Electronically delivered

April 27, 2022

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

RE: Project Number(s) SL24718015

Dear Administrator:

On April 7, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine correction of orders found on the evaluation completed on December 13, 2021. The follow-up evaluation determined your agency had not corrected all of the state licensing orders issued pursuant to the December 13, 2021 evaluation.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state licensing orders issued pursuant to the last evaluation completed on December 13, 2021, found not corrected at the time of the April 7, 2022, follow-up evaluation and/or subject to penalty assessment are as follows:

1700-Provision Of Medication Management Services-144g.71 Subd. 2 = $500.00

The details of the violations noted at the time of this follow-up evaluation completed on April 7, 2022 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $500.00**. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), by the correction order date, the licensee must document in the provider's records any action taken to comply with the correction order by the correction order date. The commissioner may request a copy of this documentation and the assisted living facility's action to respond to the correction orders in future evaluations, upon a complaint investigation, and as otherwise needed.

IMPOSITION OF FINES:

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in §144G.20 for widespread violations;

Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in §144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in §144G.20.

CORRECTION ORDER RECONSIDERATION PROCESS
In accordance with Minn. Stat. § 144G.32, Subd. 2, you have one opportunity to challenge the correction order issued, including the level and scope, and any fine assessed through the correction order reconsideration process. This written request must be received by the Department of Health within 15 calendar days of the correction order receipt date. Please send your written request via email to the following:

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

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. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

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.

We urge you to review these orders carefully. If you have questions, please contact Casey DeVries at 651-201-5917 .

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your agency's Governing Body.

Sincerely,

Casey DeVries, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-5917 Fax: 651-215-9697

PMB

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 _____	R 04/07/2022

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 Initial comments *****ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been 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: Project # SL24718015 On April 7, 2022, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on December 15, 2022, and a revisit survey completed on February 9, 2022. At the time of the survey, there were 114 residents: 92 receiving services under the Assisted Living license. As a result of the revisit, the following orders were reissued.	{0 000}	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
{0 810} SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment	{0 810}		

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{0 810}	Continued From page 1 (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: No further action required.	{0 810}		
{01700} SS=F	144G.71 Subd. 2 Provision of medication management services	{01700}		

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{01700}	Continued From page 2 (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted an individualized assessment to determine what medication management services would be provided, and how the services would be provided for five of five residents (R1, R2, R3, R4, and R5) with records reviewed.	{01700}		

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{01700}	Continued From page 3	{01700}		

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).

The findings include:

On April 7, 2022, at approximately 12:00 p.m., executive director (ED)-B and registered nurse (RN)-A confirmed the licensee provided medication management services to the licensee's residents.

R1, R2, R3, R4, and R5's records lacked evidence the RN had conducted a medication assessment to include:
- identification and review of all medications;
- indications for medications;
- side effects;
- contraindications; and
- allergic or adverse reactions.

R1
R1's prescriber orders dated March 2, 2022, included one medication to lower blood pressure and one pain reliever.

R1's Service Plan dated December 14, 2021, indicated services included medication administration and assistance with compression stockings.

R1's Medication and Treatment Assessment and Management Plan dated March 6, 2022, identified R1 required assistance with medication

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{01700}	Continued From page 4	{01700}		

management, to include administration. In addition, the plan noted the following:
- What medication and/or treatment list was reviewed while conducting this assessment? - Current medication administration record (MAR);
- Identification and review of all medications and indications for medications the resident is known to be taking has been conducted by - physician and nurse practitioner;
- Potential medication side effects of all medications have been reviewed with the resident or responsible party by - physician and nurse practitioner;
- Contraindications of medications have been reviewed with resident or responsible party by - physician and nurse practitioner; and
- All medications have been reviewed with resident or responsible party for possible allergic/adverse reactions by - physician and nurse practitioner.

R2
R2's prescriber orders dated March 29, 2022, included two medications to lower blood pressure.

R2's Resident Service Agreement dated April 8, 2022, indicated services included medication administration.

R2's Medication and Treatment Assessment and Management Plan dated March 14, 2022, identified R2 required assistance with medication management, to include administration. In addition, the plan noted the following:
- What medication and/or treatment list was reviewed while conducting this assessment? - Current MAR;
- Identification and review of all medications and indications for medications the resident is known

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{01700}	Continued From page 5	{01700}		

to be taking has been conducted by - physician and registered nurse;
- Potential medication side effects of all medications have been reviewed with the resident or responsible party by - physician and registered nurse;
- Contraindications of medications have been reviewed with resident or responsible party by - physician and registered nurse; and
- All medications have been reviewed with resident or responsible party for possible allergic/adverse reactions by - physician and registered nurse.

R3
R3's prescriber orders dated October 13, 2021, included one pain reliever and one diuretic.

R2's Resident Service Agreement dated June 30, 2021, indicated services included medication administration and nail care.

R3's Medication and Treatment Assessment and Management Plan dated March 6, 2022, identified R3 required assistance with medication management, to include administration. In addition, the plan noted the following:
- What medication and/or treatment list was reviewed while conducting this assessment? - Current MAR;
- Identification and review of all medications and indications for medications the resident is known to be taking has been conducted by - physician assistant;
- Potential medication side effects of all medications have been reviewed with the resident or responsible party by - physician assistant;
- Contraindications of medications have been reviewed with resident or responsible party by - physician assistant; and

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{01700}	Continued From page 6	{01700}		

- All medications have been reviewed with resident or responsible party for possible allergic/adverse reactions by - physician assistant.

R4
R4's Resident Service Agreement, dated February 14, 2022, indicated R4 received medication management services.

R4's prescriber's orders, dated March 3, 2022, included a blood thinner and one statin to lower cholesterol.

R4's Medication and Treatment Assessment and Management Plan dated March 6, 2022, identified R4 required assistance with medication management, to include administration. In addition, the plan noted the following:
- What medication and/or treatment list was reviewed while conducting this assessment? - Current MAR;
- Identification and review of all medications and indications for medications the resident is known to be taking has been conducted by - physician, registered nurse, and nurse practitioner;
- Potential medication side effects of all medications have been reviewed with the resident or responsible party by - physician, registered nurse, and nurse practitioner;
- Contraindications of medications have been reviewed with resident or responsible party by - physician, registered nurse, and nurse practitioner; and
- All medications have been reviewed with resident or responsible party for possible allergic/adverse reactions by - physician, registered nurse, and nurse practitioner.

