

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL31733001M
Compliance #: HL31733002C

Date Concluded: September 13, 2022

Name, Address, and County of Licensee

Investigated:

New Perspective Woodbury
2195 Century Avenue South
Woodbury, MN 55125
Washington County

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

Evaluator's Name: Michele R. Larson
Special Investigator

Finding: Substantiated, facility responsibility

Nature of Visit:

The Minnesota Department of Health investigated an allegation of maltreatment, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557, and to evaluate compliance with applicable licensing standards for the provider type.

Initial Investigation Allegation(s):

The facility neglected the resident when they forced the resident to use a Hoyer lift for three months, disregarding the resident's physician's orders to be weight bearing. The resident developed deconditioning and a deep flexion contracture with her left leg due using the Hoyer lift for months.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. Review of the resident's record indicated the facility

acknowledged receipt of the physician orders to discontinue the Hoyer (total body mechanical lift) and told the resident's family member the order was never received. The facility never contacted the resident's physician with any concerns or questions regarding discontinuing the Hoyer lift. The resident's outside agency home health aide (HHA) had no issues transferring the resident by herself using only a gait belt. The resident did not like the Hoyer lift and questioned staff why she still used the Hoyer lift for transfers. The resident did not require a Hoyer lift after she moved out of the facility.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator interviewed a family member and contacted the resident's attending physician. The investigation included review of the resident's medical records from the facility, and medical clinics. The investigation included review of the facility's policies and procedures. Also, the investigator observed the facility and staff interactions.

The resident previously resided in the independent living area of the facility for many years but moved into assisted living. The resident's diagnoses included a left leg fracture and macular degeneration. The resident's service plan included assistance with personal cares, meals, fall management, laundry, and housekeeping. The resident received in-house physical and occupational therapy (PT, OT) services. The resident's assessments from her physician and family provider indicated the resident was alert and oriented. The resident used a wheelchair for mobility and then a Hoyer lift for transfers.

The resident's record indicated the resident experienced a fall while living independently in the facility. The resident was diagnosed with a fracture of the left lower leg. The resident's attending orthopedic physician ordered the resident on weight bearing restrictions (toe touch with the left leg), and a knee brace to be worn during the day. In addition, the resident was to receive in-house PT and OT rehabilitation exercises. The resident's family moved the resident temporarily in assisted living so the resident could receive assistance with her activities of daily living (ADL)s while her leg healed.

The resident's progress note indicated a nurse reached out to the resident's family member stating the resident required a transfer assist of three staff members and stated her PT and OT recommended the resident use a Hoyer lift for transferring. The family member found the nurse's information confusing stating the resident's HHA, from another agency, was able to safely transfer the resident by herself using only a gait belt and stated he never received updates from PT and OT regarding the resident's transfer status. The family member stated he would think about the request. After speaking to the family member, the nurse contacted the resident's family provider to request orders for a Hoyer lift. The provider was not the physician actively monitoring the resident's care through her injury and rehabilitation.

The resident's external medical record indicated the resident's physician assessed the resident as being able to advance to full weight bearing on her left leg, in addition to discontinuing the

Hoyer lift and knee brace. In addition, the attending physician ordered advanced range of motion (ROM), strengthening exercises and gait training with a PT. The resident's physician indicated the resident's left leg was deconditioned due to inactivity following her leg fracture. The resident was oriented to person, place, and time. The physician faxed the new orders to the facility.

The resident's progress note indicated the same day, the family member stopped by the facility and told the nurse the resident's physician ordered the Hoyer lift to be discontinued. The nurse stated she would contact the physician's office regarding the new orders.

The resident's record lacked documentation the nurse contacted the resident's physician regarding the new orders.

A progress note documented by the nurse indicated the nurse acknowledged she received the physician's orders to have the resident to resume all activities and start weight bearing on her left leg. The note was written the same day the nurse obtained Hoyer lift orders from the family provider.

A resident progress note indicated the nurse told the family member she never received the new orders from the resident's physician to discontinue the Hoyer lift, although the nurse acknowledged receiving the orders. The nurse stated the facility would continue to use the Hoyer lift for all the resident's transfers.

A resident progress note indicated the resident was able to stand on both legs during care and transfer during the months she was forced to use a Hoyer lift. The progress note indicated the resident asked staff members why she was still using the Hoyer lift.

The resident's record indicated staff used the Hoyer lift for an additional three months after the attending physician ordered the Hoyer lift be discontinued.

The resident's external medical record indicated the resident's physician assessed the resident as being able to bear full weight without restrictions. The physician assessed the resident as having a deep flexion contracture of her left leg due to deconditioning from continued use of the Hoyer lift and not being allowed to bear weight on her left leg.

The resident's clinic medical record indicated the resident's family provider faxed an order to the facility to defer all requests for Hoyer lifts and mobility transfer equipment to the resident's physician. The resident's clinical medical record indicated during a clinical visit the resident's family provider documented the resident did not have any documented history of cognitive decline except for a recent episode of confusion due to a urinary tract infection (UTI).

The resident's record indicated the facility sent a letter to the resident and the family member requesting a pretermination hearing due to the resident and family member's refusal to have

the resident moved into their memory care unit. The facility stated this was due to the resident's inability to bear weight. The pretermination hearing was cancelled after the family member gave the facility a 30-day notice and moved the resident to a new facility.

The resident's external record from the receiving facility indicated the resident did not require using a Hoyer lift for transfers after she moved out of the facility.

During an interview, the nurse stated the facility's uniform disclosure of assisted living services (UDALSA) form initially indicated the facility used Hoyer lifts in assisted living but changed it after the resident signed the agreement for services. The nurse stated she told the family member they did not use Hoyer lifts in assisted living, but they did use them in memory care. The nurse stated the resident could move into a secured memory care unit so she could continue to use a Hoyer lift. The nurse stated, "Our goal was to move the resident to memory care to get assistance with the Hoyer."

During an interview, an unlicensed staff member stated the resident did not like using the Hoyer lift and preferred walking to the bathroom rather than waiting to be transferred using the Hoyer lift. The unlicensed staff member stated she personally thought the resident was suitable for assisted living, even though she occasionally was forgetful.

During an interview, the administrative staff person stated the resident used the Hoyer lift until she moved out of the facility.

During an interview, the resident's HHA stated she provided cares for the resident for over seven years and stated the only time the resident was confused was when she was diagnosed with a UTI. The HHA stated the resident did not like the Hoyer lift and stated unlicensed staff members had trouble using the Hoyer lift and transferred the resident without speaking to her or telling the resident what they were doing. The HHA stated the facility raised the resident's bed which made the resident more fearful of falling. The HHA stated the resident moved with minimal assist, even with her knee brace on. The HHA stated she had no trouble transferring the resident by herself even though she was only 4'10" and weighed 98 pounds.

During an interview, the family member stated the facility ignored the resident's physician's orders to discontinue the Hoyer lift and resume full weight bearing on her left leg. The family member said instead the facility obtained an order from the resident's family provider to keep the resident in the Hoyer lift. The family member stated the facility never communicated with the resident's physician. The family member stated, the facility did something that caused the resident "great physical and emotional harm." The family member said, the facility would not let her heal.

In conclusion, the Minnesota Department of Health determined that neglect was substantiated.

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.

“Substantiated” means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17

"Neglect" means:

- (a) The failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:
- (1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
 - (2) which is not the result of an accident or therapeutic conduct.

Vulnerable Adult interviewed: No.

Family/Responsible Party interviewed: Yes.

Alleged Perpetrator interviewed: Not applicable.

Action taken by facility:

No action was taken by the facility.

Action taken by the Minnesota Department of Health:

The responsible party will be notified of their right to appeal the maltreatment finding.

The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:

<https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html>

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

cc:

The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Washington County Attorney
Woodbury City Attorney
Woodbury Police Department
Minnesota Board of Nursing

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31733	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 05/05/2022
NAME OF PROVIDER OR SUPPLIER NEW PERSPECTIVE - WOODBURY		STREET ADDRESS, CITY, STATE, ZIP CODE 2195 CENTURY AVENUE SOUTH WOODBURY, MN 55125			
(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	<p>Initial Comments</p> <p>Initial comments *****ATTENTION*****</p> <p>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER</p> <p>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation.</p> <p>Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance.</p> <p>INITIAL COMMENTS:</p> <p>#HL31733002C/#HL31733001M #HL31733004C/#HL31733003M</p> <p>On May 5, 2022, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 61 clients receiving services under the provider's Assisted Living with Dementia Care license.</p> <p>The following correction orders are issued for #HL31733002C/#HL31733001M, tag identification 250, 630, 1620, 1960, 2360 and 2560</p> <p>The following correction orders are issued for #HL31733004C/#HL31733003M, tag identification 250, 620, 630, 1620, 1640, 1650, 3000.</p>	0 000	<p>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 Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction.</p> <p>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.</p> <p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</p> <p>THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.</p>		

