

Protecting, Maintaining and Improving the Health of All Minnesotans

# 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

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING	·	
		31733	B. WING		C 05/05/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	
NEW PE	RSPECTIVE - WOODE	BURY	ITURY AVEN IRY, MN 55	IUE SOUTH 125	
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(7.0)
PREFIX TAG	•	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	
0 000	Initial Comments		0 000		
	Initial comments				
	*****ATTENTION*	** <del>**</del>		Minnesota Department of Health i	S
	ASSISTED LIVING	PROVIDER LICENSING		documenting the State Licensing Correction Orders using federal se	oftware.
	CORRECTION OR			Tag numbers have been assigned	to
	In accordance with	Minnesota Statutes, section		Minnesota State Statutes for Assistation Living Facilities. The assigned tag	
		5, these correction orders are		number appears in the far left colu	
	issued pursuant to	a complaint investigation.		entitled "ID Prefix Tag." The state	
	Determination of whether a violation is corrected			number and the corresponding tex state Statute out of compliance is	
	requires compliance	e with all requirements		the "Summary Statement of Defic	
	•	ute number indicated below.		column. This column also includes	
		Statute contains several nply with any of the items will		findings which are in violation of the requirement after the statement, "	
	be considered lack			Minnesota requirement is not met	
				evidenced by." Following the evaluators'	
	INITIAL COMMENT	ΓS:		findings is the Time Period for Co	rrection.
	#HL31733002C/#H	L31733001 <b>M</b>		PLEASE DISREGARD THE HEAI	DING OF
	#HL31733004C/#H	L31733003M		THE FOURTH COLUMN WHICH	
	On May 5, 2022, the	e Minnesota Department of		STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES	
		complaint investigation at the		FEDERAL DEFICIENCIES ONLY	
	•	the following correction		WILL APPEAR ON EACH PAGE.	
		At the time of the complaint		THERE IS NO DECLURENT T	
	,	were 61 clients receiving provider's Assisted Living with		THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION	
	Dementia Care lice			VIOLATIONS OF MINNESOTA S	
				STATUTES.	
	The following corre	ction orders are issued for		THE LETTER IN THE LEFT COL	IMMI
		30, 1620, 1960, 2360 and		USED FOR TRACKING PURPOS	
	2560	•		REFLECTS THE SCOPE AND LE	VEL
	The fellowing come	otion orders are issued for		ISSUED PURSUANT TO 144G.3	1
	#HL31733004C/#H	ction orders are issued for L31733003M. tag		SUBDIVISION 1-3.	
		20, 630, 1620, 1640, 1650,			
	3000.				
Minnesota D	epartment of Health		Į		

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

TITLE (X6) DATE

Minnesota Department of Health

31733 B. WING 05/0	)5/2022
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
NEW PERSPECTIVE - WOODBURY  WOODBURY, MN 55125	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 250 SS=G (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	

Minnesota Department of Health

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AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	E CONSTRUCTION	COMPI	
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NEW PERSPECTIVE - WOOD	BURY	TURY AVEN RY, MN 551			
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section 144.057 or (12) fails to timely promissioner; (13) violates any logerating to housing (14) has repeated it performing services level; or (15) has operated hassisted living facili (b) A violation by a assisted living service by the facility.  This MN Requirem by: Based on observate review, the licensed management officing day-to-day operation resident's assisted of the assisted living the potential to affect the potential to af	245A.04; bay any fines assessed by the cal, city, or township ordinance or assisted living services; incidents of personnel is beyond their competency. Deyond the scope of the city's license category. Contractor providing the cites of the facility is a violation of the facility is a violation. The facility regulations and responsible for the cons; and residents. This had contain the facility regulations. This had contain a level three violation (and a resident's health or safety, is injury, impairment, or death, as the potential to lead to contain the facility and was a sed scope (when one or a facility occasionally).				

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NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  2195 CENTURY AVENUE SOUTH	
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NEW PERSPECTIVE - WOODBURY  WOODBURY, MN 55125	
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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 mindow),  - I have read and fully understand Minn. Stat. sect. 144G.80 (opens in a new window),  - I have read and fully understand Minn. Stat. sect. 144G.80 (opens in a new window), and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22 (opens in a new window), and laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22 (opens in a new window),  - 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), and Minnesota Rules, chapter 4659 (proposed and not final) (opens in a new window), and poperation of the facility, regardless of the existence of a 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	

Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	<b>l</b> ` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY
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0 250	Continued From pa	ge 4	0 250			
	true, correct and cowriting, of any chan required."  - I attest to have all procedures of Minn new window). and Minn new window). and Minn new window). and Minnesota Statutes.  Page five was elected on May 26, 2021.  The licensee had an effective August 1, 2000.  Four (4) level three issued, which indicated understanding of the limited, or not evide Minnesota Statutes.	emplete. I will notify MDH, in ges to this information as required policies and . Stat. chapter 144G (opens in Minn. Rules chapter 4659 final) (opens in new window), sure and to keep them current cronically signed by the owner assisted living license, 2021.				
	144G.42 Subd. 6 (a requirements for re	,	0 620			
	for reporting maltreabuse prevention p (a) The assisted living the requirements for maltreatment of vul 626.557. The facility implement a written	ing facility must comply with				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	CONSTRUCTION	(X3) DATE	E SURVEY PLETED
	31733	B. WING			C <b>05/2022</b>
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by: Based on interview licensee failed to comprehensive licensee on Acomprehensive licensee on Acomprehen	ent is not met as evidenced and record review, the comply with the requirements cted maltreatment within 24 ar residents (R2, R3) with R2 was allegedly sexually er resident in the facility. In bund walking down an entrance evening. The facility was ents but did not report the enesota Adult Abuse Reporting are din a level two violation (and tharm a resident's health or potential to have harmed a residenty, but was not likely to enter a safety, but was not likely to enter scope (when more than a residents are affected, more open of staff are involved, or the red repeatedly; but is not ive).				

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		31733	B. WING		<b>I</b>	C <b>05/2022</b>
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0 620	Continued From pa	ge 6	0 620			
	housekeeping, and	daily safety checks.				
	11, 2022, indicated and vertigo due to h	e assessment dated January R2 had experienced dizziness her diagnoses of vertigo. R2 ith transportation, and cations.				
	dated January 11, 2 difficulty reporting a being abused by oth	se prevention plan (IAPP) 2022, indicated R2 had abuse and was susceptible to her adults. Staff were to a supervisor for any signs or e or neglect.				
	2022, at 6:28 p.m., she was sexually as (R3) while taking or lower level of the fallow enforcement, R on her breast, telling you." R2 told law enforcement	report dated January 16, indicated R2 told hospital staff saulted by another resident at her trash at 6:00 a.m. in the cility. During her interview with 2 sated R3 placed his hands g R2 he was going to "Fuck aforcement she wanted the ed but did not R3 contacted."				
		red evidence a MAARC report lleged sexual assault.				
	to the licensee on N diagnoses included	d was reviewed. R3 admitted November 2, 2021. R3 dementia without behavioral ronic kidney disease Stage 3. dently.				
	indicated R3 received washing, medication	ated November 16, 2021, ed assistance with hand n management, fall y checks, weekly laundry and				

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NAME OF PROVIDER OR SUPPLIER  NEW PERSPECTIVE - WOODBURY  STREET ADDRESS, CITY, STATE, ZIP CODE  2195 CENTURY AVENUE SOUTH	
2195 CENTURY AVENUE SOUTH	5/2022
WOODBURY, MN 55125	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CORRECTION OF CORRE	(X5) COMPLETE DATE
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.  R3's IAPP dated November 16, 2021, indicated staff were to immediately notify a supervisor for any signs or symptoms of abuse or neglect.  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.  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.  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	

Minnesota Department of Health

	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY
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NAME OF I	PROVIDER OR SUPPLIER		ITURY AVEN	STATE, ZIP CODE		
NEW PE	RSPECTIVE - WOODE	BURY	JRY, MN 551			
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	nursing (DON)-F stated R2 was naked and apartment. DON-F	at 9:00 a.m., director of ated she was unsure if she or the alleged sexual assault. Went to the hospital so often hade vague comments stating harassing her outside of her stated she told R2 she and duct an investigation the				
	R2 and R3's records lacked incident reports or an investigation of the alleged sexual assault.					
	the facility did not fill Adult Abuse Report she reached out to	LD-E confirmed to DON-F, le a report to the Minnesota ing Center. LALD-E indicated the facility's district and legal LALD-E a MAARC report did for R3's incident.				
	Resident, dated No allegations, suspicions, neglect, or financial as serious, investigations.	titled, Maltreatment of a vember 5, 2021, indicated all ons, or complaints of abuse, exploitation would be treated ated with appropriate rted in accordance with state s.				
	TIME PERIOD TO	CORRECT: Seven (7) days.				
0 630 SS=G		,	0 630			
	individual abuse pre vulnerable adult. The individualized review	t develop and implement an evention plan for each ne plan shall contain an wor assessment of the lity to abuse by another				

