Electronically Delivered

July 28, 2023

Licensee
New Perspective - Prior Lake
4685 Park Nicollet Avenue
Prior Lake, MN 55372

RE: Project Number(s) SL22094015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 13, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS
The enclosed State Form documents the state correction orders. The MDH documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

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

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

The correction order documentation should include the following:

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

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

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

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

Please address your cover letter for reconsideration requests to:

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

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

If you have any questions, please contact me.

Sincerely,

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

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	22094	A. BUILDING: _____ B. WING _____	07/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE - PRIOR LAKE	4685 PARK NICOLLET AVENUE PRIOR LAKE, MN 55372

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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: SL22094015-0 On July 10, 2023, through July 13, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 94 active residents; 74 receiving services under the Assisted Living 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 License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that	0 510		

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0 510	Continued From page 1 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 (IC) program that complies with accepted health care, medical and nursing standards for infection control. The deficient practice had the potential to affect residents, employees, and visitors. 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: R3 was admitted on June 10, 2022, with diagnosis which included diabetes mellitus Type 2, cirrhosis of liver, and hypertension. R3 resided in a two-bedroom apartment which was shared with another resident not related to R3. R3 and the other resident each had their own private	0 510		

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0 510	Continued From page 2 bedroom and shared a common kitchen, laundry room, and living space. R3's Medication Administration Record (MAR) dated for July 11, 2023, included the order, "Humalog Kwik Inj [injection]100/ML," with the instruction, "Clean glucometer [a device used to check the levels of sugar in a person's blood] after each use with clorox [sic] wipe." On July 11, 2023, at 8:20 a.m. during continuous observation, unlicensed personnel (ULP)-A provided medication administration and blood glucose check treatment to R3. ULP-B entered R3's room and provided R3 their morning oral medications. ULP-B donned (put on) gloves without completing hand hygiene and completed R3's blood glucose check which included pricking R3's finger to obtain a drop of blood for the glucometer reading. ULP-B cleaned up supplies used for the glucometer reading and from providing oral medications to R3, doffed (removed) their gloves and did not complete hand hygiene. ULP-B then proceeded to leave R3's room and with contaminated hand, touched the door and door handle of R3's private room and common door to the shared apartment, touched the medication cart to replace R3's reusable items, and the shared computer used to access residents' electronic health records (EHR). ULP-B returned R3's glucometer to the storage pouch and placed the pouch back into the medication cart without cleaning with a Clorox wipe as indicated on R3's MAR. On July 12, 2023, at 11:00 a.m., licensed assisted living director (LALD)-C and clinical nurse supervisor (CNS)-D stated the licensee's expectation is for hand hygiene to be complete prior to and immediately after donning and doffing	0 510		

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0 510	Continued From page 3 gloves. CNS-D stated the glucometers are to be cleaned with Clorox wipes after each use prior to being returned to their respective pouches and stored in the medication cart. The licensee's Diabetic Care policy dated February 8, 2022, included specific instructions for blood glucose testing which indicated hand hygiene would be completed prior to donning and doffing gloves. The licensee's Hand Washing policy dated July 7, 2023, indicated hand washing would be completed before and after contact with a resident and after removal of gloves. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 660 SS=D	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	0 660		

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0 660	Continued From page 4 compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included documentation of a completed health history and symptom screening for one of two employees (unlicensed personnel (ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: The licensee's TB risk assessment dated July 10, 2023, indicated the licensee was a 'low risk.' ULP-B had a start date of December 6, 2019, to provide direct care services. ULP-B's employee record did not contain documentation of a completed health history and symptom screening. On July 10, 2023, at 1:16 p.m., licensed assisted living director (LALD)-C confirmed ULP-B had not completed the required TB history and symptom screening.	0 660		

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0 660	Continued From page 5 The licensee's Communicable Disease Tuberculosis policy dated March 13, 2023, indicated new team members will have TB rest and communicable disease screening results in the team member personnel files. 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 a facility TB risk assessment. The guidelines also indicated 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 (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be documented in the employee's record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
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	0 780		

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0 780	Continued From page 6 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 and interview, the licensee failed to provide working and/or maintenance on smoke alarms inside the resident living units. In addition, the licensee failed to provide interconnection of smoke alarms in resident living units 119, 216 237, and 239 This has the potential to directly affect the residents, visitors, and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On July 12, 2023, approximately from 10:45 a.m.	0 780		