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: 31733	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 05/05/2022
NAME OF PROVIDER OR SUPPLIER NEW PERSPECTIVE - WOODBURY			STREET ADDRESS, CITY, STATE, ZIP CODE 2195 CENTURY AVENUE SOUTH WOODBURY, MN 55125		
(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
0 250 SS=G	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under	0 250			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31733	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 05/05/2022
NAME OF PROVIDER OR SUPPLIER NEW PERSPECTIVE - WOODBURY		STREET ADDRESS, CITY, STATE, ZIP CODE 2195 CENTURY AVENUE SOUTH WOODBURY, MN 55125			
(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
0 250	<p>Continued From page 2</p> <p>section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the management officials who were in charge of the day-to-day operations; and responsible for the resident's assisted living services, understood all of the assisted living facility regulations. This had the potential to affect all residents.</p> <p>This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to 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).</p> <p>The findings include:</p> <p>The licensee's "Application for Assisted Living License", section titled "Official Verification of Owner or Authorized Agent", (page four and five of the application), identified, "I certify I have read</p>	0 250			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31733	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 05/05/2022
NAME OF PROVIDER OR SUPPLIER NEW PERSPECTIVE - WOODBURY		STREET ADDRESS, CITY, STATE, ZIP CODE 2195 CENTURY AVENUE SOUTH WOODBURY, MN 55125			
(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
0 250	Continued From page 3 and understand the following:" [a check mark was placed before each of the following]: - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45 (opens in a new window), my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17 (opens in a new window). - I have read and fully understand Minn. Stat. sect. 144G.80 (opens in a new window), 144G.81 (opens in a new window). and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22 (opens in a new window), my building(s) must comply with these sections if applicable. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G (opens in a new window). - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659 (proposed and not final) (opens in a new window). - Reporting of Maltreatment of Vulnerable Adults (opens in a new window). - Electronic Monitoring in Certain Facilities (opens in a new window)." - "I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G (opens in a new window), and Minnesota Rules, chapter 4659 (proposed and not final) (opens in a new window), governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract." - "I have examined this application and all attachments, and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is	0 250			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31733	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 05/05/2022
NAME OF PROVIDER OR SUPPLIER NEW PERSPECTIVE - WOODBURY		STREET ADDRESS, CITY, STATE, ZIP CODE 2195 CENTURY AVENUE SOUTH WOODBURY, MN 55125			
(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
0 250	Continued From page 4 true, correct and complete. I will notify MDH, in writing, of any changes to this information as required." - I attest to have all required policies and procedures of Minn. Stat. chapter 144G (opens in new window). and Minn. Rules chapter 4659 (proposed and not final) (opens in new window), in place upon licensure and to keep them current as applicable." Page five was electronically signed by the owner on May 26, 2021. The licensee had an assisted living license, effective August 1, 2021. Four (4) level three correction orders were issued, which indicated the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.01 to 144G.95. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 250			
0 620 SS=E	144G.42 Subd. 6 (a) Compliance with requirements for reporting ma 144G.42 Subd. 6. Compliance with requirements for reporting maltreatment of vulnerable adults; abuse prevention plan. (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported.	0 620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31733	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 05/05/2022
NAME OF PROVIDER OR SUPPLIER NEW PERSPECTIVE - WOODBURY		STREET ADDRESS, CITY, STATE, ZIP CODE 2195 CENTURY AVENUE SOUTH WOODBURY, MN 55125			
(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
0 620	<p>Continued From page 5</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to comply with the requirements for reporting suspected maltreatment within 24 hours for two of four residents (R2, R3) with records reviewed. R2 was allegedly sexually assaulted by another resident in the facility. In addition, R3 was found walking down an entrance freeway ramp one evening. The facility was aware of the incidents but did not report the incidents to the Minnesota Adult Abuse Reporting Agency (MAARC).</p> <p>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).</p> <p>The findings include:</p> <p>R2 R2's medical record was reviewed. R2 admitted to the licensee on April 22, 2021, under the comprehensive license and began receiving assisted living services on August 1, 2021. R2's diagnoses included major depressive disorder, anxiety, post-traumatic stress disorder (PTSD), multiple sclerosis, and mania. R2 used a cane for walking.</p> <p>R2's service plan dated January 11, 2022, indicated R2 received assistance with personal cares, fall management, weekly laundry,</p>	0 620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31733	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 05/05/2022
NAME OF PROVIDER OR SUPPLIER NEW PERSPECTIVE - WOODBURY		STREET ADDRESS, CITY, STATE, ZIP CODE 2195 CENTURY AVENUE SOUTH WOODBURY, MN 55125			
(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
0 620	<p>Continued From page 6</p> <p>housekeeping, and daily safety checks.</p> <p>R2's comprehensive assessment dated January 11, 2022, indicated R2 had experienced dizziness and vertigo due to her diagnoses of vertigo. R2 was independent with transportation, and managing her medications.</p> <p>R2's individual abuse prevention plan (IAPP) dated January 11, 2022, indicated R2 had difficulty reporting abuse and was susceptible to being abused by other adults. Staff were to immediately notify a supervisor for any signs or symptoms of abuse or neglect.</p> <p>A law enforcement report dated January 16, 2022, at 6:28 p.m., indicated R2 told hospital staff she was sexually assaulted by another resident (R3) while taking out her trash at 6:00 a.m. in the lower level of the facility. During her interview with law enforcement, R2 stated R3 placed his hands on her breast, telling R2 he was going to "Fuck you." R2 told law enforcement she wanted the incident documented but did not R3 contacted.</p> <p>Facility records lacked evidence a MAARC report was filed for R2's alleged sexual assault.</p> <p>R3 R3's medical record was reviewed. R3 admitted to the licensee on November 2, 2021. R3 diagnoses included dementia without behavioral disturbance and chronic kidney disease Stage 3. R3 walked independently.</p> <p>R3's service plan dated November 16, 2021, indicated R3 received assistance with hand washing, medication management, fall management, safety checks, weekly laundry and housekeeping.</p>	0 620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31733	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 05/05/2022
---	---	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NEW PERSPECTIVE - WOODBURY

