



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

June 22, 2026

Licensee

New Perspective Highland Park
750 Mississippi River Boulevard
Saint Paul, MN 55116

RE: Project Number(s) SL20168016

Dear Licensee:

On May 5, 2026, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on November 19, 2025. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the November 19, 2025 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on November 19, 2025, found not corrected at the time of the May 5, 2026, follow-up survey and/or subject to penalty assessment are as follows:

0780-Fire Protection And Physical Environment-144g.45 Subd. 2 (a) (1) - \$500.00

The details of the violations noted at the time of this follow-up survey completed on May 5, 2026 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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 outlined on the state form; however, plans of correction are not required to be submitted for approval.

IMPOSITION OF FINES

In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and may be imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement;

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;

Level 3: a fine of \$1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;

Level 4: a fine of \$3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;

Level 5: a fine of \$5,000 per violation, in addition to any enforcement mechanism authorized in § 144G.20.

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 MDH within 15 calendar days of the correction order receipt date.

To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

To submit a hearing request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

We urge you to review these orders carefully. If you have questions, please contact Stephanie Jones De Palma at 651-201-4320.

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

Sincerely,

A handwritten signature in black ink, reading "Stephanie Jones de Palma". The signature is fluid and cursive, with the first name "Stephanie" being the most prominent.

Stephanie Jones de Palma, Supervisor
State Rapid Response Team / State Evaluation Team
Email: stephanie.jones.de.palma@state.mn.us
Telephone: 651-201-4320 Fax: 1-800-337-9238 / 1-866-890-9290

KKM

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20168	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 05/05/2026
NAME OF PROVIDER OR SUPPLIER NEW PERSPECTIVE HIGHLAND PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 750 MISSISSIPPI RIVER BLVD SAINT PAUL, MN 55116		
(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 FOLLOW UP SURVEY WITH RE-ISSUE OF ORDERS INITIAL COMMENTS SL20168016-2 On May 4, 2026, the Minnesota Department of Health conducted a follow-up survey for the above provider to follow-up on orders issued pursuant to a license order follow up completed on February 10, 2026. As a result of the follow-up survey, the following orders were issued and/or reissued.	{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.		
{0 480} SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	{0 480}			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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{0 480}	Continued From page 1 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are	{0 480}			

Minnesota Department of Health

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{0 480}	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by:	{0 480}	Not reviewed during this survey.		
{0 510} SS=E	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 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:	{0 510}			

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{0 650}	Continued From page 3	{0 650}			
{0 650} SS=D	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by:	{0 650}			
{0 660} SS=E	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control	{0 660}	Not reviewed during this survey.		

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{0 660}	Continued From page 4 and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by:	{0 660}	Not reviewed during this survey.		
{0 780} SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke	{0 780}			

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Minnesota Department of Health

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{01440} SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by:	{01440}	Not reviewed during this survey.		
{01620} SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective	{01620}			

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{01620}	Continued From page 9 resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a	{01620}			

Minnesota Department of Health

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{01620}	Continued From page 10 prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by:	{01620}	Not reviewed during this survey.		
{01760} SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by:	{01760}			
{01880} SS=E	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced	{01880}			

Minnesota Department of Health

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{01880}	Continued From page 11 by:	{01880}	Not reviewed during this survey.		
{02310} SS=E	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by:	{02310}	Not reviewed during this survey.		

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL20168016-2	Date: May 4, 2026
Facility Name: New Perspective Highland Park	
Facility Address: 750 Mississippi River Blvd	

☒ TAG IDENTIFICATION: 0780

SCOPE/ SEVERITY: Level 2; Widespread

1. Smoke alarms interconnected so that actuation of one alarm causes all alarms in the individual dwelling or sleeping unit to operate where more than one smoke alarm is required within an individual dwelling or sleeping unit. [Minn. Stat. 144G.45 subd.2]

Comments: Following up on a survey conducted on February 10, 2026, surveyor found resident units throughout the facility had multiple sets of smoke alarms present that did not properly interconnect. Hardwired smoke alarms were present in many of the residents’ rooms as well as at least one wireless smoke alarm. When tested in each case these smoke alarms were not interconnected. Where multiple smoke alarms are present the activation of any one alarm must cause all alarms to sound within the resident unit.

2. Smoke Alarm power supply complies with MN State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated. [Minn. Stat. 144G.45 subd.2]

Comments: Following up on a survey conducted on February 10, 2026, surveyor found existing hardwired smoke alarms were removed from the majority of renovated resident rooms. Battery powered wireless alarms were added separately. Existing hardwired (receiving power from the building electrical system) smoke alarms are required to be maintained as installed previously and interconnected to additional battery-operated alarms so activation of one alarm activates all alarms throughout the facility.



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

March 4, 2026

Licensee

New Perspective Highland Park
750 Mississippi River Boulevard
Saint Paul, MN 55116

RE: Project Number(s) SL20168016

Dear Licensee:

On February 10, 2026, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on November 19, 2025. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the November 19, 2025 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on November 19, 2025, found not corrected at the time of the February 10, 2026, follow-up survey and/or subject to penalty assessment are as follows:

0775-Fire Protection And Physical Environment-144g.45 Subd. 2. (a) - \$1,000.00

0780-Fire Protection And Physical Environment-144g.45 Subd. 2 (a) (1) - \$1,000.00

The details of the violations noted at the time of this follow-up survey completed on February 10, 2026 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Also, at the time of this follow-up survey completed on February 10, 2026, we identified the following violation(s):

0830-Local Laws Apply-144g.45 Subd. 3 - \$1,000.00

The details of the violation(s) noted at the time of this follow-up survey are delineated on the attached State Form. Only the ID Prefix Tag in the left hand column without brackets will identify these state correction orders. It is not necessary to develop a plan of correction.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$3,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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 outlined on the state form; however, plans of correction are not required to be submitted for approval.

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We urge you to review these orders carefully. If you have questions, please contact Stephanie Jones

de Palma at 651-201-4320.

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

Sincerely,

A handwritten signature in black ink, reading "Stephanie Jones de Palma". The signature is fluid and cursive, with a large, sweeping initial 'S'.

Stephanie Jones de Palma, Supervisor
State Engineering Services Section
Email: stephanie.jones.de.palma@state.mn.us
Telephone: 651-201-4320 Fax: 1-866-890-9290

CLN

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20168	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 02/10/2026
NAME OF PROVIDER OR SUPPLIER NEW PERSPECTIVE HIGHLAND PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 750 MISSISSIPPI RIVER BLVD SAINT PAUL, MN 55116		
(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 FOLLOW UP SURVEY WITH RE-ISSUE OF ORDERS INITIAL COMMENTS SL20168016-1 On February 9, 2026, through February 10, 2026, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on November 17, 2025. At the time of the survey, there were 92 residents; 85 receiving services under the Assisted Living with Dementia Care license. As a result of the follow-up survey, the following orders were issued and/or reissued.	{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.		
{0 480} SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	{0 480}			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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{0 480}	Continued From page 1 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are	{0 480}			

Minnesota Department of Health

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{0 480}	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by:	{0 480}	Not reviewed during this survey.		
{0 510} SS=E	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 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:	{0 510}			

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{0 650}	Continued From page 3	{0 650}			
{0 650} SS=D	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by:	{0 650}			
{0 660} SS=E	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control	{0 660}	Not reviewed during this survey.		