R5

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{01700}	Continued From page 7	{01700}		

R5's Resident Service Agreement, dated June 30, 2021, indicated R5 received medication management services.

R5's prescriber's orders dated February 14, 2022, included a pain reliever and a diuretic.

R5's Medication and Treatment Assessment and Management Plan dated March 6, 2022, identified R5 required assistance with medication management, to include administration. In addition, the plan noted the following:
- What medication and/or treatment list was reviewed while conducting this assessment? - Current MAR;
- Identification and review of all medications and indications for medications the resident is known to be taking has been conducted by - nurse practitioner;
- Potential medication side effects of all medications have been reviewed with the resident or responsible party by - nurse practitioner;
- Contraindications of medications have been reviewed with resident or responsible party by - nurse practitioner; and
- All medications have been reviewed with resident or responsible party for possible allergic/adverse reactions by - nurse practitioner.

On April 7, 2022, at approximately 1:10 p.m., RN-A stated she uses the current medication administration record in her assessment, and looks to be sure the indications for medications, side effects, contraindications, and allergic or adverse reactions has been reviewed by the prescriber, selects their title to insert, and proceeds to do the medication management plan. RN-A stated she does not review these required topics with the residents as a part of her assessment. In addition, RN-A stated she did not

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{01700}	Continued From page 8 know if the prescriber noted in their report each of these items had been reviewed with the resident. The licensee's Assessments and Evaluations policy dated November 5, 2021, lacked information on the medication assessment requirements. No further information was provided.	{01700}		
{02040} SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: No further action required.	{02040}		

Electronically delivered

February 28, 2022

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

RE: Project Number(s) SL24718015

Dear Administrator:

On February 9, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine correction of orders found on the evaluation completed on December 15, 2021. The follow-up evaluation determined your agency had not corrected all of the state licensing orders issued pursuant to the December 15, 2021 evaluation.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state licensing orders issued pursuant to the last evaluation completed on December 15, 2021, found not corrected at the time of the February 9, 2022, follow-up evaluation and/or subject to penalty assessment are as follows:

0680-Disaster Planning And Emergency Preparedness-144g.42 Subd. 10 = $500.00
1700-Provision Of Medication Management Services-144g.71 Subd. 2 = $500.00
2110-Policies-144g.82 Subd. 3 = $500.00

The details of the violations noted at the time of this follow-up evaluation completed on February 9, 2022 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

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 after 15 days of the receipt of this notice, subject to appeal.

Also, at the time of this follow-up evaluation completed on February 9, 2022, we identified the following violation(s):

0340-Correction Orders-144g.30 Subd. 5 = $500.00

The details of the violation(s) noted at the time of this follow-up evaluation are delineated on the attached State Form. Only the ID Prefix Tag in the left hand column without brackets will identify these licensing orders. It is not necessary to develop a plan of correction.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), by the correction order date, the licensee must document in the provider's records any action taken to comply with the correction order by the correction order date. The commissioner may request a copy of this documentation and the assisted living facility's action to respond to the correction orders in future evaluations, upon a complaint investigation, and as otherwise needed.

IMPOSITION OF FINES:

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in §144G.20 for widespread violations;
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Reconsideration Unit
Health Regulation Division
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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.

We urge you to review these orders carefully. If you have questions, please contact Casey DeVries at 651-201-5917.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Sincerely,

Casey DeVries, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55164-0970 / 55101-3879
Telephone: 651-201-5917 Fax: 651-215-9697

PMB

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{0 000}	Initial Comments Initial comments *****ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been 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: Project # SL24718015 On February 9, 2022, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on December 15, 2022. At the time of the survey, there were 116 residents; 96 receiving services under the Assisted Living license. As a result of the revisit, the following orders were reissued and/or issued.	{0 000}	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 340 SS=F	144G.30 Subd. 5 Correction orders (a) A correction order may be issued whenever	0 340		

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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
0 340	Continued From page 1 the commissioner finds upon survey or during a complaint investigation that a facility, a managerial official, or an employee of the facility is not in compliance with this chapter. The correction order shall cite the specific statute and document areas of noncompliance and the time allowed for correction. (b) The commissioner shall mail or e-mail copies of any correction order to the facility within 30 calendar days after the survey exit date. A copy of each correction order and copies of any documentation supplied to the commissioner shall be kept on file by the facility and public documents shall be made available for viewing by any person upon request. Copies may be kept electronically. (c) By the correction order date, the facility must document in the facility's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have sufficient documentation with actions taken to comply with the correction orders for a revisit survey completed on February 9, 2022, with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), 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	0 340		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 340	Continued From page 2 of the residents). The findings include: During the revisit survey on February 9, 2022, the surveyor reviewed the licensee's policies and procedures, resident records, employee records, and conducted interviews with executive director (ED)-B and registered nurse (RN)-A. The licensee lacked evidence to indicate the orders issued on December 15, 2021, were corrected. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 340		
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (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 tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must	{0 680}		

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{0 680}	Continued From page 3 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 (EP) plan that included all required content. This had the potential to affect all 116 current residents in the facility, staff and any visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On February 9, 2022, at approximately 2:40 p.m., the surveyor reviewed the emergency preparedness plan and Appendix Z with executive director (ED)-B. ED-B stated they had met with a representative of the health care coalition, and the plan was to meet again with leadership, but the meeting had not yet been set. The surveyor observed notes were penciled in, but no changes were made to the emergency preparedness plan or Appendix Z. In addition, ED-B confirmed the licensee lacked a customized emergency	{0 680}		

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{0 680}	Continued From page 4 preparedness plan and Appendix Z to include: -current, all-hazards approach facility assessment and analysis of how it minimizes or mitigates identified vulnerabilities; (the licensee's included vulnerability assessment had no summation or analysis of vulnerabilities specific to the licensee's location); -current assessment of the population served by licensee and analysis of how it minimized or mitigated identified vulnerabilities; -subsistence needs for staff and residents during emergency situation; -policy and procedures to addressed medical documentation to preserve resident information, protects confidentiality and maintains availability of records; -policy and procedures regarding use of volunteers; -procedure/methods for tracking staff and residents; -a communication plan (to include phone lists for staff and resident's physicians); -details regarding employee training program, such a schedule of on-going staff training, plan for resident-involved training, and including documentation of participants the training specific to the licensee's plan; and -plan/schedule of testing of the licensee's emergency plan, including analysis and documentation of such tests. The licensee's Disaster and Emergency Preparedness policy, effective November 1, 2021, indicated the community (licensee) would develop and maintain all necessary plans and procedures to ensure the safety of all residents and team members in event of a disaster or emergency. Further, the policy indicated the community's executive director was responsible for the development and maintenance of the	{0 680}		

