Electronically Delivered

March 24, 2026

Licensee
New Perspective - Mankato
100 Dublin Road
Mankato, MN 56001

RE: Project Number(s) SL24718017

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on February 26, 2026, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement;
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;
Level 3: a fine of $1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 4: a fine of $3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 5: a fine of $5,000 per violation, in addition to any enforcement mechanism authorized in § 144G.20.

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

pursuant to this survey:

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00
St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $500.00
St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - $1,000.00

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

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

The correction order documentation should include the following:

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

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

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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

To submit a hearing request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,

Jodi Johnson, Supervisor
State Evaluation Team
Email: Jodi.Johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

CLN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24718	A. BUILDING: _____ B. WING _____	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE - MANKATO	100 DUBLIN ROAD MANKATO, MN 56001

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL24718017-0 On February 23, 2026, through February 26, 2026, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were 115 residents; 88 receiving services under the Assisted Living Facility with Dementia Care license. 1290: An immediate correction order was issed on February 24, 2026, at a level 3/Widespread (I). The licensee took imediate action; however, the scope and level remains at I.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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

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0 480	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated February 24, 2026, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.	0 480		

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0 480	Continued From page 3 TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an infection control program that complies with accepted health care, medical and nursing standards for infection control for three of four unlicensed personnel (ULP-H, ULP-D, ULP-I). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	0 510		

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0 510	Continued From page 4 The findings include: ULP-H On February 23, 2026, beginning at 11:12 a.m., the surveyor continually observed ULP-H administering medications. The surveyor observed the following: - 11:12 a.m. ULP-H set up medications for R21, administered the medications at the dining room table and returned to the medication cart. ULP-H did not wash hands or use hand sanitizer; - aproximately 11:15 a.m. ULP-H set up medications for R20, administered the medications at the dining room table and returned to the medication cart. ULP-H did not wash hands or use hand sanitizer; - 11:19 a.m. ULP-H set up medications for R3, administered the medications at the dining room table and returned to the medication cart. ULP-H did not wash hands or use hand sanitizer. - 11:22 a.m. ULP-H set up medications for R11, administered the medications at the dining room table and returned to the medication cart. ULP-H did not wash hands or use hand sanitizer. - 11:25 a.m. ULP-H set up medications for R4, administered the medications at the dining room table and returned to the medication cart. ULP-H did not wash hands or use hand sanitizer. On February 24, 2026, at 1:15 p.m., the surveyor observed ULP-H emptying R5's catheter bag. ULP-H put on gloves, opened the port of the leg bag, emptied the urine into a graduate, closed the port of the bag, and re-attached the bag to R5's leg. ULP-H did not cleanse the port of the catheter before or after emptying the bag. ULP-D On February 23, 2026, at 11:33 a.m., the surveyor continually observed ULP-D	0 510		

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0 510	Continued From page 5 administering medications. The surveyor observed the following: - 11:33 a.m. ULP-D set up R12's medications, went to R12's room, administered the medications and returned to the medication cart. ULP-D did not wash hands or use hand sanitizer; - 11:47 a.m. ULP-D retrieved an ointment for R9, from the medication cart, went to R9's room, applied gloves and applied the ointment. ULP-D then removed the gloves, returned to the medication cart, and used hand sanitizer. On February 23, 2026, at 1:31 p.m., the surveyor continuously observed ULP-D administering medications. The surveyor observed the following: - 1:31 p.m. ULP-D set up oral medications and an ointment for R12, went to R12's room, administered the oral medications, put on gloves and administered the ointment. ULP-D returned to the medication cart. ULP-D did not wash hands or use hand sanitizer; - 1:39 p.m. ULP-D set up oral medications and a cream for R2, went to R2's room, administered the oral medications, put on gloves and R2 requested the cream to a different area than was ordered, ULP-D removed gloves, went to the nursing office, returned to R2's room, applied gloves and administered the cream. ULP-D returned to the medication cart. ULP-D did not wash hands or use hand sanitizer, ULP-I On February 24, 2026, at 12:55 p.m., the surveyor continuously observed ULP-I administering medications. The surveyor observed the following: - 12:55 p.m. ULP-I set up oral medications for R19, went to R19's room and administered the medications. ULP-I returned to the medication	0 510		

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0 510	Continued From page 6 cart. ULP-I did not wash hands or use hand sanitizer; - 1:00 p.m. ULP-I set up oral medications for R18, went to R18's room and administered the medications. ULP-I returned to the medication cart. ULP-I did not wash hands or use hand sanitizer. On February 23, 2026, at 3:22 p.m., clinical nurse supervisor (CNS)-B stated staff should be using hand sanitizer or washing their hands between residents. On February 26, 2026, at 8:46 a.m., CNS-B stated during catheter emptying, staff should have clean the port before and after emptying the catheter bag. The licensee's Hand Washing policy dated October 15, 2024, indicated the following: "Team members will wash hands between resident care and whenever direct physical contact with a resident takes place. Use of gloves does not replace hand washing. Hands will be washed: - Before and after direct care of a resident - If moving from a contaminated body site to a clean body site during resident care - After contact with surfaces or equipment in the immediate vicinity of the resident - Before applying and after removing personal protective equipment (PPE)" The licensee's Community Delegations policy dated August 25, 2023, indicated the following: "Emptying Catheter Drainage Bag 1. Wash hands 2. Gather supplies: gloves, alcohol wipes, graduate cylinder 3. Introduce self and explain procedure	0 510		

