



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

May 11, 2023

Licensee
New Perspective - Carlson Park
500 Carlson Parkway
Minnetonka, MN 55305

RE: Project Number(s) SL30757015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 19, 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).

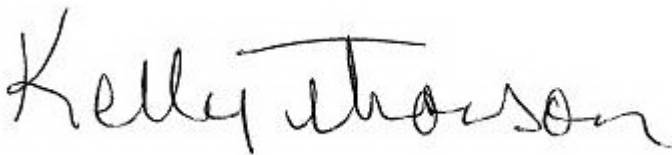
Please address your cover letter for reconsideration requests to:

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,

A handwritten signature in black ink that reads "Kelly Thorson". The signature is written in a cursive, flowing style.

Kelly Thorson, Supervisor
State Evaluation Team
Email: kelly.thorson@state.mn.us
Telephone: 320-223-7336 Fax: 651-281-9796

PMB

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30757	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/19/2023
NAME OF PROVIDER OR SUPPLIER NEW PERSPECTIVE - CARLSON PARK		STREET ADDRESS, CITY, STATE, ZIP CODE 500 CARLSON PARKWAY MINNETONKA, MN 55305		
(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: SL30757015-0 On April 17, 2023, through April 19, 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 76 residents, with 74 receiving services under the provider's Assisted Living with Dementia license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	0 480		