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{0 680}	Continued From page 5 community's written plan of action to address resident care and services in response to a disaster. The policy did not address all requirements identified in Appendix Z, including items detailed above. No additional information was provided.	{0 680}		
{0 810} SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one	{0 810}		

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{0 810}	Continued From page 6 evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: No further action required.	{0 810}		
{0 910} SS=C	144G.50 Subd. 2 Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the license number of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for six of six residents (R1, R2, R3, R4, R5 and R8) with records reviewed. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of	{0 910}		

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{0 910}	Continued From page 7 the residents). The findings include: R1, R2, R3, R4, R5 and R8's Residency Agreement dated July 29, 2021, November 30, 2021, June 30, 2021, August 31, 2021, June 30, 2021, and July 27, 2021, respectively contained handwritten notes to indicate the licensee was licensed by the Minnesota Department of Health and included the facility's the license number. The notes were dated February 1, 2022 and initialed by executive director (ED)-B. On February 9, 2022, at approximately 1:00 p.m., ED-B stated the licensee had not sent the contracts with the above information to the resident or their representative as required. A policy related to the content of the contract was requested but not available. No further information was provided.	{0 910}		
{01700} SS=F	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the	{01700}		

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{01700}	Continued From page 8	{01700}		

resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues.
(b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted an individualized assessment to determine what medication management services would be provided, and how the services would be provided for four of four residents (R1, R2, R4, and R5) with records reviewed.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).

The findings include:

On February 9, 2022, at approximately 11:00

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{01700}	Continued From page 9	{01700}		

a.m., executive director (ED)-B and registered nurse (RN)-A confirmed the licensee provided medication management services to the licensee's residents.

R1, R2, R4, and R5's records lacked evidence the RN had conducted a medication assessment to include:
- identification and review of all medications;
- indications for medications;
- side effects;
- contraindications; and
- allergic or adverse reactions.

R1
R1's prescriber orders dated December 1, 2021, included one medication to lower blood pressure and one pain reliever.

R1's Resident Service Agreement dated December 14, 2021, indicated services included medication administration and assistance with compression stockings.

R1's Medication & Treatment Management Plan dated January 21, 2022, identified R1 required assistance with medication management, to include administration. In addition, the plan noted the following:
- "Rn has competed [sic] medication review and faxed medication list to pharmacy for review for contraindications and allergies."

R2
R2's prescriber orders dated November 23, 2021, included two medications to lower blood pressure and one medication to lower blood glucose levels.

R2's Resident Service Agreement dated November 30, 2021, indicated services included

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{01700}	Continued From page 10	{01700}		

medication administration and assistance with activities of daily living.

R2's Medication & Treatment Management Plan dated February 8, 2022, identified R2 required assistance with medication management, to include administration. In addition, the plan noted the following:
- "Medication list is reviewed by RPH [pharmacist] for contraindications and possible allergies."

R4
R4's prescriber's orders, dated December 1, 2021, included a mild pain reliever, multiple blood pressure medications, one diuretic, vitamin supplements, two oral anti-diabetics, insulin, one thyroid replacement hormone and a cholesterol-lowering medication, a prostate drug, two diuretics and a bowel medication.

R4's service plan, dated August 31, 2021, indicated R4 received medication management services.

R4's Medication & Treatment Management Plan dated September 28, 2021, identified R4 required assistance with medication management, to include administration. In addition, the plan noted the following:
- "RN has assessed medication list and faxed to pharmacist to review for contraindications and allergies."

R5
R5's prescriber's orders dated November 17, 2021, included a mild pain reliever, two as-needed narcotic pain relievers, one blood pressure medication, one allergy medication, an antidepressant, two cognition-enhancing drugs, an anti-coagulant, a cholesterol-lowering

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{01700}	Continued From page 11 medication, a diuretic, cholesterol-lowering medication and an oral anti-diabetic medication. R5's service plan, dated June 30, 2021, indicated R5 received medication management services. R5's Medication & Treatment Management Plan dated November 12, 2021, identified R5 required assistance with medication management, to include administration. In addition, the plan noted the following: - "Medication list is faxed to RPH for review for contraindications and allergies." On February 9, 2022, at approximately 3:00 p.m., RN-A verified the above required content had not been included in the medication assessment. The licensee's Assessments policy dated November 1, 2021, noted the medication management plan would be completed on admission, with a change in condition, and annually. No further information was provided.	{01700}		
{02040} SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an	{02040}		

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{02040}	Continued From page 12 approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: No further action required.	{02040}		
{02110} SS=F	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to	{02110}		

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{02110}	Continued From page 13 and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. This MN Requirement is not met as evidenced by: Based on interview and record review, licensee failed to ensure policies and procedures required in the licensing of assisted living facilities with dementia care were developed and/or implemented, and were provided to each resident and/or the residents legal/designated representative at the time of move-in. This had the potential to affect all dementia care residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee lacked evidence the following required policies and procedures related to dementia care had been developed: - safekeeping of residents' possessions. The licensee's Residency Agreement noted they had the above required policies, and upon request the licensee would provide copies.	{02110}		

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{02110}	Continued From page 14 On February 9, 2022, at approximately 1:00 p.m., executive director (ED)-B confirmed the above required policy had not been developed. No further information was provided.	{02110}		

Electronically Delivered

January 18, 2022

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

RE: Project Number(s) SL24718015-0

Dear Administrator:

The Minnesota Department of Health completed an evaluation on December 15, 2021, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health 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.

The enclosed State Form documents the state licensing orders. The Department of Health 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 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 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

In accordance with Minn. Stat. § 144G.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation

that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5)(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, no immediate fines are assessed.

DOCUMENTATION OF ACTION TO COMPLY

Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up surveys. The licensee is not required to submit a plan of correction 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 issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by the Department of Health within 15 calendar days of the correction order receipt date.