**2195 CENTURY AVENUE SOUTH
WOODBURY, MN 55125**

(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
0 620	<p>Continued From page 7</p> <p>R3's comprehensive assessment dated February 14, 2022, indicated R3 lacked physical, mental, and cognitive capability to evacuate self in an emergency. R3 had having cognitive impairment, memory loss, chronic pain, and being unable to report abuse and was susceptible to being abused by others. R3 was independent in personal cares and required no 1:1 supervision.</p> <p>R3's IAPP dated November 16, 2021, indicated staff were to immediately notify a supervisor for any signs or symptoms of abuse or neglect.</p> <p>R3's incident report dated May 2, 2022, at 5:40 p.m., indicated unlicensed personnel (ULP)-B found R3 walking down a freeway ramp. ULP-B assisted R3 into her vehicle after unsuccessful attempts. R3 started crying when he got into ULP-B's vehicle, stating he did not know where he was going, and requested ULP-B not tell anyone. R3's family and licensed assisted living director (LALD)-E were notified. R3 had no apparent injuries. R3's incident report indicated R3's vital signs were not obtained. R3's physician was notified on May 11, 2022, at 8:00 a.m.</p> <p>R3's progress note, dated May 5, 2022, at 6:01 a.m., indicated a staff member found R3 walking down an entrance ramp to a major freeway. The staff member assisted R3 back to the facility after multiple attempts. R3's family was contacted. The progress note indicated R3 returned to his baseline with no concerns from nursing staff.</p> <p>On June 14, 2022, at 10:00 a.m., licensed assisted living director (LALD)-E stated the facility did not file a MAARC report on R2's alleged assault stating she was told law enforcement filed a report.</p>	0 620		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31733	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 05/05/2022
NAME OF PROVIDER OR SUPPLIER NEW PERSPECTIVE - WOODBURY		STREET ADDRESS, CITY, STATE, ZIP CODE 2195 CENTURY AVENUE SOUTH WOODBURY, MN 55125			
(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
0 620	Continued From page 8 On June 16, 2022, at 9:00 a.m., director of nursing (DON)-F stated she was unsure if she reassessed R2 after the alleged sexual assault. DON-F stated R2 went to the hospital so often. DON-F stated R2 made vague comments stating R3 was naked and harassing her outside of her apartment. DON-F stated she told R2 she and LALD-E would conduct an investigation the following day. R2 and R3's records lacked incident reports or an investigation of the alleged sexual assault. On July 7, 2022, LALD-E confirmed to DON-F, the facility did not file a report to the Minnesota Adult Abuse Reporting Center. LALD-E indicated she reached out to the facility's district and legal executives who told LALD-E a MAARC report did not need to be filed for R3's incident. The licensee policy titled, Maltreatment of a Resident, dated November 5, 2021, indicated all allegations, suspicions, or complaints of abuse, neglect, or financial exploitation would be treated as serious, investigated with appropriate follow-up, and reported in accordance with state laws and regulations. TIME PERIOD TO CORRECT: Seven (7) days.	0 620			
0 630 SS=G	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another	0 630			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31733	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 05/05/2022
NAME OF PROVIDER OR SUPPLIER NEW PERSPECTIVE - WOODBURY		STREET ADDRESS, CITY, STATE, ZIP CODE 2195 CENTURY AVENUE SOUTH WOODBURY, MN 55125			
(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
0 630	<p>Continued From page 9</p> <p>individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statement of specific measures to be taken to minimize the risk of abuse to the person and other vulnerable adults for four of four residents (R1, R2, R3, R4) with records reviewed. In addition, the licensee failed to update R2's IAPP after she told licensee staff R3 sexually assaulted her and failed to update R3's IAPP after he was found wandering down a major freeway ramp.</p> <p>This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to 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).</p> <p>The findings include:</p> <p>R1 R1's medical record was reviewed. R1 moved</p>	0 630			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31733	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 05/05/2022
NAME OF PROVIDER OR SUPPLIER NEW PERSPECTIVE - WOODBURY			STREET ADDRESS, CITY, STATE, ZIP CODE 2195 CENTURY AVENUE SOUTH WOODBURY, MN 55125		
(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
0 630	<p>Continued From page 10</p> <p>into independent living on July 29, 2015, and began receiving assisted living services on September 2, 2021. R1's diagnoses included macular degeneration, rheumatoid arthritis, and chronic low back pain. R1 used a wheelchair for mobility and a Hoyer lift for all transfers.</p> <p>R1's service plan dated October 27, 2021, indicated R1 received assistance with personal cares, meals, cognition cues, prompts, hearing aids, glasses, pain control, housekeeping, laundry, fall management, and toileting. In addition, R1 received weekly physical and occupational therapy for lower and upper body strengthening due to a lower left leg fracture (left medial tibial plateau).</p> <p>R1's IAPP dated October 27, 2021, indicated staff were to minimize potential risks to self and other vulnerable adults. Staff were to immediately notify a supervisor for any signs or symptoms of abuse or neglect.</p> <p>R1's IAPP lacked evidence an individualized review or assessment was developed that assessed R1's susceptibility to abuse by another individual, including other vulnerable adults; the risk of abusing other vulnerable adults; and statement of specific measures to be taken to minimize the risk of abuse to R1 and other vulnerable adults</p> <p>R2 R2's medical record was reviewed. R2 was admitted to the facility on April 22, 2021, under the comprehensive license and began receiving assisted living services on August 1, 2021. R2's diagnoses included major depressive disorder, anxiety, post-traumatic stress disorder (PTSD), multiple sclerosis (MS), and mania. R2 used a</p>	0 630			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31733	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 05/05/2022
NAME OF PROVIDER OR SUPPLIER NEW PERSPECTIVE - WOODBURY		STREET ADDRESS, CITY, STATE, ZIP CODE 2195 CENTURY AVENUE SOUTH WOODBURY, MN 55125			
(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
0 630	<p>Continued From page 11</p> <p>cane for walking during times of MS exacerbations.</p> <p>R2's service plan dated January 11, 2022, indicated R2 received assistance with personal cares, fall management, weekly laundry, housekeeping, and daily safety checks.</p> <p>R2's comprehensive assessment dated January 11, 2022, indicated R2 was assessed as experienced dizziness and vertigo due to her diagnoses of vertigo. R2 was independent with transportation, and managing her medications.</p> <p>R2's IAPP dated January 11, 2022, indicated R2 had difficulty reporting abuse and was susceptible to being abused by other adults. Staff were to immediately notify a supervisor for any signs or symptoms of abuse or neglect.</p> <p>R2's IAPP lacked evidence an individualized review or assessment was developed that assessed R2's susceptibility to abuse by another individual, including other vulnerable adults; the risk of abusing other vulnerable adults; and statement of specific measures to be taken to minimize the risk of abuse to R2 and other vulnerable adults.</p> <p>A law enforcement report dated January 16, 2022, at 6:28 p.m., indicated R2 was at a local hospital where she told hospital staff she was sexually assaulted by another resident (R3) while taking out her trash at 6:00 a.m. in the lower level of the facility. During her interview with law enforcement, R2 sated R3 placed his hands on her breast, telling R2 he was going to "Fuck you." R2 told law enforcement she wanted the incident documented but did not R3 contacted.</p>	0 630			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31733	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 05/05/2022
NAME OF PROVIDER OR SUPPLIER NEW PERSPECTIVE - WOODBURY		STREET ADDRESS, CITY, STATE, ZIP CODE 2195 CENTURY AVENUE SOUTH WOODBURY, MN 55125			
(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
0 630	<p>Continued From page 12</p> <p>R2's record lacked evidence her IAPP was updated addressing R2's alleged sexual assault along with specific measures to be taken for her new listed vulnerability.</p> <p>R3 R3's medical record was reviewed. R3 was admitted to the facility on November 2, 2021. R3 diagnoses included dementia without behavioral disturbance and chronic kidney disease Stage 3. R3 walked independently.</p> <p>R3's service plan dated November 16, 2021, indicated R3 received assistance with hand washing, medication management, fall management, safety checks, weekly laundry and housekeeping.</p> <p>R3's comprehensive assessment dated February 14, 2022, indicated R3 lacked physical, mental, and cognitive capability to evacuate self in an emergency. R3 was assessed as having cognitive impairment, memory loss, chronic pain, and being unable to report abuse and was susceptible to being abused by others. R3 was independent in personal cares and required no 1:1 supervision.</p> <p>R3's IAPP dated November 16, 2021, indicated staff were to immediately notify a supervisor for any signs or symptoms of abuse or neglect.</p> <p>R3's IAPP lacked evidence an individualized review or assessment was developed that assessed R3's susceptibility to abuse by another individual, including other vulnerable adults; the risk of abusing other vulnerable adults; and statement of specific measures to be taken to minimize the risk of abuse to R3 and other vulnerable adults.</p>	0 630			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31733	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 05/05/2022
NAME OF PROVIDER OR SUPPLIER NEW PERSPECTIVE - WOODBURY		STREET ADDRESS, CITY, STATE, ZIP CODE 2195 CENTURY AVENUE SOUTH WOODBURY, MN 55125			
(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