Minnesota Department of Health

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
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		31733	B. WING			)5/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
NEW PE	RSPECTIVE - WOODE	BURY	ITURY AVEN JRY, MN 551			
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0 630	Continued From pa	ige 9	0 630			
	person's risk of abutand statements of the taken to minimize the and other vulnerable	other vulnerable adults; the using other vulnerable adults; the specific measures to be he risk of abuse to that person le adults. For purposes of the lan, abuse includes				
	by: Based on interview licensee failed to en prevention plan (IAI an individualized reperson's susceptibility individual, including person's risk of abutand statement of special to minimize the risk other vulnerable ad (R1, R2, R3, R4) what addition, the license after she told license after she told license her and failed to up found wandering do This practice result violation that harms	ent is not met as evidenced  y and record review, the hsure an individual abuse PP) was developed to include eview or assessment of the lity to abuse by another y other vulnerable adults; the using other vulnerable adults; becific measures to be taken to f abuse to the person and lults for four of four residents ith records reviewed. In the failed to update R2's IAPP see staff R3 sexually assaulted to date R3's IAPP after he was own a major freeway ramp.  The dinal level three violation (a ted a resident's health or safety,				
	not including serious or a violation that he serious injury, impairs issued at an isolate limited number of real limited number of	as the potential to lead to airment, or death, as the potential to lead to airment, or death) and was ed scope (when one or a esidents are affected or one or staff are involved or the red only occasionally).				
		d was reviewed. R1 moved				

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	NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	<b>`</b>	E CONSTRUCTION	COMP	SURVEY
		31733	B. WING		05/0	) 5/2022
	PROVIDER OR SUPPLIER	BURY 2195 CEN	DRESS, CITY, S TURY AVEN RY, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
0 630	began receiving ass September 2, 2021 macular degeneratic chronic low back paramobility and a Hoye R1's service plan daindicated R1 received cares, meals, cognicalds, glasses, pain laundry, fall manage addition, R1 received occupational therap strengthening due to medial tibial plateau R1's IAPP dated Occupational therap strengthening due to medial tibial plateau R1's IAPP lacked experience or assessed R1's suscindividual, including risk of abusing others assessed R1's suscindividual, including risk of abusing risk of abusing ri	ing on July 29, 2015, and sisted living services on . R1's diagnoses included on, rheumatoid arthritis, and ain. R1 used a wheelchair for er lift for all transfers.  ated October 27, 2021, ed assistance with personal tion cues, prompts, hearing control, housekeeping, ement, and toileting. In ed weekly physical and by for lower and upper body o a lower left leg fracture (left	0 630			

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PRÉFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  DEFICIENCY)  Continued From page 11  cane for walking during times of MS exacerbations.  R2's service plan dated January 11, 2022, indicated R2 received assistance with personal cares, fall management, weekly laundry, housekeeping, and daily safety checks.  R2's comprehensive assessment dated January		NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	<b>l</b> ` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
NEW PERSPECTIVE - WOODBURY  2195 CENTURY AVENUE SOUTH WOODBURY, MN 55125  (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  0 630  Continued From page 11  cane for walking during times of MS exacerbations.  R2's service plan dated January 11, 2022, indicated R2 received assistance with personal cares, fall management, weekly laundry, housekeeping, and daily safety checks.  R2's comprehensive assessment dated January			31733	B. WING			
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Deficiency  O 630  Continued From page 11  cane for walking during times of MS exacerbations.  R2's service plan dated January 11, 2022, indicated R2 received assistance with personal cares, fall management, weekly laundry, housekeeping, and daily safety checks.  R2's comprehensive assessment dated January			SURY 2195 CEN	TURY AVEN	UE SOUTH		
cane for walking during times of MS exacerbations.  R2's service plan dated January 11, 2022, indicated R2 received assistance with personal cares, fall management, weekly laundry, housekeeping, and daily safety checks.  R2's comprehensive assessment dated January	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	LD BE	(X5) COMPLETE DATE
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.  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.  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; 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.  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.	0 630	cane for walking du exacerbations.  R2's service plan di indicated R2 receiv cares, fall manager housekeeping, and R2's comprehensiv 11, 2022, indicated experienced dizzine diagnoses of vertige transportation, and R2's IAPP dated Jahad difficulty report to being abused by immediately notify a symptoms of abuse R2's IAPP lacked e review or assessment assessed R2's suscindividual, including risk of abusing other statement of specific minimize the risk of vulnerable adults.  A law enforcement 2022, at 6:28 p.m., hospital where she sexually assaulted taking out her trash of the facility. During enforcement, R2 sa her breast, telling R R2 told law enforcement.	ated January 11, 2022, ed assistance with personal ment, weekly laundry, daily safety checks.  e assessment dated January R2 was assessed as ess and vertigo due to her o. R2 was independent with managing her medications.  Inuary 11, 2022, indicated R2 ing abuse and was susceptible other adults. Staff were to a supervisor for any signs or e or neglect.  vidence an individualized ent was developed that ceptibility to abuse by another other vulnerable adults; the er vulnerable adults; and ic measures to be taken to a buse to R2 and other  report dated January 16, indicated R2 was at a local told hospital staff she was by another resident (R3) while at 6:00 a.m. in the lower level gher interview with law ated R3 placed his hands on the was going to "Fuck you." ment she wanted the incident				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ` ′	E CONSTRUCTION	` '	(X3) DATE SURVEY COMPLETED	
		31733	B. WING			C <b>05/2022</b>
	PROVIDER OR SUPPLIER	SURY 2195 CEN	DRESS, CITY, S ITURY AVENI JRY, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
0 630	updated addressing along with specific in new listed vulnerable.  R3 R3's medical record admitted to the facilities diagnoses included disturbance and character and specific management, safethousekeeping.  R3's service plan distincted R3 receiv washing, medication management, safethousekeeping.  R3's comprehensive 14, 2022, indicated and cognitive capallemergency. R3 was cognitive impairment and being unable to susceptible to being independent in personal susceptible to being independent in personal susceptible.  R3's IAPP dated No staff were to immediant signs or symptomatical symptoms.	evidence her IAPP was g R2's alleged sexual assault measures to be taken for her ility.  d was reviewed. R3 was lity on November 2, 2021. R3 dementia without behavioral ronic kidney disease Stage 3. dently.  ated November 16, 2021, ed assistance with hand n management, fall by checks, weekly laundry and e assessment dated February R3 lacked physical, mental, collity to evacuate self in an es assessed as having ent, memory loss, chronic pain, or report abuse and was g abused by others. R3 was sonal cares and required no evember 16, 2021, indicated diately notify a supervisor for oms of abuse or neglect.	0 630			
	assessed R3's suscindividual, including risk of abusing other statement of specifications.	ent was developed that ceptibility to abuse by another other vulnerable adults; the r vulnerable adults; and ic measures to be taken to abuse to R3 and other				

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	CONSTRUCTION	l \ '	E SURVEY PLETED
		31733	B. WING		l	C <b>05/2022</b>
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
NEW PE	RSPECTIVE - WOODE	BURY	NTURY AVENU			
			JRY, MN 5512			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
0 630	Continued From pa	ige 13	0 630			
	a.m., indicated a stadown an entrance restaff member assis multiple attempts. For progress note indicated unlied baseline with no confound R3 walking dassisted R3 into he attempts. R3 starte ULP-B's vehicle, state ULP-B's vehicle, state unique anyone. R3's family director (LALD)-E was going, and anyone. R3's family director (LALD)-E was going were apparent injuries. R3's vital signs were	aff member found R3 walking ramp to a major freeway. The ted R3 back to the facility after R3's family was contacted. The ated R3 returned to his ncerns from nursing staff.  I dated May 2, 2022, at 5:40 censed personnel (ULP)-B own a freeway ramp. ULP-B r vehicle after unsuccessful d crying when he got into ating he did not know where requested ULP-B not tell and licensed assisted living were notified. R3 had no R3's incident report indicated to not obtained. R3's physician				
	R3's record lacked	y 11, 2022, at 8:00 a.m. evidence his IAPP was as found walking down a				
	admitted to the faci under the compreh- receiving assisted I 2021. R4's diagnos abnormalities of ga	d was reviewed. R4 was lity on October 12, 2017, ensive license and began iving services on August 1, es included dementia and it and mobility. R4 used a bed a Hoyer lift for all transfers or mobility.				
	2022, indicated R4 unable to use a call	e assessment dated April 9, was assessed as being I pendant. R4 was assessed sist using a Hoyer lift due to				