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: 30757	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/19/2023
NAME OF PROVIDER OR SUPPLIER NEW PERSPECTIVE - CARLSON PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 500 CARLSON PARKWAY MINNETONKA, MN 55305		
(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	
0 480	Continued From page 1 following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This had the potential to affect all 76 residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated April 17, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480			
0 500 SS=F	144G.41 Subd. 2 Policies and procedures Each assisted living facility must have policies and procedures in place to address the following and keep them current: (1) requirements in section 626.557, reporting of maltreatment of vulnerable adults;	0 500			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30757	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/19/2023
NAME OF PROVIDER OR SUPPLIER NEW PERSPECTIVE - CARLSON PARK		STREET ADDRESS, CITY, STATE, ZIP CODE 500 CARLSON PARKWAY MINNETONKA, MN 55305		
(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
0 500	Continued From page 2 (2) conducting and handling background studies on employees; (3) orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; (4) handling complaints regarding staff or services provided by staff; (5) conducting initial evaluations of residents' needs and the providers' ability to provide those services; (6) conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; (7) orientation to and implementation of the assisted living bill of rights; (8) infection control practices; (9) reminders for medications, treatments, or exercises, if provided; (10) conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; (11) ensuring that nurses and licensed health professionals have current and valid licenses to practice; (12) medication and treatment management; (13) delegation of tasks by registered nurses or licensed health professionals; (14) supervision of registered nurses and licensed health professionals; and (15) supervision of unlicensed personnel performing delegated tasks. This MN Requirement is not met as evidenced by:	0 500		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30757	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/19/2023
NAME OF PROVIDER OR SUPPLIER NEW PERSPECTIVE - CARLSON PARK		STREET ADDRESS, CITY, STATE, ZIP CODE 500 CARLSON PARKWAY MINNETONKA, MN 55305		
(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
0 500	Continued From page 3 Based on interview and record review, the licensee failed to show they had met the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations, had developed and implemented current policies and procedures, as required. Based on interview and record review, the licensee failed to show they had met the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations, had developed and implemented current policies and procedures, as required. 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: During the entrance conference on April 17, 2023, at 10:30 a.m., the surveyors requested to review the licensee's current policies and procedures. The licensee failed to ensure the following policy was in place: - a process for evaluating staff performance On April 19, 2023, at 11:30 a.m., surveyor requested the policy for the process for evaluating staff performance. No policy provided to surveyor. No further information was provided.	0 500		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30757	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/19/2023
NAME OF PROVIDER OR SUPPLIER NEW PERSPECTIVE - CARLSON PARK		STREET ADDRESS, CITY, STATE, ZIP CODE 500 CARLSON PARKWAY MINNETONKA, MN 55305		
(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
0 500	Continued From page 4	0 500		
	TIME PERIOD FOR CORRECTION: Twenty-One (21) days			
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, 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 interview and record review, the licensee failed to ensure employee records included all the required content for one of three employees (clinical nurse supervisor (CNS)- B) with employee records reviewed.	0 650		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30757	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/19/2023
NAME OF PROVIDER OR SUPPLIER NEW PERSPECTIVE - CARLSON PARK		STREET ADDRESS, CITY, STATE, ZIP CODE 500 CARLSON PARKWAY MINNETONKA, MN 55305		
(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
0 650	Continued From page 5 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: Based on interview and record review, the licensee failed to ensure employee records included all the required content for one of three employees (clinical nurse supervisor (CNS)- B) with employee records reviewed. 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: CNS-B began employment on April 10, 2010, to provide supervision and oversight of unlicensed personnel and provide direct care and services to the licensee's residents. CNS-B's employee record lacked the following required content: -documentation of annual performance reviews that identify areas of improvement needed and training needs	0 650		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30757	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/19/2023
NAME OF PROVIDER OR SUPPLIER NEW PERSPECTIVE - CARLSON PARK		STREET ADDRESS, CITY, STATE, ZIP CODE 500 CARLSON PARKWAY MINNETONKA, MN 55305		
(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
0 650	Continued From page 6 On April 19, 2023, at 9:26 a.m., licensed assisted living director (LALD)-C confirmed CNS-B's record did not contain an annual evaluation. On April 19, 2023, upon the exit conference, at 11:13 a.m., director of operations (DOO)-A confirmed oversight of CNS-B's annual evaluation stating the annual evaluation was not performed due to changes to in-person reviews due to covid. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
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	0 780		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30757	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/19/2023
NAME OF PROVIDER OR SUPPLIER NEW PERSPECTIVE - CARLSON PARK		STREET ADDRESS, CITY, STATE, ZIP CODE 500 CARLSON PARKWAY MINNETONKA, MN 55305		
(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