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{0 660}	Continued From page 4 and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by:	{0 660}	Not reviewed during this survey.		
{0 775} SS=I	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) 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).	{0 775}			

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{0 775}	Continued From page 5 The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated February 10, 2026 for the specific violations related the physical environment under Minnesota Statute 144G.	{0 775}			
{0 780} SS=I	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated;	{0 780}			

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{0 780}	Continued From page 6 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) 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: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated February 10, 2026 for the specific violations related the physical environment under Minnesota Statute 144G.	{0 780}			
{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.	{0 800}			

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{0 800}	Continued From page 7	{0 800}			
	This MN Requirement is not met as evidenced by:		Not reviewed during this survey.		
{0 810} SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill.	{0 810}			

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{0 810}	Continued From page 8	{0 810}			
0 830 SS=I	This MN Requirement is not met as evidenced by: 144G.45 Subd. 3 Local laws apply Assisted living facilities shall comply with all applicable state and local governing laws, regulations, standards, ordinances, and codes for fire safety, building, and zoning requirements, except a facility with a licensed resident capacity of six or fewer is exempt from rental licensing regulations imposed by any town, municipality, or county. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) 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).	0 830	Not reviewed during this survey.		

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0 830	Continued From page 9 The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated February 10, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Two (2) days.	0 830			
{01290} SS=F	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by:	{01290}			
{01440} SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or	{01440}	Not reviewed during this survey.		

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{01440}	Continued From page 10 therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by:	{01440}	Not reviewed during this survey.		
{01620} SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on	{01620}			

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{01620}	Continued From page 11 which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier.	{01620}			

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{01620}	Continued From page 12	{01620}			
	This MN Requirement is not met as evidenced by:		Not reviewed during this survey.		
{01760} SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by:	{01760}			
			Not reviewed during this survey.		
{01880} SS=E	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by:	{01880}			
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{02310}	Continued From page 13	{02310}			
{02310} SS=E	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by:	{02310}			
			Not reviewed during this survey.		



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

December 12, 2025

Licensee

New Perspective Highland Park
750 Mississippi River Boulevard
Saint Paul, MN 55116

RE: Project Number(s) SL20168016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on November 19, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, 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.

MDH concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

STATE CORRECTION ORDERS

The enclosed State Form documents the state correction orders. 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 . . ."

IMPOSITION OF FINES

In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and may be imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement;

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;

Level 3: a fine of \$1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;

Level 4: a fine of \$3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;

Level 5: a fine of \$5,000 per violation, in addition to any enforcement mechanism authorized in § 144G.20.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed pursuant to this survey:

St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - \$1,000.00

St - 0 - 0780 - 144g.45 Subd. 2 (a) (1) - Fire Protection And Physical Environment - \$1,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$2,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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 MDH within 15 calendar days of the correction order receipt date.

To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each

matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

To submit a hearing request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

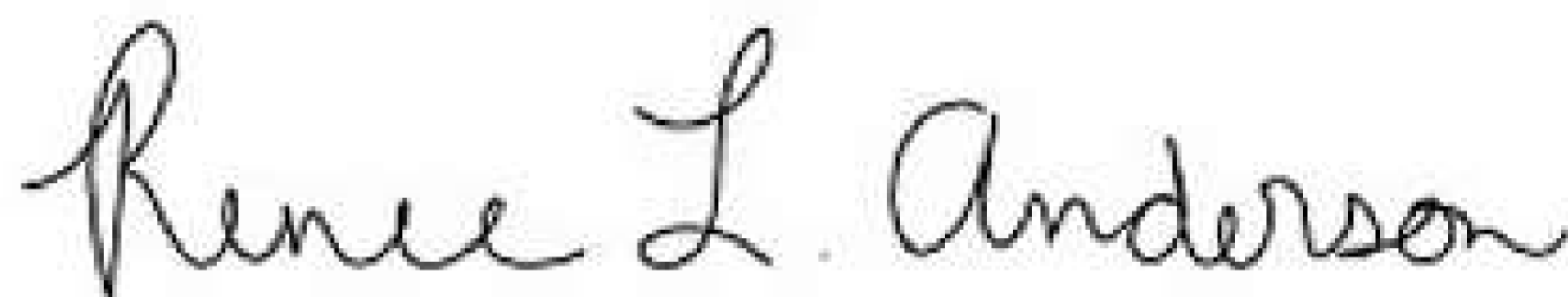
To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **<https://forms.office.com/g/Bm5uQEPhVa>**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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,

A handwritten signature in cursive script that reads "Renee L. Anderson".

Renee L. Anderson, Supervisor

State Evaluation Team

Email: Renee.L.Anderson@state.mn.us

Telephone: 651-201-5871 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20168	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/19/2025
NAME OF PROVIDER OR SUPPLIER NEW PERSPECTIVE HIGHLAND PARK		STREET ADDRESS, CITY, STATE, ZIP CODE 750 MISSISSIPPI RIVER BLVD SAINT PAUL, MN 55116			
(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: SL20168016-0 On November 17, 2025, through November 19, 2025, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were 92 residents; 85 receiving services under the Assisted Living Facility with Dementia Care license.	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.		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20168	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/19/2025
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0 480	Continued From page 1 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are	0 480			

Minnesota Department of Health

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0 480	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. 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, but was not likely to cause serious injury, impairment, or death), and is 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: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated November 18, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.	0 480			

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0 480	Continued From page 3	0 480			
0 510 SS=E	TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates. 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 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 infection control program that complies with accepted health care, medical and nursing standards for infection control, including proper hand hygiene (HH) for two of four employees (unlicensed personnel (ULP)-H, ULP-M). 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not	0 510			

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0 510	Continued From page 4 found to be pervasive). The findings include: ULP-H ULP-H was hired June 22, 2021, and provided direct care services to the residents. On November 18, 2025, from 7:00 a.m., to 7:28 a.m., the surveyor observed ULP-H assisting R2 with activities of daily living. ULP-H donned gloves, then brought a walker to R2 and assisted her to the bathroom. ULP-H realized there were no wipes in the bathroom, so ULP-H touched the door handle with same donned gloves and left R2's room to go down the hall and get wipes in the administrative secure care area. ULP-H doffed gloves in the hallway, then without completing hand hygiene, returned to R2's room with box of gloves and donned gloves. ULP-H assisted R2 in the bathroom with personal cares and peri-cares. Without changing gloves, ULP-H used a washcloth to wash R2's face, under arms, mouth area and eyes. ULP-H doffed gloves and completed hand hygiene with soap for five seconds. ULP-H then combed R2's hair and used a washcloth with water only on R2's hands. Finally, ULP-H assisted R2 with putting on socks and shoes, and assisted with walker to transfer R2 into their wheelchair. ULP-H donned clean gloves to grab garbage and escorted R2 to the secure area dining room. ULP-H then removed the gloves, and washed hands with soap for five seconds. On November 18, 2025, at 7:32 a.m., ULP-H stated they train on hand washing during the year and when asked, she thought she was taught to wash her hand for five seconds. ULP-H also stated she realized she should have washed her	0 510			