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	NT OF DEFICIENCIES NOF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	<b>l</b> `´	E CONSTRUCTION	` ′	X3) DATE SURVEY COMPLETED	
		31733	B. WING		05/0	5 5/2022	
	PROVIDER OR SUPPLIER	SURY 2195 CEN	DRESS, CITY, S ITURY AVENI JRY, MN 551				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE	
0 630	as being unable to and interventions do with others. R4 was physical, mental, or recognize a danger evacuate self in an as having the follow impairment; unable environment; exhibited a chronic condition difficulty following difficulties were service plan/individual following following report in the property.  R4's service plan danger following following difficulties are also indicated there were located on staff assignmentately report for property.  R4's IAPP lacked experience of property.  R4's IAPP lacked experience of abusing other statement of specificulties and including risk of abusing other statement of specificulties.	n mobility. R4 was assessed respond to cues, prompting, ue to the inability to interact assessed as lacking cognitive capability to signal, or alarm in order to emergency. R4 was assessed ving vulnerabilities: cognitive to maintain a safe and clean ited visual or hearing deficits; ition, pain, disability; had irections or making needs anage finances; difficulty in others and was susceptible to istory of actions that resulted lect. R4's assessment					

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		` ′	(X3) DATE SURVEY COMPLETED	
		31733	B. WING		05/0	) 5/2022	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
NEW PE	RSPECTIVE - WOODE	BURY	TURY AVEN				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE	
0 630	Continued From pa	ge 15	0 630				
	vulnerable adults.						
	nursing, (DON)-F st embedded in their st IAPP's were a task alerting staff they w adults and if there v	at 9:00 a.m., director of tated resident IAPP's were service plans. DON-B stated in their software system ere working with vulnerable vere a reason to believe they stating, "that was the extent					
	Resident, updated I IAPP would contain the person's suscer individuals, including person's risk of abute and statements of storminimize the risk other vulnerable admandatory assessing during the initial operation.	November 5, 2021, indicated an individual assessment of otibility to abuse by other g other vulnerable adults; the sing other vulnerable adults; specific measures to be taken of abuse to that person and ults. The IAPP was a nent that would be performed ening of the service chart.  CORRECT: Seven (7) days.					
	144G.70 Subd. 2 (c) Resident reasses be conducted no mafter initiation of ser reassessment and as needed based or resident and cannot from the last date of (d) For residents on services specified in 9, clauses (1) to (5)	e-e) Initial reviews, monitoring essment and monitoring must ore than 14 calendar days rvices. Ongoing resident monitoring must be conducted in changes in the needs of the texceed 90 calendar days	01620				

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PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMP	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
NEW PERSPECTIVE - WOODBURY  2195 CENTURY AVENUE SOUTH WOODBURY, MN 55125    Xummary Statement of Deficiencies (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG   PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)   PREFIX TAG   PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)   PREFIX TAG   PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)   DATE OF TAGE			31733	B. WING			
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  01620  Continued From page 16  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.  (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			BURY 2195 CEN	ITURY AVENU	JE SOUTH		
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.  (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	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	ILD BE	(X5) COMPLETE DATE
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.  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).  Findings include:  R1  R1's medical record was reviewed. R1 moved	01620	and preferences. To completed within 30 services. Resident be conducted as not the needs of the recalendar days from (e) A facility must in of the availability of long-term care consection 256B.0911, prospective resider facility or the date of resident moves in, and the days from this MN Requirements (R1, R2, addition, the license assessment was performed a reasseresidents (R1, R2, addition, the license assessment was performed attending longer requiring a horizontal frestrictions.  This practice result violation that harmonic including serious or a violation that harmonic including serious injury, impaissued at an isolate limited number of realimited number of realimited number of realimited number of realimited number of situation has occurrence.	he initial review must be calendar days of the start of monitoring and review must be deeded based on changes in sident and cannot exceed 90 the date of the last review. Inform the prospective resident and contact information for sultation services under prior to the date on which a prospective which a prospective which a prospective whichever is earlier.  The ent is not met as evidenced and document review, the neure a registered nurse (RN) essments for three of four R3) with records reviewed. In the failed to ensure an accurate erformed on R1 after R1's giphysician assessed as not aloyer lift or weightbearing and the potential to lead to be injury, impairment, or death, as the potential to lead to be injury, impairment, or death, as the potential to lead to be injury, impairment, or death, as the potential to lead to be injury, impairment, or death, as the potential to lead to be injury, impairment, or death, as the potential to lead to be injury, impairment, or death, as the potential to lead to be injury, impairment, or death, as the potential to lead to be injury, impairment, or death, as the potential to lead to be injury, impairment, or death, as the potential to lead to be injury, impairment, or death, as the potential to lead to be injury, impairment, or death, as the potential to lead to be injury, impairment, or death, as the potential to lead to be injury, impairment, or death, as the potential to lead to be injury.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		31733	B. WING			) 5/2022
	PROVIDER OR SUPPLIER	SURY 2195 CEN	DRESS, CITY, S TURY AVEN RY, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
01620	began receiving ass September 2, 2021 R1 was discharged diagnoses included rheumatoid arthritis R1 used a wheelch for all transfers.  R1's physician prov 2021, indicated R1 lower leg fracture (r having an unwitnes independent living i transferred to assis September 2, 2021 left knee brace, and restrictions in order  R1's record lacked after being diagnos  R1's initial service prindicated R1 receiv cares, hearing aide housekeeping, laun toileting. R1's was a assist using a gait to R1's initial compreh September 2, 2022 Transfer/Mobility, in pendant, had seven her right and left low with the assistance independent with m	ing on July 29, 2015, and sisted living services on , until January 24, 2022, when from the facility. R1's macular degeneration, , and chronic low back pain. air for mobility and a Hoyer lift ider note dated September 1, was diagnosed with a left nedial tibial plateau) after sed fall while residing in n the facility. R1 was ted living services on , and was fitted with a hinged d non-weightbearing (NWB) to protect her fractured leg. evidence R1 was reassessed ed with a left leg fracture. Dan dated September 2, 2021, ed assistance with personal , daily safety checks, adry, fall prevention, and assessed as a one-person	01620			
	2021, at 11:05 a.m.	, indicated on September 2, R1 began assisted living				

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		· · · ·	(X3) DATE SURVEY COMPLETED	
		31733	B. WING			C <b>05/2022</b>	
	PROVIDER OR SUPPLIER	SURY 2195 CEN	DRESS, CITY, ST NTURY AVENU JRY, MN 5512				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
01620	diagnosed with a leattending physician R1's knee brace wo facility.  R1's attending physical states attending physical to be aring (TTWB) on to be worn when up night and during sk tolerated (WBAT) of open 0-90 degrees range of motion (PRR1's record lacked after she was diagnormal strengthening a pain and healing of attending physician physical therapist (IR1 being decondition her leg fracture. R1 physician assessed person, place, and R1's progress note 2:07 p.m., written be received orders for from R1's family profits.	ress note indicated R1 was ft knee fracture. R1's provided a left knee brace. build be managed by the  sician orders dated September R1 was a toe-touch weight left leg with a left knee brace during the day, removed at in cares; weight bearing as n right leg; knee brace set at with left leg to receive passive ROM), 0-90 degrees.  evidence R1 was reassessed losed with a left leg fracture.  ed on October 20, 2021, at hopedic attending physician weight bearing on her left loced range of motion (ROM) as tolerated due to decreased her leg fracture. R1's indicated gait training with a PT) would be beneficial due to bened due to inactivity following 's orthopedic attending I R1 as being oriented to time.  dated, October 20, 2021, at y DON-F, indicated DON-F R1's Hoyer lift for all transfers byider.					
	4:00 p.m., written b	dated October 20, 2021, at y DON-F, indicated FM-C told er needed to wear the left knee t following orders from R1's					