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0 510	Continued From page 7 4. Provide privacy as appropriate 5. Position resident correctly, to access the drainage bag 6. Apply gloves 7. Clean the tip of the drainage bag with an alcohol wipe, using friction. 8. Discard the alcohol wipe 9. Open the clasp of the drainage tube over the graduate cylinder/urinal and allow for the urine to drain completely. 10. Close the clasp 11. Wipe the end of the drainage tube with the second alcohol wipe and discard. 12. Note the amount of urine and any characteristics to report to the nurse if not within normal limits 13. Rinse the graduate/urinal with water and return to the bathroom 14. Remove and discard gloves 15. Wash hands" No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 650 SS=D	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency	0 650		

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0 650	Continued From page 8 evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records included all required content for one of two employees (unlicensed personnel (ULP)-I). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-I was hired and began providing direct care services under the assisted living with dementia care license on August 16, 2022. On February 24, 2026, at 12:55 p.m., the surveyor observed ULP-I administering medications to the facility's residents.	0 650		

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0 650	Continued From page 9 ULP-I's employee record included a performance evaluation dated February 8, 2024. No further performance evaluations were in ULP-I's record. On February 26, 2026, at 8:46 a.m. clinical nurse supervisor stated ULP-I's record did not include a performance evaluation for 2025. Performance evaluations should be completed annually. The licensee's Team Member Supervision policy dated October 7, 2024, indicated: "The delegating registered nurse will: 1. Complete a performance review using the Unlicensed Team Member Annual Performance Review form for each delegated Community team member, based on the documentation of the supervisor's observations and other relevant information". No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide	0 660		

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0 660	Continued From page 10 technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included completion of a two-step TST (tuberculin skin test) or other evidence of TB screening such as a blood test, prior to providing direct care services, for one of two employees (unlicensed personnel (ULP)-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: On February 23, 2026, at 11:33 a.m., the surveyor observed ULP-D administering medications to the facility's residents. ULP-D was hired on November 12, 2024. ULP-D's employee record indicated ULP-D had completed training with another ULP November 12, 2024, through December 12, 2024. ULP-D had been competency tested by a registered nurse (RN) on November 14, 2024. ULP-D had a	0 660		

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0 660	Continued From page 11 supervision of delegated tasks by and RN on January 9, 2025. ULP-D's record included a TB blood test completed on January 17, 2025. This was after ULP-D had direct contact with the facility's residents. On February 26, 2026, at 8:46 a.m., clinical nurse supervisor (CNS)-B stated ULP-D should have had TB testing completed prior to contact with the facility's residents. "Regulations for Tuberculosis Control in Minnesota Health Care Settings", dated July 2013, indicated the following: "Baseline TB screening is required for all HCWs [health care workers]. Baseline TB screening consists of three components: 1. Assessing for current symptoms of active TB disease, 2. Assessing TB history, and 3. Testing for the presence of infection with Mycobacterium tuberculosis by administering either a two-step TST or single IGRA [blood test]. An employee may begin working with patients after a negative TB symptom screen (i.e., no symptoms of active TB disease) and a negative IGRA or TST (i.e., first step) dated within 90 days before hire. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness	0 680		

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0 680	Continued From page 12 (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency preparedness plan (EPP) with all the required content and failed to prominently post the EPP. This had the potential to affect all residents, staff, and visitors of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	0 680		

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0 680	Continued From page 13 cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's Missing Residents and Elopement policy was dated as last reviewed on October 27, 2023. There was no documentation the policy had been reviewed quarterly as required. On February 26, 2026, at 4:58 p.m., licensed assisted living director (LALD)-A stated the missing resident policy had not bee reviewed quarterly as she was unaware of the requirement. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a	0 775		

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0 775	Continued From page 14 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated February 23, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 775		
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits.	01290		

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01290	Continued From page 15 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a background study was submitted through Department of Human Services (DHS) NETStudy 2.0 and received in affiliation with the assisted living license for four of four employees (unlicensed personnel (ULP)-D, ULP-E, ULP-G, and server (S)-F). This resulted in an immediate correction order on February 24, 2026. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-D ULP-D was hired on November 12, 2024, and provided direct care services to the facility's residents. On February 23, 2026, at 11:33 a.m., the surveyor observed ULP-D, unsupervised, administering medications to residents. The licensee's NETStudy 2.0 roster did not include ULP-D. NETStudy 2.0 indicates a background study was initiated for ULP-D on November 13, 2024; however, fingerprints were not completed and the background study was closed on November 28,	01290		