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0 780	Continued From page 7 to 1:15 p.m., survey staff toured the facility with the maintenance staff (M)-E. During the tour, survey staff observed the following: -The smoke alarms located inside the one-bedroom resident units 119, 216 237, and 239 were not interconnected when tested by the M-E. The findings were evident as each smoke alarm sounded local when activated and did not sound other smoke alarm inside each resident living unit. -The smoke alarms were not maintained as required by state standards throughout the facility to ensure smoke alarms did not exceed 10 years from the date of manufacture. The M-E tested the smoke alarms during the tour for facility and survey staff observed/heard and the M-E verified that the sounds of the smoke alarms were impaired and/or delayed to sound for notification inside the living units. The M-E verified that the label on the back of a unit had a manufactured date stamp, May 14, 2003. The M-E also agreed and confirmed that there are about 75 percent of the smoke alarms throughout the facility that were originals to the facility and have not been replaced. Survey staff explained that the failure to replace and maintain the smoke alarms in the resident rooms within 10 years of date of manufacture will compromised the functioning of the smoke alarm sensors causing delays in proper notification to ensure safety of residents. -At least one of the required smoke alarms inside resident units 312, 311, 306, 239, 237, and 216 failed to sound when tested by the M-E. All listed findings were visually and verbally verified by the M-E accompanying the tour. On July 12, 2023, at approximately 2:30 p.m., during the exit interview, the licensed assisted	0 780		

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0 780	Continued From page 8 living director-C, M-E, and the director of operations-F acknowledged the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	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. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment of the facility in a continuous state of good repair and operation. This has the potential to directly affect the health, safety, and well-being of all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	0 800		

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0 800	Continued From page 9 On July 12, 2023, approximately from 10:45 a.m. to 1:15 p.m., survey staff toured the facility with the maintenance staff (M)-E. During the tour, survey staff observed the following: -The fire-rated door in the elevator lobby of the basement parking level failed to positively latch when closed to maintain the fire rating of the elevator lobby. -The fire-rated door for the third-floor stairway failed to positively latch when closed to maintain the fire rating of the stairway. -The water line to the trash chute had the incorrect backflow preventer (low hazard type) to prevent cross-connection and protect the building water system. The M-E commented that they no longer use the water line to clean the trash chute and will dismantle it and cap it off at the tee to minimize dead ends. -The chemical soap dispenser connected to the faucet of the mop sink located inside the first floor electrical room was not protected with the proper pressure bleeding device, creating a risk of backflow of chemicals into the potable water supply. -The emergency light inside the first-floor elevator lobby failed to work when tested by the M-E. The above findings were verified physically and/or verbally with the M-E during the facility tour. On July 12, 2023, at approximately 2:30 p.m., during the exit interview, the licensed assisted living director-C, the M-E, and the director of operations-F acknowledged the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	0 800		

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0 800	Continued From page 10 (21) days	0 800		
0 810 SS=E	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) employee 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) Employees 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 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.	0 810		

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0 810	Continued From page 11 This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to provide the minimum required employee evacuation drills for the year 2022. This has the potential to directly affect the safety of residents receiving services, staff, and visitors. 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: On July 12, 2023, at approximately 10:40 a.m., survey staff received the facility fire safety and evacuation plan and related documentation for review from the licensed assisted living director (LALD)-C before the facility tour. On July 12, 2023, approximately from 10:45 a.m. to 1:15 p.m., survey staff toured the facility with the maintenance staff (M)-E. At approximately 2:15 p.m., document review and interview with the maintenance staff (M)-E indicated that the licensee failed to provide the minimum evacuation drills of two drills per shift per year and every other month. The findings were evident as survey staff requested and did not have records of employee evacuation drills between August 31, 2021, to February 25, 2022, and February 25, 2022, to August 14, 2022. The M-E went through their electronic system (TELS) and paper documentation between those dates, and no records were available. He explained that	0 810		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 810	Continued From page 12 he was not working at this location from the period of August 2021 to early August 2022. On July 12, 2023, at approximately 2:30 p.m., during the exit interview, the LALD-C, M-E, and the director of operations-F acknowledged the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
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.	01440		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	22094	A. BUILDING: _____ B. WING _____	07/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE - PRIOR LAKE	4685 PARK NICOLLET AVENUE PRIOR LAKE, MN 55372