0 630	<p>Continued From page 13</p> <p>R3's progress note, dated May 5, 2022, at 6:01 a.m., indicated a staff member found R3 walking down an entrance ramp to a major freeway. The staff member assisted R3 back to the facility after multiple attempts. R3's family was contacted. The progress note indicated R3 returned to his baseline with no concerns from nursing staff.</p> <p>R3's incident report dated May 2, 2022, at 5:40 p.m., indicated unlicensed personnel (ULP)-B found R3 walking down a freeway ramp. ULP-B assisted R3 into her vehicle after unsuccessful attempts. R3 started crying when he got into ULP-B's vehicle, stating he did not know where he was going, and requested ULP-B not tell anyone. R3's family and licensed assisted living director (LALD)-E were notified. R3 had no apparent injuries. R3's incident report indicated R3's vital signs were not obtained. R3's physician was notified on May 11, 2022, at 8:00 a.m.</p> <p>R3's record lacked evidence his IAPP was updated after he was found walking down a freeway ramp.</p> <p>R4 R4's medical record was reviewed. R4 was admitted to the facility on October 12, 2017, under the comprehensive license and began receiving assisted living services on August 1, 2021. R4's diagnoses included dementia and abnormalities of gait and mobility. R4 used a bed mobility device and a Hoyer lift for all transfers and a wheelchair for mobility.</p> <p>R4's comprehensive assessment dated April 9, 2022, indicated R4 was assessed as being unable to use a call pendant. R4 was assessed as a two-person assist using a Hoyer lift due to</p>	0 630			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31733	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 05/05/2022
NAME OF PROVIDER OR SUPPLIER NEW PERSPECTIVE - WOODBURY		STREET ADDRESS, CITY, STATE, ZIP CODE 2195 CENTURY AVENUE SOUTH WOODBURY, MN 55125			
(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
0 630	<p>Continued From page 14</p> <p>severe limitations in mobility. R4 was assessed as being unable to respond to cues, prompting, and interventions due to the inability to interact with others. R4 was assessed as lacking physical, mental, or cognitive capability to recognize a danger, signal, or alarm in order to evacuate self in an emergency. R4 was assessed as having the following vulnerabilities: cognitive impairment; unable to maintain a safe and clean environment; exhibited visual or hearing deficits; had a chronic condition, pain, disability; had difficulty following directions or making needs known; unable to manage finances; difficulty in reporting abuse by others and was susceptible to abuse; and had a history of actions that resulted in harm or self-neglect. R4's assessment indicated interventions for R4's listed vulnerabilities were described in his individualized service plan/individualized abuse prevention plan.</p> <p>R4's service plan dated May 5, 2022, indicated R4 required assistance with personal cares, transfers, mobility, eating, cognition cues, medication management, toileting, laundry, and housekeeping. R4's service plan indicated his IAPP identified areas of potential vulnerability but indicated there were no signs of abuse or neglect. Interventions were built into the service plan and located on staff assignments. Staff were to immediately report signs or symptoms of abuse, neglect, financial exploitation, or misappropriation of property.</p> <p>R4's IAPP lacked evidence an individualized review or assessment was developed that assessed R4's susceptibility to abuse by another individual, including other vulnerable adults; the risk of abusing other vulnerable adults; and statement of specific measures to be taken to minimize the risk of abuse to R4 and other</p>	0 630			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31733	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 05/05/2022
NAME OF PROVIDER OR SUPPLIER NEW PERSPECTIVE - WOODBURY			STREET ADDRESS, CITY, STATE, ZIP CODE 2195 CENTURY AVENUE SOUTH WOODBURY, MN 55125		
(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
0 630	Continued From page 15 vulnerable adults. On June 16, 2022, at 9:00 a.m., director of nursing, (DON)-F stated resident IAPP's were embedded in their service plans. DON-B stated IAPP's were a task in their software system alerting staff they were working with vulnerable adults and if there were a reason to believe they were being abused, stating, "that was the extent of it." The licensee policy titled, Maltreatment of a Resident, updated November 5, 2021, indicated IAPP would contain an individual assessment of the person's susceptibility to abuse by other individuals, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. The IAPP was a mandatory assessment that would be performed during the initial opening of the service chart. TIME PERIOD TO CORRECT: Seven (7) days.	0 630			
01620 SS=G	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31733	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 05/05/2022
NAME OF PROVIDER OR SUPPLIER NEW PERSPECTIVE - WOODBURY		STREET ADDRESS, CITY, STATE, ZIP CODE 2195 CENTURY AVENUE SOUTH WOODBURY, MN 55125			
(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
01620	<p>Continued From page 16</p> <p>and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review.</p> <p>(e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to ensure a registered nurse (RN) performed a reassessments for three of four residents (R1, R2, R3) with records reviewed. In addition, the licensee failed to ensure an accurate assessment was performed on R1 after R1's orthopedic attending physician assessed as no longer requiring a Hoyer lift or weightbearing restrictions.</p> <p>This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to 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).</p> <p>Findings include:</p> <p>R1 R1's medical record was reviewed. R1 moved</p>	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31733	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 05/05/2022
NAME OF PROVIDER OR SUPPLIER NEW PERSPECTIVE - WOODBURY		STREET ADDRESS, CITY, STATE, ZIP CODE 2195 CENTURY AVENUE SOUTH WOODBURY, MN 55125			
(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
01620	<p>Continued From page 17</p> <p>into independent living on July 29, 2015, and began receiving assisted living services on September 2, 2021, until January 24, 2022, when R1 was discharged from the facility. R1's diagnoses included macular degeneration, rheumatoid arthritis, and chronic low back pain. R1 used a wheelchair for mobility and a Hoyer lift for all transfers.</p> <p>R1's physician provider note dated September 1, 2021, indicated R1 was diagnosed with a left lower leg fracture (medial tibial plateau) after having an unwitnessed fall while residing in independent living in the facility. R1 was transferred to assisted living services on September 2, 2021, and was fitted with a hinged left knee brace, and non-weightbearing (NWB) restrictions in order to protect her fractured leg.</p> <p>R1's record lacked evidence R1 was reassessed after being diagnosed with a left leg fracture.</p> <p>R1's initial service plan dated September 2, 2021, indicated R1 received assistance with personal cares, hearing aide, daily safety checks, housekeeping, laundry, fall prevention, and toileting. R1's was assessed as a one-person assist using a gait belt.</p> <p>R1's initial comprehensive RN assessment dated September 2, 2022, page five, under the section Transfer/Mobility, indicated R1 used a call pendant, had severe range of motion (ROM) in her right and left lower extremities, transferred with the assistance of one staff member, and was independent with mobility assistive equipment.</p> <p>R1's late entry progress note dated September 3, 2021, at 11:05 a.m., indicated on September 2, 2021, at 8:00 a.m., R1 began assisted living</p>	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31733	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 05/05/2022
NAME OF PROVIDER OR SUPPLIER NEW PERSPECTIVE - WOODBURY			STREET ADDRESS, CITY, STATE, ZIP CODE 2195 CENTURY AVENUE SOUTH WOODBURY, MN 55125		
(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
01620	<p>Continued From page 18</p> <p>services. The progress note indicated R1 was diagnosed with a left knee fracture. R1's attending physician provided a left knee brace. R1's knee brace would be managed by the facility.</p> <p>R1's attending physician orders dated September 3, 2021, indicated R1 was a toe-touch weight bearing (TTWB) on left leg with a left knee brace to be worn when up during the day, removed at night and during skin cares; weight bearing as tolerated (WBAT) on right leg; knee brace set at open 0-90 degrees with left leg to receive passive range of motion (PROM), 0-90 degrees.</p> <p>R1's record lacked evidence R1 was reassessed after she was diagnosed with a left leg fracture.</p> <p>R1's record indicated on October 20, 2021, at 3:38 p.m., R1's orthopedic attending physician advanced R1 to full weight bearing on her left leg/knee with advanced range of motion (ROM) and strengthening as tolerated due to decreased pain and healing of her leg fracture. R1's attending physician indicated gait training with a physical therapist (PT) would be beneficial due to R1 being deconditioned due to inactivity following her leg fracture. R1's orthopedic attending physician assessed R1 as being oriented to person, place, and time.</p> <p>R1's progress note dated, October 20, 2021, at 2:07 p.m., written by DON-F, indicated DON-F received orders for R1's Hoyer lift for all transfers from R1's family provider.</p> <p>R1's progress note dated October 20, 2021, at 4:00 p.m., written by DON-F, indicated FM-C told DON-F R1 no longer needed to wear the left knee brace or a Hoyer lift following orders from R1's</p>	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31733	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 05/05/2022
NAME OF PROVIDER OR SUPPLIER NEW PERSPECTIVE - WOODBURY		STREET ADDRESS, CITY, STATE, ZIP CODE 2195 CENTURY AVENUE SOUTH WOODBURY, MN 55125			
(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
01620	<p>Continued From page 19</p> <p>attending physician. FM-C requested the Hoyer lift be removed from R1's care plan along with her medication and treatment plan. DON-F wrote she would follow-up with the orthopedic clinic.</p> <p>R1's record lacked evidence DON-F contacted R1's orthopedic attending physician.</p> <p>R1's progress note dated October 21, 2021, at 8:55 a.m., written by DON-F, indicated DON-F received faxed orders from R1's orthopedic attending physician indicating R1 could resume all activities and weight bearing as tolerated.</p> <p>R1's progress note dated October 21, 2021, at 9:51 p.m., written by DON-F, indicated DON-F discussed R1's need to use the Hoyer lift for safe transfers. FM-C reminded DON-F of R1's primary attending physician orders for removal of the Hoyer lift and knee brace. DON-F indicated she never received orders from R1's primary attending physician indicating to discontinue the Hoyer lift, knee brace, and start full weight bearing on the left leg. DON-F stated she collaborated R1's care with R1's family provider, indicating the order for R1's Hoyer lift came from R1's family provider and indicated the facility would continue to use the Hoyer lift for R1's transfers. FM-C indicated he would contact R1's family provider to cancel the facility's request for a Hoyer lift.</p> <p>R1's record indicated on October 22, 2021, DON-F reassessed R1 as being able to understand others and communicate her needs. R1 was assessed as required assistance from two staff with transfers using a mechanical lift due to severe limitations.</p> <p>On June 16, 2022, at 9:00 a.m., DON-F stated</p>	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31733	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 05/05/2022