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0 510	Continued From page 5 hands and changed gloves after R2's peri care and assisting with washing R2's face. On November 18, 2025, at 8:12 a.m., clinical nurse supervisor (CNS)-B stated the employees are trained to wash their hands with soap and water for at least 20 seconds, between cares, and with glove changes. ULP-M ULP-M was hired May 20, 2011, and provided direct care services to the residents. On November 19, 2025, from 7:51 a.m., to 8:20 a.m., the surveyor observed ULP-M removed a garbage bag out from a resident's room and placed in the trash room. Without completing hand hygiene ULP-M then entered another resident's (R7) room, to assist with personal cares. The surveyor observed ULP-M, wearing gloves, assit R7 with personal cares and peri cares. After completing peri cares, without removing soiled gloves or performing hand hygiene, ULP-M proceeded to assist R7 with washing his face and setting up his toothbrush to assist with oral cares. Next, ULP-M retrieved R7's walker and assisted him with a transfer to his wheelchair. Without removing soiled gloves, ULP-M then picked up R7's glasses and cleaned them in the resident's bathroom sink and placed on R7's face. Finally, ULP-M removed the soiled gloves and without completing hand hygiene transported R7 in his wheelchair, touched elevator buttons and brought R7 down to the dining room for breakfast. On November 19, 2025, at 8:22 a.m., ULP-M stated she was nervous, and this may have been why she missed completing hand hygiene between cares. ULP-M verbalized she did receive	0 510			

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0 510	Continued From page 6 training on handwashing and glove changes from the nurses. On November 19, 2024, at 9:06 a.m., regional director of clinical services (RDCS)-L verbalized all employees are trained on infection control, including hand hygiene and glove changes, upon hire, annually and as needed. RDCS-L stated employees are taught to complete hand hygiene between cares, and between cares of residents. The CDC guidance, CDC's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings, revised April 12, 2024, indicated, standard precautions were to be used to care for all patients (residents) in all settings to include HH, and noted, "Use an alcohol-based hand rub or wash with soap and water for the following clinical indications: a. Immediately before touching a patient b. Before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices c. Before moving from work on a soiled body site to a clean body site on the same patient d. After touching a patient or the patient's immediate environment e. After contact with blood, body fluids or contaminated surfaces f. Immediately after glove removal." The licensee's Infection Control Hand Washing policy, dated October 14, 2024, indicated, "When hands should be washed using soap and water: Team members will wash hands between resident care and whenever direct physical contact with a resident takes place. Use of gloves does not replace hand washing. Hands will be washed: -Before and after direct care of a resident	0 510			

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0 510	Continued From page 7 -If moving from a contaminated body site to a clean body site during resident care -After contact with surfaces or equipment in the immediate vicinity of the resident -Before applying and after removing personal protective equipment (PPE) -Before eating or preparing food -After using a restroom -When hands look dirty." In addition, included, "How to Wash Hands: 1. Stand away from the sink to ensure clothing and hands do not touch the sink. 2. Turn on water and adjust to a comfortably warm temperature. 3. Wet hands and wrists. 4. Apply soap over hands and wrists, working into a generous lather by scrubbing vigorously. 5. Use friction while scrubbing hands vigorously for at least 20 seconds. Clean fingernails by rubbing fingertips against opposite palm; clean around the knuckles and along the sides of the fingers and hands. 6. Rinse hands and wrists completely under running water to wash away suds and micro-organisms. Keep hands lower than the elbows and fingertips in a downward position. 7. Pat hands, wrists, and fingers with a dry, clean paper towel to dry hands thoroughly. 8. Turn off water using a clean paper towel to mitigate recontamination of the hands. 9. Use lotions to protect the integrity of the skin as warranted." The licensee's Use of Gloves policy, dated October 14, 2024, indicated, "Team members will follow proper glove changing protocols to include: -Changing gloves if a glove becomes torn or heavily soiled when additional tasks must be performed for the resident; -Performing hand hygiene between glove	0 510			

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0 510	Continued From page 8 changes; and -Never washing gloves for reuse or reusing gloves after caring for a resident." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510			
0 650 SS=D	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on record review and interview, the	0 650			

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0 650	Continued From page 9 licensee failed to ensure employee records included the required content for one of three employees (licensed practical nurse (LPN)-F). 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: LPN-F was hired by the licensee on December 4, 2023, to provide nursing services and direct cares to residents. LPN-F's employee record lacked evidence of an annual performance evaluation that identified areas of improvement needed and training needs. On November 18, 2025, at 11:04 a.m., licensed assisted living director (LALD)-A stated, via email, they were unable to locate an annual performance review for LPN-F. On November 18, 2025, at 1:30 p.m., LALD-A stated LPN-F's employee record lacked evidence of an annual performance evaluation. LALD-A verbalized the licensee performs annual performance reviews for all employees, but this LPN-F's must have been missed. The licensee's Team Member Supervision policy dated October 7, 2024, included on page three, labeled Annual Performance Review, "The	0 650			

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0 650	Continued From page 10 delegating registered nurse will: 1. Complete a performance review using the Unlicensed Team Member Annual Performance Review form for each delegated Community team member, based on the documentation of the supervisor's observations and other relevant information; and 2. Verify that completed performance reviews are uploaded to team member personnel records." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650			
0 660 SS=E	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) 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 maintain a	0 660			

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NAME OF PROVIDER OR SUPPLIER NEW PERSPECTIVE HIGHLAND PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 750 MISSISSIPPI RIVER BLVD SAINT PAUL, MN 55116		
(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
0 660	Continued From page 11 tuberculosis (TB) prevention and control program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC). The licensee failed to ensure screening for active TB including history and symptom screening and baseline testing (either by a two-step tuberculin skin test (TST) or a single interferon gamma release assay (IGRA) TB blood test) was completed and documented for two of three employees (unlicensed personnel (ULP)-E, licensed practical nurse (LPN)-F). 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: The licensee's TB facility risk assessment, dated December 30, 2024, indicated the facility was a "low" risk for TB transmission. ULP-E ULP-E was hired October 18, 2023, and provided direct cares and services to residents. On November 17, 2025, at 11:34 a.m., the surveyor observed ULP-E assisting R3 with an escort from her apartment in the secured area of the facility to the secure area dining room. ULP-E's employee record contained a one-step TB skin test, dated September 9, 2024, (327 days	0 660			

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0 660	Continued From page 12 after the date of hire). ULP-E's record lacked a second step TB skin test. LPN-F LPN-F was hired December 4, 2023, and provided direct nursing cares and services to residents. LPN-F's employee record contained an IGRA blood test, dated December 1, 2023, but lacked a TB screening questionnaire as required. On November 18, 2025, at 11:04 a.m., licensed assisted living director (LALD)-A stated, via email, "We have the TB test for [LPN-F] but can not locate the questionnaire, same with an annual performance." On November 18, 2025, at 1:45 p.m., LALD-A stated the TB documents provided for ULP-E and LPN-F were all they had in their employee records. LALD-A verbalized ULP-E's TB test appears to have been completed after 90 days from hire. Also, LALD-A stated LPN-F's record only contained the one step TB test. The Minnesota Department of Health (MDH) guidelines, "Regulations for Tuberculosis Control in Minnesota Health Care Settings", dated July 2013, and based on CDC guidelines, indicated a TB infection control program should include the following: a team responsible for TB infection control; a facility TB risk assessment; written TB infection control procedures; and HCW education. The guidelines also indicate an employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST-tuberculin skin test (first step) dated within 90 days before hire.	0 660			