A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557. Please email general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general reconsideration requests to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place

Free from Maltreatment reconsideration requests should addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place

St. Paul, MN 55164-0970 St. Paul, MN 55164-0970

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,

Casey DeVries, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-5917 Fax: 651-215-9697

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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 _____	12/15/2021

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 Initial comments *****ATTENTION****** ASSISTED LIVING LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey investigation. 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: SL24718015 On December 13, 2021, through December 15, 2021, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 117 residents receiving services under the provider's Assisted Living with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 130 SS=C	144G.12, Subd. 1 Application for Licensure Each application for an assisted living facility	0 130		

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0 130	Continued From page 1 license, including provisional and renewal applications, must include information sufficient to show that the applicant meets the requirements of licensure, including: (1) the business name and legal entity name of the licensee, and the street address and mailing address of the facility; (2) the names, e-mail addresses, telephone numbers, and mailing addresses of all owners, controlling individuals, managerial officials, and the assisted living director; (3) the name and e-mail address of the managing agent and manager, if applicable; (4) the licensed resident capacity and the license category; (5) the license fee in the amount specified in section 144.122; (6) documentation of compliance with the background study requirements in section 144G.13 for the owner, controlling individuals, and managerial officials. Each application for a new license must include documentation for the applicant and for each individual with five percent or more direct or indirect ownership in the applicant; (7) evidence of workers' compensation coverage as required by sections 176.181 and 176.182; (8) documentation that the facility has liability coverage; (9) a copy of the executed lease agreement between the landlord and the licensee, if applicable; (10) a copy of the management agreement, if applicable; (11) a copy of the operations transfer agreement or similar agreement, if applicable; (12) an organizational chart that identifies all organizations and individuals with an ownership interest in the licensee of five percent or greater	0 130		

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0 130	Continued From page 2 and that specifies their relationship with the licensee and with each other; (13) whether the applicant, owner, controlling individual, managerial official, or assisted living director of the facility has ever been convicted of: (i) a crime or found civilly liable for a federal or state felony level offense that was detrimental to the best interests of the facility and its resident within the last ten years preceding submission of the license application. Offenses include: felony crimes against persons and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions; financial crimes such as extortion, embezzlement, income tax evasion, insurance fraud, and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions; any felonies involving malpractice that resulted in a conviction of criminal neglect or misconduct; and any felonies that would result in a mandatory exclusion under section 1128(a) of the Social Security Act; (ii) any misdemeanor conviction, under federal or state law, related to: the delivery of an item or service under Medicaid or a state health care program, or the abuse or neglect of a patient in connection with the delivery of a health care item or service; (iii) any misdemeanor conviction, under federal or state law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service; (iv) any felony or misdemeanor conviction, under federal or state law, relating to the interference with or obstruction of any investigation into any criminal offense described in Code of Federal Regulations, title 42, section 1001.101 or	0 130		

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0 130	Continued From page 3 1001.201; (v) any felony or misdemeanor conviction, under federal or state law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance; (vi) any felony or gross misdemeanor that relates to the operation of a nursing home or assisted living facility or directly affects resident safety or care during that period; (vii) any revocation or suspension of a license to provide health care by any state licensing authority. This includes the surrender of such a license while a formal disciplinary proceeding was pending before a state licensing authority; (viii) any revocation or suspension of accreditation; or (ix) any suspension or exclusion from participation in, or any sanction imposed by, a federal or state health care program, or any debarment from participation in any federal executive branch procurement or nonprocurement program; (14) whether, in the preceding three years, the applicant or any owner, controlling individual, managerial official, or assisted living director of the facility has a record of defaulting in the payment of money collected for others, including the discharge of debts through bankruptcy proceedings; (15) the signature of the owner of the licensee, or an authorized agent of the licensee; (16) identification of all states where the applicant or individual having a five percent or more ownership, currently or previously has been licensed as an owner or operator of a long-term care, community-based, or health care facility or agency where its license or federal certification has been denied, suspended, restricted, conditioned, refused, not renewed, or revoked	0 130		

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0 130	Continued From page 4 under a private or state-controlled receivership, or where these same actions are pending under the laws of any state or federal authority; (17) statistical information required by the commissioner; and (18) any other information required by the commissioner. This MN Requirement is not met as evidenced by: Based on interview and record review the facility failed to include their independent living resident capacity during transition to an assisted living license to meet the requirements of licensure. This had the potential to affect all 117 residents, staff, and visitors. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: The licensee's Application for Assisted Living License, signed by the owner (O)-N on May 26, 2021, identified an application for a secured dementia care unit and a building total licensed resident capacity for 97 residents. The assisted living license effective August 1, 2021, indicated a capacity of 97 assisted living residents. During the entrance conference on December 13, 2021, at approximately 11:00 a.m., executive	0 130		

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0 130	Continued From page 5 director (ED)-B stated the licensee had a current census of 117 residents, 26 in memory care, 72 assisted living receiving services, and 19 assisted living without services. In addition, ED-B stated two residents were currently on leave of absence and included in the total of 117. On December 13, at approximately 4:40 p.m., ED-B verified the current census of 117, and stated the licensee was aware they had a capacity above the licensed amount. A policy was requested but not available. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 130		
0 250 SS=F	144G.20 Subdivision 1. Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this	0 250		

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0 250	Continued From page 6 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 section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to show they had met the requirements of licensure, by attesting the managerial officials who were in charge of the day-to-day operations, had developed and implemented current policies and procedures, as	0 250		

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0 250	Continued From page 7 required, with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on December 13, 2021, at approximately 11:00 a.m., executive director (ED)-B stated she viewed the regulations online and in the printed book. The licensee's "Application for Assisted Living License", section titled "Official Verification of Owner or Authorized Agent", (page four and five of the application), identified, "I certify I have read and understand the following:" [a check mark was placed before each of the following]: - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45 (opens in a new window), my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17 (opens in a new window). - I have read and fully understand Minn. Stat. sect. 144G.80 (opens in a new window), 144G.81 (opens in a new window). and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22 (opens in a new window), my building(s) must comply with these sections if applicable. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G (opens in a new window).	0 250		

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0 250	Continued From page 8 - 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)." - In understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data (opens in a new window), the Commissioner will use information provided in this application, which may include an in-person or telephone conference, to determine if the applicant meets the requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying a license. I understand that information submitted to the commissioner in the application may, in some circumstances, be disclosed to the appropriate state, federal or local agency, and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices. - I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons (opens in a new window), all data submitted on this application shall be classified as public information upon issuance of a provisional license. All data submitted are considered private until MDH issues a license. - 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,	0 250		

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0 250	Continued From page 9	0 250		

chapter 4659 (proposed and not final) (opens in a new window), governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract.
- I have examined this application and all attachments, and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct and complete. I will notify MDH, in writing, of any changes to this information as required.
- I attest to have all required policies and procedures of Minn. Stat. chapter 144G (opens in new window). and Minn. Rules chapter 4659 (proposed and not final) (opens in new window), in place upon licensure and to keep them current as applicable. Page five was electronically signed by owner (O)-N on May 26, 2021.

