables. ULP-B and ULP-H were hired on August 9, 2022, and October 11, 2022, respectively. ULP-B and ULP-H's Care Skills Assessment signed on August 9, 2022, and October 11, 2022, indicated both ULPs passed the verbal understanding of specialty and modified diets, but the return demonstration was "blocked out," not allowing the registered nurse to document return competency on that task. R6's provider orders dated January 20, 2023, included mechanical soft food textures and thin liquids due to dysphagia (difficulty swallowing). R6's Service Checkoff List dated April 21, 2023, through April 30, 2023, indicated ULPs provided dining assistance due to choking risk. During interview on May 2, 2023, at 2:20 p.m., RN-A indicated R6 and another resident were on mechanical soft diets. RN-A stated ULPs cook and prepare all meals for the residents. During interview on May 3, 2023, at 10:05 a.m., district director of operations (DDO)-C stated the return demonstration on the Care Skills Assessment was blocked out because it needed to be completed on site not at the corporate	01950		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE - MAHTOMEDI	111 EAST AVENUE MAHTOMEDI, MN 55115

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01950	Continued From page 18 training. During interview on May 3, 2023, at 11:01 a.m., RN-A stated no one was on a modified diet until January 2023. RN-A stated there were no evidence of competency for all staff. RN-A stated as of yesterday, they were training all staff on modified diets. The licensee's Modifying Food and Specialty Diets policy dated August 9, 2022, indicated the licensee would train designated team members on the following: -International Dysphagia Diet Standardization Initiative (IDDSI) standards and levels, -requirements and restrictions for food textures, -specialty diet preparation methods and outcomes, and -liquid thickness and food texture testing. The licensee's Team Member Orientation and Training policy dated January 27, 2023, indicated all staff would receive training and competency evaluations on preparation of modified diets as ordered by a licensed health professional. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		

DEPARTMENT OF HEALTH

Environmental Health
Food, Pools, and Lodging
625 Robert St. N
St. Paul
651-201-5000

Type: Follow-Up
Date: *05/05/23*
Time: 08:05:30
Report: 1031231109

Food and Beverage Establishment Inspection Report

Location:
New Perspective - Mahtomedi
111 East Avenue
Mahtomedi, MN55115
Washington County, 82

Establishment Info:
ID #: 0038558
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6516533515
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

The following orders previously issued on 05/01/23 have NOT been corrected.

3-200B Food Characteristics:Receiving: temperature, condition

3-202.15 ***** Priority 2 *****

MN Rule 4626.0190 Food packages must be in good condition and must protect the food from adulteration and potential contaminants.

2 CANS FOUND DENTED AT TOP SEAM. CANS REMOVED FROM STOCK - TO BE RETURNED OR DISCARDED. MONITOR CONDITION OF CANS PRIOR TO ADDING THEM TO KITCHEN STOCK.

Issued on: 05/01/23 *Comply By: 05/01/23*

3-500C Microbial Control: date marking

3-501.17A ***** Priority 2 *****

MN Rule 4626.0400A Mark the refrigerated, ready-to-eat, TCS food prepared and held for more than 24 hours in the food establishment using an effective method to indicate the date by which the food must be consumed on the premises, sold, or discarded.

DELI MEAT AND MILK IN KITCHENTTE REFRIGERATOR DATED PAST 7 DAYS. ITEMS DISCARDED. REMOVE ANY ITEMS THAT ARE DATED PAST 7 DAYS.

Issued on: 05/01/23 *Comply By: 05/01/23*

4-100 Equipment Construction Materials

4-101.11BCDE

MN Rule 4626.0450BCDE Remove all multi-use equipment, utensils, and food storage containers that are not durable, corrosion-resistant, nonabsorbent, smooth, easily cleanable, resistant to pitting, chipping, scratching or not able to withstand repeated warewashing.

3 SPATULAS AND 1 SPOON FOUND WITH DAMAGE TO FOOD CONTACT SURFACES. ITEMS DISCARDED. REMOVE FROM SERVICE ALL DAMAGED UTENSILS THAT ARE UNCLEANABLE OR MAY CAUSE PHYSICAL CONTAMINATION.

Type: Follow-Up
Date: *05/05/23*
Time: 08:05:30
Report: 1031231109
New Perspective - Mahtomedi

Food and Beverage Establishment Inspection Report

Issued on: 05/01/23 *Comply By: 05/01/23*

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Hot Water: = at 161 Degrees Fahrenheit
Location: Disn Machine
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	0	2	1

Inspection conducted by Chris F (MDH).

All violations discussed with Nicole after inspection.

Discussed:
- Illness and illness log
- Facilities upkeep and maintenance
- Handwashing and glove use
- Thermometer use

NOTIFY INSPECTOR OF ADDITIONS OR CHANGES TO THE BUILDING, MAJOR EQUIPMENT ADDITIONS, OR CHANGES OF EQUIPMENT DUE TO A MENU CHANGE. THESE ACTIONS MAY REQUIRE A REMODEL PLAN REVIEW.

***ANY CUSTOMER COMPLAINS OF ILLNESS, CONTACT THE MINNESOTA DEPARTMENT OF HEALTH AND PROVIDE THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER TO THE CUSTOMER. THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER IS 1-877-366-3455.