NAME OF PROVIDER OR SUPPLIER NEW PERSPECTIVE - WOODBURY		STREET ADDRESS, CITY, STATE, ZIP CODE 2195 CENTURY AVENUE SOUTH WOODBURY, MN 55125			
(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
01620	<p>Continued From page 20</p> <p>she performed annual, 90-day, and change-in-condition assessments for residents.</p> <p>R2 R2's medical record was reviewed. R2 was admitted to the facility on April 22, 2021, under the comprehensive license and began receiving assisted living services on August 1, 2021. R2's diagnoses included major depressive disorder, anxiety, post-traumatic stress disorder (PTSD), multiple sclerosis, and mania. R2 used a cane for walking.</p> <p>R2's service plan dated January 11, 2022, indicated R2 received assistance with personal cares, fall management, weekly laundry, housekeeping, and daily safety checks.</p> <p>R2's comprehensive assessment dated January 11, 2022, indicated R2 was assessed as experienced dizziness and vertigo due to her diagnoses of vertigo. R2 was independent with transportation, and managing her medications.</p> <p>R2's IAPP dated January 11, 2022, indicated R2 had difficulty reporting abuse and was susceptible to being abused by other adults. Staff were to immediately notify a supervisor for any signs or symptoms of abuse or neglect.</p> <p>R2's law enforcement report dated January 16, 2022, at 6:28 p.m., indicated R2 was at a local hospital where she told hospital staff she was sexually assaulted by another resident (R3) while taking out her trash at 6:00 a.m. in the lower level of the facility. During her interview with law enforcement, R2 stated R3 placed his hands on her breast, telling R2 he was going to "Fuck you." R2 told law enforcement she wanted the incident documented but did not R3 contacted.</p>	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31733	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 05/05/2022
NAME OF PROVIDER OR SUPPLIER NEW PERSPECTIVE - WOODBURY		STREET ADDRESS, CITY, STATE, ZIP CODE 2195 CENTURY AVENUE SOUTH WOODBURY, MN 55125			
(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
01620	<p>Continued From page 21</p> <p>R2's record lacked evidence R2 was reassessed after she told staff she was sexually assaulted.</p> <p>R2's record lacked evidence an investigation was completed for the alleged sexual assault.</p> <p>R3 R3's medical record was reviewed. R3 was admitted to the facility on November 2, 2021. R3 diagnoses included dementia without behavioral disturbance and chronic kidney disease Stage 3. R3 walked independently.</p> <p>R3's service plan dated November 16, 2021, indicated R3 received assistance with hand washing, medication management, fall management, safety checks, weekly laundry and housekeeping.</p> <p>R3's comprehensive assessment dated February 14, 2022, indicated R3 lacked physical, mental, and cognitive capability to evacuate self in an emergency. R3 was assessed as having cognitive impairment, memory loss, chronic pain, and being unable to report abuse and was susceptible to being abused by others. R3 was independent in personal cares and required no 1:1 supervision.</p> <p>R3's progress note, dated May 5, 2022, at 6:01 a.m., indicated a staff member found R3 walking down an entrance ramp to a major freeway. The staff member assisted R3 back to the facility after multiple attempts. R3's family was contacted. The progress note indicated R3 returned to his baseline with no concerns from nursing staff.</p> <p>R3's incident report dated May 2, 2022, at 5:40 p.m., indicated unlicensed personnel (ULP)-B</p>	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31733	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 05/05/2022
NAME OF PROVIDER OR SUPPLIER NEW PERSPECTIVE - WOODBURY		STREET ADDRESS, CITY, STATE, ZIP CODE 2195 CENTURY AVENUE SOUTH WOODBURY, MN 55125			
(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
01620	<p>Continued From page 22</p> <p>found R3 walking down a freeway ramp. ULP-B assisted R3 into her vehicle after unsuccessful attempts. R3 started crying when he got into ULP-B's vehicle, stating he did not know where he was going, and requested ULP-B not tell anyone. R3's family and licensed assisted living director (LALD)-E were notified. R3 had no apparent injuries. R3's incident report indicated R3's vital signs were not obtained. R3's physician was notified on May 11, 2022, at 8:00 a.m.</p> <p>R3's record lacked evidence R3 was reassessed after being found on the freeway ramp.</p> <p>On June 16, 2022, at 9:00 a.m., DON-F stated she performed annual, 90-day, and change-in-condition assessments for residents. DON-F stated she was unsure she reassessed R2 after her alleged sexual assault. DON-F stated R2 made a comment to her indicating R3 showed up naked at her apartment and harassed her. DON-F stated, it was the first time she had heard about the incident and told R2 she and LALD-E would conduct an investigation the following day.</p> <p>On July 7, 2022, at 12:35 p.m., DON-F stated R3 on May 9, 2022, R3 received his 90-day assessment but was not reassessed after his wandering incident on the freeway ramp.</p> <p>On July 7, 2022, LALD-E confirmed to DON-F, the facility did not file a report to the Minnesota Adult Abuse Reporting Center. LALD-E indicated she reached out to the facility's district and legal executives who told LALD-E a MAARC report did not need to be filed for R3's incident.</p> <p>The licensee policy titled, Changes in Condition, updated November 5, 2021, indicated staff must</p>	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31733	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 05/05/2022
NAME OF PROVIDER OR SUPPLIER NEW PERSPECTIVE - WOODBURY		STREET ADDRESS, CITY, STATE, ZIP CODE 2195 CENTURY AVENUE SOUTH WOODBURY, MN 55125			
(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
01620	Continued From page 23 report any observed or suspected change in a resident's condition to a licensed nurse for appropriate follow-up. TIME PERIOD TO CORRECT: Seven (7) days.	01620			
01640 SS=F	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. (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 residents service plans included a signature or other authentication by the facility and by the resident documenting	01640			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31733	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 05/05/2022
NAME OF PROVIDER OR SUPPLIER NEW PERSPECTIVE - WOODBURY		STREET ADDRESS, CITY, STATE, ZIP CODE 2195 CENTURY AVENUE SOUTH WOODBURY, MN 55125			
(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	<p>Continued From page 24</p> <p>agreement on the services to be provided for three of four residents (R2, R3, R4) with records reviewed. In addition, the licensee failed to revise R3's service plan after he was found wandering down a major freeway ramp at night.</p> <p>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).</p> <p>The findings include:</p> <p>R2 R2's medical record was reviewed. R2 admitted to the licensee on April 22, 2021, under the comprehensive license and began receiving assisted living services on August 1, 2021. R2's diagnoses included major depressive disorder, anxiety, post-traumatic stress disorder (PTSD), multiple sclerosis (MS), and mania. R2 used a cane for walking during times of MS exacerbations.</p> <p>R2's service plan dated January 11, 2022, indicated R2 received assistance with personal cares, fall management, weekly laundry, housekeeping, and daily safety checks.</p> <p>R2's service plan lacked signatures or other authentication by the facility and resident documenting agreement on the services to be provided.</p> <p>R3</p>	01640			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31733	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 05/05/2022
NAME OF PROVIDER OR SUPPLIER NEW PERSPECTIVE - WOODBURY		STREET ADDRESS, CITY, STATE, ZIP CODE 2195 CENTURY AVENUE SOUTH WOODBURY, MN 55125			
(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	<p>Continued From page 25</p> <p>R3's medical record was reviewed. R3 admitted to the licensee on November 2, 2021. R3 diagnoses included dementia without behavioral disturbance and chronic kidney disease Stage 3. R3 walked independently.</p> <p>R3's service plan dated November 16, 2021, indicated R3 received assistance with hand washing, medication management, fall management, safety checks, weekly laundry and housekeeping.</p> <p>R3's service plan lacked signatures or other authentication by the facility and resident documenting agreement on the services to be provided.</p> <p>R3's progress note, dated May 5, 2022, at 6:01 a.m., indicated a staff member found R3 walking down an entrance ramp to a major freeway. The staff member assisted R3 back to the facility after multiple attempts. R3's family was contacted. The progress note indicated R3 returned to his baseline with no concerns from nursing staff.</p> <p>R3's incident report dated May 2, 2022, at 5:40 p.m., indicated unlicensed personnel (ULP)-B found R3 walking down a freeway ramp. ULP-B assisted R3 into her vehicle after unsuccessful attempts. R3 started crying when he got into ULP-B's vehicle, stating he did not know where he was going, and requested ULP-B not tell anyone. R3's family and licensed assisted living director (LALD)-E were notified. R3 had no apparent injuries. R3's incident report indicated R3's vital signs were not obtained. R3's physician was notified on May 11, 2022, at 8:00 a.m.</p> <p>R3's record lacked evidence his service plan was updated after his wandering incident.</p>	01640			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31733	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 05/05/2022
NAME OF PROVIDER OR SUPPLIER NEW PERSPECTIVE - WOODBURY		STREET ADDRESS, CITY, STATE, ZIP CODE 2195 CENTURY AVENUE SOUTH WOODBURY, MN 55125			
(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	<p>Continued From page 26</p> <p>R4</p> <p>R4's medical record was reviewed. R4 admitted to the licensee on October 12, 2017, under the comprehensive license and began receiving assisted living services on August 1, 2021. R4's diagnoses included dementia and abnormalities of gait and mobility. R4 used a bed mobility device and a Hoyer lift for all transfers and a wheelchair for mobility.</p> <p>R4's service plan dated May 5, 2022, indicated R4 required assistance with personal cares, transfers, mobility, eating, cognition cues, medication management, toileting, laundry, and housekeeping. R4's service plan indicated his abuse prevention plan identified areas of potential vulnerability but indicated there were no signs of abuse or neglect. Interventions were built into the service plan and located on staff assignments. Staff were to immediately report signs or symptoms of abuse, neglect, financial exploitation, or misappropriation of property.</p> <p>R4's service plan lacked signatures or other authentication by the facility and resident documenting agreement on the services to be provided.</p> <p>On June 16, 2022, at 9:00 a.m., former director of nursing (DON)-F said she was responsible for developing service plans.</p> <p>The licensee policy titled, Resident Service Plan, updated November 5, 2021, indicated the service plan would be revised and signed by a nurse and the resident and/or the resident's legal representative.</p>	01640			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31733	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 05/05/2022