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	<b>`</b>	E CONSTRUCTION	(X3) DATE COMP	SURVEY
			A. BUILDING:			_
		31733	B. WING			5/ <b>2022</b>
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
NEW PE	RSPECTIVE - WOODI	BURY	TURY AVEN RY, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
01620	Continued From pa	ige 19	01620			
	lift be removed from medication and trea	. FM-C requested the Hoyer n R1's care plan along with her atment plan. DON-F wrote she h the orthopedic clinic.				
	R1's record lacked R1's orthopedic atte	evidence DON-F contacted ending physician.				
	8:55 a.m., written be received faxed order attending physician	dated October 21, 2021, at y DON-F, indicated DON-F ers from R1's orthopedic indicating R1 could resume eight bearing as tolerated.				
	9:51 p.m., written be discussed R1's need transfers. FM-C remattending physician Hoyer lift and kneed never received order attending physician Hoyer lift, kneed brain bearing on the left I collaborated R1's collaborated R1's condicating the order R1's family provided would continue to uttransfers. FM-C indicating the collaborated R1's family provided would continue to uttransfers. FM-C indicating the collaborated R1's family provided would continue to uttransfers. FM-C indicating the collaborated R1's family provided would continue to uttransfers. FM-C indicating the collaborated R1's family provided would continue to uttransfers. FM-C indicating the collaborated R1's c	dated October 21, 2021, at y DON-F, indicated DON-F ed to use the Hoyer lift for safe minded DON-F of R1's primary orders for removal of the brace. DON-F indicated she ers from R1's primary indicating to discontinue the ce, and start full weight eg. DON-F stated she are with R1's family provider, for R1's Hoyer lift came from r and indicated the facility ise the Hoyer lift for R1's licated he would contact R1's ancel the facility's request for a				
	DON-F reassessed and understand others and R1 was assessed at two staff with transformations	ed on October 22, 2021, I R1 as being able to and communicate her needs. as required assistance from fers using a mechanical lift due s. at 9:00 a.m., DON-F stated				

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NAME OF PROVIDER OR SUPPLIER   STREET ADDRESS, CITY, STATE, ZIP CODE	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
NEW PERSPECTIVE - WOODBURY   2195 CENTURY AVENUE SOUTH   WOODBURY, MIN 55125   ID   PRETIX   (EACH DEFICIENCY MUST SEE PRECEDED BY FULL   TAG   TAG			31733	B. WING			
PRÉFIX TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  O1620  Continued From page 20 she performed annual, 90-day, and change-in-condition assessments for residents.  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.  R2's service plan dated January 11, 2022, indicated R2 received assistance with personal cares, fall management, weekly laundry, housekeeping, and daily safety checks.  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.  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.  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 sated R3 placed his hands on her breast, telling R2 he was going to "Fuck you".			BURY 2195 CEN	ITURY AVEN	UE SOUTH		
she performed annual, 90-day, and change-in-condition assessments for residents.  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.  R2's service plan dated January 11, 2022, indicated R2 received assistance with personal cares, fall management, weekly laundry, housekeeping, and daily safety checks.  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.  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.  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 sated R3 placed his hands on her breast, telling R2 he was going to "Fuck you."	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	ULD BE	COMPLETE
	01620	she performed annochange-in-condition R2 R2's medical record admitted to the facilithe comprehensive assisted living servidiagnoses included anxiety, post-traum multiple sclerosis, awalking. R2's service plan daindicated R2 received cares, fall manager housekeeping, and R2's comprehensive 11, 2022, indicated experienced dizzined diagnoses of vertigot transportation, and R2's IAPP dated Jahad difficulty reportito being abused by immediately notify a symptoms of abused R2's law enforcement post and the facility. During enforcement, R2 saher breast, telling R	ual, 90-day, and assessments for residents.  If was reviewed. R2 was lity on April 22, 2021, under license and began receiving ces on August 1, 2021. R2's major depressive disorder, atic stress disorder (PTSD), and mania. R2 used a cane for ated January 11, 2022, ed assistance with personal ment, weekly laundry, daily safety checks.  If a sasessment dated January R2 was assessed as ess and vertigo due to her on R2 was independent with managing her medications.  Inuary 11, 2022, indicated R2 and abuse and was susceptible other adults. Staff were to a supervisor for any signs or a corneglect.  In the port dated January 16, indicated R2 was at a local told hospital staff she was by another resident (R3) while at 6:00 a.m. in the lower level g her interview with law ated R3 placed his hands on 2 he was going to "Fuck you."				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		31733	B. WING		05/0	5/2022
	PROVIDER OR SUPPLIER	SURY 2195 CEN	DRESS, CITY, S TURY AVEN IRY, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
01620	Continued From pa	ge 21	01620			
	after she told staff s	evidence R2 was reassessed the was sexually assaulted.				
		lleged sexual assault.				
	admitted to the facilities diagnoses included	d was reviewed. R3 was lity on November 2, 2021. R3 dementia without behavioral ronic kidney disease Stage 3. dently.				
	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.  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.					
	a.m., indicated a stadown an entrance restaff member assist multiple attempts. For progress note indicated a stadown an entrance restaff member assist multiple attempts.	dated May 5, 2022, at 6:01 aff member found R3 walking amp to a major freeway. The ted R3 back to the facility after R3's family was contacted. The ated R3 returned to his neerns from nursing staff.				
		dated May 2, 2022, at 5:40 censed personnel (ULP)-B				

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	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	CONSTRUCTION	l \	E SURVEY PLETED
		31733	B. WING		l l	C <b>05/2022</b>
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
NEW PE	RSPECTIVE - WOODE	BURY	NTURY AVENU			
		WOODB	JRY, MN 5512			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
01620	Continued From pa	ge 22	01620			
01020	found R3 walking dassisted R3 into he attempts. R3 starte ULP-B's vehicle, starte ULP-B's vehicle, starte uller-B's vehicle, starte uller-B's vehicle, starte uller-B's vehicle, started anyone. R3's family director (LALD)-E wapparent injuries. R3's vital signs were was notified on May R3's record lacked after being found on On June 16, 2022, she performed annother change-in-condition DON-F stated she R2 after her alleged stated R2 made a construction being stated R2 made a construction being day.  On July 7, 2022, at on May 9, 2022, R3 assessment but was wandering incident.  On July 7, 2022, LA the facility did not find Adult Abuse Report	own a freeway ramp. ULP-B r vehicle after unsuccessful d crying when he got into ating he did not know where requested ULP-B not tell and licensed assisted living were notified. R3 had no 3's incident report indicated e not obtained. R3's physician 11, 2022, at 8:00 a.m. evidence R3 was reassessed in the freeway ramp.				
	not need to be filed  The licensee policy	titled, Changes in Condition, 5, 2021, indicated staff must				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		31733	B. WING		05/0	5/2022
	PROVIDER OR SUPPLIER	SURY 2195 CEN	DRESS, CITY, S ITURY AVEN IRY, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
01620	Continued From pa	ge 23	01620			
	•	d or suspected change in a to a licensed nurse for ip.				
	TIME PERIOD TO	CORRECT: Seven (7) days.				
	144G.70 Subd. 4 (a implementation and	,	01640			
	that services are first facility shall finalize (b) The service plan include a signature facility and by the reagreement on the service plan must be resident reassessmant facility must provide about changes to the and how to contact Long-Term Care.  (c) The facility must services required by (d) The service plan must be entered intincluding notice of a when applicable.  (e) Staff providing set the current written services.					
	by: Based on interview licensee failed to en included a signature	and record review, the sure residents service plans or other authentification by the resident documenting				

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_ `		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	<b>l</b> ` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY
		31733	B. WING		05/0	) 5/2022
	PROVIDER OR SUPPLIER	SURY 2195 CEN	DRESS, CITY, S TURY AVEN RY, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	LD BE	(X5) COMPLETE DATE
01640	three of four resident reviewed. In addition R3's service plan and down a major freew. This practice results violation that did not safety but had the president's health or widespread scope (or represent a system or has the potential of the residents).  The findings included R2 R2's medical record to the licensee on Accomprehensive licentes assisted living service diagnoses included anxiety, post-traum multiple sclerosis (National Cane for walking due exacerbations.  R2's service plan daindicated R2 received cares, fall manager housekeeping, and R2's service plan la authentication by the service	services to be provided for ints (R2, R3, R4) with records in, the licensee failed to revise fter he was found wandering vay ramp at night.  ed in a level two violation (a tharm a resident's health or potential to have harmed a safety) and was issued at a (when problems are pervasive emic failure that has affected to affect a large portion or all e:  d was reviewed. R2 admitted april 22, 2021, under the inse and began receiving ices on August 1, 2021. R2's major depressive disorder, atic stress disorder (PTSD), MS), and mania. R2 used a	01640			
	R3					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		<b>I</b> ` ´	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:	A. BUILDING:		_
		31733	B. WING			C <b>05/2022</b>
NAME OF	PROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, S	STATE, ZIP CODE		
NEW PE	RSPECTIVE - WOODE	BURY	NTURY AVEN			
			URY, MN 551		000000000000	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TON SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
01640	Continued From pa	age 25	01640			
	to the licensee on National diagnoses included disturbance and characters and characters walked independent					
	indicated R3 received washing, medication	ated November 16, 2021, ed assistance with hand on management, fall ty checks, weekly laundry and				
	authentication by th	acked signatures or other ne facility and resident ement on the services to be				
	a.m., indicated a stadown an entrance restaff member assist multiple attempts. For progress note indicated a stadown an entrance restaff member assist multiple attempts.	dated May 5, 2022, at 6:01 aff member found R3 walking ramp to a major freeway. The ted R3 back to the facility afte R3's family was contacted. The ated R3 returned to his incerns from nursing staff.				
	p.m., indicated unlice found R3 walking departments and into he attempts. R3 started ULP-B's vehicle, started unlice was going, and in anyone. R3's family director (LALD)-E was apparent injuries. R3's vital signs were was notified on May	t dated May 2, 2022, at 5:40 censed personnel (ULP)-B lown a freeway ramp. ULP-B er vehicle after unsuccessfuled crying when he got into ating he did not know where requested ULP-B not tell y and licensed assisted living vere notified. R3 had no R3's incident report indicated re not obtained. R3's physician y 11, 2022, at 8:00 a.m.				
	updated after his wa	evidence his service plan was andering incident.				