0 780	Continued From page 7 (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 provide audible and interconnected smoke alarms in the resident rooms throughout the facility. This deficient condition had the ability to affect all staff and residents. 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 potential to affect a large portion or all of the residents). Findings include: On a facility tour on April 18, 2023, at approximately 12:30 p.m. with environmental services director (ESD)-F it was observed that smoke detectors were installed in the resident rooms of the dementia care unit and connected to the general fire alarm system, but it was unknown if the detectors are audible in the room. Resident room smoke alarms are required to be audible in the resident room. It was observed throughout the facility that when multiple smoke alarms were installed in resident rooms the activation of one alarm did not activate all alarms in the resident room. Smoke alarms are required to be interconnected in resident	0 780		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30757	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/19/2023
NAME OF PROVIDER OR SUPPLIER NEW PERSPECTIVE - CARLSON PARK		STREET ADDRESS, CITY, STATE, ZIP CODE 500 CARLSON PARKWAY MINNETONKA, MN 55305		
(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
0 780	Continued From page 8 rooms so that activation of one activates all alarms in the resident room. A smoke alarm was observed hanging from the wires in resident room 314. This deficient finding was visually verified by ESD-F at the time of discovery. TIME PERIOD FOR CORRECTION: Seven (7) 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 facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected	0 800		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30757	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/19/2023
NAME OF PROVIDER OR SUPPLIER NEW PERSPECTIVE - CARLSON PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 500 CARLSON PARKWAY MINNETONKA, MN 55305		
(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	
0 800	Continued From page 9 or has potential to affect a large portion or all of the residents). Findings include: On a facility tour on April 18, 2023, at approximately 1:00 p.m. with environmental services director (ESD)-F it was observed that the fin tube radiation (hot water heat baseboard heater) was missing all the covers in the 3rd floor nurses office. It was also observed that the door latches were missing on corridor doors of resident rooms 324, 214, 203, 218 and 223. Latches are required to be maintained as designed and installed on fire resistant rated doors. A hole was observed in the fire-resistant rated ceiling in the electrical room on 3rd floor. Fire-resistant rated walls and assemblies are required to be maintained as designed and constructed. It was also observed that the exhaust fan in the bathroom of resident room 311 was noisy and in need of repair. It was observed pipe and wire penetrations were not fire caulked in the fire-resistant rating ceiling in the electrical room of 2nd floor electrical room. Fire-resistant rated walls, assemblies and penetrations are required to be maintained as designed and constructed. A chair rail was observed damaged and detaching from the wall in the second-floor corridor to the left when exiting the elevator. An exit sign was observed not working and	0 800			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30757	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/19/2023
NAME OF PROVIDER OR SUPPLIER NEW PERSPECTIVE - CARLSON PARK		STREET ADDRESS, CITY, STATE, ZIP CODE 500 CARLSON PARKWAY MINNETONKA, MN 55305		
(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
0 800	Continued From page 10 illuminated in the corridor near resident room 214. An exit sign was observed not working and illuminated in the corridor near the wellness room. It was observed that items were stored in the exit vestibule from the corridor near the boiler room. Exits shall be maintained free of storage that would impede full and immediate use of the exit for building occupants and emergency responders. It was observed that the boiler room door would not close and positively latch, it was out of adjustment. Fire resistant doors are required to close and latch as designed and installed. It was observed carbon monoxide alarms were installed and alarm locally in the boiler room only. Carbon monoxide detection and alarms are required to be installed and maintained in accordance with MN Statute. Consult local fire code official regarding the requirements for carbon monoxide detection and alarms. A light was observed laying on the ground with exposed electrical wires in the secured exterior courtyard. It was observed that electrical conduit was laying on the ground with exposed electrical wire left behind after removal of a fence. An exit sign was observed on the floor in the exit vestibule near resident room 179. These deficient conditions were visually verified by ESD-F accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7)	0 800		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30757	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/19/2023
NAME OF PROVIDER OR SUPPLIER NEW PERSPECTIVE - CARLSON PARK		STREET ADDRESS, CITY, STATE, ZIP CODE 500 CARLSON PARKWAY MINNETONKA, MN 55305		
(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
0 800	Continued From page 11 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) 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		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30757	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/19/2023
NAME OF PROVIDER OR SUPPLIER NEW PERSPECTIVE - CARLSON PARK		STREET ADDRESS, CITY, STATE, ZIP CODE 500 CARLSON PARKWAY MINNETONKA, MN 55305		
(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 This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to maintain the facility's fire safety and evacuation plan with required elements. This had the potential to directly affect all residents, 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) 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). A record review of available documentation and interview were conducted on April 18, 2023, at approximately 11:15 a.m. of documents provided by licensed assisted living director (LALD)-C and environmental services director (ESD)-F on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Findings include: Record review of the available documentation indicated that the licensee did not have specific employee actions for this facility to be taken in the event of a fire or similar emergency located within the plan. Record review of the available documentation indicated that the licensee did not have fire protection procedures necessary for residents located within the plan. Record review of the available documentation	0 810		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30757	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/19/2023