The licensee had an Assisted Living Dementia Care license, issued on July 29, 2021.

The licensee failed to ensure the following policies and procedures were developed and/or implemented:
- orientation, training, and competency evaluations of staff;
- infection control practices;
- ensuring nurses had current and valid licenses to practice; and
- medication and treatment management.

Refer to licensing order at Statute 144G.41, Subd. 3. The licensee failed to establish and maintain an effective infection control program to

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0 250	Continued From page 10	0 250		

comply with accepted health care, medical, and nursing standards for infection control for one of two unlicensed personnel (ULP)-C observed to perform blood glucose monitoring.

Refer to licensing order at Statute 144G.42, Subd. 8. The licensee failed to ensure the employee record contained the required content for two of four employees (registered nurse (RN)-A and RN-F) with records reviewed.

Refer to licensing order at Statute 144G.63, Subd. 2. The licensee failed to ensure employees received orientation to assisted living licensing requirements and regulations prior to providing services for one of five employees (registered nurse (RN)-F) with records reviewed.

Refer to licensing order at Statute 144G.64(a). The licensee failed to ensure direct-care staff completed at least two hours annual training for one of four employees (licensed practical nurse (LPN)-E) with records reviewed.

Refer to licensing order at Statute 144G.71, Subd. 2. The licensee failed to ensure the registered nurse (RN) conducted an individualized assessment to determine what medication management services would be provided, and how the services would be provided for five of five residents (R1, R2, R3, R4, and R5) with records reviewed.

Refer to licensing order at Statute 144G.71, Subd. 23. The licensee failed to ensure policies and procedures included the required verbiage to investigate any known loss or unaccounted prescription drugs as required.

Refer to licensing order at Statute 144G.72,

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0 250	Continued From page 11 Subd. 3. The licensee failed to develop and implement a treatment or therapy management plan to include all required content for two of five residents (R4 and R5) with records reviewed. Refer to licensing order at Statute 144G.72, Subd. 6. The licensee failed to obtain prescriber's order for a treatment provided for one of five residents (R4) with records reviewed. Fifteen (15) correction orders were issued, which indicated the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 250		
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that 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:	0 510		

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0 510	Continued From page 12 Based on observation, interview and record review the licensee failed to establish and maintain an infection control program to comply with accepted health care, medical, and nursing standards for infection control for one of two unlicensed personnel (ULP)-C observed to perform blood glucose monitoring. 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 December 14, 2021, at approximately 8:25 a.m., ULP-C performed blood glucose monitoring on R7 in her room. ULP-C donned clean gloves, wiped R7's finger with an alcohol wipe, and poked it with a lancet to draw blood. ULP-C placed a sample of blood on the strip and inserted it into the glucometer. After completion of the task, ULP-C gathered the supplies, and returned to the medication cart. ULP-C then placed the lancet and glucometer on top of the medication cart, removed her gloves, and performed hand hygiene. ULP-C placed the lancet in the sharps container and placed the glucometer in the drawer of the medication cart. When questioned, ULP-C informed the surveyor that she would normally clean the glucometer after every other time it was used. However, ULP-C removed the glucometer from the drawer, wiped it with a cleansing wipe and returned it to the drawer, then cleaned the top of the medication cart.	0 510		

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0 510	Continued From page 13 On December 15, 2021, at approximately 1:55 p.m., registered nurse (RN)-A stated the glucometer is to be cleaned with a bleach wipe after each use. The licensee's Resident Care: Diabetic Care policy dated November 1, 2021, instructed staff to clean the resident blood glucose monitors when visibly soiled per manufacturer's directions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 650 SS=E	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place	0 650		

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0 650	Continued From page 14 and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. (b) Each employee record must be retained for at least three years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the employee record contained the required content for two of four employees (registered nurse (RN)-A and RN-F) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: RN-A RN-A started employment on February 8, 2021, under the comprehensive home care license and began providing assisted living services on August 1, 2021. RN-A's record lacked documented evidence of the following:	0 650		

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0 650	Continued From page 15 - current professional licensure. On December 15, 2021, at approximately 1:55 p.m., RN-A stated she had discovered her license had expired on December 13, 2021, after a copy was requested with the entrance documents for survey. At that time, RN-A stated she renewed her license and notified the Minnesota Board of Nursing she had been practicing without a valid license, and paid the fines associated. In addition, RN-A stated she had removed herself from performing any nursing duties until the license was renewed. RN-F RN-F was a contracted nurse with a hire date of July 14, 2021. RN-F's record lacked documented evidence of the following requirements: - evidence of professional licensure - current job description, including qualifications, responsibilities, and identification of staff persons providing supervision RN-F's license was verified to be current, with an expiration date of May 31, 2022. On December 15, 2021, at approximately 3:00 p.m., business manager (BM)-G confirmed the licensee had an employee record for RN-F at the resource center, but the record lacked the above required content. The licensee's Team Member Orientation and Training policy dated November 5, 2021, noted all team members providing and supervising direct services must complete orientation to the community requirements prior to providing assisted living services to residents.	0 650		

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0 650	Continued From page 16 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (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 tenant 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 observation, interview and record	0 680		