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0 660	Continued From page 13 The second TST may be performed after the HCW starts working with patients. Baseline TB screening should be documented in the employee's record. On November 19, 2025, at 11:20 a.m., during the exit conference, regional director of clinical services (RDCL)-L stated she planned to follow up on the missing TB screening and TB test. The licensee's Communicable Disease - Tuberculosis policy, revised October 11, 2023, indicated, "The Community will establish and maintain a Tuberculosis (TB) prevention and control program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) and the state health department." In addition, included on page three, "Team Members, The Human Resources department is responsible for establishing and maintaining the TB prevention and control program for team members. Responsibilities include: 10. Ensuring baseline communicable disease screening is completed for new team members. 11. Ensuring that TB tests and communicable disease screening results are maintained in team member personnel files." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660			
0 775 SS=I	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter	0 775			

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0 775	Continued From page 14 7511, and: This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) 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: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated November 17, 2025, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Two (2) days	0 775			
0 780 SS=I	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for	0 780			

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0 780	Continued From page 15 sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) 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).	0 780			

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0 780	Continued From page 16 The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated Novemeber 17, 2025, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Two (2) days	0 780			
0 790 SS=C	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when	0 790			

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0 790	Continued From page 17 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 document titled, Physical Environment Inspection Report (PEIR) dated Novemeber 17, 2025. for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790			
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, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. 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 18 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 the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated November 17, 2025. for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800			
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter.	0 810			

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0 810	Continued From page 19 (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. 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 the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated November 17, 2025, for the specific violations	0 810			

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0 810	Continued From page 20 related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty One (21) days	0 810			
01290 SS=F	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to obtain a cleared Minnesota Department of Human Services (DHS) background study affiliated with the licensee's health facility identification number (HFID), upon hire, and prior to providing services for one of three employees (unlicensed personnel (ULP)-K). 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	01290			

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01290	Continued From page 21 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: The licensee's HFID was 20168 and the licensee provided assisted living services beginning August 1, 2021. ULP-K was hired September 29, 2025, and provided direct assisted living cares to the licensee's residents. ULP-K's employee record included a cleared background study dated April 23, 2023, affiliated with HFID 30649, a facility also owned by the licensee. The record lacked evidence of a cleared background study affiliated with the licensee's HFID 20168 on the DHS Net Study 2.0 Roster at the time of survey initiation. On November 17, 2025, at 2:36 p.m., licensed assisted living director (LALD)-A stated, via email, "[ULP-K] is an on call/PRN [as needed] caregiver, she has worked 11/8, 11/11, 11/14 and 11/16... This week on the schedule for 11/18 and 11/21." LALD-A verbalized ULP-K was not affiliated to the current licensee, HFID 20168. On November 17, 2025, at 2:53 p.m., LALD-A provided the surveyor with a background study clearance letter for ULP-K affiliated to 20168, completed during the time of survey. The licensee's Background Checks policy, revised February 14, 2022, included, "Offers of	01290			

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01290	Continued From page 22 employment at New Perspective are contingent upon passing a thorough background check. This contingency will be clearly stated in the verbal and written job offer. All written job offers require the use of the approved Job Offer Letter template which includes required language. Background checks must be conducted on all final candidates after a job offer is extended. Background check guidelines vary by state and job relatedness (e.g., driving records should only be checked for those expected to drive as part of their job duties), and are designed to be cost effective. In addition, indicated, "Important: Candidates may attend Team Member Orientation prior to receiving background study results. However, they may not work on the floor and/or interact with residents until they have met both company and applicable state requirements." No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290			
01440 SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional	01440			

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01440	Continued From page 23 and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) The completed direct supervision of staff performing delegated tasks within 30 calendar days after the date on which the individual began working for the facility and first performed the delegated task for one of two employees (unlicensed personnel (ULP)-E). 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: ULP-E was hired on October 18, 2023, to provide assisted living services to residents. On November 17, 2025, at 11:34 a.m., the surveyor observed ULP-E assisting R3 with an	01440			

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01440	Continued From page 24 escort from her apartment in the secured area of the facility to the secure area dining room. ULP-E showed the surveyor R3's oxygen equipment and verbalized she assists R3 with her oxygen as needed. ULP-E stated the nurses trained her how to assist the residents who have oxygen ordered. ULP-E's Care Skills Assessment dated October 16, 2023, indicated ULP-E demonstrated competency to the nurse with resident cares including oxygen administration, continuous positive airway pressure (CPAP) (for sleep apnea), bilevel positive airway pressure (BiPAP) (for sleep apnea), catheter cares, ostomy cares, compression stockings, and mechanical lifts. ULP-E's record lacked evidence a RN completed a 30-day supervision of delegated nursing tasks. On November 19, 2025, at 10:04 a.m., clinical nurse supervisor (CNS)-B stated licensee was unable to find a 30-day supervision documented for ULP-E of a delegated nursing task. The licensee's Team Member Supervision policy dated October 7, 2024, included under Supervision of Unlicensed Team Members, "Supervision Parameters: 1. Supervision of unlicensed team members will exist when unlicensed team members perform delegated caregiving, treatment, or assigned therapy services. Caregivers and med passers will be supervised by a licensed nurse. 2. Team members must be supervised by the nurse within 30 days of date of delegation and thereafter as warranted based on performance. This requirement also applies to team members who have not performed delegated tasks for one (1) year or longer. 3. The supervision should be through the direct	01440			

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01440	Continued From page 25 and indirect observation of the team member performing the services. Supervision of med passers will include direct observation of the team member administering the medication or treatment and the interaction with residents. 4. The resident or resident's representative may be interviewed in an effort to ensure they are satisfied with the services they are receiving. 5. Supervision activities will be documented using the Unlicensed Team Member Supervisory Note form. 6. The health and wellness director (HWD) will verify that: a. Supervision is done within the required timeframe outlined above; b. Completed supervisory notes are uploaded to team member personnel records; and c. Supervision is specified on the resident's service plan in the electronic health record." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440			
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic	01620			

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01620	Continued From page 26 distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by:	01620			

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01620	Continued From page 27 Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing resident monitoring and reassessment, utilizing a uniform assessment tool, to include a reassessment no more than 14 days after start of services for one of four residents (R3). 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 September 29, 2025, at 10:15 a.m., during the entrance conference, clinical nurse supervisor (CNS)-B stated the licensee completed nursing assessments upon admission, within 14 days of admission, every 90 days, and with a change in condition. R3 was admitted on March 28, 2024, and had diagnoses including chronic obstructive pulmonary disease (COPD), peripheral artery disease (PAD), and dementia. R3's Resident Services Agreement (Includes IAPP) indicated R3 received services including assistance with housekeeping, laundry, meals, activities of daily living, treatment and medication administration. On November 17, 2025, at 11:34 a.m., the surveyor observed ULP-E assisting R3 with an	01620			