NAME OF PROVIDER OR SUPPLIER NEW PERSPECTIVE - CARLSON PARK		STREET ADDRESS, CITY, STATE, ZIP CODE 500 CARLSON PARKWAY MINNETONKA, MN 55305		
(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 13 indicated that employees did not receive training upon initial hire and twice per year thereafter on the facility fire safety and evacuation plan. Record review of the available documentation did not indicate that evacuation drills had been conducted twice per year per shift and least once every other month as required. All deficiencies were verified by LALD-C and ESD-F during the interview at approximately 12:00 p.m. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and	01060		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30757	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/19/2023
NAME OF PROVIDER OR SUPPLIER NEW PERSPECTIVE - CARLSON PARK		STREET ADDRESS, CITY, STATE, ZIP CODE 500 CARLSON PARKWAY MINNETONKA, MN 55305		
(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
01060	Continued From page 14 (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section. currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with required content for an emergency relocation and failed to notify the Office of Ombudsman for Long-Term Care of the emergency relocation for two of two residents (R1, 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).	01060		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30757	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/19/2023
NAME OF PROVIDER OR SUPPLIER NEW PERSPECTIVE - CARLSON PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 500 CARLSON PARKWAY MINNETONKA, MN 55305		
(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	
01060	Continued From page 15 The findings include: R1 R1 admitted for assisted living services on May 4, 2022. R1's Service Agreement effective July 19, 2022, indicated R1 received services for cognition cues, skin monitoring, monthly vitals, housekeeping, bathroom assistance, fall management, and medication administration. R1's record lacked a written notice that contains, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident has been relocated and any new service provider; - if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G. 54. The facility must provide contact information for the agency to which the resident may submit an appeal. On April 18, 2023, at 2:40 p.m., clinical nurse supervisor (CNS)-B stated R1 did not have an emergency relocation form for his hospitalization because they were under the impression that you only had to provide the emergency relocation form on day five. R5 R5 admitted for assisted living services on May 6, 2021.	01060			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30757	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/19/2023
NAME OF PROVIDER OR SUPPLIER NEW PERSPECTIVE - CARLSON PARK		STREET ADDRESS, CITY, STATE, ZIP CODE 500 CARLSON PARKWAY MINNETONKA, MN 55305		
(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
01060	Continued From page 16 R5's Service Agreement effective January 10, 2023, indicated R5 received services for dressing, grooming, nail care, skin monitoring, transfer assist, catheter assist, laundry, housekeeping, bathing, and medication administration. R5's record lacked a written notice that contains, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident has been relocated and any new service provider; - if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G. 54. The facility must provide contact information for the agency to which the resident may submit an appeal. On April 18, 2023, at 10:39 a.m. clinical nurse supervisor (CNS)-B confirmed a written notice related to R5's emergency relocation had not been completed as they had misunderstood the staute requirement. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01060		
01460 SS=D	144G.63 Subdivision 1 Orientation of staff and supervisors All staff providing and supervising direct services	01460		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30757	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/19/2023
NAME OF PROVIDER OR SUPPLIER NEW PERSPECTIVE - CARLSON PARK		STREET ADDRESS, CITY, STATE, ZIP CODE 500 CARLSON PARKWAY MINNETONKA, MN 55305		
(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
01460	Continued From page 17 must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility. This MN Requirement is not met as evidenced by: Based on interview and record review, licensee failed to ensure employee received orientation training to the assisted living licensing requirements and regulations for one of three employees (clinical nurse supervisor (CNS)-B) with records reviewed. 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: CNS-B began employment on April 10, 2010, to provide supervision and oversight of unlicensed personnel and provide direct care and services to the licensee's residents. Upon entrance conference on April 17, 2023, at 10:30 a.m., CNS- B confirmed oversight for education to unlicensed personnel and supervision of direct care and services to the licensee's residents.	01460		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30757	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/19/2023
NAME OF PROVIDER OR SUPPLIER NEW PERSPECTIVE - CARLSON PARK		STREET ADDRESS, CITY, STATE, ZIP CODE 500 CARLSON PARKWAY MINNETONKA, MN 55305		
(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
01460	Continued From page 18 CNS-B's employee records did not contain documentation CNS-B completed orientation to the assisted living facility licensing requirements and regulations before providing assisted living services to residents: -overview of Assisted Living statutes -review of provider's policies and procedures -handling emergencies and using emergency services -assisted Living bill of rights -handing of resident complaints, reporting of complaints, where to report -consumer advocacy services -review of types of Assisted Living services the employee will provide and provider's scope of license -principles of person-centered planning/service delivery. On April 19, 2023, at 9:05 a.m., licensed assisted living director (LALD)-C confirmed CNS-B's Academy New Perspective Team Member Learning Center and Relias Course Completion History forms were CNS-B's completed courses for the assisted living facility licensing requirements and regulations as required. On April 19, 2023, at 9:48 a.m., CNS-B reported they had attended an assisted living regulations boot camp via skype in the total of three hours with one of the three hours focused on dementia that was led by the licensee on December 7, 2022. The licensee's Team Member Orientation and Training policy dated, January 27, 2023, indicated per applicable law, all team members providing and supervising direct services must complete their orientation to community requirements and	01460		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30757	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/19/2023