(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
01440	Continued From page 13 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of two unlicensed personnel ((ULP)-B) was supervised by a registered nurse (RN) within 30 days after providing delegated tasks. 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-B had a hire date of December 6, 2019, under the comprehensive home care license, and began providing assisted living services on August 1, 2021. ULP-B's employee record lacked evidence an RN conducted direct supervision of ULP-B within 30 days of performing delegated tasks. On July 11, 2023, at 8:19 a.m., ULP-B was observed to administer morning medications to a resident (R6.) On July 10, 2023, at 1:16 p.m., licensed assisted living director (LALD)-C confirmed the 30-day supervision was not completed for ULP-B. The licensee's Team Member Supervision policy dated March 16, 2023, indicated team members must be supervised by the nurse within 30 days	01440		

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	22094	A. BUILDING: _____ B. WING _____	07/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE - PRIOR LAKE	4685 PARK NICOLLET AVENUE PRIOR LAKE, MN 55372

(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
01440	Continued From page 14 of date of delegation and thereafter as warranted based on performance. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440		
01640 SS=E	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the current service plan included a signature or other authentication by	01640		

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	22094	A. BUILDING: _____ B. WING _____	07/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE - PRIOR LAKE	4685 PARK NICOLLET AVENUE PRIOR LAKE, MN 55372

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01640	Continued From page 15 the licensee and resident or resident's representative to document agreement of services to be provided for two of four residents (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 June 10, 2022. R3's Resident Service Agreement (Includes IAPP) dated March 15, 2023, identified by licensed assisted living director (LALD)-C as R3's most recent authenticated service plan included 15 listed services to be provided by the licensee. R3's Resident Service Agreement (Includes IAPP) dated July 11, 2023, identified by LALD-C as R3's current service plan include 18 listed services to be provided and an increase in total monthly charges. R3's record lacked an authenticated service plan with all current services and charges. R5 R5 was admitted on January 2, 2020. R5's Resident Service Agreement (Includes IAPP) dated February 23, 2023, identified by	01640		

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	22094	A. BUILDING: _____ B. WING _____	07/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE - PRIOR LAKE	4685 PARK NICOLLET AVENUE PRIOR LAKE, MN 55372

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01640	Continued From page 16 LALD-C as R5's most recent authenticated service plan included 26 listed services to be provided by the licensee. R5's Resident Service Agreement (Includes IAPP) dated July 11, 2023, identified by LALD-C as R5's current service plan include 25 listed services to be provided and an increase in total monthly charges. R5's record lacked an authenticated service plan with all current services and charges. On July 11, 2023, at 2:10 p.m., LALD-C stated service plans should all be authenticated when changes occur. Clinical nurse supervisor (CNS)-D stated the service plan were updated when each respective resident's comprehensive assessments indicated changes, but the nurse failed to obtain authentication when the changes were implemented. The licensee's Resident Service Plan policy dated June 22, 2023, indicated the service plan and any revisions would be signed by the nurse and the resident or resident's designated represented and included in the resident's record. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements:	02040		

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	22094	A. BUILDING: _____ B. WING _____	07/13/2023

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NEW PERSPECTIVE - PRIOR LAKE	4685 PARK NICOLLET AVENUE PRIOR LAKE, MN 55372

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02040	Continued From page 17 (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on observation, document review, and interview, the licensee failed to develop complete content of the required memory care site-specific hazard vulnerabiliy or safety risk assessment and mitigation plan. This has the potential to directly affect staff and all memory care residents receiving assisted living 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) 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 residents). The findings include: On July 12, 2023, approximately from 10:45 a.m. to 1:15 p.m., survey staff toured the facility with the maintenance staff (M)-E. On July 12, 2023, at approximately 10:40 a.m., survey staff received the documentation (undated), Memory Care Specific-2023, inside a binder for review from the licensed assisted living director (LALD)-C. At approximately 2:15 p.m., a	02040		