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01620	Continued From page 28 escort from her apartment in the secured area of the facility to the secure area dining room. R3's medical record included a Uniform Assessment Tool nursing assessment, dated March 28, 2024, and lacked a subsequent nursing assessment completed within 14 days after start of services. On November 19, 2025, at 9:18 a.m., regional director of clinical services (RDCS)-L stated R3's 14-day assessment was missed. RDCS-L did not state a reason for the missing assessment. The licensee's Assessments and Evaluations policy revised June 24, 2025, indicated, "Additional assessments, reassessments, and evaluations will be: 1. Conducted by a licensed nurse in accordance with the Assessments and Evaluations Schedule: a. Within 14 days of the start of services; Note: This may be on or after the date of move-in. b. After changes in condition of a resident; and c. No more than 90 days from the most recent assessment; 2. Documented in the resident health record either as "Assessments" or "Notes," whether conducted in person or via telecommunication; and 3. Accompanied by progress notes." No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620			

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01760	Continued From page 29	01760			
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were administered according to manufacturer's instructions for one of four residents (R8). 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: R8's Resident Service Agreement (Includes IAPP) (individual abuse prevention plan) dated, October 4, 2024, indicated R8 received services	01760			

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01760	Continued From page 30 including assistance with housekeeping, meals, laundry, bathing, treatment and medication administration. R8's medication administration record (MAR) dated November 2025, indicated R8 received Lantus Solostar (long-acting) insulin 30 units (u) subcutaneous (under the skin), two times daily. On November 19, 2025, at 8:30 a.m., the surveyor observed unlicensed personnel (ULP)-I checked R8's blood sugar and noted a blood sugar reading of 134 milligrams (mg) per deciliter(dl). ULP-I stated she needed to administer 30 u of Lantus insulin via an insulin pen when she reviewed the electronic medical record. ULP-I dialed the pen to administer 30 u of insulin, and without first priming the insulin pen, administered the insulin to R8. On November 19, 2025, at 8:38 a.m., ULP-I stated she did not prime the insulin pen prior to administering the insulin to R8. ULP-I stated she was trained by the nurse to first prime the insulin pen with two units of insulin prior to dialing the pen to the ordered dosage. ULP-I stated she was aware she should prime the insulin pen, but she was nervous and missed that step. Lantus Solostar manufacturer directions revised December 1, 2021, indicated, Step 3: Perform a safety test Always perform the safety test before each injection. This ensures that you get an accurate dose by: -ensuring that pen and needle work properly -removing air bubbles A. Select a dose of 2 units by turning the dosage selector clockwise. B. Take off the outer needle cap and keep it to	01760			

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01760	Continued From page 31 remove the used needle after injection. Take off the inner needle cap and discard it. C. Hold the pen with the needle pointing upwards. D. Tap the insulin reservoir so that any air bubbles rise up towards the needle. E. Press the injection button all the way in. Check if insulin comes out of the needle tip. You may have to perform the safety test several times before insulin is seen. -If no insulin comes out, check for air bubbles and repeat the safety test two more times to remove them. -If still no insulin comes out, the needle may be blocked. Change the needle and try again. -If no insulin comes out after changing the needle, your SoloSTAR may be damaged. Do not use this Solostar. You must perform safety tests before you use the pen until you see insulin coming out of the needle tip. If you see insulin coming out of the needle tip, the pen is ready to use. If you do not see insulin coming out before taking your dose, you could get an underdose or no insulin at all. This could cause high blood sugar." The licensee's Medication Administration Insulin and Insulin Derivatives (GLP-1 Receptor Agonists), revised November 21, 2021, included, "3. Prepare the insulin pen: a. Remove cap from the insulin pen and place cap on a clean surface with the interior side of cap facing up or to the side; b. Sanitize the rubber seal located at the top of the pen with an alcohol wipe; c. Remove safety pen needle from its packaging and apply to the top of the pen; d. Press the injection button to prime needle with two (2) units of insulin; e. Dial pen to the prescribed dose of insulin as indicated in the eMAR;	01760			

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01760	Continued From page 32 f. Double check the insulin dose against the eMAR to verify the dose dialed is accurate." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760			
01880 SS=E	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were stored in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access for three of four residents (R5, R6, R7) who received medication management services. 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include:	01880			

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01880	Continued From page 33 R5 R5 was admitted December 28, 2021, and had diagnoses including type two diabetes and chronic obstructive pulmonary disease (COPD). R5's Resident Services Agreement (Includes IAPP) (individual abuse prevention plan), dated June 5, 2025, indicated R5 received services including assistance with housekeeping, laundry, meals, bathing, dressing, oxygen administration, treatment and medication administration. On November 17, 2025, from 3:05 p.m., to 3:20 p.m., the surveyor observed R5's apartment with clinical nurse supervisor (CNS)-B. There were medications observed on R5's chair side table, including Genteal ointment eye drops (for dry eyes), one bottle of Tums (for indigestion), one bottle of Senna S (for constipation) tablets, and one bottle of multivitamin (a supplement) tablets. CNS-B stated they provided medication administration for R5, and the medications found in apartment should have been secured. CNS-B took the medications and told R5 she planned to store the medications with her other medications they assisted with. R5's medication administration record (MAR) dated November 2025, indicated R5 was administered the following medication found in her apartment: -Genteal Tear (for dry eyes) ointment, instill into both eyes, once daily at bedtime. R5's MAR dated November 2025 or provider orders did not include the other three medications found in her apartment, Tums, Senna S, and multivitamin.	01880			

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01880	Continued From page 34 R5's Medication and Treatment and Therapies Management Pan dated December 12, 2024, indicated on page two, section 1.b11., "Where are resident's medications stored? A. Yes." R6 R6 was admitted June 30, 2025, and had diagnoses including type two diabetes with chronic kidney disease and spinal stenosis. R6's Resident Services Agreement (Includes IAPP), dated August 7, 2025, indicated R6 received services including assistance with housekeeping, laundry, meals, activities of daily living, catheter care, and medication administration. On November 18, 2025, the surveyor observed R6's apartment with unlicensed personnel (ULP)-M. ULP-M brought breakfast to R6's apartment. There was a medication observed on R6's table; one box of Baqsimi (glucagon nasal spray-to treat very low blood sugar). R6's MAR dated November or provider orders did not include the medication found in her apartment, Baqsimi. R6's Medication and Treatment and Therapies Management Pan dated July 14, 2025, indicated on page two, section 1.b11., "Where are resident's medications stored? A. Medications are stored in locked medication carts. B. Medications are centrally stored in locked medication rooms. C. Medication requiring refrigeration are centrally stored in the medication refrigerator." R7 R7 was admitted September 13, 2024, and had diagnoses including cerebral infarction, cerebral	01880			