NAME OF PROVIDER OR SUPPLIER NEW PERSPECTIVE - CARLSON PARK		STREET ADDRESS, CITY, STATE, ZIP CODE 500 CARLSON PARKWAY MINNETONKA, MN 55305		
(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
01460	Continued From page 19 applicable regulations before providing assisted living services to residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01460		
01530 SS=D	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced	01530		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30757	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/19/2023
NAME OF PROVIDER OR SUPPLIER NEW PERSPECTIVE - CARLSON PARK		STREET ADDRESS, CITY, STATE, ZIP CODE 500 CARLSON PARKWAY MINNETONKA, MN 55305		
(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
01530	Continued From page 20 by: Based on interview and record review the licensee failed to provide evidence of dementia care training on required topics for one of three employees (certified nurse supervisor (CNS)-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) 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: CNS-B began employment on April 10, 2010, to provide supervision and oversight of unlicensed personnel and provide direct care and services to the licensee's residents. CNS-B's Community Training Sign-In Sheet dated December 7, 2022, indicated CNS-B had completed the licensee's Assisted Living Regulations Boot Camp via remote with training duration of three hours with one out of the three hours focused on dementia care. CNS-B's employee record lacked at least eight hours of annual training for each 12 months of employment to include the following topics: - dementia training meeting two hours -dementia training required for all direct care staff and supervisors On April 19, 2023, at 9:48 a.m., clinical nurse supervisor (CNS)-B reported completing annual training that the licensee's home office learning and development team had assigned to CNS-B.	01530		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30757	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/19/2023
NAME OF PROVIDER OR SUPPLIER NEW PERSPECTIVE - CARLSON PARK		STREET ADDRESS, CITY, STATE, ZIP CODE 500 CARLSON PARKWAY MINNETONKA, MN 55305		
(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
01530	Continued From page 21 On April 19, 2023, at 10:47 a.m., CNS-B reported they had completed the licensee's boot camp via "skyping in later" with focused education on dementia for "about an hour." The licensee's Team Member Orientation and Training policy dated, January 27, 2023, indicated per applicable law, all team members providing direct services will receive at least eight (8) hours of annual training for each 12 months of employment. Supervisors of direct-care team members will have at least two (2) hours of annual training for each 12 months of employment on topics related to dementia care. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services 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	01640		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30757	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/19/2023
NAME OF PROVIDER OR SUPPLIER NEW PERSPECTIVE - CARLSON PARK		STREET ADDRESS, CITY, STATE, ZIP CODE 500 CARLSON PARKWAY MINNETONKA, MN 55305		
(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 22 services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a written service plan was revised to reflect the current services provided for one of four residents (R1). 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: R1's diagnoses included dementia with behavior disturbance and unspecified atrial fibrillation (irregular heartbeat). On April 18, 2023, the surveyor observed R1 sitting in the dining area of the secure unit awaiting breakfast. R1's Progress Notes dated November 17, 2022, indicated the resident was moving from the unsecure unit to the secure unit and a comprehensive assessment was completed.	01640		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30757	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/19/2023
NAME OF PROVIDER OR SUPPLIER NEW PERSPECTIVE - CARLSON PARK		STREET ADDRESS, CITY, STATE, ZIP CODE 500 CARLSON PARKWAY MINNETONKA, MN 55305		
(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 23 R1's Resident Service Agreement dated July 19, 2022, indicated R1 was being charged for Care Plan - AL 4 and Medication Plan - AL 2, which are charges for the unsecure unit. R1's service agreement had not been updated to reflect the move to the secure unit. On April 18, 2023, at 2:40 p.m., clinical nurse supervisor (CNS)-B confirmed R1's Service Plan had not been updated with the move to the secure unit. The licensee's Resident Service Plan policy, last revised March 16, 2023, indicated the service plan will serve as a basis for the service delivery contract between the Community and the resident. It will be updated to reflect changes to the services provided to the resident due to change in the residence condition, after receipt of new or revised orders from the residence physician or other prescribing provider, following an incident, or the residence return from a hospital or nursing home. The Service plan, including any revisions, is maintained in the resident health record. This Service plan is revised and signed by a nurse and the resident or the resident's legal representative anytime services change based on changes in the residents needs or preferences, and anytime the communities fee schedule changes. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01640		
01830 SS=D	144G.71 Subd. 14 Renewal of prescriptions Prescriptions must be renewed at least every 12	01830		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30757	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/19/2023
NAME OF PROVIDER OR SUPPLIER NEW PERSPECTIVE - CARLSON PARK		STREET ADDRESS, CITY, STATE, ZIP CODE 500 CARLSON PARKWAY MINNETONKA, MN 55305		
(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