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0 680	Continued From page 17 review, the licensee failed to have a written emergency preparedness (EP) plan that included all required content. This had the potential to affect all 117 current residents in the facility, staff and any visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a 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: During the entrance conference on December 13, 2021, at approximately 11:38 a.m. surveyors made a request to executive director (ED)-B to view the licensee's emergency preparedness (EP) plan. ED-B stated they do have an emergency plan, that it had been revised and revisions and updates were "on-going", and they would share the plan with the surveyors. On December 14, 2021, at approximately 12:30 p.m., surveyors observed information about the licensee's emergency preparedness plan displayed in a flip chart in the main entry of the facility. There was a disaster evacuation plan and information about sheltering in place. Also observed was signage, posted on walls near the facility's elevators, which highlighted exits and had information about calling 911. The licensee's emergency preparedness plan, dated September 14, 2021, was contained in a three-ring binder that provided necessary,	0 680		

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0 680	Continued From page 18 required emergency preparedness planning including numerous required policies, various contact lists, a communication plan, methods for sharing information; agreements with other facilities; and other required information. However, the EP document lacked content as required in Appendix Z, the state-adopted rule addressing emergency preparedness. The licensee's plan lacked the following required content: -current, all-hazards approach facility assessment and analysis of how it minimizes or mitigates identified vulnerabilities; (the licensee's included vulnerability assessment had no summation or analysis of vulnerabilities specific to the licensee's location); -current assessment of the population served by licensee and analysis of how it minimized or mitigated identified vulnerabilities; -subsistence needs for staff and residents during emergency situation; -policy and procedures to addressed medical documentation to preserve resident information, protects confidentiality and maintains availability of records; -policy and procedures regarding use of volunteers; -procedure/methods for tracking staff and residents; -a communication plan (to include phone lists for staff and resident's physicians); -details regarding employee training program, such a schedule of on-going staff training, plan for resident-involved training, and including documentation of participants the training specific to the licensee's plan; -plan/schedule of testing of the licensee's emergency plan, including analysis and documentation of such tests	0 680		

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0 680	Continued From page 19 On December 15, at approximately 1:59 p.m., ED-B, while discussing and reviewing the plan with the surveyor, acknowledged shortcomings with their current emergency plan. Based on past experience while working in other states, ED-B said Minnesota needed "to get up to par" and have things "more developed" with respect to emergency planning and management. ED-B stated the update of their EP plan "can be done" and had already taken steps to continue to improve their current plan. The licensee's Disaster and Emergency Preparedness policy, effective November 1, 2021, indicated the community (licensee) would develop and maintain all necessary plans and procedures to ensure the safety all residents and team members in event of a disaster or emergency. Further, the policy indicated the community's executive director was responsible for the development and maintenance of the community's written plan of action to address resident care and services in response to a disaster. The policy did not address all requirements identified in Appendix Z, including items detailed above. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 680		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to:	0 810		

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0 810	Continued From page 20 (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop a fire safety and evacuation plan with required elements; failed to provide required employee training on fire safety and evacuation; and failed to complete required employee evacuation drills. This had the potential to affect all staff, residents, and visitors.	0 810		

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0 810	Continued From page 21 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: An interview and record review were conducted on December 15, 2021 between approximately 12:20 p.m. and 12:55 p.m. with the Director of Maintenance (DM)-J and the Executive Director (ED)-B on the fire safety and evacuation plan, fire safety and evacuation training for the facility, and fire safety and evacuation drills for the facility. Record review indicated that the fire safety and evacuation plan lacked procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. ED-B stated that the licensee did not have a policy or a fire safety and evacuation plan that prescribed different measures or provided identification of unique needs of residents for movement or evacuation. Record review indicated that employees did not receive training twice per year after initial hire. ED-B stated that the licensee provided annual training to employees, but not twice per year after initial hire on the fire safety and evacuation plan, as required by statute. Record review also indicated that evacuation drills for employees had not been performed	0 810		

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0 810	Continued From page 22 every other month as required. During interview, ED-B stated that evacuation drills had not been performed for the employees as of the time of survey. A policy was requested on employee training and one was provided indicating that the licensee only provides annual training. A policy was requested on evacuation drills, but one was not provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 910 SS=C	144G.50 Subd. 2 Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the license number of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to execute a written contract with the required content for five of five residents (R1, R2, R3, R4 and R5) with records reviewed.	0 910		

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0 910	Continued From page 23 This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1, R2, R3, R4 and R5's records lacked a written contract to include: - the licensee of the facility R1 On December 15, 2021, at approximately 7:45 a.m., unlicensed personnel (ULP)-H and ULP-K assisted R1 with morning cares. R1's Resident Service Agreement dated December 14, 2021, indicated services included medication administration and assistance with compression stockings. R1's Residency Agreement dated July 29, 2021, lacked the above required content. R2 On December 14, 2021, at approximately 7:25 a.m., ULP-C administered medications to R2 in her apartment. R2's Resident Service Agreement dated November 30, 2021, indicated services included medication administration and assistance with activities of daily living. The resident's Residency Agreement dated November 30, 2021, lacked the above required	0 910		

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0 910	Continued From page 24	0 910		

content.
R3
On December 14, 20201, at approximately 7:23 a.m., ULP-D stated R3 was pretty self-sufficient with her cares, that R3 used oxygen but managed that independently and R3 received medication management services.

R3's Resident Service Agreement dated June 30, 2021, indicated services included medication administration and assistance with a CPAP (continuous, positive airway pressure) machine (device prescribed for treating sleep apnea disorders).

R3's Residency Agreement, dated June 30, 2021, lacked the above required content.

R4
On December 14, 2021, at approximately 7:57 a.m., ULP-D put on R4's TED (thromboembolism-deterrent) stockings, (specialized hosiery worn around and compressing the leg to guard against edema and other venous disorders) in R4's apartment.

R4's Resident Service Agreement dated August 31, 2021, indicated services included medication and treatment administrations and assistance with activities of daily living.

R4's Residency Agreement dated August 31, 2021, lacked the above required content.

R5
On December 14, 2021, at approximately 10:47 a.m., the surveyor observed R5 in his apartment, seated in a recliner, groomed and appropriately dressed and appeared free of distress or pain. R5 talked about services he received, and said he

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0 910	Continued From page 25 had assistance with showers and getting dressed, housekeeping, checking blood sugar, and everything to do with medications. R5's Resident Service Agreement dated June 30, 2021, indicated services included medication administration and assistance with activities of daily living. R5's Residency Agreement dated June 30, 2021, lacked the above required content. On December 15, 2021, at approximately 2:35 p.m., executive director (ED)-B stated the name of the licensee was not included on the contract, and verified the same contract template was utilized for all residents. A policy related to the content of the contract was requested but not available. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 910		
01470 SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the	01470		

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01470	Continued From page 26	01470		

maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC);
(5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights;
(6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person;
(7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints;
(8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and
(9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure.
(b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics:
(1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication;
(2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or
(3) information about strategies and technology

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that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to ensure employees received orientation to assisted living licensing requirements and regulations prior to providing services for one of five employees (registered nurse (RN)-F) with records reviewed.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).