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01880	Continued From page 35 vascular accident (CVA/stroke), type two diabetes, and bipolar disorder (a mental health disease). R7's Resident Services Agreement (Includes IAPP), dated October 2, 2025, indicated R7 received services including assistance with housekeeping, laundry, meals, activities of daily living, dressing, grooming, and medication administration. On November 19, 2025, from 7:51 a.m., to 8:20 a.m., the surveyor observed R7's apartment with ULP-M. There were medications observed on R7's bedside table, including one bottle of men's multivitamins gummies, one bottle of Dulcolax (for constipation) liquid laxative, and one bottle of generic stool softener tablets. R7's MAR dated November 2025, indicated R5 was administered the following medication found in his apartment: -Senna S 8.6 - 50 milligrams (mg), take two tablets twice daily. R7's MAR dated November 2025 or provider orders did not include the other two medications found in his apartment, dulcolax, and multivitamin. R7's Medication and Treatment and Therapies Management Pan dated December 19, 2024, indicated on page two, section 1.b11., "Where are resident's medications stored? A. Medications are stored in locked medication carts." On November 19, 2025, at 9:30 a.m., CNS-B stated R5, R6, R7 extra medications found in their apartments have now been secured. CNS-B verbalized she planned to ensure residents that	01880			

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01880	Continued From page 36 received medication administration from the licensee all medications would be secured or assessed if a resident could self-administer a medication. The licensee's Medication Management Medication Storage policy, revised June 27, 2024, indicated, "Medication that is managed by the Community will be securely stored in original pharmacy-labeled containers per pharmacy instructions and organized by resident, in accordance with applicable law." In addition, included in section Location and Design, "1. Medications will be centrally stored in locked medication carts, secure medication rooms, or secure medication refrigerators located in the Community. 2. The medication cart will be designed to allow for storage of resident medications by resident, maintaining resident medications in compartments within the medication cart that are separate from other residents' medications. 3. Medication will be stored in accordance with pharmacy label instructions." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880			
02310 SS=E	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards.	02310			

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02310	Continued From page 37 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure that oxygen cylinders were properly stored for two of three residents utilizing oxygen (R3, 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 a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R3 R3 was admitted on March 28, 2024, and had diagnoses including chronic obstructive pulmonary disease (COPD), peripheral artery disease (PAD), and dementia. R3's Resident Services Agreement (Includes IAPP), dated August 15, 2025, indicated R3 received services including assistance with housekeeping, laundry, meals, activities of daily living, treatment and medication administration. On November 17, 2025, at 11:34 a.m., the surveyor observed ULP-E assist R3 with an escort from her apartment in the secured area of the facility to the secure area dining room. One unsecured upright oxygen tank was observed in R3's main area of apartment. ULP-E stated she was not sure why the oxygen tank was not in a secure cart and she would planned to update the	02310			

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NAME OF PROVIDER OR SUPPLIER NEW PERSPECTIVE HIGHLAND PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 750 MISSISSIPPI RIVER BLVD SAINT PAUL, MN 55116		
(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
02310	Continued From page 38 nurse. On November 17, 2025, at 12:10 p.m., clinical nurse supervisor (CNS)-B stated she was not aware R3 had an unsecured oxygen cylinder in her apartment. CNS-B verbalized she would contact the oxygen vendor to provide a secure cart in which the oxygen cylinder would be stored. R5 R5 was admitted December 28, 2021, and had diagnoses including type two diabetes and COPD. R5's Resident Services Agreement (Includes IAPP), dated June 5, 2025, indicated R5 received services including assistance with housekeeping, laundry, meals, bathing, dressing, oxygen administration, treatment and medication administration. On November 17, 2025, at 3:05 p.m., the surveyor observed R5's apartment with CNS-B. The surveyor observed one oxygen concentrator and one unsecured upright oxygen cylinder located in R5's bedroom. CNS-B stated the staff did assist R5 with her oxygen as needed. CNS-B stated she was aware the oxygen cylinders should be secured in a rack to prevent them from tipping over. CNS-B verbalized she planned to follow up with the oxygen company to ensure the oxygen cylinders were securely stored as required. The licensee's Oxygen Use, Safety, and Storage policy, dated November 19, 2024, indicated, "The health and wellness director (HWD) or licensed nurse designee will: 5. Verify the resident has an appropriate storage cart or stand for the oxygen cylinder or concentrator."	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20168	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/19/2025
NAME OF PROVIDER OR SUPPLIER NEW PERSPECTIVE HIGHLAND PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 750 MISSISSIPPI RIVER BLVD SAINT PAUL, MN 55116		
(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
02310	Continued From page 39 The Minnesota Department of Health Oxygen Cylinder Storage Requirements, dated April 16, 2020, indicated, "cylinders must be secured (chains or racks) to prevent them from falling over." No further information was provided TIME PERIOD FOR CORRECTION: Seven (7) days	02310			



Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164
Phone: 651-201-4500

Food & Beverage Inspection Report

Page: 1

Establishment Info

NEW PERSPECTIVE HIGHLAND PARK
750 MISSISSIPPI RIVER BLVD
St Paul, MN 55116
Ramsey County
Parcel:

Phone:

License Info

License: HFID 20168

Risk:
License:
Expires on:
CFPM: MICHAEL JOS
CFPM #: 61149; Exp: 8/24/2028

Inspection Info

Report Number: F1023251215
Inspection Type: Full - Single
Date: 11/18/2025 Time: 11:11:30 AM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 1
Total Priority 2 Orders: 0
Total Priority 3 Orders: 3
Delivery:

New Order: 3-300C Protection from Contamination: equipment/utensils, consumers

3-304.14B Priority Level: Priority 3 CFP#: 41

MN Rule 4626.0285B Wiping cloths used for wiping counters and other equipment surfaces must be held in an approved sanitizing solution and laundered daily.

COMMENT: SANITIZER CONCENTRATION OF WIPING CLOTH BUCKET IN MEMORY CARE AREA TOO LOW.

Comply By: 11/18/2025 Originally Issued On: 11/18/2025

! New Order: 4-500 Equipment Maintenance and Operation

4-501.114C1 Priority Level: Priority 1 CFP#: 16

MN Rule 4626.0805C1 Provide and maintain an approved chlorine chemical sanitizer solution that has a minimum concentration of 50 ppm and a minimum temperature of 75 degrees F (24 degrees C) for water with a pH of 8 or less or a minimum temperature of 100 degrees F (38 degrees C) for water with a pH of 8.1 to 10.

COMMENT: CHLORINE CONCENTRATION FOR MEMORY CARE AREA TOO LOW.

Comply By: 11/18/2025 Originally Issued On: 11/18/2025

New Order: 4-600 Cleaning Equipment and Utensils

4-601.11C Priority Level: Priority 3 CFP#: 49

MN Rule 4626.0840C Clean non-food contact surfaces of equipment and maintain free of accumulations of dust, dirt, food residue, and other debris.

COMMENT: OBSERVED ACCUMULATION OF FOOD DEBRIS AT BOTTOM OF ICE CREAM FREEZER.

Comply By: 11/18/2025 Originally Issued On: 11/18/2025

New Order: 6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.11 Priority Level: Priority 3 CFP#: 55

MN Rule 4626.1515 Maintain the physical facilities in good repair.

COMMENT: MEMORY CARE FOOD SERVICE AREA HAS LIGHTS THAT DON'T WORK.