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AND DIAN OF CORRECTION INTERPRETATION NUMBERS	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
31733	B. WING		C <b>05/05/2022</b>	<u>)</u>
NAME OF PROVIDER OR SUPPLIER STREET ADDI	RESS, CITY, ST	TATE, ZIP CODE		
NEW PERSPECTIVE - WOODBURY	TURY AVENU RY, MN 5512			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE COMPL	LETE
01640 Continued From page 26	01640			
R4  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.  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.  R4's service plan lacked signatures or other authentication by the facility and resident documenting agreement on the services to be provided.  On June 16, 2022, at 9:00 a.m., former director of nursing (DON)-F said she was responsible for developing service plans.  The licensee policy titled, Resident Service Plan, updated November 5, 2021, indicated the service plan would be revised and signed by a nurse and				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		31733	B. WING		05/0	) 5/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS CITY S	STATE, ZIP CODE		
NAIVIL OI I	NOVIDEN ON SUFFEIEN		TURY AVEN			
NEW PE	RSPECTIVE - WOODE	BURY	RY, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
01640	Continued From page 27		01640			
	TIME PERIOD TO	CORRECT: Seven (7) days.				
01650 SS=E	144G.70 Subd. 4 (f) and revisions to	Service plan, implementation	01650			
	the fees for services service, according to assessment and rest (2) the identification who will provide the (3) the schedule an assessments of the (4) the schedule an providing services; (5) a contingency plant (i) the action to be to cannot be provided (ii) information and facility; (iii) the names and the resident wishes emergency or if the change in the residentification of and	the services to be provided, s, and the frequency of each to the resident's current sident preferences; of staff or categories of staff services; d methods of monitoring resident; d methods of monitoring staff and lan that includes: aken if the scheduled service				
	medical services ar consistent with chap	es in which emergency e not to be summoned pters 145B and 145C, and by the resident under those				
	by: Based on interview licensee failed to er	ent is not met as evidenced and record review, the sure the resident's service the required content for two of				

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` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	COMP	SURVEY
		31733	B. WING		05/0	) 5/2022
		31733	<u> </u>		1 03/0	312022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
NEW PE	RSPECTIVE - WOODE	BURY	TURY AVEN RY, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
01650	This practice resulted violation that did not safety but had the president's health or cause serious injury was issued at a patt limited number of rethan a limited number situation has occurre found to be pervasive.  R2 R2's medical record to the licensee on Accomprehensive licenses assisted living servidiagnoses included anxiety, post-traumanultiple sclerosis (National Cane for walking durexacerbations.  R2's service plan daindicated R2 received cares, fall manager housekeeping, and R2's service plan lainformation:  (1) Description of the fees for the services	R3) with records reviewed.  R4 in a level two violation (a tharm a resident's health or otential to have harmed a safety, but was not likely to a safety, but was reviewed, or the sed repeatedly; but is not we).  A was reviewed. R2 admitted a pril 22, 2021, under the nse and began receiving ces on August 1, 2021. R2's major depressive disorder, atic stress disorder (PTSD), and mania. R2 used a ring times of MS  Ated January 11, 2022, and assistance with personal nent, weekly laundry, daily safety checks.  Cked the following  Table 11 to 12 to 13 to 14 to 15 t	01650	DEFICIENCY)		
	assessments of the	•				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		` '	(X3) DATE SURVEY COMPLETED	
		31733	B. WING			C <b>05/2022</b>
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
NEW PE	RSPECTIVE - WOODE	BURY	TURY AVENU IRY, MN 5512			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE
01650	Continued From pa	ge 29	01650			
	(3) Schedule and momentum (3) who provided home	ethods of monitoring staff care services;				
	to be taken if the so provided; (ii) circum medical services we consistent with cha	lan that included: (i) the action cheduled service could not be stances in which emergency ere not to be summoned oters 145B and 145C, and by the resident under those				
	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.					
	indicated R3 received washing, medication	ated November 16, 2021, ed assistance with hand n management, fall y checks, weekly laundry and				
	R3's service plan la information:	cked the following				
	(1) Description of the fees for the services	ne services to be provided and s;				
	(2) The schedule ar	nd methods of monitoring resident;				
	(3) Schedule and momentum (3) who provided home	ethods of monitoring staff care services;				
	to be taken if the so provided; and (ii) c	lan that included: (i) the action heduled service could not be ircumstances in which services were not to be				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		31733	B. WING		05/0	) 5/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
NEW DE	DEDECTIVE WOODS	2195 CEN	TURY AVEN			
NEW PE	RSPECTIVE - WOODE	WOODBU	RY, MN 551	25		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
01650	Continued From pa	ge 30	01650			
		ent with chapters 145B and ions made by the resident rs.				
	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.					
	updated November plan served as a ba	titled, Resident Service Plan, 5, 2021, indicated the service sis for the service delivery le licensee and the resident.				
	TIME PERIOD TO	CORRECT: Seven (7) days.				
01960 SS=G	144G.72 Subd. 5 D administration of tre		01960			
	assisted living facility record. The docume signature and title of administered the trainclude the date and treatment or theraptordered or prescribe document the reason	eatment or therapy and must d time of administration. When ies are not administered as ed, the provider must on why it was not administered rocedures that were provided				
	by: Based on interview licensee failed to enders were implement (R1) reviwe orders from R1's at	and record review, the sure the attending physician's nented for one of one of one ed. The licensee received tending physician to se of a Hoyer (total body) lift,				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		31733	B. WING			C <b>05/2022</b>
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
NEW PE	RSPECTIVE - WOODE	BURY	NTURY AVENU			
()(1) ID	STIMMADV STA	TEMENT OF DEFICIENCIES	JRY, MN 5512	PROVIDER'S PLAN OF C	CODDECTION	()/5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC)	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
01960	Continued From pa	ige 31	01960			
	exercises on her leading physician orders and lift with R1 for over out of the facility. Redeconditioned and	art full weight-bearing It leg, failed to implement the Id continued to use the Hoyer Ithree months until she moved I's left leg became Is developed a deep Ithree from not bearing full weight				
	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).					
	Findings Include:					
	into independent live began receiving assessing September 2, 2021 R1 was discharged diagnoses included rheumatoid arthritis	d was reviewed. R1 moved ring on July 29, 2015, and sisted living services on , until January 24, 2022, when from the facility. R1's macular degeneration, s, and chronic low back pain. air for mobility and a Hoyer lift				
	dated September 1 diagnosed with a le tibial plateau) after while residing in inc R1 was transferred September 2, 2021 left knee brace, and	opedic physician provider note, 2021, indicated R1 was oft lower leg fracture (medial having an unwitnessed fall dependent living in the facility. to assisted living services on, and was fitted with a hinged of non-weightbearing (NWB) to protect her fractured leg.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		<b>l</b> `´´	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		31733	B. WING		C 05/05/2022	
		31733			1 05/0	13/2022
NAME OF I	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
NEW PE	RSPECTIVE - WOODE	BURY	ITURY AVEN IRY, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
01960	Continued From pa	ge 32	01960			
	R1's late entry prog 2021, at 11:01 a.m. (DON)-F, indicated told family member staff to assist her detransfers, cues, and and required a Hoylindicated the informability to transfer withome health aide (November 1) would re-evaluate fappointment with he scheduled for October 10:57 a.m., and 2:4 contacted R1's famproviding follow up injury) to request or R1's record indicated 3:38 p.m., R1's orthadvanced R1 to full leg/knee with advarand strengthening a pain and healing of attending physician physical therapist (R1 being decondition that leg fracture. R1 physician assessed person, place, and R1's progress note 2:07 p.m., written by	ress note dated October 19, , written by director of nursing on October 18, 2021, DON-F (FM)-C, R1 required three ue to her inability to assist with d weight bearing restrictions er lift for all transfers. FM-C nation conflicted with R1's th the assist of one with her HHA)-H. DON-F wrote she R1 after her orthopedic er attending physician, ber 20, 2021.  Is dated October 19, 2021, at 2 p.m., indicated DON-F illy provider (who was not care to R1 at the time of her reders for a Hoyer lift.  Indicated on October 20, 2021, at appedic attending physician weightbearing on her left need range of motion (ROM) as tolerated due to decreased her leg fracture. R1's indicated gait training with a PT) would be beneficial due to oned due to inactivity following 's orthopedic attending IR1 as being oriented to				
	from R1's family pro	dated October 20, 2021, at				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	31733				05/0	) 5/2022
	PROVIDER OR SUPPLIER	BURY 2195 CEN	DRESS, CITY, S TURY AVENU RY, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
01960	brace or a Hoyer lift orthopedic attending the Hoyer lift be renalong with her medical DON-F wrote she worthopedic clinic.  R1's progress note 8:55 a.m., written by received faxed order attending physician all activities and were (WBAT).  R1's progress note 9:51 p.m., written by discussed R1's neet transfers. FM-C renorthopedic attending of the Hoyer lift and she never received orthopedic attending came from R1's far facility would continue the Hoyer lift and she never received orthopedic attending came from R1's far facility would continue the Hoyer lift.  A faxed order dated p.m., from R1's orthopedic attending came from R1's far facility, indicated longer needs to we advance to full weigh she does not required.	ge 33  y DON-F, indicated FM-C told or needed to wear the left knee of following orders from R1's group physician. FM-C requested noved from R1's care plan order and treatment plan. It would follow-up with the dated October 21, 2021, at any DON-F, indicated DON-F or from R1's orthopedic indicating R1 could resume ight bearing as tolerated dated October 21, 2021, at any DON-F, indicated DON-F do to use the Hoyer lift for safe physician orders for removal knee brace. DON-F indicated orders from R1's primary group physician indicating to der lift and knee brace. DON-F ated R1's care with R1's family the order for R1's Hoyer lift in the order for R1's Hoyer lift or C indicated he would contact to cancel the facility's request a loctober 22, 2021, at 12:06 nopedic attending physician to dethe following, "patient no are hinged knee brace and may int-bearing. Because of this e the use of a Hoyer lift. We e starts physical therapy to	01960			