NAME OF PROVIDER OR SUPPLIER NEW PERSPECTIVE - WOODBURY		STREET ADDRESS, CITY, STATE, ZIP CODE 2195 CENTURY AVENUE SOUTH WOODBURY, MN 55125			
(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 27 TIME PERIOD TO CORRECT: Seven (7) days.	01640			
01650 SS=E	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident's service plans contained all the required content for two of	01650			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31733	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 05/05/2022
NAME OF PROVIDER OR SUPPLIER NEW PERSPECTIVE - WOODBURY		STREET ADDRESS, CITY, STATE, ZIP CODE 2195 CENTURY AVENUE SOUTH WOODBURY, MN 55125			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01650	<p>Continued From page 28</p> <p>four residents (R2, R3) with records reviewed.</p> <p>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).</p> <p>Findings include:</p> <p>R2 R2's medical record was reviewed. R2 admitted to the licensee on April 22, 2021, under the comprehensive license and began receiving assisted living services on August 1, 2021. R2's diagnoses included major depressive disorder, anxiety, post-traumatic stress disorder (PTSD), multiple sclerosis (MS), and mania. R2 used a cane for walking during times of MS exacerbations.</p> <p>R2's service plan dated January 11, 2022, indicated R2 received assistance with personal cares, fall management, weekly laundry, housekeeping, and daily safety checks.</p> <p>R2's service plan lacked the following information:</p> <p>(1) Description of the services to be provided and fees for the services;</p> <p>(2) The schedule and methods of monitoring assessments of the resident;</p>	01650			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31733	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 05/05/2022
NAME OF PROVIDER OR SUPPLIER NEW PERSPECTIVE - WOODBURY			STREET ADDRESS, CITY, STATE, ZIP CODE 2195 CENTURY AVENUE SOUTH WOODBURY, MN 55125		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01650	<p>Continued From page 29</p> <p>(3) Schedule and methods of monitoring staff who provided home care services;</p> <p>(4) A contingency plan that included: (i) the action to be taken if the scheduled service could not be provided; (ii) circumstances in which emergency medical services were not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters.</p> <p>R3 R3's medical record was reviewed. R3 admitted to the licensee on November 2, 2021. R3 diagnoses included dementia without behavioral disturbance and chronic kidney disease Stage 3. R3 walked independently.</p> <p>R3's service plan dated November 16, 2021, indicated R3 received assistance with hand washing, medication management, fall management, safety checks, weekly laundry and housekeeping.</p> <p>R3's service plan lacked the following information:</p> <p>(1) Description of the services to be provided and fees for the services;</p> <p>(2) The schedule and methods of monitoring assessments of the resident;</p> <p>(3) Schedule and methods of monitoring staff who provided home care services;</p> <p>(4) A contingency plan that included: (i) the action to be taken if the scheduled service could not be provided; and (ii) circumstances in which emergency medical services were not to be</p>	01650			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31733	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 05/05/2022
NAME OF PROVIDER OR SUPPLIER NEW PERSPECTIVE - WOODBURY		STREET ADDRESS, CITY, STATE, ZIP CODE 2195 CENTURY AVENUE SOUTH WOODBURY, MN 55125			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01650	Continued From page 30 summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. On June 16, 2022, at 9:00 a.m., former director of nursing (DON)-F stated she and another registered nurse (RN) developed resident's service plans. The licensee policy titled, Resident Service Plan, updated November 5, 2021, indicated the service plan served as a basis for the service delivery contract between the licensee and the resident. TIME PERIOD TO CORRECT: Seven (7) days.	01650			
01960 SS=G	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the attending physician's orders were implemented for one of one of one resident (R1) reviewed. The licensee received orders from R1's attending physician to discontinue R1's use of a Hoyer (total body) lift,	01960			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31733	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 05/05/2022
NAME OF PROVIDER OR SUPPLIER NEW PERSPECTIVE - WOODBURY		STREET ADDRESS, CITY, STATE, ZIP CODE 2195 CENTURY AVENUE SOUTH WOODBURY, MN 55125			
(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
01960	<p>Continued From page 31</p> <p>knee brace, and start full weight-bearing exercises on her left leg, failed to implement the physician orders and continued to use the Hoyer lift with R1 for over three months until she moved out of the facility. R1's left leg became deconditioned and she developed a deep contracture in her leg from not bearing full weight on her left leg.</p> <p>This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to 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).</p> <p>Findings Include:</p> <p>R1's medical record was reviewed. R1 moved into independent living on July 29, 2015, and began receiving assisted living services on September 2, 2021, until January 24, 2022, when R1 was discharged from the facility. R1's diagnoses included macular degeneration, rheumatoid arthritis, and chronic low back pain. R1 used a wheelchair for mobility and a Hoyer lift for all transfers.</p> <p>R1's attending orthopedic physician provider note dated September 1, 2021, indicated R1 was diagnosed with a left lower leg fracture (medial tibial plateau) after having an unwitnessed fall while residing in independent living in the facility. R1 was transferred to assisted living services on September 2, 2021, and was fitted with a hinged left knee brace, and non-weightbearing (NWB) restrictions in order to protect her fractured leg.</p>	01960			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31733	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 05/05/2022
NAME OF PROVIDER OR SUPPLIER NEW PERSPECTIVE - WOODBURY		STREET ADDRESS, CITY, STATE, ZIP CODE 2195 CENTURY AVENUE SOUTH WOODBURY, MN 55125			
(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
01960	<p>Continued From page 32</p> <p>R1's late entry progress note dated October 19, 2021, at 11:01 a.m., written by director of nursing (DON)-F, indicated on October 18, 2021, DON-F told family member (FM)-C, R1 required three staff to assist her due to her inability to assist with transfers, cues, and weight bearing restrictions and required a Hoyer lift for all transfers. FM-C indicated the information conflicted with R1's ability to transfer with the assist of one with her home health aide (HHA)-H. DON-F wrote she would re-evaluate R1 after her orthopedic appointment with her attending physician, scheduled for October 20, 2021.</p> <p>R1's progress notes dated October 19, 2021, at 10:57 a.m., and 2:42 p.m., indicated DON-F contacted R1's family provider (who was not providing follow up care to R1 at the time of her injury) to request orders for a Hoyer lift.</p> <p>R1's record indicated on October 20, 2021, at 3:38 p.m., R1's orthopedic attending physician advanced R1 to full weightbearing on her left leg/knee with advanced range of motion (ROM) and strengthening as tolerated due to decreased pain and healing of her leg fracture. R1's attending physician indicated gait training with a physical therapist (PT) would be beneficial due to R1 being deconditioned due to inactivity following her leg fracture. R1's orthopedic attending physician assessed R1 as being oriented to person, place, and time.</p> <p>R1's progress note dated October 20, 2021, at 2:07 p.m., written by DON-F, indicated DON-F received orders for R1's Hoyer lift for all transfers from R1's family provider.</p> <p>R1's progress note dated October 20, 2021, at</p>	01960			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31733	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 05/05/2022
NAME OF PROVIDER OR SUPPLIER NEW PERSPECTIVE - WOODBURY			STREET ADDRESS, CITY, STATE, ZIP CODE 2195 CENTURY AVENUE SOUTH WOODBURY, MN 55125		
(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
01960	<p>Continued From page 33</p> <p>4:00 p.m., written by DON-F, indicated FM-C told DON-F R1 no longer needed to wear the left knee brace or a Hoyer lift following orders from R1's orthopedic attending physician. FM-C requested the Hoyer lift be removed from R1's care plan along with her medication and treatment plan. DON-F wrote she would follow-up with the orthopedic clinic.</p> <p>R1's progress note dated October 21, 2021, at 8:55 a.m., written by DON-F, indicated DON-F received faxed orders from R1's orthopedic attending physician indicating R1 could resume all activities and weight bearing as tolerated (WBAT).</p> <p>R1's progress note dated October 21, 2021, at 9:51 p.m., written by DON-F, indicated DON-F discussed R1's need to use the Hoyer lift for safe transfers. FM-C reminded DON-F of R1's primary orthopedic attending physician orders for removal of the Hoyer lift and knee brace. DON-F indicated she never received orders from R1's primary orthopedic attending physician indicating to discontinue the Hoyer lift and knee brace. DON-F stated she collaborated R1's care with R1's family provider, indicating the order for R1's Hoyer lift came from R1's family provider and indicated the facility would continue to use the Hoyer lift for R1's transfers. FM-C indicated he would contact R1's family provider to cancel the facility's request for a Hoyer lift.</p> <p>A faxed order dated October 22, 2021, at 12:06 p.m., from R1's orthopedic attending physician to the facility, indicated the following, "patient no longer needs to wear hinged knee brace and may advance to full weight-bearing. Because of this she does not require the use of a Hoyer lift. We recommend that she starts physical therapy to</p>	01960			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31733	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 05/05/2022
---	---	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NEW PERSPECTIVE - WOODBURY