01830	Continued From page 24 months or more frequently as indicated by the assessment in subdivision 2. Prescriptions for controlled substances must comply with chapter 152. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the facility failed to renew prescriptions at least every 12 months for one of four residents (R2). 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: R2's diagnoses included type 2 diabetes mellitus (a condition that happens because of a problem in the way the body regulates and uses sugar as a fuel), protein-calorie malnutrition, and metabolic encephalopathy (abnormalities of the water, electrolytes, vitamins, and other chemicals that adversely affect brain function). R2's Resident Service Agreement, signed February 24, 2022, indicated R2 required services including medication plan. R2's Medication and Treatment Assessment and Management Plan, dated September 13, 2022, indicated R2 received medication and treatment management services to be provided by	01830		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30757	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/19/2023
NAME OF PROVIDER OR SUPPLIER NEW PERSPECTIVE - CARLSON PARK		STREET ADDRESS, CITY, STATE, ZIP CODE 500 CARLSON PARKWAY MINNETONKA, MN 55305		
(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
01830	Continued From page 25 unlicensed personnel. On April 18, 2023, at 8:00 a.m., the surveyor observed unlicensed personnel (ULP)-G assist R2 with blood glucose monitoring and medication administration. R2's Medication Administration Record, dated April 2023, included the following medications: - NovoLog Flexpen 100U/ml Inject 12 units subcutaneous (under the skin) with breakfast and lunch; - NovoLog Flexpen 100U/ml Inject 10 units subcutaneous with supper; - olanzapine 5mg one tablet once daily at noon and one tablet as needed for anxiety; - polyethylene glycol mix 1 capful (17Grams) in liquid and take by mouth once daily for bowel management; - quetiapine 25mg one tablet by mouth two times a day and one tablet by mouth daily as needed for agitation; - acetaminophen (pain reliever) extra strength 500 mg two tablets by mouth three times daily as needed for pain; - loperamide 2 mg two tablets by mouth as needed and in addition one tablet by mouth for each additional loose stool not to exceed 16mg in 24 hours; - Baza protect barrier cream apply three times topically (on top of skin) to intact stage 1 pressure area as needed; - bisacodyl suppository 10 mg insert one suppository rectally once daily as needed; - Milk of Magnesia 400 mg by mouth once daily as needed for bowel management; - mucus-chest congestion 200mg/10ml take 10ml by mouth as needed for congestion; - Nystatin 100,000u/gm cream apply a small amount to affected area twice daily as needed;	01830		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30757	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/19/2023
NAME OF PROVIDER OR SUPPLIER NEW PERSPECTIVE - CARLSON PARK		STREET ADDRESS, CITY, STATE, ZIP CODE 500 CARLSON PARKWAY MINNETONKA, MN 55305		
(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
01830	Continued From page 26 - Off family care insect repelle apply a small amount to skin for bug bite protection as needed; - Sunscreen Banana Boat 30 spf (skin protection factor) apply a small amount topically to skin exposed to sun as needed; and - triple antibiotic ointment apply a small amount topically to affected area three times a day as needed for minor skin abrasions. R2's most current prescriber orders, dated February 25, 2022, included all the above medications or the licensee had provided new signed orders for unincluded medications; however, the prescriber's orders were 51 days past the annual renewal date requirement. On April 18, 2023, at 2:40 p.m., clinical nurse supervisor (CNS)-B stated R2's prescriber orders were late. The licensee's Medication Management policy, revised September 2022, indicated the nurse would ensure that a system is in place ensuring that physician orders are review and reordered by the resident's physicians every 12 months. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01830		
02140 SS=F	144G.83 Subd. 3 Supervising staff training Persons providing or overseeing staff training must have experience and knowledge in the care of individuals with dementia, including: (1) two years of work experience related to Alzheimer's disease or other dementias, or in health care, gerontology, or another related field;	02140		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30757	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/19/2023
NAME OF PROVIDER OR SUPPLIER NEW PERSPECTIVE - CARLSON PARK		STREET ADDRESS, CITY, STATE, ZIP CODE 500 CARLSON PARKWAY MINNETONKA, MN 55305		
(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
02140	Continued From page 27 and(2) completion of training equivalent to the requirements in this section and successfully passing a skills competency or knowledge test required by the commissioner. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the designated person overseeing staff training in the care of individuals with dementia (clinical nurse supervisor (CNS)-B), had documented evidence of competency or knowledge test required by the commissioner. This had the potential to affect all residents and staff of the facility. 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: The facility was licensed as an assisted living facility with dementia care. During the entrance conference on April 17, 2023, at 10:30 a.m., CNS-B and director of operations (DOO)-A identified CNS-B responsible for oversight for the dementia care training for staff. On April 19, 2023, at 8:18 a.m., licensed assisted living director (LALD)-C provided the surveyor with Relias Course Completion History dated, February 28, 2019, and Academy New	02140		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30757	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/19/2023
NAME OF PROVIDER OR SUPPLIER NEW PERSPECTIVE - CARLSON PARK		STREET ADDRESS, CITY, STATE, ZIP CODE 500 CARLSON PARKWAY MINNETONKA, MN 55305		
(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
02140	Continued From page 28 Perspective Team Member Learning Center form. On April 19, 2023, at 8:19 a.m., CNS-B reported they had not completed the competency knowledge test in required dementia training. The licensee's Team Member Orientation and Training policy dated, January 27, 2023, indicated persons providing or overseeing team member training will have experience and knowledge om care of individuals with dementia, including completion of training equivalent to the requirements of applicable law and successfully passing a skills competency or knowledge test. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02140		