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01290	Continued From page 16 2024. ULP-E ULP-E was hired on June 28, 2024, and provided direct care services to the facility's residents. The licensee's NETStudy 2.0 roster did not include ULP-E. NETStudy 2.0 indicates a background study was initiated for ULP-E on July 1, 2024; however, fingerprints were not completed and the background study was closed on July 16, 2024. Another background study was initiated on September 15, 2024; however, fingerprints were not completed and the background study was closed on September 30, 2024. ULP-G ULP-G was hired on October 30, 2023, and provided direct care services to the facility's residents. The licensee's NETStudy 2.0 roster did not include ULP-G. NETStudy 2.0 indicates a background study was initiated for ULP-G on February 1, 2023, and ULP-G separated from the facility on July 21, 2023. S-F S-F was hired on December 6, 2024, and provided dietary serving services to the residents. The licensee's NETStudy 2.0 roster did not include S-F. NETStudy 2.0 indicates a background study was initiated for S-F on December 19, 2024; however,	01290		

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01290	Continued From page 17 fingerprints were not completed and the background study was closed on January 3, 2025. On February 23, 2026, at 3:08 p.m., licensed assisted living director (LALD)-A stated all four staff worked independently and would have unsupervised interactions with the facility's residents. The licensee's Background Checks policy dated February 14, 2022, indicated "Background checks must be conducted on all final candidates after a job offer is extended." No further information provided. Time period for correction: Immediate The licensee took immediate action; however, the scope and level remain at I.	01290		
01530 SS=D	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of	01530		

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01530	Continued From page 18 employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure direct care staff received the required two hours of initial training on mental illness and de-escalation topics for one of two employees (unlicensed personnel lead (ULP)-I). This had the potential to affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	01530		

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01530	Continued From page 19 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-I was hired and began providing direct care services under the assisted living with dementia care license on August 16, 2022. On February 24, 2026, at 12:55 p.m., the surveyor observed ULP-I administering medications to the facility's residents. ULP-I's employee record identified ULP-1 had been assigned the required mental health and de-escalation training but had only completed one hour of the training. On February 26, 2026, at 10:09 a.m., business office manager (BOM)-J stated ULP-I had been assigned the two hour of mental health and de-escalation training but had only completed one hour. All staff should have 2 hours mental health and de-escalation training. The licensee's Team Member Orientation and Training policy dated January 1, 2026, indicated direct-care team members will have completed at least two hours of initial training on mental illness and de--escalation upon hire, within 80 working hours of the employment start date. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		

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01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of	01620		

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01620	Continued From page 21 services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to complete a comprehensive assessment at least every 90 days as required for one of two residents (R2) and failed to complete a comprehensive assessment within 14 days of start of services for one of one resident (R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 R2 was admitted March 29, 2021, with diagnoses including chronic kidney disease with heart failure, anxiety, macular degeneration, and chronic pain.	01620		

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01620	Continued From page 22 On February 23, 2026, at 1:39 p.m., the surveyor observed unlicensed personnel (ULP)-D administering medications to R2. R2's service plan dated January 28, 2026, indicated R2's services included dressing, grooming, transferring and medication administration. R2's record included the following assessments: - Comprehensive Assessment (MN) completed July 25, 2025; and - Comprehensive Assessment (MN) completed October 24, 2025, which was 91 days between the assessments, thus exceeding 90 calendar days. R5 R5 was admitted on December 18, 2025, with diagnoses including heart failure, chronic obstructive pulmonary disease, and dementia. On February 24, 2026, at 1:15 p.m., the surveyor observed ULP-H emptying R5's urinary catheter bag. R5's service plan dated February 24, 2026, indicated R5's services included dressing, grooming, bathing, catheter cares, transfers with a mechanical sit to stand lift, and medication management. R5's record included the following assessments: - Comprehensive Assessment (MN) identified as an admission assessment, completed December 18, 2025; and - Comprehensive Assessment (MN) identified as a change in condition assessment, completed February 12, 2026.	01620		

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01620	Continued From page 23 R5's record lacked evidence a 14 day assessment had been completed as required. On February 26, 2026, at 12:44 p.m., clinical nurse supervisor (CNS)-B stated R5 should have had a 14 day assessment and ongoing assessments should be completed at least every 90 days. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan.	01640		

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01640	Continued From page 24 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a service plan was developed and signed within 14 days for one of one resident (R5) and failed to ensure a service plan was updated after a change in condition for one of one resident (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R5 R5 was admitted on December 18, 2025, and diagnoses included heart failure, chronic obstructive pulmonary disease, and dementia. On February 24, 2026, at 1:15 p.m., the surveyor observed unlicensed personnel (ULP)-H emptying R5's urinary catheter bag. R5's record included the following assessments: - Comprehensive Assessment (MN) identified as an admission assessment, completed December 18, 2025. R5's record lacked evidence a 14 day assessment had been completed as required. R5's service plan was signed February 24, 2026,	01640		