**2195 CENTURY AVENUE SOUTH
WOODBURY, MN 55125**

(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
01960	<p>Continued From page 34</p> <p>work on strengthening and gait training." The faxed order indicated to call the orthopedic office with any questions.</p> <p>R1's record lacked evidence DON-F or the facility contacted R1's orthopedic attending physician regarding the new orders.</p> <p>R1's late entry progress note dated December 16, 2021, at 10:43 a.m., indicated on December 15, 2021, indicated R1 suggested to staff they use her bed mobility device so she could stand while staff placed the Hoyer sling underneath her. The progress note indicated R1 was able to stand on both legs with a gait belt around her waist while staff positioned the Hoyer sling. R1 questioned staff why she was still using the Hoyer lift.</p> <p>R1's record indicated on December 15, 2021, R1's orthopedic attending physician assessed R1 as being able to bear weight as tolerated with no restrictions. R1's was assessed as having a deep flexion contracture in the left knee due to decondition of her left leg from continued use of the Hoyer lift and not being allowed to bear weight on her left leg. R1 received a cortisone injection with orders for PT to work on strengthening exercises for R1.</p> <p>R1's record indicated on December 21, 2021, at 9:37 a.m., R1's family provider faxed orders to the facility to defer all transfer requests, Hoyer lift, and mobility devices be deferred to R1's orthopedic attending physician.</p> <p>R1's family provider note, dated December 27, 2021, indicated R1's family provider assessed R1 as having no cognitive decline, with only past minor confusion due to a urinary tract infection</p>	01960		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31733	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 05/05/2022
NAME OF PROVIDER OR SUPPLIER NEW PERSPECTIVE - WOODBURY			STREET ADDRESS, CITY, STATE, ZIP CODE 2195 CENTURY AVENUE SOUTH WOODBURY, MN 55125		
(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
01960	<p>Continued From page 35</p> <p>(UTI).</p> <p>R1's progress note indicated on January 24, 2022, at 1:30 p.m., R1 moved out of the facility to an undisclosed location with the assistance from family.</p> <p>On May 5, 2022, at 12:45 p.m., unlicensed personnel (ULP)-A stated R1 did not like using the Hoyer lift and preferred walking to the bathroom rather than waiting for the Hoyer lift.</p> <p>On June 13, 2022, at 9:30 a.m., FM-C stated, the facility ignored R1's orthopedic attending physician's orders to remove her knee brace, Hoyer lift, and to begin weight-bearing exercises and instead went to R1's family physician to obtain an order to keep R1 in the Hoyer lift. FM-C stated the facility never communicated with R1's attending physician. FM-C stated R1's orthopedic clinic told him the facility hurt R1 by not allowing heal by not being allowed to bear any weight on her leg to build stamina to perform safe transfers. "The facility did something that caused R1 physical and emotional harm. They wouldn't let her heal."</p> <p>On June 14, 2022, at 10:00 a.m., licensed assisted living director (LALD)-E stated R1 used a Hoyer lift until January 24, 2022, the day she moved out of the facility. LALD-E stated R1 required a higher level of care so the facility recommended R1 be placed in their secured memory care unit. LALD-E stated FM-C did not want R1 placed in memory care, so the facility started a pretermination of R1's assisted living contract. LALD-E stated FM-C provided the facility with a 30-day notice for R1's move from the facility so the pretermination was discontinued.</p>	01960			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31733	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 05/05/2022
NAME OF PROVIDER OR SUPPLIER NEW PERSPECTIVE - WOODBURY		STREET ADDRESS, CITY, STATE, ZIP CODE 2195 CENTURY AVENUE SOUTH WOODBURY, MN 55125			
(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
01960	Continued From page 36 On June 16, 2022, at 9:00 a.m., DON-F stated the facility's Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) form indicated the assisted living section performed two-person transfers using a Hoyer lift but stated, "that was an error, so we had to change the paperwork so it made sense. Our goal was to move R1 to memory care to get assistance with her Hoyer." On June 21, 2022, at 1:30 p.m., HHA-H stated she had been providing cares for R1 for over seven years. HHA-H stated R1 moved with minimal assist, even with her left knee brace on. Review of the facility's UDALSA dated May 24, 2021, provided by LALD-E, indicated on page 10, the facility offered the following mobility services: transfers with the assist of two staff using a mechanical lift or gait belt for transfer from floor, transfers with assist of one staff using a gait belt, and transfers utilizing sit-to-stand lifts. TIME PERIOD TO CORRECT: Seven (7) days.	01960			
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: Based on observations, interviews, and document review, the facility failed to ensure one of one residents (R1) reviewed was free from maltreatment. R1 was neglected.	02360	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31733	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 05/05/2022
NAME OF PROVIDER OR SUPPLIER NEW PERSPECTIVE - WOODBURY		STREET ADDRESS, CITY, STATE, ZIP CODE 2195 CENTURY AVENUE SOUTH WOODBURY, MN 55125			
(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
02360	Continued From page 37 Findings include: On September 13, 2022, the Minnesota Department of Health (MDH) issued a determination that neglect occurred, and that the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. MDH concluded there was a preponderance of evidence that maltreatment occurred.	02360			
02560 SS=G	144G.92 Subdivision 1. Retaliation prohibited A facility or agent of a facility may not retaliate against a resident or employee if the resident, employee, or any person acting on behalf of the resident: (1) files a good faith complaint or grievance, makes a good faith inquiry, or asserts any right; (2) indicates a good faith intention to file a complaint or grievance, make an inquiry, or assert any right; (3) files, in good faith, or indicates an intention to file a maltreatment report, whether mandatory or voluntary, under section 626.557; (4) seeks assistance from or reports a reasonable suspicion of a crime or systemic problems or concerns to the director or manager of the facility, the Office of Ombudsman for Long-Term Care, a regulatory or other government agency, or a legal or advocacy organization; (5) advocates or seeks advocacy assistance for necessary or improved care or services or enforcement of rights under this section or other law; (6) takes or indicates an intention to take civil action; (7) participates or indicates an intention to	02560			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31733	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 05/05/2022
NAME OF PROVIDER OR SUPPLIER NEW PERSPECTIVE - WOODBURY		STREET ADDRESS, CITY, STATE, ZIP CODE 2195 CENTURY AVENUE SOUTH WOODBURY, MN 55125			
(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
02560	<p>Continued From page 38</p> <p>participate in any investigation or administrative or judicial proceeding; (8) contracts or indicates an intention to contract to receive services from a service provider of the resident's choice other than the facility; or (9) places or indicates an intention to place a camera or electronic monitoring device in the resident's private space as provided under section 144.6502.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of four residents (R1) with records reviewed, was not retaliated against. The licensee failed to implement physician orders to discontinue a Hoyer (total body) lift and begin walking after a leg fracture. R1's physician documented R1 was alert and oriented to person, place and time. When R1 and R1's family questioned the facility on the continued use of the Hoyer lift when it had been discontinued and R1 had deconditioned, the licensee told R1's family R1 needed to relocated to the secured memory care unit where they could continue to use the Hoyer lift. When R1's family refused, the licensee initiated a pretermination hearing to terminate R1's assisted living contract.</p> <p>This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to 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).</p>	02560			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31733	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 05/05/2022
NAME OF PROVIDER OR SUPPLIER NEW PERSPECTIVE - WOODBURY		STREET ADDRESS, CITY, STATE, ZIP CODE 2195 CENTURY AVENUE SOUTH WOODBURY, MN 55125			
(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
02560	<p>Continued From page 39</p> <p>The findings include:</p> <p>Minnesota (MN) Statute 144G.92, subdivision 1, clause (1-3), Retaliation Prohibited. A facility or agent of a facility may not retaliate against a resident or an employee if the resident, employee, or any person acting on behalf of the resident: (1) files a good faith complaint or grievance, makes a good faith inquiry, or asserts any right; (2) indicates a good faith intention to file a complaint or grievance, make an inquiry, or assert any right; (3) files, in good faith, or indicates an intention to file a maltreatment report, whether mandatory or voluntary, under section 626.557.</p> <p>R1's medical record was reviewed. R1 moved into independent living on July 29, 2015, and began receiving assisted living services on September 2, 2021, until January 24, 2022, when R1 was discharged from the facility. R1's diagnoses included macular degeneration, rheumatoid arthritis, and chronic low back pain. R1 used a wheelchair for mobility and a Hoyer lift for all transfers.</p> <p>R1's attending orthopedic physician provider note dated September 1, 2021, indicated R1 was diagnosed with a left lower leg fracture (medial tibial plateau) after having an unwitnessed fall while residing in independent living in the facility. R1 was transferred to assisted living services on September 2, 2021, and was fitted with a hinged left knee brace, and non-weightbearing (NWB) restrictions in order to protect her fractured leg.</p> <p>R1's late entry progress note dated October 19, 2021, at 11:01 a.m., written by director of nursing (DON)-F, indicated on October 18, 2021, DON-F told family member (FM)-C, R1 required three</p>	02560			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31733	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 05/05/2022
NAME OF PROVIDER OR SUPPLIER NEW PERSPECTIVE - WOODBURY		STREET ADDRESS, CITY, STATE, ZIP CODE 2195 CENTURY AVENUE SOUTH WOODBURY, MN 55125			
(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
02560	<p>Continued From page 40</p> <p>staff to assist her due to her inability to assist with transfers, cues, and weight bearing restrictions and required a Hoyer lift for all transfers. FM-C indicated the information conflicted with R1's ability to transfer with the assist of one with her home health aide (HHA)-H. DON-F wrote she would re-evaluate R1 after her orthopedic appointment with her attending physician, scheduled for October 20, 2021.</p> <p>R1's progress notes dated October 19, 2021, at 10:57 a.m., and 2:42 p.m., indicated DON-F contacted R1's family provider (who was not providing follow up care to R1 at the time of her injury) to request orders for a Hoyer lift.</p> <p>R1's record indicated on October 20, 2021, at 3:38 p.m., R1's orthopedic attending physician advanced R1 to full weightbearing on her left leg/knee with advanced range of motion (ROM) and strengthening as tolerated due to decreased pain and healing of her leg fracture. R1's attending physician indicated gait training with a physical therapist (PT) would be beneficial due to R1 being deconditioned due to inactivity following her leg fracture. R1's orthopedic attending physician assessed R1 as being oriented to person, place, and time.</p> <p>R1's progress note dated, October 20, 2021, at 2:07 p.m., written by DON-F, indicated DON-F received orders for R1's Hoyer lift for all transfers from R1's family provider.</p> <p>R1's progress note dated October 20, 2021, at 4:00 p.m., written by DON-F, indicated FM-C told DON-F R1 no longer needed to wear the left knee brace or a Hoyer lift following orders from R1's attending orthopedic physician. FM-C requested the Hoyer lift be removed from R1's care plan</p>	02560			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31733	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 05/05/2022
---	---	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NEW PERSPECTIVE - WOODBURY

**2195 CENTURY AVENUE SOUTH
WOODBURY, MN 55125**

(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
02560	<p>Continued From page 41</p> <p>along with her medication and treatment plan. DON-F wrote she would follow-up with the orthopedic clinic.</p> <p>R1's progress note dated October 21, 2021, at 8:55 a.m., written by DON-F, indicated DON-F received faxed orders from R1's orthopedic attending physician indicating R1 could resume all activities and weight bearing as tolerated (WBAT).</p> <p>R1's progress note dated October 21, 2021, at 9:51 p.m., written by DON-F, indicated DON-F discussed R1's need to use the Hoyer lift for safe transfers. FM-C reminded DON-F of R1's primary attending physician orders for removal of the Hoyer lift and knee brace. DON-F indicated she never received orders from R1's primary attending physician indicating to discontinue the Hoyer lift and knee brace. DON-F stated she collaborated R1's care with R1's family provider, indicating the order for R1's Hoyer lift came from R1's family provider and indicated the facility would continue to use the Hoyer lift for R1's transfers. FM-C indicated he would contact R1's family provider to cancel the facility's request for a Hoyer lift.</p> <p>A faxed order dated October 22, 2021, at 12:06 p.m., from R1's orthopedic attending physician to the facility, indicated the following, "patient no longer needs to wear hinged knee brace and may advance to full weight-bearing. Because of this she does not require the use of a Hoyer lift. We recommend that she starts physical therapy to work on strengthening and gait training." The faxed order indicated to call the orthopedic office with any questions.</p> <p>R1's record lacked evidence DON-F or the facility</p>	02560		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31733	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 05/05/2022
NAME OF PROVIDER OR SUPPLIER NEW PERSPECTIVE - WOODBURY		STREET ADDRESS, CITY, STATE, ZIP CODE 2195 CENTURY AVENUE SOUTH WOODBURY, MN 55125			
(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
02560	<p>Continued From page 42</p> <p>contacted R1's orthopedic attending physician regarding the new orders.</p> <p>R1's late entry progress note dated December 16, 2021, at 10:43 a.m., indicated on December 15, 2021, indicated R1 suggested to staff they use her bed mobility device so she could stand while staff placed the Hoyer sling underneath her. The progress note indicated R1 was able to stand on both legs with a gait belt around her waist while staff positioned the Hoyer sling. R1 questioned staff why she was still using the Hoyer lift.</p> <p>R1's record indicated on December 15, 2021, R1's orthopedic attending physician assessed R1 as being able to bear weight as tolerated with no restrictions. R1's was assessed as having a deep flexion contracture in the left knee due to decondition of her left leg from continued use of the Hoyer lift and not being allowed to bear weight on her left leg. R1 received a cortisone injection with orders for PT to work on strengthening exercises for R1.</p> <p>R1's record indicated on December 21, 2021, at 9:37 a.m., R1's family provider faxed orders to the facility to defer all transfer requests, Hoyer lift, and mobility devices be deferred to R1's orthopedic attending physician.</p> <p>R1's family provider note, dated December 27, 2021, indicated R1's family provider assessed R1 as having no cognitive decline, with only past minor confusion due to a urinary tract infection (UTI).</p> <p>R1's progress note indicated on January 24, 2022, at 1:30 p.m., R1 moved out of the facility to an undisclosed location with the assistance from</p>	02560			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31733	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 05/05/2022
NAME OF PROVIDER OR SUPPLIER NEW PERSPECTIVE - WOODBURY		STREET ADDRESS, CITY, STATE, ZIP CODE 2195 CENTURY AVENUE SOUTH WOODBURY, MN 55125			
(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
02560	<p>Continued From page 43</p> <p>family.</p> <p>On May 5, 2022, at 12:45 p.m., unlicensed personnel (ULP)-A stated R1 did not like using the Hoyer lift and preferred walking to the bathroom rather than waiting for the Hoyer lift. ULP-A stated she personally thought the resident was suitable for assisted living, even though she occasionally was forgetful.</p> <p>On June 13, 2022, at 9:30 a.m., FM-C stated, the facility ignored R1's orthopedic attending physician's orders to remove her knee brace, Hoyer lift, and to begin weight-bearing exercises and instead went to R1's family physician to obtain an order to keep R1 in the Hoyer lift. FM-C stated the facility never communicated with R1's orthopedic attending physician. FM-C stated R1's orthopedic clinic told him the facility hurt R1 by not allowing heal by not being allowed to bear any weight on her leg to build stamina to perform safe transfers. "The facility did something that caused R1 physical and emotional harm. They wouldn't let her heal."</p> <p>On June 14, 2022, at 10:00 a.m., licensed assisted living director (LALD)-E stated R1 used a Hoyer lift until January 24, 2022, the day she moved out of the facility. LALD-E stated R1 required a higher level of care so the facility recommended R1 be placed in their secured memory care unit. LALD-E stated FM-C did not want R1 placed in memory care, so the facility started a pretermination of R1's assisted living contract. LALD-E stated FM-C provided the facility with a 30-day notice for R1 to move from the facility so the pretermination was discontinued.</p> <p>On June 16, 2022, at 9:00 a.m., DON-F stated,</p>	02560			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31733	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 05/05/2022
---	---	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NEW PERSPECTIVE - WOODBURY