The findings include:

RN-F was a contracted nurse with a hire date of July 14, 2021.

RN-F's record lacked documented evidence of the following requirements:
- an overview of this chapter
- an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person
- handling of emergencies and use of emergency services
- compliance with and reporting of the

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maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC)
- the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights;
- the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person;
- handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints;
- consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and
- a review of the types of assisted living services the employee will be providing and the facility's category of licensure.

On December 15, 2021, at approximately 3:00 p.m., business manager (BM)-G confirmed the licensee had an employee record for RN-F at the resource center but was unable to provide evidence the above required orientation had been completed.

The licensee's Team Member Orientation and Training policy dated November 5, 2021, noted all team members providing and supervising direct services must complete orientation to the community requirements prior to providing assisted living services to residents.

No further information was provided.

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01470	Continued From page 29 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01470		
01540 SS=D	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure direct-care staff completed at least two hours annual training for one of four employees (licensed practical nurse (LPN)-E) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a	01540		

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01540	Continued From page 30 limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The licensee had a current assisted living facility with dementia care license. LPN-E started employment on June 16, 2014, under the comprehensive home care license and began providing assisted living services on August 1, 2021. LPN-E's record lacked documentation the employee had completed the required two hours annual training related to dementia as required. On December 15, 2021, business manager (BM)-G confirmed the employee record lacked evidence of the required annual training in dementia care. The licensee's Team Member Orientation and Training policy dated November 5, 2021, noted direct-care staff would have at least two-hour annual training for each 12 months of employment on topic related to dementia care. No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days	01540		
01700 SS=F	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication	01700		

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management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues.
(b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications.

This MN Requirement is not met as evidenced by:
Based on observation, interview and record review, the licensee failed to ensure the registered nurse (RN) conducted an individualized assessment to determine what medication management services would be provided, and how the services would be provided for five of five residents (R1, R2, R3, R4, and R5) with records reviewed.

This practice resulted in a level two violation (a violation that did not harm a resident's health or

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safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).

The findings include:

During the entrance conference on December 13, 2021, at approximately 11:00 a.m., executive director (ED)-B and registered nurse (RN)-A confirmed the licensee provided medication management services to the licensee's residents.

R1, R2, R3, R4, and R5's records lacked evidence the RN had conducted a medication assessment to include:
- identification and review of all medications
- indications for medications
- side effects
- contraindications
- allergic or adverse reactions

R1
On December 15, 2021, at approximately 7:15 a.m., unlicensed personnel (ULP)-H and ULP-K provided morning cares to R1 in his room.

R1's prescriber orders dated December 1, 2021, included one medication to lower blood pressure and one pain reliever.

R1's Resident Service Agreement dated December 14, 2021, indicated services included medication administration and assistance with compression stockings.

R1's Medication & Treatment Management Plan

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dated August 9, 2021, identified R1 required assistance with medication management, to include administration. In addition, the plan noted the following:
- Potential medication side effects of all medications have been reviewed with resident or responsible party by at least one of the following: Physician / Pharmacist / Physician Extender / Registered Nurse - Yes
- Contraindications of all medications have been reviewed with resident or responsible party by at least one of the following: Physician / Pharmacist / Physician Extender / Registered Nurse - Yes
- All medications have been reviewed with resident or responsible party for possible allergic/adverse reactions by at least one of the following: Physician / Pharmacist / Physician Extender / Registered Nurse - Yes

The above plan lacked identification of who conducted the reviews.

R1's December 2021, Medication Administration Record (MAR) listed medications as prescribed, times to administer, and staff initials on each date to indicate the medications had been given.

R2
On December 14, 2021, at approximately 7:25 a.m., ULP-C administered medications to R2 in her apartment.

R2's prescriber orders dated November 23, 2021, included two medications to lower blood pressure and one medication to lower blood glucose levels.

R2's Resident Service Agreement dated November 30, 2021, indicated services included medication administration and assistance with activities of daily living.

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01700	Continued From page 34 R2's Medication & Treatment Management Plan dated August 9, 2021, identified R2 required assistance with medication management, to include administration. In addition, the plan noted the following: - Potential medication side effects of all medications have been reviewed with resident or responsible party by at least one of the following: Physician / Pharmacist / Physician Extender / Registered Nurse - Yes - Contraindications of all medications have been reviewed with resident or responsible party by at least one of the following: Physician / Pharmacist / Physician Extender / Registered Nurse - Yes - All medications have been reviewed with resident or responsible party for possible allergic/adverse reactions by at least one of the following: Physician / Pharmacist / Physician Extender / Registered Nurse - Yes The above plan lacked identification of who conducted the reviews. R2's December 2021, MAR listed medications as prescribed, times to administer, and staff initials on each date to indicate the medications had been given. R3 On December 14, 20201, at approximately 7:23 a.m., ULP-D indicated R3 was "pretty self-sufficient" with her cares, that R3 used oxygen but managed that independently and R3 received medication management services. R3's prescriber's orders dated October 13, 2021, included a diuretic, an inhaler, dietary supplements, two antidepressants, two pain relievers, a mood-stabilizing medication, a blood pressure medication, a cholesterol-lowering	01700		

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medication, two medications for esophageal reflux, a drug to treat restless legs, and medication for dry eyes.

R3's Resident Service Agreement dated June 30, 2021, indicated services included medication administration.

R3's Medication & Treatment Management Plan dated August 9, 2021, identified R3 required assistance with medication management, to include administration. In addition, the plan noted the following:
- Potential medication side effects of all medications have been reviewed with resident or responsible party by at least one of the following: Physician / Pharmacist / Physician Extender / Registered Nurse - Yes
- Contraindications of all medications have been reviewed with resident or responsible party by at least one of the following: Physician / Pharmacist / Physician Extender / Registered Nurse - Yes
- All medications have been reviewed with resident or responsible party for possible allergic/adverse reactions by at least one of the following: Physician / Pharmacist / Physician Extender / Registered Nurse - Yes

The above plan lacked identification of who conducted the reviews.