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	<b>l</b> ` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		31733	B. WING	B. WING		5/2022
NAME OF	PROVIDER OR SUPPLIER	•	DRESS CITY S	STATE, ZIP CODE	1 03/0	312022
	RSPECTIVE - WOODE	SURY 2195 CEN	TURY AVEN	UE SOUTH		
040.15	CLIMANA DV CTA		RY, MN 551		ION	0.45
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
01960	Continued From pa	ige 34	01960			
	_	ing and gait training." The ed to call the orthopedic office				
	R1's record lacked evidence DON-F or the facility contacted R1's orthopedic attending physician regarding the new orders.					
	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.					
	R1's orthopedic attends being able to be restrictions. R1's was flexion contracture decondition of her letter the Hoyer lift and no on her left leg. R1 r	ed on December 15, 2021, ending physician assessed R1 ar weight as tolerated with no as assessed as having a deep in the left knee due to eft leg from continued use of ot being allowed to bear weight eceived a cortisone injection o work on strengthening				
	9:37 a.m., R1's fam the facility to defer a	ed on December 21, 2021, at hily provider faxed orders to all transfer requests, Hoyer lift, s be deferred to R1's g physician.				
	2021, indicated R1' as having no cognit	r note, dated December 27, s family provider assessed R1 tive decline, with only past e to a urinary tract infection				

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PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (UTI).  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.  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.  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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		<b>l</b> ` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
NEW PERSPECTIVE - WOODBURY  2195 CENTURY AVENUE SOUTH WOODBURY, MN 55125  (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  01960 Continued From page 35 (UTI).  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.  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.  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			31733	B. WING			
PRÉFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  01960  Continued From page 35  (UTI).  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.  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.  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			SURY 2195 CEN	TURY AVEN	UE SOUTH		
(UTI).  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.  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.  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	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	LD BE	(X5) COMPLETE DATE
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."  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	01960	R1's progress note 2022, at 1:30 p.m., an undisclosed loca family.  On May 5, 2022, at personnel (ULP)-A the Hoyer lift and probathroom rather that On June 13, 2022, facility ignored R1's physician's orders to Hoyer lift, and to be and instead went to obtain an order to k stated the facility neattending physician clinic told him the facility did son physical and emotion her leg to build stan "The facility did son physical and emotion her heal."  On June 14, 2022, assisted living direct a Hoyer lift until Jan moved out of the face a Hoyer lift until Jan moved out of the face a Hoyer lift until Jan moved out of the face and	indicated on January 24, R1 moved out of the facility to ation with the assistance from 12:45 p.m., unlicensed stated R1 did not like using referred walking to the an waiting for the Hoyer lift.  at 9:30 a.m., FM-C stated, the corthopedic attending to remove her knee brace, egin weight-bearing exercises of R1's family physician to seep R1 in the Hoyer lift. FM-C ever communicated with R1's are FM-C stated R1's orthopedic acility hurt R1 by not allowing llowed to bear any weight on mina to perform safe transfers. The performing that caused R1 and harm. They wouldn't let the stated R1 used the performing that caused R1 are placed in their secured LALD-E stated R1 evel of care so the facility attention of R1's assisted living that the performing that sated FM-C did not memory care, so the facility attention of R1's assisted living that the provided the youtce for R1's move from	01960			

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AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ,	E CONSTRUCTION	COMPLETED	
	31733 B. WING			C <b>05/05/2022</b>	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	
NFW PF	RSPECTIVE - WOODE	SURY 2195 CEN	TURY AVEN	UE SOUTH	
		WOODBU	RY, MN 551		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE
01960	Continued From pa	ge 36	01960		
	the facility's Uniform Services and Amen the assisted living stransfers using a Hoan error, so we had made sense. Our gomemory care to get On June 21, 2022, she had been provide seven years. HHA-I minimal assist, even	at 9:00 a.m., DON-F stated in Disclosure of Assisted Living ities (UDALSA) form indicated ection performed two-person over lift but stated, "that was to change the paperwork so it oal was to move R1 to assistance with her Hoyer."  at 1:30 p.m., HHA-H stated ding cares for R1 for over H stated R1 moved with with her left knee brace on.			
	2021, provided by Lathe facility offerred to transfers with the asserbanical lift or gater transfers with assistand transfers utilizing	y's UDALSA dated May 24, ALD-E, indicated on page 10, the following mobility services: ssist of two staff using a ait belt for transfer from floor, t of one staff using a gait belt, ng sit-to-stand lifts.  CORRECT: Seven (7) days.			
02360	Residents have the sexual, and emotion exploitation; and all	reedom from maltreatment right to be free from physical, nal abuse; neglect; financial forms of maltreatment /ulnerable Adults Act.	02360		
	by: Based on observati			No Plan of Correction (PoC) required Please refer to the public maltreat report (report sent separately) for of this tag.	ment