Type: Full
Date: 04/17/23
Time: 11:31:44
Report: 7994231086

Food and Beverage Establishment Inspection Report

Page 1

Location:

New Perspective - Carlson Park
500 Carlson Parkway
Minnetonka, MN55305
Hennepin County, 27

Establishment Info:

ID #: 0038263
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 9524733330
ID #:

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

The following orders were issued during this inspection.

4-300 Equipment Numbers and Capacities

4-302.13B ** Priority 2 **

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

FACILITY DOES NOT HAVE A MEASURING DEVICE TO MEASURE THE UTENSIL TEMPERATURE IN THE DISHWASHER. DISCUSSED SEVERAL OPTIONS SUCH AS THERMOMETERS OR COLOR CHANGING STRIPS/STICKERS.

Comply By: 04/17/23

4-200 Equipment Design and Construction

4-204.11

MN Rule 4626.0565 Prevent grease or condensation from exhaust ventilation hood systems from draining or dripping onto food, equipment, utensils, linens, single-service articles, and single-use articles.

BUILD UP FOUND ON HOOD VENT FILTERS. CLEAN THESE MORE FREQUENTLY TO PREVENT BUILD UP.

Comply By: 04/28/23

4-500 Equipment Maintenance and Operation

4-501.11AB

MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.