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01640	Continued From page 25 and indicated R5's services included dressing, grooming, bathing, catheter cares, transfers with a mechanical sit to stand lift, and medication management. The service plan was signed 68 days after admission. R3 R3 was admitted on April 5, 2023, and diagnoses included failure to thrive, diabetes, muscle weakness and dementia. On February 23, 2026, at 11:19 a.m., the surveyor observed ULP-H administering oral medications to R3. On February 25, 2026, at 7:14 a.m., the surveyor observed ULP-H checking R3's blood glucose and administering insulin in R3's room. The surveyor observed R3's bed did not have any bed rails. R3's service plan dated March 12, 2025, - bed rail checks every shift, "Resident receives bed rail checks to verify bed rail is securely attached to the bed and does not appear damaged. Team Members to alert nursing if the bed rail is not securely attached, appears damaged, or does not have a green tag indicating assessment has been completed."; - heel protectors as needed; and - thrombo-embolic deterrent (TED) hose (compression stockings used to increase circulation and decrease swelling) as needed. Although R3's service plan included these services, R3 did not have bed rails, heel protectors or TED hose at the time of survey. R3's record included a significant change in condition assessment dated June 24, 2025, due to a discharge from hospice.	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24718	A. BUILDING: _____ B. WING _____	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE - MANKATO	100 DUBLIN ROAD MANKATO, MN 56001

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01640	Continued From page 26 R3's Service Checkoff List dated February 2026, included bed rail checks every shift, "Resident receives bed rail checks to verify bed rail is securely attached to the bed and does not appear damaged. Team Members to alert nursing if the bed rail is not securely attached, appears damaged, or does not have a green tag indicating assessment has been completed". Although R3 did not have bed rails, this was signed off every shift by the facility staff. The check off list did not include heel protectors or TED hose. R3's medication administration record dated February 2026, did not include bed rails, heel protectors, or TED hose. R3's physician orders dated August 6, 2025, included bed rails, but did not include TED hose or heel protectors. On February 26, 2026, at 3:03 p.m., clinical nurse supervisor (CNS)-B stated the bed rails, heel protectors and TED hose were from when R3 was receiving hospice services. The services should have been updated when the significant change for discharge of hospice was completed. At 4:28 p.m., CNS-B further stated R5 did not have a service plan signed within 14 days, and the February 24, 2026, was the only signed service plan in R5's record. The licensee's Resident Service Plan policy dated January 12, 2026 indicated "1. The licensed nurse's initial assessment and any other Community evaluation conducted before nursing services are initiated will be the basis for the resident's written service plan. 2. The resident or resident's legal representative	01640		

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01640	Continued From page 27 will be informed in advance of care or treatment to be provided and be given the opportunity to participate in decisions regarding proposed care or treatment. The service plan will be developed by the resident, the legal representative as appropriate, the Community licensed nurse, the executive director, and other necessary parties as allowed by applicable law." "Services to be provided on a schedule (e.g., twice daily) will be scheduled as such to be completed at the designated time (e.g., AM, PM, NOC). The service will not be scheduled on an as needed (PRN) only basis. For example, dressing will be scheduled twice a day, AM and PM, every day. It will not be scheduled as "PRN" only." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01650 SS=D	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the	01650		

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01650	Continued From page 28 facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the service plan included all required content for one of one resident (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3 was admitted on April 5, 2023, and diagnoses included failure to thrive, diabetes, muscle weakness and dementia. On February 25, 2026, at 7:14 a.m., the surveyor observed ULP-H checking R3's blood glucose and administering insulin in R3's room.	01650		

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01650	Continued From page 29 R3's physician orders dated August 6, 2025, included blood glucose monitoring twice a day. R3's medication administration record dated February 1-24, 2026, included blood glucose monitoring documented by staff as completed with results twice a day. R3's service plan dated March 12, 2025, included blood glucose monitoring as needed. R3's service plan did not include the frequency of the blood glucose monitoring as twice a day. On February 26, 2026, at 3:03 p.m., clinical nurse supervisor (CNS)-B stated blood glucose monitoring should have been listed as twice a day on the service plan. The licensee's Resident Service Plan policy dated January 12, 2026, indicated "1. The licensed nurse's initial assessment and any other Community evaluation conducted before nursing services are initiated will be the basis for the resident's written service plan. 2. The resident or resident's legal representative will be informed in advance of care or treatment to be provided and be given the opportunity to participate in decisions regarding proposed care or treatment. The service plan will be developed by the resident, the legal representative as appropriate, the Community licensed nurse, the executive director, and other necessary parties as allowed by applicable law." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	01650		

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01750 SS=F	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure staff administered medications as ordered for three of three residents (R2, R9, R8) with topical medications. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R2 On February 23, 2026, at 1:39 p.m., unlicensed personnel (ULP)-G retrieved capsaicin from the medication cart for R2 and checked the	01750		