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02040	Continued From page 18 document review indicated the facility's safety risk assessment and mitigation plan, Memory Care Specific-2023, was incomplete and lacked mitigations in the plan to protect the memory care residents from harm. The findings were evident as there was no column to identify mitigations on the plan. On July 12, 2023, at approximately 2:30 p.m., during the exit interview, survey staff discussed with the LALD-C, M-E, and the director of operations-F about the findings and explained that the mitigations must be identified and documented in the plan documentation to protect the memory care residents from harm. In addition, survey staff advised that assessed hazard, Lake Owasso, should be further reviewed for accurate assessment and/or removed from the safety risk column as the lake is not near the property and any safety risk assessment must be site specific. The LALD-C, M-E, and the director of operations-F acknowledged the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		
02310 SS=D	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		

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02310	Continued From page 19 Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards for one of three residents (R4) with bed rails. 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: R4 was admitted on August 26, 2021. R4's Comprehensive Assessments (MN) dated February 8, 2023, May 16, 2023, and June 13, 2023, indicated under Transfer/Mobility section R4 utilized grab bars (a device attached to a person's bed to aid in bed mobility, getting in and out of bed, and commonly referred to as bed rails). On July 11, 2023, at 8:08 a.m., the surveyor observed bed rails attached to R4's bed. The bed rails were attached firmly to the frame of R4's bed and R4 stated they used the bed rails to safely get in and out of bed and to move more easily while laying in bed. On July 11, 2023, at 2:10 p.m., the surveyor directed licensed assisted living director (LALD)-C to the Minnesota Department of Health's (MDH) Assisted Living Licensure's Recourses and FAQs page related to consumer	02310		

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02310	Continued From page 20 bed rails. The surveyor requested all identified required items related to successful implementation of consumer bed rails for R4. On July 11, 2023, at 2:20 p.m., LALD-C provided R4's Individualized Bed Rail Assessment dated July 11, 2023 (after initiation of the survey). LALD-C indicated the assessment had just been completed and no bed rail assessment had been completed prior to that date. Additionally, LALD-C stated there was no documentation of when the bed rails were installed but believed a family member may have installed the bed rails. The licensee's Bed Rails policy dated June 22, 2023, indicated the required identified assessment, documentation risk vs. benefits were discussed, and guidelines would be completed when bed rails were in place. No further information provided. TIME PERIOD FOR CORRECTION: Two (2) days	02310		

Minnesota Department of Health
Environmental Health, FPLS
P.O Box 64975
Saint Paul
651-201-4500

Type: Full
Date: *07/11/23*
Time: 15:22:07
Report: 1018231120

Food and Beverage Establishment Inspection Report

Location:
New Perspective - Prior Lake
4685 Park Nicollet Avenue
Prior Lake, MN55372
Scott County, 70

Establishment Info:
ID #: 0037595
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 9522269200
ID #:

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

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Quaternary Ammonia: = 200PPM at Degrees Fahrenheit
Location: BUCKET
Violation Issued: No

Quaternary Ammonia: = 200PPM at Degrees Fahrenheit
Location: BUCKET
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding/ TOMATO
Temperature: 39 Degrees Fahrenheit - Location: PREP COOLER
Violation Issued: No

Process/Item: Cold Holding/ LETTUCE
Temperature: 39 Degrees Fahrenheit - Location: PREP COOLER
Violation Issued: No

Process/Item: Cold Holding/ CHICKEN
Temperature: 39 Degrees Fahrenheit - Location: WALK IN COOLER
Violation Issued: No

Process/Item: Hot Holding/ SOUP
Temperature: 175 Degrees Fahrenheit - Location: WARMER
Violation Issued: No

Type: Full
Date: *07/11/23*
Time: 15:22:07
Report: 1018231120
New Perspective - Prior Lake

Food and Beverage Establishment Inspection Report

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

ESTABLISHMENT USES ALL PASTEURIZED EGGS.

VIEWED EMPLOYEE ILLNESS LOG AND DISCUSSED ILLNESS POLICY.

DISHWASHER IS BEING SERVICED FOR LOW TMP READING. ESTABLISHMENT HAS A 3 COMPARTMENT SINK FOR SANITZING DISHES.

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1018231120 of 07/11/23.

Certified Food Protection Manager: MICHAEL D HERSTINE

Certification Number: FM38741 Expires: 03/13/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
MICHAEL HERSTINE

Signed: _____
Rebecca Prestwood
Sanitarian 3
6512013777
rebecca.prestwood@state.mn.us