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	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE	
					С	
		31733	B. WING		05/0	5/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
NEW PE	RSPECTIVE - WOODE	BURY	ITURY AVEN			
	CLINANA DV CTA		JRY, MN 551		ON	2.15
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
02360	Continued From pa	ge 37	02360			
	Findings include:					
	Department of Head determination that refacility was response connection with including facility. MDH concludes	neglect occurred, and that the lible for the maltreatment, in dents which occurred at the				
02560 SS=G		n 1. Retaliation prohibited	02560			
	against a resident of employee, or any peresident:  (1) files a good faith makes a good faith (2) indicates a good complaint or grieval assert any right;  (3) files, in good faith file a maltreatment voluntary, under see (4) seeks assistant reasonable suspicite problems or concert of the facility, the O Long-Term Care, a government agency organization;  (5) advocates or seen necessary or improven forcement of right law;  (6) takes or indicate action;	e from or reports a on of a crime or systemic ns to the director or manager ffice of Ombudsman for				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		31733	B. WING		C <b>05/05/2022</b>	
	PROVIDER OR SUPPLIER	SURY 2195 CEN	DRESS, CITY, S TURY AVENU			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUT CROSS-REFERENCED TO THE APPRODEFICIENCY)	LD BE	(X5) COMPLETE DATE
02560	or judicial proceeding (8) contracts or indicator receive services resident's choice of (9) places or indicator camera or electronic resident's private spacetion 144.6502.  This MN Requirement by: Based on interview licensee failed to er (R1) with records reagainst. The license physician orders to body) lift and beging R1's physician docuoriented to person, R1's family question continued use of the discontinued and R licensee told R1's fato the secured ment could continue to us family refused, the pretermination hear living contract.  This practice results violation that has practice results violation that has precious injury, impairs a limited number of real limited number of li	vestigation or administrative ng; cates an intention to contract from a service provider of the her than the facility; or tes an intention to place a c monitoring device in the pace as provided under ent is not met as evidenced and record review, the asure one of four residents eviewed, was not retaliated be failed to implement discontinue a Hoyer (total walking after a leg fracture. Immented R1 was alert and place and time. When R1 and ned the facility on the legal Hoyer lift when it had been thad deconditioned, the amily R1 needed to relocated nory care unit where they see the Hoyer lift. When R1's				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` ′	CONSTRUCTION	` '	(X3) DATE SURVEY COMPLETED	
	31733	B. WING		l l	C <b>05/05/2022</b>	
NAME OF PROVIDER OR SUPPLIER  NEW PERSPECTIVE - WOODB	URY 2195 CEN	DRESS, CITY, ST NTURY AVENU JRY, MN 5512	IE SOUTH			
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE	
clause (1-3), Rétalia agent of a facility ma resident or an employement or an employement or any peresident: (1) files a grievance, makes a any right; (2) indicate a complaint or grievance assert any right; (3) indicates an intention report, whether man section 626.557.  R1's medical record into independent living began receiving assequent of september 2, 2021, R1 was discharged diagnoses included rheumatoid arthritis, R1 used a wheelchafor all transfers.  R1's attending orthough dated September 1, diagnosed with a left tibial plateau) after his while residing in indexent the september 2, 2021, left knee brace, and restrictions in order and restrictions in ord	tute 144G.92, subdivision 1, ition Prohibited. A facility or ay not retaliate against a					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		31733	B. WING		l	C <b>05/2022</b>
	PROVIDER OR SUPPLIER	SURY 2195 CEN	DRESS, CITY, S TURY AVENU RY, MN 551			
(X4) ID PREFIX TAG	PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPR <b>I</b> ATE	(X5) COMPLETE DATE
02560	transfers, cues, and and required a Hoy indicated the informability to transfer withome health aide (It would re-evaluate Fappointment with he scheduled for Octobro R1's progress notes 10:57 a.m., and 2:4 contacted R1's famproviding follow up injury) to request or R1's record indicate 3:38 p.m., R1's orthadvanced R1 to full leg/knee with advarand strengthening a pain and healing of attending physician physical therapist (It R1 being decondition her leg fracture. R1 physician assessed person, place, and R1's progress note 2:07 p.m., written breceived orders for from R1's family progress note 4:00 p.m., written brace or a Hoyer lift attending orthopedicatending orthopedic	ue to her inability to assist with diveight bearing restrictions er lift for all transfers. FM-C nation conflicted with R1's th the assist of one with her HHA)-H. DON-F wrote she R1 after her orthopedic er attending physician, ber 20, 2021.  Is dated October 19, 2021, at 12 p.m., indicated DON-F illy provider (who was not care to R1 at the time of her reders for a Hoyer lift.  Indicated of motion (ROM) as tolerated due to decreased her leg fracture. R1's indicated gait training with a PT) would be beneficial due to oned due to inactivity following is orthopedic attending renerated to time.  Indicated, October 20, 2021, at y DON-F, indicated DON-F R1's Hoyer lift for all transfers	02560			

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l ` ´	CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
						)
		31733	B. WING		05/0	5/2022
NAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, ST			
NEW PE	RSPECTIVE - WOODE	BURY	TURY AVENU RY, MN 5512			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
02560	Continued From pa	ge 41	02560			
	along with her medi	ication and treatment plan.  yould follow-up with the				
	8:55 a.m., written by received faxed order attending physician	dated October 21, 2021, at y DON-F, indicated DON-F ers from R1's orthopedic indicating R1 could resume light bearing as tolerated				
	9:51 p.m., written by discussed R1's need transfers. FM-C remattending physician Hoyer lift and kneed never received order attending physician Hoyer lift and kneed collaborated R1's callaborated R1's callaborated R1's family provided would continue to utransfers. FM-C indicating the collaborated R1's family provided would continue to utransfers. FM-C indicating the collaborated R1's family provided would continue to utransfers. FM-C indicating the collaborated R1's family provided would continue to utransfers. FM-C indicating the collaborated R1's family provided would continue to utransfers.	dated October 21, 2021, at y DON-F, indicated DON-F ed to use the Hoyer lift for safe ninded DON-F of R1's primary orders for removal of the brace. DON-F indicated she ers from R1's primary indicating to discontinue the brace. DON-F stated she are with R1's family provider, for R1's Hoyer lift came from and indicated the facility se the Hoyer lift for R1's icated he would contact R1's ancel the facility's request for a				
	p.m., from R1's orth the facility, indicated longer needs to we advance to full weigh she does not require recommend that she work on strengthen	d October 22, 2021, at 12:06 hopedic attending physician to d the following, "patient no ar hinged knee brace and may ght-bearing. Because of this e the use of a Hoyer lift. We se starts physical therapy to ing and gait training." The ed to call the orthopedic office				
	R1's record lacked	evidence DON-F or the facility				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		31733	B. WING		I	C <b>05/2022</b>	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE			
NEW PE	RSPECTIVE - WOODE	BURY	ITURY AVENU JRY, MN 5512				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE	
02560	R1's late entry prog 16, 2021, at 10:43 a 15, 2021, indicated use her bed mobility while staff placed the The progress note on both legs with a while staff positioned questioned staff who lift.  R1's record indicated R1's orthopedic attendance on the legs R1's was flexion contracture decondition of her left leg. R1 record indicated R1's family device orthopedic attendin R1's family provided 2021, indicated R1' as having no cognition of the R1's family provided	opedic attending physician orders.  Tress note dated December a.m., indicated on December R1 suggested to staff they y device so she could stand ne Hoyer sling underneath her indicated R1 was able to stand gait belt around her waisted the Hoyer sling. R1 by she was still using the Hoyer as assessed as having a deep in the left knee due to left leg from continued use of lot being allowed to bear weight eceived a cortisone injection of work on strengthening.  The provider faxed orders to all transfer requests, Hoyer lift, is be deferred to R1's					
	2022, at 1:30 p.m.,	indicated on January 24, R1 moved out of the facility to ation with the assistance from					

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	<b>l</b> `´´	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
					С	
		31733	B. WING		05/0	5/2022
NAME OF F	PROVIDER OR SUPPLIER		,	STATE, ZIP CODE		
NEW PE	RSPECTIVE - WOODE	BURY	ITURY AVEN IRY, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
02560	Continued From pa	ge 43	02560			
	family.					
	personnel (ULP)-A the Hoyer lift and probathroom rather that ULP-A stated she processionally was for On June 13, 2022, facility ignored R1's physician's orders to Hoyer lift, and to be and instead went to obtain an order to k stated the facility ne orthopedic attending orthopedic clinic tol not allowing heal by weight on her leg to transfers. "The facility	stated R1 did not like using referred walking to the an waiting for the Hoyer lift. Dersonally thought the resident sisted living, even though she orgetful.  at 9:30 a.m., FM-C stated, the corthopedic attending to remove her knee brace, egin weight-bearing exercises of R1's family physician to keep R1 in the Hoyer lift. FM-C ever communicated with R1's g physician. FM-C stated R1's d him the facility hurt R1 by y not being allowed to bear any of build stamina to perform safe lity did something that caused notional harm. They wouldn't				
	assisted living direct a Hoyer lift until Jan moved out of the farequired a higher learecommended R1 kmemory care unit. I want R1 placed in restarted a pretermination contract. LALD-E stated facility with a 30-day the facility so the prediscontinued.	at 10:00 a.m., licensed ctor (LALD)-E stated R1 used nuary 24, 2022, the day she icility. LALD-E stated R1 evel of care so the facility be placed in their secured LALD-E stated FM-C did not memory care, so the facility ation of R1's assisted living tated FM-C provided the y notice for R1 to move from retermination was				