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01750	Continued From page 31 prescription label to the medication administration record (MAR). The prescription label and MAR indicated the cream was to be applied to bilateral shoulders and hands three times a day. ULP-G went to R2's room to administer the cream and R2 requested it to be put on her feet instead of the shoulders and hands. ULP-G informed R2 she would have to check with the nurse. ULP-G went to the nursing office and spoke with clinical nurse supervisor (CNS)-B. ULP-G stated the nurse instructed her to administer to the feet and the nurse would notify the doctor. ULP-G returned to R2's room and administered the capsaicin to R2's feet. R2's physician orders dated August 5, 2025, included capsaicin cream to shoulders and bilateral hands three times a day R2's medication administration record (MAR) dated February 1-24, 2026, included capsaicin cream to shoulders and bilateral hands three times a day. ULP-G signed off as administered on February 23, 2026, mid afternoon. There was no indication on the MAR that it was applied to the feet instead of the shoulders and hands. On February 26, 2025, at 8:46 a.m. CNS-B stated ULP-G must have misunderstood as she instructed her that she would notify the doctor but did not instruct her to administer to R2's feet. CNS-B stated the capsaicin should not have been administered to the feet until the physician's order was received. R9 On February 23, 2026, at 11:47 a.m., ULP-G retrieved R9's diclofenac gel from the medication cart, went to R9's room, put on gloves, put some diclofenac gel directly on the gloves and	01750		

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01750	Continued From page 32 administered to R9's lower back. R9's MAR dated February 1-25, 2026, included diclofenac gel apply 4 grams to lower back three times a day. R9's physician orders dated November 6, 2025, included diclofenac gel apply 4 grams to lower back three times a day. R8 On February 23, 2026, at 1:31 p.m., ULP-G retrieved R8's diclofenac gel from the medication cart, went to R8's room and put on gloves. ULP-G put some diclofenac gel directly on the gloves and administered to R8's hip per her request. R8's MAR dated February 1-25, 2026, included diclofenac gel apply to joints four times a day. R8's physician orders dated August 5, 2025, included diclofenac 2 grams to shoulders four times a day. On February 23, 2026, at 1:38 p.m., ULP-G stated the nurse had trained her to place a quarter size amount of the diclofenac onto the glove and administer. On February 23. 2026, at 1:38 p.m., the surveyor observed there was not a diclofenac measuring strip in the medication cart. On February 23, 2026, at 3:22 p.m., CNS-B stated staff were not trained to administer diclofenac using the manufacturer's measuring strip and therefore, staff would not know if they were administering the proper dosage. On February 26, 2026, at 8:46 a.m., CNS-B	01750		

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01750	Continued From page 33 stated R8's MAR should include the location and the dosage for the diclofenac. The licensee's Medication Administration - Topical policy dated February 16, 2026, indicated the following: - when administering medication staff were to "Follow the seven (7) rights; - Right resident; - Right medication; - Right dose; - Right route; - Right time and day; - Right reason; and - Right documentation". - "Identify the appropriate site for the topical medication administration, rotating sites, if directed, to prevent skin irritation" - "Apply the topical medication: a. Double check the medication dose against the eMAR to verify the dose is accurate;; b. Wash and dry area to which the medication will be applied, as indicated in the eMAR; c. Remove cap to the cream/gel/ointment, and hold in a gloved hand; d. Apply medication as directed in the eMAR". The Voltaren (diclofenac) gel instructions for use dated revised May 2016, identified to use the dosing card to correctly measure each dose. Place the dosing card on a flat surface so that you can read the print. Squeeze the gel onto the dosing card evenly, up to the 2-gram line (a 2.25-inch length of gel) or 4-gram line (a 4.5 inch length of gel). Make sure that the gel covers the 2-gram or 4-gram area of the dosing card. After using the dosing card, hold end with fingertips, rinse and dry. Store the dosing card until next use.	01750		

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01750	Continued From page 34 No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure time sensitive medications were labeled with the date opened for one of one resident (R22). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On February 23, 2026, at 1:02 p.m., the surveyor reviewed a medication cart with unlicensed personnel (ULP)-I. The surveyor observed R22's bottle of latanoprost open and in use, but it did not include an open date.	01890		

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01890	Continued From page 35 On February 26, 2026, at 8:46 a.m., clinical nurse supervisor (CNS)-B stated time sensitive medications should be labeled with an open date. Latanoprost prescribing information dated August 2011, indicated once a bottle is opened for use, it may be stored at room temperature for six weeks. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to	01940		

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01940	Continued From page 36 documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to include a written statement of the treatment on the service plan for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 was admitted March 29, 2021, with diagnoses including chronic kidney disease with heart failure, anxiety, macular degeneration, and chronic pain. On February 24, 2026, at 7:56 a.m., the surveyor observed unlicensed personnel (ULP)-K completing wound care on R2's left heel. R2's medication administration record dated February 1-24, 2026, included: - Simple Dressing Change, cleanse with dermal	01940		