Comply By: 11/18/2025 Originally Issued On: 11/18/2025

Food & Beverage General Comment

THIS INSPECTION WAS CONDUCTED IN CONJUNCTION WITH MDH HEALTH REGULATORY DIVISION (HRD) SURVEY. INSPECTION CONDUCTED IN PRESENCE OF THE PERSON IN CHARGE.

THIS FACILITY CONSISTS OF A MAIN KITCHEN AREA WITH TYPE I HOOD/FIRE SUPPRESSION, 3 COMP SINK, DISH MACHINE, WALK IN COOLER AND PREP SINK AND AS WELL AS A MEMORY CARE AREA SERVICE KITCHEN WITH STEAM WELL, UPRIGHT COOLER, AND DISH MACHINE.

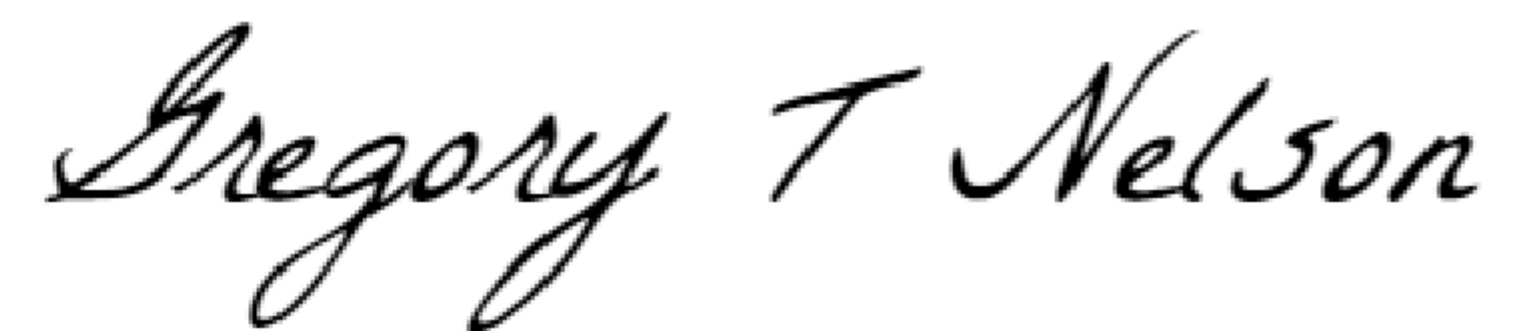
FOOD SERVICE IS PROVIDED BY FACILITY STAFF.

THESE TOPICS WERE DISCUSSED WITH THE PERSON IN CHARGE:

- EMPLOYEE ILLNESS EXCLUSION
 - HAND WASHING PROCEDURE
 - NO BARE HAND CONTACT WITH RTE FOOD
 - FOOD COOLING METHODS
 - VOMIT CLEAN UP PROCEDURE
 - FULLY COOKING FOOD FOR HIGH RISK POPULATIONS
 - PASTEURIZED SHELL EGGS
-

NOTE: All new food equipment must meet the applicable standards of the American National Standards Institute (ANSI). Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Metro District Office inspection report number F1023251215 from 11/18/2025



MICHAEL JOST
PERSON IN CHARGE

Greg Nelson,
Public Health Sanitarian 3
651-201-4259
greg.nelson@state.mn.us



Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164

Temperature Observations/Recordings

Page: 1

Establishment Info

NEW PERSPECTIVE HIGHLAND PARK
St Paul
County/Group: Ramsey County

Inspection Info

Report Number: F1023251215
Inspection Type: Full
Date: 11/18/2025
Time: 11:11:30 AM

Food Temperature: **Product/Item/Unit:** PASTA; **Temperature Process:** Hot-Holding

Location: Steam Table Memory Care at 120 Degrees F.

Comment:

Violation Issued?: Yes

Food Temperature: **Product/Item/Unit:** CHEESE; **Temperature Process:** Cold-Holding

Location: Walk-in Cooler at 39 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: **Product/Item/Unit:** CUT TOMATO; **Temperature Process:** Cold-Holding

Location: Prep Cooler at 41 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: **Product/Item/Unit:** SOUP; **Temperature Process:** Hot-Holding

Location: Steam Table at 147 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: **Product/Item/Unit:** BEEF; **Temperature Process:** Freezer

Location: Walk-in Freezer at Degrees F.

Comment: frozen

Violation Issued?: No

Food Temperature: **Product/Item/Unit:** MILK; **Temperature Process:** Cold-Holding

Location: Upright Cooler Memory Care at 41 Degrees F.

Comment:

Violation Issued?: No



Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164

Sanitizer Observations/Recordings

Page: 1

Establishment Info

NEW PERSPECTIVE HIGHLAND PARK
St Paul
County/Group: Ramsey County

Inspection Info

Report Number: F1023251215
Inspection Type: Full
Date: 11/18/2025
Time: 11:11:30 AM

Sanitizing Chemical: Product: Chlorine; **Sanitizing Process:** Dish Machine

Location: Memory Care **Equal To** 10 PPM

Comment:

Violation Issued?: Yes

Sanitizing Chemical: Product: Quaternary Ammonia; **Sanitizing Process:** Wiping Cloth Bucket

Location: Prep Area Memory Care **Equal To** 100 PPM

Comment:

Violation Issued?: Yes

Sanitizing Equipment: Product: Hot Water; **Sanitizing Process:** Dish Machine

Location: Kitchen **Equal To** 165 Degrees F.

Comment:

Violation Issued?: No

Sanitizing Chemical: Product: Quaternary Ammonia; **Sanitizing Process:** Dispenser

Location: 3-Comp Sink **Equal To** 400 PPM

Comment:

Violation Issued?: No

Sanitizing Chemical: Product: Quaternary Ammonia; **Sanitizing Process:** Wiping Cloth Bucket

Location: Prep Area **Equal To** 400 PPM

Comment:

Violation Issued?: No

Physical Environment Inspection Report
ENGINEERING | ASSISTED LIVING

Project No: SL20168016	Date: November 17, 2025
Facility Name: New Perspective Highland Park	
Facility Address: 750 Mississippi River Blvd	

☒ TAG IDENTIFICATION: 0775

SCOPE/ SEVERITY: Level 3; Widespread TIME PERIOD OF CORRECTION: Two (2) days

1. Each assisted living facility must comply with the provisions of the Minnesota State Fire Code (MSFC) in Minnesota Rules chapter 7511. [Minn. Stat. 144G.45 subd. 2]

2. Building fire alarm systems shall be maintained and shall be inspected and tested annually. [Minn. Stat. 144G.45 subd. 2; MSFC 901.6.1]

Comments: The fire alarm panel indicated an alarm for a malfunction detector in resident room 228. The environmental services director acknowledged the alarm but stated they were unaware prior to the survey. The surveyor requested annual inspection reports on the fire alarm system and the provided report from Summit dated 1/30/25 indicated the system was not in proper working order with multiple defects or malfunctions including 18 smoke detectors. Hardwired smoke alarms were removed from the majority of resident rooms and capped over with wireless alarms. The environmental services director indicated that the newer alarms connected to the fire alarm system, but upon request was unable to provide documentation that alarms functioned properly or connected to the fire alarm system.