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Environmental Health inspection report number 1031231109 of 05/05/23.

Certified Food Protection Manager Nicole C Webber

Certification Number: FM113260 Expires: 05/04/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
Nicole C Webber
Person in Charge

Signed: _____
Chris Foster
Public Health Sanitarian I
Freeman Office Building
651-983-8760
chris.j.foster@state.mn.us

Report #: 1031231109

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Environmental Health
Food, Pools, and Lodging
625 Robert St. N
St. Paul

No. of RF/PHI Categories Out	2	Date	05/05/23
No. of Repeat RF/PHI Categories Out	2	Time In	08:05:30
Legal Authority MN Rules Chapter 4626		Time Out	

	Address	City/State	Zip Code	Telephone
New Perspective - Mahtomedi	111 East Avenue	Mahtomedi, MN	55115	6516533515

License/Permit #	Permit Holder	Purpose of Inspection	Est Type	Risk Category
0038558		Follow-Up		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item — Mark "X" in appropriate box for COS and/or R

IN=in compliance OUT=not in compliance N/O=not observed N/A=not applicable COS=corrected on-site during inspection R=repeat violation

	Compliance Status		COS	R
	Supervision			
1	IN OUT	PIC knowledgeable; duties & oversight		
2	IN OUT N/A	Certified food protection manager, duties		
	Employee Health			
3	IN OUT	Mgmt/Staff;knowledge,responsibilities&reporting		
4	IN OUT	Proper use of reporting, restriction & exclusion		
5	IN OUT	Procedures for responding to vomiting & diarrheal events		
	Good Hygenic Practices			
6	IN OUT N/O	Proper eating, tasting, drinking, or tobacco use		
7	IN OUT N/O	No discharge from eyes, nose, & mouth		
	Preventing Contamination by Hands			
8	IN OUT N/O	Hands clean & properly washed		
9	IN OUT N/A N/O	No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed		
10	IN OUT	Adequate handwashing sinks supplied/accessible		
	Approved Source			
11	IN OUT	Food obtained from approved source		
12	IN OUT N/A N/O	Food received at proper temperature		
13	IN OUT	Food in good condition, safe, & unadulterated		X
14	IN OUT N/A N/O	Required records available; shellstock tags, parasite destruction		
	Protection from Contamination			
15	IN OUT N/A N/O	Food separated and protected		
16	IN OUT N/A	Food contact surfaces: cleaned & sanitized		
17	IN OUT	Proper disposition of returned, previously served, reconditioned, & unsafe food		

	Compliance Status		COS	R
	Time/Temperature Control for Safety			
18	IN OUT N/A N/O	Proper cooking time & temperature		
19	IN OUT N/A N/O	Proper reheating procedures for hot holding		
20	IN OUT N/A N/O	Proper cooling time & temperature		
21	IN OUT N/A N/O	Proper hot holding temperatures		
22	IN OUT N/A	Proper cold holding temperatures		
23	IN OUT N/A N/O	Proper date marking & disposition		X
24	IN OUT N/A N/O	Time as a public health control: procedures & records		
	Consumer Advisory			
25	IN OUT N/A	Consumer advisory provided for raw/undercooked food		
	Highly Susceptible Populations			
26	IN OUT N/A	Pasteurized foods used; prohibited foods not offered		
	Food and Color Additives and Toxic Substances			
27	IN OUT N/A	Food additives: approved & properly used		
28	IN OUT	Toxic substances properly identified, stored, & used		
	Conformance with Approved Procedures			
29	IN OUT N/A	Compliance with variance/specialized process/HACCP		

Risk factors (RF) are improper practices or proceedures identified as the most prevalent contributing factors of foodborne illness or injury. **Public Health Interventions** (PHI) are control measures to prevent foodborne illness or injury.

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.
Mark "X" in box if numbered item is **not** in compliance — Mark "X" in appropriate box for COS and/or R — COS=corrected on-site during inspection R= repeat violation

			COS	R
		Safe Food and Water		
30	IN OUT N/A	Pasteurized eggs used where required		
31		Water & ice obtained from an approved source		
32	IN OUT N/A	Variance obtained for specialized processing methods		
		Food Temperature Control		
33		Proper cooling methods used; adequate equipment for temperature control		
34	IN OUT N/A N/O	Plant food properly cooked for hot holding		
35	IN OUT N/A N/O	Approved thawing methods used		
36		Thermometers provided & accurate		
		Food Identification		
37		Food properly labled; original container		
		Prevention of Food Contamination		
38		Insects, rodents, & animals not present		
39		Contamination prevented during food prep, storage & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

			COS	R
		Proper Use of Utensils		
43		In-use utensils: properly stored		
44		Utensils, equipment & linens: properly stored, dried, & handled		
45		Single-use/single service articles: properly stored & used		
46		Gloves used properly		
		Utensil Equipment and Vending		
47	X	Food & non-food contact surfaces cleanable, properly designed, constructed, & used		X
48		Warewashing facilities: installed, maintained, & used; test strips		
49		Non-food contact surfaces clean		
		Physical Facilities		
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		Physical facilities installed, maintained, & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature) **Date:** 05/05/23

Inspector (Signature)