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01940	Continued From page 37 cleanser and allow to dry. Use a thin layer of triple antibiotic ointment. Place a non-adhesive pad over left heel, cover the heel and the bottom of left foot, and secure with kerlix and tape. Replace as needed. The treatment was scheduled every other day in the morning and had an effective date of January 15, 2025. R2's service plan dated January 28, 2026, indicated R2's services included dressing, grooming, transferring and medication administration. R2's service plan did not include wound care. On February 26, 2026, at 1:15 p.m., clinical nurse supervisor (CNS)-B stated the wound care treatment was on the MAR, but not on the service plan. The licensee's Treatment or Therapy Management Services policy dated February 19, 2025, indicated the licensed nurse will prepare and include in the resident's service plan a written statement of the treatment or therapy services that will be provided to the resident. The licensee's Resident Service Plan dated January 12, 2026, indicated the service plan would "identify the program services, frequency, and approaches the Community will provide under applicable law, to include personal care, supervision, activities, health monitoring, medication administration, behavior management, information and referral, and transportation; Note: Services to be provided on a schedule (e.g., twice daily) will be scheduled as such to be completed at the designated time (e.g., AM, PM, NOC). The service will not be scheduled on an as	01940		

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01940	Continued From page 38 needed (PRN) only basis. For example, dressing will be scheduled twice a day, AM and PM, every day. It will not be scheduled as "PRN" only." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01970 SS=F	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure they had treatment orders for one of one resident (R5) receiving treatments. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	01970		

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01970	Continued From page 39 The findings include: R5 was admitted on December 18, 2025, and diagnoses included heart failure, chronic obstructive pulmonary disease, and dementia. On February 24, 2026, at 1:15 p.m., the surveyor observed unlicensed personnel (ULP)-H putting thrombo-embolic deterrent (TED) stockings (compression stockings used to improve circulation and decrease swelling) on R5. R5's service plan was signed February 24, 2026, and indicated R5's services included TED stockings- put on in the morning and take off in the evening. R5's record lacked a physician order for TED stockings. On February 26, 2026, at 5:25 p.m., clinical nurse supervisor (CNS)-B stated R5 was admitted with the stockings. R5 did not have an order for the TED stockings and CNS-B was unaware an order was required. The licensee's Treatment or Therapy Management Services policy dated February 19, 2025, indicated the registered nurse was responsible for requesting and receiving orders or prescriptions for treatments. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		
02310 SS=D	144G.91 Subd. 4 (a) Appropriate care and services	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24718	A. BUILDING: _____ B. WING _____	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE - MANKATO	100 DUBLIN ROAD MANKATO, MN 56001

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 40 (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards for two of two residents (R5, R4) with side rails. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R5 On February 25, 2026, at 7:10 a.m., the surveyor observed R5's bed with unlicensed personnel (ULP)-H. R5's bed was a hospital bed with bilateral 1/2 rails in the up position. R5 was admitted on December 18, 2025, with diagnoses including heart failure, chronic obstructive pulmonary disease, and dementia. R5's service plan dated February 24, 2026, included bed rails and staff were to complete checks to verify bed rail is securely attached to	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24718	A. BUILDING: _____ B. WING _____	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE - MANKATO	100 DUBLIN ROAD MANKATO, MN 56001

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 41 the bed and does not appear damaged. Team Members to alert nursing if the bed rail is not securely attached, appears damaged, or does not have a green tag indicating assessment has been completed. R5's Individualized Bed Rail Evaluation dated February 5, 2026, indicated R5 had hospital bed rails. The assessment included measurements for zone 1, 3, and four. Zone 2 indicated it was less than 4 3/4 inches but did not include a measurement. R4 On February 25, 2026, at 7:15 a.m., the surveyor observed R4's bed with ULP-H. R4's bed was a hospital bed with bilateral 1/2 rails. R4's service plan dated September 17, 2025, included bed rails and staff were to complete checks to verify bed rail is securely attached to the bed and does not appear damaged. Team Members to alert nursing if the bed rail is not securely attached, appears damaged, or does not have a green tag indicating assessment has been completed. R4's Individualized Bed Rail Evaluation dated December 11, 2025 indicated R4 had hospital bed rails. The measurements for zones 1-3 indicated less than 4.75 inches and zone 4 indicated less than 2 3/8 inches. Zones 1-4 did not include measurements. On February 26, 2026, at 9:35 a.m., clinical nurse supervisor (CNS)-B stated hospital bed rails have been measured and the measurements should be on the assessments for all residents who have hospital bed rails.	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24718	A. BUILDING: _____ B. WING _____	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE - MANKATO	100 DUBLIN ROAD MANKATO, MN 56001

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 42 The Food and Drug Administration's (FDA), A Guide to Bed Safety, dated 2000, and revised April 2010, indicated following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." The guide indicates zones 1-3 should be less than 4 3/4 inches and zone 4 was should be less than 2 3/8 inches to prevent risks of entrapment. The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) dated February 20, 2024, indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, "Documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks);	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24718	A. BUILDING: _____ B. WING _____	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE - MANKATO	100 DUBLIN ROAD MANKATO, MN 56001