3. Where used in Group I-2 (ALFDC) and ambulatory care facilities, portable, electric space heaters shall be limited to those having a heating element that cannot exceed a temperature of 212°F (100°C), and such heaters shall only be used in nonsleeping staff and employee areas. [Minn. Stat. 144G.45 subd. 2; MSFC 604.10.5]

Comments: Space heaters were in use in resident room 237, resident room 135, and resident room 115.

4. Fire doors shall be maintained to be self-closing and latch as designed. Fire doors shall not be blocked, obstructed, or otherwise made inoperable. [Minn. Stat. 144G.45 subd. 2; MSFC 705]

Comments:

The door to resident room 237 was propped open.

The fire doors in the center hallway of the second floor were missing fire rating placards. The environmental services director confirmed that the doors were fire doors and that they should have been equipped with proper rated and identified doors.

The fire doors in the memory care wing hallway were missing fire rating placards. The environmental services director confirmed that the doors were fire doors and that they should have been equipped with proper rated and identified doors.

Fire rated doors to the gym were propped open with door stops preventing them from properly closing in emergency.

5. The means of egress shall be maintained free of obstructions or impediments to full instant use in case of fire or another emergency. [Minn. Stat. 144G.45 subd. 2; MSFC 1031.2]

Comments:

Furniture including shelving and couches were stored in front of an external egress door near the dumpsters. The storage of these items obstructed the path from the building. The environmental services director indicated that the furniture was scheduled to be picked up.

The stairwell on the “high-side” of the building had two mattresses stored on the landing, obstructing the path of egress.

Resident room 322 had an excessive amount of materials stored including dozens of cat litter boxes and bags of cat food in a manner that limited walking path in the unit and could obstruct egress.

6. Clothes dryers and their exhaust systems shall be cleaned as necessary to keep lint traps, exhaust ducts, and mechanical and heating components free from excessive lint accumulation. [Minn. Stat. 144G.45 subd. 2; MSFC 304.4]

Comments:

The second-floor laundry room had a significant buildup of lint, and the dryer venting was not properly attached.

The laundry room in the memory care unit on the first floor had a significant buildup of lint and the dryer venting was not properly attached.

7. Fueled equipment including, but not limited to, motorcycles, mopeds, lawn-care equipment, portable generators and portable cooking equipment, shall not be stored, operated or repaired within a building. [Minn. Stat. 144G.45 subd. 2; MSFC 313.1]

Comments: Containers of gasoline and a fueled snow blower were located in the basement hallway and must be removed.

☒ **TAG IDENTIFICATION: 0780**

SCOPE/ SEVERITY: Level 3; Widespread

TIME PERIOD OF CORRECTION: Two (2) days

1. Smoke alarms interconnected so that actuation of one alarm causes all alarms in the individual dwelling or sleeping unit to operate where more than one smoke alarm is required within an individual dwelling or sleeping unit. [Minn. Stat. 144G.45 subd.2]

Comments:

Resident units throughout the facility had multiple sets of smoke alarms present that did not properly interconnect. Hardwired smoke alarms were present in many of the resident rooms as well as at least one wireless smoke alarm. When tested in each case these smoke alarms were not interconnected. Where multiple smoke alarms are present the activation of any one alarm must cause all alarms to sound within the resident unit.

Resident room 115 did not have any functional smoke alarm installed within the unit.

2. Smoke Alarm power supply complies with MN State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated. [Minn. Stat. 144G.45 subd.2]

Comments: Hardwired smoke alarms were removed from the majority of resident rooms and capped over with wireless alarms separately. The environmental services director indicated that the newer alarms were connected to the fire alarm system, but upon request was unable to provide documentation that alarms functioned properly or connected to the fire alarm system. Existing hardwired (receiving power from the building electrical system) smoke alarms are required to be maintained as installed previously and interconnected to additional battery-operated alarms so activation of one alarm activates all alarms throughout the facility.

☒ **TAG IDENTIFICATION: 0790**

SCOPE/ SEVERITY: Level 1; Widespread

TIME PERIOD OF CORRECTION: Seven (7) days

1. Portable fire extinguishers installed and maintained to MN State Fire Code. [Minn. Stat. 144G.45 subd.2]

Comments: Fire extinguishers throughout the building had a current annual inspection tag but lacked record of monthly visual inspections by facility staff as required.

☒ **TAG IDENTIFICATION: 0800**

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Seven (7) days

1. The physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment are 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. [Minn. Stat. 144G.45 subd.2]

Comments:

The door closer on the sunroom was broken and not functional.

The faucet in resident room 311 was leaking and could not be turned off completely.

An outlet cover was missing in resident room 235

The bathroom vent fan was not properly functional in resident room 235

The floor of the housekeeping closet on the “high side” of second floor was deteriorated and crumbling with pieces missing and chipped. The floor posed a sanitation issue and tripping hazard.

The bathroom faucet was not functional in resident room 229.

Significant water damage was present on the ceiling tiles in the hallway near resident room 224.

Proper clearance was not maintained around sprinkler head in storage closet on second floor.

The cabinets in the community room kitchen were hanging loose and the hinge was damaged.

The floor in the second-floor laundry room was cracked and damaged posing a tripping hazard.

An outlet cover was missing from electrical outlet in second floor laundry room.

The light in the closet of resident room 206 was not functional when tested.

The drawer front was missing from kitchen drawer.

Damage to the wall near the resident unit door was present in resident room 206 with holes in the drywall.

The carpet had visible stains in resident room 206.

The toilet was not flushing or properly operational in resident room 311.

The closet door was missing from track in resident room 313.

The bathroom fan in resident room 313 was loud and grinding and visibly dusty. Vent should be cleaned and maintained in proper condition.

An outlet in the third-floor mechanical room was missing an outlet cover.

The thermostat unit in the third-floor mechanical room was damaged and had fallen off of mounting on the wall.

The door fob to the middle staircase (stairwell F) was damaged and could not be scanned to operate the door lock. The door was disabled and stuck in the unlocked state, but the fob was not properly maintained.

The sprinkler head in the third-floor storage room was obstructed by storage of boxes and materials.

Fire caulking was degraded and missing from openings in the furnace room connected to the gym.

The vent registers located in the gym were visibly covered in dust and dirt and should be cleaned.

An escutcheon was missing from a sprinkler head in the closet in the memory care storage closet.

Ceiling ties were absent from the ceiling in resident room 115.

The bathroom fan and venting were not properly operational in resident room 115 and should be restored and maintained.

Fire caulking was degraded and missing around the risers in the fire panel room.

There was trash and refuse in resident room 228, which should be cleared.

An inoperable wanderguard system was found installed on the staircase in the Northeast corner of the building. That equipment should be restored and maintained or removed from the door.

☒ TAG IDENTIFICATION: 0810

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Twenty One (21) days

-
1. Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. [Minn. Stat. 144G.45 subd.2]

Comments: No documentation of fire drills was provided to the surveyor when requested. The environmental services director stated they were unaware of trainings and did not think that any records existed.

2. Each assisted living facility shall develop and maintain fire safety and evacuation plans that include fire protection procedures necessary for residents. [Minn. Stat. 144G.45 subd.2]

Comments: No evacuation plan or procedures for residents were provided. Environmental services director indicated that no such plan had been created.