**2195 CENTURY AVENUE SOUTH
WOODBURY, MN 55125**

(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
02560	<p>Continued From page 44</p> <p>DON-F stated the facility's Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) form indicated the assisted living section performed two-person transfers using a Hoyer lift but stated, "that was an error, so we had to change the paperwork so it made sense. Our goal was to move R1 to memory care to get assistance with her Hoyer."</p> <p>On June 21, 2022, at 1:30 p.m., HHA-H stated she had been providing cares for R1 for over seven years. HHA-H stated the only time R1 was confused was when she had a UTI. HHA-H stated R1 moved with minimal assist, even with her left knee brace on, "if you don't speak to her and tell her what you're doing she will be upset." HHA-H stated the facility raised R1's bed to accommodate the Hoyer lift which created the potential for R1 being injured if she fell out of bed. HHA-H stated R1 did not like the Hoyer lift, stating the sling was positioned behind her knees, causing her pain. HHA-H stated there were times when only one staff person transferred R1 using the Hoyer lift. HHA-H stated she never used the Hoyer lift and stated she had no problem transferring R1 by herself. HHA-H stated, "I'm 4'10" and weigh 98 pounds, and I had no trouble transferring her by myself."</p> <p>Review of the facility's UDALSA dated May 24, 2021, provided by LALD-E, indicated on page 10, the facility offered the following mobility services: transfers with the assist of two staff using a mechanical lift or gait belt for transfer from floor, transfers with assist of one staff using a gait belt, and transfers utilizing sit-to-stand lifts.</p> <p>The licensee policy titled, Resident Grievances, updated November 5, 2021, indicated retaliation of any kind against the resident or the resident's</p>	02560		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31733	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 05/05/2022
NAME OF PROVIDER OR SUPPLIER NEW PERSPECTIVE - WOODBURY		STREET ADDRESS, CITY, STATE, ZIP CODE 2195 CENTURY AVENUE SOUTH WOODBURY, MN 55125			
(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
02560	Continued From page 45 legal representative in response to a grievance was strictly prohibited. TIME PERIOD TO CORRECT: Seven (7) Days	02560			
03000 SS=E	626.557 Subd. 3 Timing of report (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section	03000			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31733	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 05/05/2022
NAME OF PROVIDER OR SUPPLIER NEW PERSPECTIVE - WOODBURY		STREET ADDRESS, CITY, STATE, ZIP CODE 2195 CENTURY AVENUE SOUTH WOODBURY, MN 55125			
(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
03000	<p>Continued From page 46</p> <p>626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to comply with the requirements for reporting suspected maltreatment within 24 hours for two of four residents (R2, R3) with records reviewed. R2 was allegedly sexually assaulted by another resident in the facility. In addition, R3 was found walking down an entrance freeway ramp one evening. The facility was aware of the incidents but did not report the incidents to the Minnesota Adult Abuse Reporting Agency (MAARC).</p> <p>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</p>	03000			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31733	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 05/05/2022
NAME OF PROVIDER OR SUPPLIER NEW PERSPECTIVE - WOODBURY		STREET ADDRESS, CITY, STATE, ZIP CODE 2195 CENTURY AVENUE SOUTH WOODBURY, MN 55125			
(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
03000	<p>Continued From page 47</p> <p>found to be pervasive).</p> <p>The findings include:</p> <p>R2 R2's medical record was reviewed. R2 admitted to the licensee on April 22, 2021, under the comprehensive license and began receiving assisted living services on August 1, 2021. R2's diagnoses included major depressive disorder, anxiety, post-traumatic stress disorder (PTSD), multiple sclerosis, and mania. R2 used a cane for walking.</p> <p>R2's service plan dated January 11, 2022, indicated R2 received assistance with personal cares, fall management, weekly laundry, housekeeping, and daily safety checks.</p> <p>R2's comprehensive assessment dated January 11, 2022, indicated R2 had experienced dizziness and vertigo due to her diagnoses of vertigo. R2 was independent with transportation, and managing her medications.</p> <p>R2's individual abuse prevention plan (IAPP) dated January 11, 2022, indicated R2 had difficulty reporting abuse and was susceptible to being abused by other adults. Staff were to immediately notify a supervisor for any signs or symptoms of abuse or neglect.</p> <p>A law enforcement report dated January 16, 2022, at 6:28 p.m., indicated R2 told hospital staff she was sexually assaulted by another resident (R3) while taking out her trash at 6:00 a.m. in the lower level of the facility. During her interview with law enforcement, R2 sated R3 placed his hands on her breast, telling R2 he was going to "Fuck you." R2 told law enforcement she wanted the</p>	03000			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31733	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 05/05/2022
NAME OF PROVIDER OR SUPPLIER NEW PERSPECTIVE - WOODBURY		STREET ADDRESS, CITY, STATE, ZIP CODE 2195 CENTURY AVENUE SOUTH WOODBURY, MN 55125			
(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
03000	<p>Continued From page 48</p> <p>incident documented but did not R3 contacted.</p> <p>Facility records lacked evidence a MAARC report was filed for R2's alleged sexual assault.</p> <p>R3 R3's medical record was reviewed. R3 admitted to the licensee on November 2, 2021. R3 diagnoses included dementia without behavioral disturbance and chronic kidney disease Stage 3. R3 walked independently.</p> <p>R3's service plan dated November 16, 2021, indicated R3 received assistance with hand washing, medication management, fall management, safety checks, weekly laundry and housekeeping.</p> <p>R3's comprehensive assessment dated February 14, 2022, indicated R3 lacked physical, mental, and cognitive capability to evacuate self in an emergency. R3 had having cognitive impairment, memory loss, chronic pain, and being unable to report abuse and was susceptible to being abused by others. R3 was independent in personal cares and required no 1:1 supervision.</p> <p>R3's IAPP dated November 16, 2021, indicated staff were to immediately notify a supervisor for any signs or symptoms of abuse or neglect.</p> <p>R3's incident report dated May 2, 2022, at 5:40 p.m., indicated unlicensed personnel (ULP)-B found R3 walking down a freeway ramp. ULP-B assisted R3 into her vehicle after unsuccessful attempts. R3 started crying when he got into ULP-B's vehicle, stating he did not know where he was going, and requested ULP-B not tell anyone. R3's family and licensed assisted living director (LALD)-E were notified. R3 had no</p>	03000			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31733	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 05/05/2022
NAME OF PROVIDER OR SUPPLIER NEW PERSPECTIVE - WOODBURY		STREET ADDRESS, CITY, STATE, ZIP CODE 2195 CENTURY AVENUE SOUTH WOODBURY, MN 55125			
(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
03000	<p>Continued From page 49</p> <p>apparent injuries. R3's incident report indicated R3's vital signs were not obtained. R3's physician was notified on May 11, 2022, at 8:00 a.m.</p> <p>R3's progress note, dated May 5, 2022, at 6:01 a.m., indicated a staff member found R3 walking down an entrance ramp to a major freeway. The staff member assisted R3 back to the facility after multiple attempts. R3's family was contacted. The progress note indicated R3 returned to his baseline with no concerns from nursing staff.</p> <p>On June 14, 2022, at 10:00 a.m., licensed assisted living director (LALD)-E stated the facility did not file a MAARC report on R2's alleged assault stating she was told law enforcement filed a report.</p> <p>On June 16, 2022, at 9:00 a.m., director of nursing (DON)-F stated she was unsure if she reassessed R2 after the alleged sexual assault. DON-F stated R2 went to the hospital so often. DON-F stated R2 made vague comments stating R3 was naked and harassing her outside of her apartment. DON-F stated she told R2 she and LALD-E would conduct an investigation the following day.</p> <p>R2 and R3's records lacked incident reports or an investigation of the alleged sexual assault.</p> <p>On July 7, 2022, LALD-E confirmed to DON-F, the facility did not file a report to the Minnesota Adult Abuse Reporting Center. LALD-E indicated she reached out to the facility's district and legal executives who told LALD-E a MAARC report did not need to be filed for R3's incident.</p> <p>The licensee policy titled, Maltreatment of a Resident, dated November 5, 2021, indicated all</p>	03000			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31733	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/05/2022
NAME OF PROVIDER OR SUPPLIER NEW PERSPECTIVE - WOODBURY			STREET ADDRESS, CITY, STATE, ZIP CODE 2195 CENTURY AVENUE SOUTH WOODBURY, MN 55125		
(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
03000	Continued From page 50 allegations, suspicions, or complaints of abuse, neglect, or financial exploitation would be treated as serious, investigated with appropriate follow-up, and reported in accordance with state laws and regulations. TIME PERIOD TO CORRECT: Seven (7) days.	03000			