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 43 - The resident's preferences; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements". Additionally, the MDH website indicated for hospital-style bed rails, the licensee must include in their documentation, the bed rail measurements and that the bed rail has not shifted and is securely attached to the bed frame per manufacturer recommendations. No further information was provided. TIME PERIOD FOR CORRECTION: seven (7) days	02310		
02320 SS=D	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were administered according to policy and accepted standards of practice for one of one resident (R17) with an inhaler. This practice resulted in a level two violation (a	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24718	A. BUILDING: _____ B. WING _____	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE - MANKATO	100 DUBLIN ROAD MANKATO, MN 56001

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02320	Continued From page 44 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On February 24, 2026, at 7:29 a.m., the surveyor observed unlicensed personnel (ULP)-L administering medications to R17. ULP-L shook the albuterol HFA inhaler and put it into R17's mouth instructing her to inhale. ULP-L then shook the inhaler and immediately put it back into R17's mouth instructing her to inhale. ULP-L did not assist R17 to rinse their mouth and spit nor did she instruct R17 to rinse their mouth and spit. R17's medication administration record dated February 1-25, 2026, included albuterol HFA 90 mcg inhaler inhale two puffs twice a day. On February 26, 2026, at 8:46 a.m., clinical nurse supervisor (CNS)-B stated staff were trained, when administering inhalers, they were to wait one minute between inhalations and assist or cue resident to rinse and spit after administration. The licensee's Medication Administration | Inhalants policy dated February 16, 2026, indicated: - If administering a second dose of the same inhalant, wait one (1) minute, and then repeat administration steps. - Provide the resident with water and instruct resident to rinse their mouth, as the medication can irritate the mucosal membrane of the mouth	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24718	A. BUILDING: _____ B. WING _____	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE - MANKATO	100 DUBLIN ROAD MANKATO, MN 56001

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02320	Continued From page 45 and cause a burning sensation. The prescribing information for albuterol HFA inhaler dated November 2024, included: - If your doctor has prescribed additional puffs, wait one minute, shake the inhaler again and repeat. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		

Mankato District Office
Minnesota Department of Health
12 Civic Center Plaza, Suite 2105
Mankato, MN 56001
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

New Perspective Mankato
100 Dublin Road
Mankato, MN 56001
Blue Earth County
Parcel:

Phone:

License Info

License: HFID 24718

Risk:
License:
Expires on:
CFPM: Crystal Grace Koenig
CFPM #: CFPM-55669; Exp: 1/28/2028

Inspection Info

Report Number: F1034261037
Inspection Type: Full - Single
Date: 2/24/2026 Time: 10:45:48 AM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 1
Total Priority 2 Orders: 0
Total Priority 3 Orders: 2
Delivery: Emailed

! **New Order: 2-300 Personal Cleanliness**
2-301.14A *Priority Level: Priority 1 CFP#: 8*
MN Rule 4626.0075A Food employees must wash their hands before: food preparation activities, including working with exposed food; touching clean equipment and utensils; touching unwrapped single-service and single-use articles.
COMMENT: Employee in the memory care area left the serving area for approximately five minutes, returned, did not wash hands, and began delivering food to residents. Food employees must wash hands before handling or delivering food.
Comply By: 2/24/2026 Originally Issued On: 2/24/2026

New Order: 4-200 Equipment Design and Construction
4-204.11 *Priority Level: Priority 3 CFP#: 56*
MN Rule 4626.0565 Prevent grease or condensation from exhaust ventilation hood systems from draining or dripping onto food, equipment, utensils, linens, single-service articles, and single-use articles.
COMMENT: Clean the hood and hood filters to remove dust and grease. PIC stated that they have been trying to get a company to clean the hood for a number of months but have not had success getting them to come to the establishment. Discussed that it may be necessary to have a different company clean the hood.
Comply By: 3/24/2026 Originally Issued On: 2/24/2026

New Order: 6-300 Physical Facility Numbers and Capacities
6-301.14A *Priority Level: Priority 3 CFP#: 10*
MN Rule 4626.1457 Provide a sign or poster at all handwashing sinks used by food employees that notifies them to wash their hands.
COMMENT: A sign is needed at the memory care handwashing sink. Further, one of the compartments needs to be dedicated for handwashing and the other for dumping.
Comply By: 3/3/2026 Originally Issued On: 2/24/2026

Food & Beverage General Comment

Discussed employee illness log. Kitchen will begin using an employee illness log specifically for the kitchen.
Discussed using cooling logs when cooling large batches of foods.

Inspection conducted in conjunction with HRD.