SINGLE DOOR COOLER UNDER JUICE DISPENSER IS MISSING A WHEEL OR SUPPORT LEG. REPAIR OR REPLACE THIS COOLER.

Comply By: 04/28/23

Type: Full
Date: 04/17/23
Time: 11:31:44
Report: 7994231086
New Perspective - Carlson Park

Food and Beverage Establishment Inspection Report

Page 2

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

INSPECTION CONDUCTED IN THE PRESENCE OF HRD STAFF AND FINDINGS SHARED AT THE END OF INSPECTION WITH THE PERSON IN CHARGE AND HRD STAFF.

TEMPERATURES:

EGG 38

TOMATO 38

HAMBURGER 39

HAM 39

SAUCE 173

NOODLES 149

VEG 154

SANITIZERS:

DISHWASHER 161 F

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 7994231086 of 04/17/23.

Certified Food Protection Manager: Troy M Benedict

Certification Number: 59882 Expires: 03/12/24

Inspection report reviewed with person in charge and emailed.

Signed: _____

Establishment Representative

Signed: 

Crystal Elva
Public Health Sanitarian 3
St Paul
651-201-3981
Crystal.Elva@state.mn.us

Report #: 7994231086

Food Establishment Inspection Report



Minnesota Department of Health

625 Robert Street North
St Paul

No. of RF/PHI Categories Out

0

Date 04/17/23

No. of Repeat RF/PHI Categories Out

0

Time In 11:31:44

Legal Authority MN Rules Chapter 4626

Time Out

New Perspective - Carlson Park

Address

500 Carlson Parkway

City/State

Minnetonka, MN

Zip Code

55305

Telephone

9524733330

License/Permit #
0038263

Permit Holder

Purpose of Inspection
Full

Est Type

Risk Category

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item

Mark "X" in appropriate box for COS and/or R

IN= in compliance

OUT= not in compliance

N/O= not observed

N/A= not applicable

COS= corrected on-site during inspection

R= repeat violation

Compliance Status		COS	R
Supervision			
1	IN OUT		
2	IN OUT N/A		
Employee Health			
3	IN OUT		
4	IN OUT		
5	IN OUT		
Good Hygienic Practices			
6	IN OUT N/O		
7	IN OUT N/O		
Preventing Contamination by Hands			
8	IN OUT N/O		
9	IN OUT N/A N/O		
10	IN OUT		
Approved Source			
11	IN OUT		
12	IN OUT N/A N/O		
13	IN OUT		
14	IN OUT N/A N/O		
Protection from Contamination			
15	IN OUT N/A N/O		
16	IN OUT N/A		
17	IN OUT		

Compliance Status		COS	R
Time/Temperature Control for Safety			
18	IN OUT N/A N/O		
19	IN OUT N/A N/O		
20	IN OUT N/A N/O		
21	IN OUT N/A N/O		
22	IN OUT N/A		
23	IN OUT N/A N/O		
24	IN OUT N/A N/O		
Consumer Advisory			
25	IN OUT N/A		
Highly Susceptible Populations			
26	IN OUT N/A		
Food and Color Additives and Toxic Substances			
27	IN OUT N/A		
28	IN OUT		
Conformance with Approved Procedures			
29	IN OUT N/A		

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

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" in box if numbered item is **not** in compliance

Mark "X" in appropriate box for COS and/or R

COS= corrected on-site during inspection

R= repeat violation

Compliance Status		COS	R
Safe Food and Water			
30	IN OUT N/A		
31			
32	IN OUT N/A		
Food Temperature Control			
33			
34	IN OUT N/A N/O		
35	IN OUT N/A N/O		
36			
Food Identification			
37			
Prevention of Food Contamination			
38			
39			
40			
41			
42			

Compliance Status		COS	R
Proper Use of Utensils			
43			
44			
45			
46			
Utensil Equipment and Vending			
47	X		
48	X		
49			
Physical Facilities			
50			
51			
52			
53			
54			
55			
56	X		
57			
58			

Food Recalls:

Person in Charge (Signature)

Date: 04/17/23

Inspector (Signature)