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	NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		31733	B. WING		<b>I</b>	C <b>05/2022</b>	
	PROVIDER OR SUPPLIER	SURY 2195 CEN	DRESS, CITY, ST TURY AVENU RY, MN 5512				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC)	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
02560	Assisted Living Ser (UDALSA) form ind section performed to Hoyer lift but stated had to change the pour goal was to montassistance with here.  On June 21, 2022, she had been proving seven years. HHA-confused was where R1 moved with mink here brace on, "if year what you're doing stated the facility rate accommodate the potential for R1 being her had the sling was position causing her pain. Here when only one staff the Hoyer lift, here what you're doing the sling was position causing her pain. Here when only one staff the Hoyer lift and stated transferring R1 by here when only one staff the Hoyer lift and stated transferring R1 by here where we will have a stated transferring R1 by here where we will have a stated transferring R1 by here we will have a stated transferring R1 by here we will have a stated transferring R1 by here we will have a stated transferring R1 by here we will have a stated transferring R1 by here we will have a stated transferring R1 by here we will have a stated transferring R1 by here we will have a stated transferring R1 by here we will have a stated transferring R1 by here we will have a stated transferring R1 by here.	acility's Uniform Disclosure of vices and Amenities icated the assisted living two-person transfers using a , "that was an error, so we caperwork so it made sense. It is well to memory care to get Hoyer."  at 1:30 p.m., HHA-H stated ding cares for R1 for over H stated the only time R1 was in she hd a UTI. HHA-H stated imal assist, even with her left ou don't speak to her and telling she will be upset." HHA-H ised R1's bed to Hoyer lift which created the ing injured if she fell out of bed. Id no like the Hoyer lift, stating oned behind her knees, where the stated there were times if person transferred R1 using the stated she never used the dishe had no problem herself. HHA-H stated, "I'm pounds, and I had no trouble myself."	02560				
	2021, provided by Lead the facility offerred transfers with the amechanical lift or ga	Ly's UDALSA dated May 24, ALD-E, indicated on page 10, the following mobility services: ssist of two staff using a ait belt for transfer from floor, t of one staff using a gait belt, ng sit-to-stand lifts.					
	updated November	titled, Resident Grievances, 5, 2021, indicated retaliation the resident or the resident's					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		31733	B. WING			C <b>)5/2022</b>
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	-	
		2195 CEN	NTURY AVEN			
NEW PE	RSPECTIVE - WOODE	WOODBU	JRY, MN 551	25		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
02560	Continued From pa	ge 45	02560			
	legal representative was strictly prohibite	e in response to a grievance ed.				
	TIME PERIOD TO	CORRECT: Seven (7) Days				
03000 SS=E	626.557 Subd. 3 Tii	ming of report	03000			
	believe that a vulne been maltreated, or vulnerable adult has which is not reason immediately report common entry poin vulnerable adult sol admitted to a facility required to report si individual that occurunless:  (1) the individual was another facility and believe the vulneral previous facility; or  (2) the reporter knothat the individual is in section 626.5572  (a), clause (4).  (b) A person not record provisions of this section 626.5572  (a), clause (4).  (b) A person not record provisions of this section above.  (c) Nothing in this section was or has reason been made to the control of the contr	orter who has reason to rable adult is being or has who has knowledge that a sustained a physical injury ably explained shall the information to the t. If an individual is a ely because the individual is a, a mandated reporter is not uspected maltreatment of the red prior to admission,  as admitted to the facility from the reporter has reason to be adult was maltreated in the ws or has reason to be be a vulnerable adult as defined a, subdivision 21, paragraph quired to report under the ection may voluntarily report as ection requires a report of d maltreatment, if the reporter on to know that a report has ommon entry point. ection shall preclude a reporting to a law enforcement orter who knows or has not an error under section				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		31733	B. WING		05/0	) 5/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
NEW PE	RSPECTIVE - WOODE	BURY	TURY AVENURY, MN 551			
(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 CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
03000	(5), occurred must a subdivision. If the rebelieves that an invinvestigative agency determine that the reaccording to the critisubdivision 17, parareporter or facility mentry point or direct agency information meets the criteria usubdivision 17, paralead investigative aginformation when meets the report under sufformation when meets the reporting suspect hours for two of four records reviewed. For assaulted by another addition, R3 was for freeway ramp one of aware of the incident incidents to the Min Agency (MAARC).  This practice results violation that did not safety but had the president's health or cause serious injury was issued at a pat limited number of rethan a limited number of rethan a limited number.	on 17, paragraph (c), clause make a report under this eporter or a facility, at any time estigation by a lead y will determine or should reported error was not neglect teria under section 626.5572, agraph (c), clause (5), the nay provide to the common ly to the lead investigative explaining how the event explaining an initial disposition of	03000			

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	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ID PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` ′	CONSTRUCTION	` '	E SURVEY PLETED
		31733	B. WING			C <b>05/2022</b>
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DDRESS, CITY, S	TATE, ZIP CODE		
NEW PE	RSPECTIVE - WOODE	SURY 2195 CEN	NTURY AVENU	JE SOUTH		
.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		WOODBI	JRY, MN 5512			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
03000	Continued From pa	ge 47	03000			
	found to be pervasi	ve).				
	The findings include	e:				
	to the licensee on A comprehensive lice assisted living servidiagnoses included anxiety, post-traum multiple sclerosis, a walking.  R2's service plan daindicated R2 received cares, fall manager	d was reviewed. R2 admitted april 22, 2021, under the use and began receiving lees on August 1, 2021. R2's major depressive disorder, atic stress disorder (PTSD), and mania. R2 used a cane for ed assistance with personal ment, weekly laundry, daily safety checks.				
	11, 2022, indicated and vertigo due to h	e assessment dated January R2 had experienced dizziness er diagnoses of vertigo. R2 ith transportation, and cations.				
	dated January 11, 2 difficulty reporting a being abused by oth	se prevention plan (IAPP) 2022, indicated R2 had buse and was susceptible to her adults. Staff were to a supervisor for any signs or e or neglect.				
	2022, at 6:28 p.m., she was sexually as (R3) while taking or lower level of the fallow enforcement, R on her breast, telling	report dated January 16, indicated R2 told hospital staff saulted by another resident at her trash at 6:00 a.m. in the cility. During her interview with 2 sated R3 placed his hands g R2 he was going to "Fuck forcement she wanted the				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		` ′	(X3) DATE SURVEY COMPLETED	
		31733	B. WING		I	C <b>05/2022</b>
	PROVIDER OR SUPPLIER	SURY 2195 CEN	DRESS, CITY, S TURY AVEN RY, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOOT CROSS-REFERENCED TO THE APPLICATION DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
03000	Continued From pa	ge 48 ed but did not R3 contacted.	03000			
		ked evidence a MAARC report lleged sexual assault.				
	to the licensee on Noting diagnoses included	d was reviewed. R3 admitted November 2, 2021. R3 dementia without behavioral ronic kidney disease Stage 3. dently.				
	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.					
	14, 2022, indicated and cognitive capal emergency. R3 had memory loss, chror report abuse and was abused by others. F	e assessment dated February R3 lacked physical, mental, pility to evacuate self in an having cognitive impairment, nic pain, and being unable to as susceptible to being R3 was independent in required no 1:1 supervision.				
	staff were to immed	ovember 16, 2021, indicated diately notify a supervisor for oms of abuse or neglect.				
	p.m., indicated unlighted found R3 walking deasted R3 into he attempts. R3 started ULP-B's vehicle, started he was going, and anyone. R3's family	dated May 2, 2022, at 5:40 censed personnel (ULP)-B own a freeway ramp. ULP-B r vehicle after unsuccessful d crying when he got into ating he did not know where requested ULP-B not tell and licensed assisted living vere notified. R3 had no				

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	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		l \ ′	(X3) DATE SURVEY COMPLETED	
			7 to 201201110.			C	
		31733	B. WING		05/	05/2022	
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
NEW PE	RSPECTIVE - WOODE	BURY	ITURY AVEN JRY, MN 551				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPR <b>I</b> ATE	(X5) COMPLETE DATE	
03000	Continued From pa	ige 49	03000				
	R3's vital signs wer was notified on May R3's progress note,	R3's incident report indicated e not obtained. R3's physician y 11, 2022, at 8:00 a.m. dated May 5, 2022, at 6:01 aff member found R3 walking					
	down an entrance restaff member assistments. From the progress note indicates	ramp to a major freeway. The ted R3 back to the facility after R3's family was contacted. The ated R3 returned to his neerns from nursing staff.					
	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.						
	nursing (DON)-F st reassessed R2 after DON-F stated R2 w DON-F stated R2 m R3 was naked and apartment. DON-F	at 9:00 a.m., director of ated she was unsure if she or the alleged sexual assault. Went to the hospital so often. Inade vague comments stating harassing her outside of her stated she told R2 she and duct an investigation the					
		ls lacked incident reports or an alleged sexual assault.					
	the facility did not fi Adult Abuse Report she reached out to	ALD-E confirmed to DON-F, le a report to the Minnesota ting Center. LALD-E indicated the facility's district and legal LALD-E a MAARC report did for R3's incident.					
		titled, Maltreatment of a vember 5, 2021, indicated all					

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
	31733		B. WING		C 05/05/2022	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
NEW PE	RSPECTIVE - WOODI	BURY	TURY AVEN			
		WOODBU	RY, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE	
03000	Continued From pa	ige 50	03000			
	neglect, or financia as serious, investig follow-up, and repo laws and regulation	ons, or complaints of abuse, I exploitation would be treated ated with appropriate rted in accordance with state is.  CORRECT: Seven (7) days.				

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