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

I acknowledge receipt of the Mankato District Office inspection report number F1034261037 from 2/24/2026

Crystal Koenig

McKenna Mathews, RS
Public Health Sanitarian 2
507-344-2729
mckenna.mathews@state.mn.us

Mankato District Office
Minnesota Department of Health
12 Civic Center Plaza, Suite 2105
Mankato, MN 56001

Temperature Observations/Recordings

Establishment Info

New Perspective Mankato
Mankato
County/Group: Blue Earth County

Inspection Info

Report Number: F1034261037
Inspection Type: Full
Date: 2/24/2026
Time: 10:45:48 AM

Food Temperature: Product/Item/Unit: Tomato**; Temperature Process:** Cold-Holding
Location: Prep Cooler at 37.1 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Pork Chop**; Temperature Process:** Hot-Holding
Location: Steam Table at 204 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Peaches**; Temperature Process:** Cold-Holding
Location: Walk-in Cooler at 35.1 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Juice**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 37.0 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Lemonade**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 32.0 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Coffee**; Temperature Process:** Cold-Holding
Location: Beverage Cooler at 39.1 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Juice**; Temperature Process:** Cold-Holding
Location: Beverage Cooler at 37.1 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Soup**; Temperature Process:** Hot-Holding
Location: Soup Kettle at 187 Degrees F.
Comment:
Violation Issued?: No

Mankato District Office
Minnesota Department of Health
12 Civic Center Plaza, Suite 2105
Mankato, MN 56001

Sanitizer Observations/Recordings

Establishment Info

New Perspective Mankato
Mankato
County/Group: Blue Earth County

Inspection Info

Report Number: F1034261037
Inspection Type: Full
Date: 2/24/2026
Time: 10:45:48 AM

Sanitizing Chemical: **Product:** Quaternary Ammonia**; Sanitizing Process:** Wiping Cloth Bucket
Location: Kitchen **Equal To** 200 PPM
Comment:
Violation Issued?: No

Sanitizing Chemical: **Product:** Quaternary Ammonia**; Sanitizing Process:** Dispenser
Location: 3-Comp Sink **Equal To** 200 PPM
Comment:
Violation Issued?: No

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Dishwashing Area **Equal To** 166.9 Degrees F.
Comment:
Violation Issued?: No

DEPARTMENT OF HEALTH

Physical Environment Inspection Report

ASSISTED LIVING | ASSISTED LIVING WITH DEMENTIA CARE

Project No: SL24718017-0	**Date:** 2/23/2026
Facility Name: New Perspective Mankato	
Facility Address: 100 Dublin Road, Mankato, MN 56001	

☒ **TAG IDENTIFICATION: 0775**

SCOPE/ SEVERITY: Level 2; Widespread **TIME PERIOD OF CORRECTION:** Seven (7) days

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

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

   Comments: Labeled fire-rated doors in the following locations were not maintained to be self-closing or latching.

   1. *Employee break room door was held open with a toe kick device.*
   2. *Resident rooms 2231, 1015, 1018 and 1112 did not self-close and latch.*
   3. *Basement tenant storage B and C, basement trash room by garage stall 64, and basement elevator lobby had double fire rated doors that were held open with a toe kick device.*
   4. *Second floor stair H door from corridor into stairway did not latch.*
   5. *Set of double doors in the third-floor corridor by stair C did not latch. The drywall was cracked and separated in the corners and from the door frame. There was a gap between the top of the door frame and the drywall.*

3. Controlled egress locking systems shall have the capability of being unlocked from the fire command center, a nursing station, or other approved location. The procedures for the operation of the unlocking system shall be described as part of the fire safety and evacuation plan. All clinical staff shall have the keys, codes, or other means necessary to operate the locking device. [Minn. Stat. 144G.45 subd. 2; MSFC 1010.1.9.7]

Comments: Controlled egress locks were installed on the exit doors from the memory care wing. Survey staff did not observe a button or switch capable of unlocking these locks. ESD-C stated there was no button or switch, but they plan to have one installed.

4. Sensor release of electrically locked egress doors shall be permitted where the following criteria are met.

    a. The electric locks shall unlock upon loss of power to the lock.

    b. A manual unlocking device shall be installed 40 inches to 48 inches above the floor and within 5 feet of the secured doors. Ready access shall be provided to the manual unlocking device, and the device shall be clearly identified by a sign that reads “PUSH TO EXIT”. When operated, the device shall interrupt power to the electric lock, independent of other electronics, and the electric lock shall remain unlocked for a period of not less than 30 seconds.

    c. Activation of the building fire alarm system or automatic sprinkler system shall automatically unlock the electric lock, and the lock shall remain unlocked until the alarm or sprinkler systems have been reset. [Minn. Stat. 144G.45 subd. 2; MSFC 1010.1.9.9]

Comments: There was an exit sign above a door that led from the kitchen to the loading dock area. The door from the loading dock to the exterior was locked with a magnetic lock that unlocked with a motion sensor. No manual unlocking device was observed by the door. ESD-C stated there was no manual unlock button and was unsure if the lock would unlock upon activation of the fire alarm or sprinkler system.