R3's December 2021, MAR listed medications as prescribed, times to administer, and staff initials on each date to indicate medications had been given.

R4
On December 14, 2021, at approximately 7:51 a.m., ULP-D administered R4's morning medications.

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R4's prescriber's orders, dated December 1, 2021, included the following medications: mild pain reliever, multiple blood pressure medications, one diuretic, vitamin supplements, two oral anti-diabetics, insulin, one thyroid replacement hormone and a cholesterol-lowering medication, a prostate drug, two diuretics and a bowel medication.

R4's service plan, dated August 31, 2021, indicated R4 received medication management services.

R4's Medication & Treatment Management Plan dated September 28, 2021, identified R4 required assistance with medication management, to include administration. In addition, the plan noted the following:
- Potential medication side effects of all medications have been reviewed with resident or responsible party by at least one of the following: Physician / Pharmacist / Physician Extender / Registered Nurse - Yes
- Contraindications of all medications have been reviewed with resident or responsible party by at least one of the following: Physician / Pharmacist / Physician Extender / Registered Nurse - Yes
- All medications have been reviewed with resident or responsible party for possible allergic/adverse reactions by at least one of the following: Physician / Pharmacist / Physician Extender / Registered Nurse - Yes

The above plan lacked identification of who conducted the reviews.

R4's December 2021, MAR listed medications as prescribed, times to administer, and staff initials on each date to indicate medications had been

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01700	Continued From page 37 given. R5 On December 14, 2021, at approximately 10:47 a.m., R5 said staff administered his daily medications and verified medication management was included in the services he received from the licensee. R5's prescriber's orders dated November 17, 2021, included a mild pain reliever; two as-needed narcotic pain relievers; one blood pressure medication; one allergy medication; an antidepressant; two cognition-enhancing drugs; an anti-coagulant; a cholesterol-lowering medication; a diuretic; cholesterol-lowering medication and an oral anti-diabetic medication. R5's service plan, dated June 30, 2021, indicated R5 received medication management services. R5's Medication & Treatment Management Plan dated November 12, 2021, identified R5 required assistance with medication management, to include administration. In addition, the plan noted the following: - Potential medication side effects of all medications have been reviewed with resident or responsible party by at least one of the following: Physician / Pharmacist / Physician Extender / Registered Nurse - Yes - Contraindications of all medications have been reviewed with resident or responsible party by at least one of the following: Physician / Pharmacist / Physician Extender / Registered Nurse - Yes - All medications have been reviewed with resident or responsible party for possible allergic/adverse reactions by at least one of the following: Physician / Pharmacist / Physician Extender / Registered Nurse - Yes	01700		

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01700	Continued From page 38 The above plan lacked identification of who conducted the reviews. R5's December 2021, MAR listed medications as prescribed, times to administer, and staff initials on each date to indicate medications had been given. On December 15, 2021, at approximately 3:10 p.m., RN-A confirmed the medication management plan lacked the required content, and stated the side effects, contraindications, and review sections lacked identification of who had completed the required portions. In addition, RN-A confirmed the same template was utilized for all residents receiving medication management services. The licensee's Assessments policy dated November 1, 2021, noted the medication management plan would be completed on admission, with a change in condition, and annually. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700		
01920 SS=F	144G.71 Subd. 23 Loss or spillage (a) Assisted living facilities providing medication management must develop and implement procedures for loss or spillage of all controlled substances defined in Minnesota Rules, part 6800.4220. These procedures must require that when a spillage of a controlled substance occurs, a notation must be made in the resident's record	01920		

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explaining the spillage and the actions taken. The notation must be signed by the person responsible for the spillage and include verification that any contaminated substance was disposed of according to state or federal regulations.
(b) The procedures must require that the facility providing medication management investigate any known loss or unaccounted for prescription drugs and take appropriate action required under state or federal regulations and document the investigation in required records.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to ensure policies and procedures included the required verbiage to investigate any known loss or unaccounted prescription drugs as required.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), 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:

During the entrance conference on December 13, 2021, at approximately 11:00 a.m., registered nurse (RN)-A confirmed the licensee provided medication management services to their residents.

The licensee's Medication Management Lost or Spilled Medications policy dated November 5,

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01920	Continued From page 40 2021, noted when lost or spillage of any medication occurred, the nurse would document the disposition in the medication disposition record. However, the policy lacked the required content to include the notation must be signed by the person responsible for the spillage. On December 15, 2021, at approximately 2:10 p.m., executive director (ED)-B confirmed the policy lacked the required content. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01920		
01940 SS=E	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	01940		

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services; and
(5) any resident-specific requirements relating to 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 develop and implement a treatment or therapy management plan to include all required content for two of five residents (R4 and R5) with records reviewed.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).

The findings include:

R4
R4's diagnoses included hypertension, atrial fibrillation, chronic kidney disease and type 2 diabetes.

R4's Medication & Treatment Management Plan, dated September 28, 2021, indicated nursing staff would provide treatment services in

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 _____	12/15/2021

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
01940	Continued From page 42	01940		

accordance with a physician's order, and indicated R4 had a physician's order for glucose monitoring. Additionally, R4's treatment plan indicated licensed nurses and unlicensed personnel would follow resident-specific instructions for treatments as noted in the resident service plan or eMAR (electronic medication administration record).

R4's prescriber's order, dated December 1, 2021, included "Accu-Chek Avivia Plus" (brand name of glucometer, blood sugar testing device) and directed to check blood sugars 4 times daily. The prescriber's order contained no further information about R4's blood sugar testing.

On December 14, 2021, at approximately 7:57 a.m., unlicensed personnel (ULP)-D gathered supplies, donned a pair of gloves, and completed the steps to obtain a blood glucose measurement from R4, which was 94 mg/dl (milligrams per deciliter). ULP-D stated the result meant at that time, R4 did not require insulin.

R4's medication administration record (MAR) for December 2021, indicated R4's blood glucose (sugar) was tested four times daily. Instructions in the MAR directed "Use as directed to check blood glucose." The directions lacked any further instructions, or information such as when to call a nurse if the blood sugars were too low or too high, and specifically what those parameters were.

On December 14, 2021, at approximately 8:24 a.m., ULP-D talked with the surveyor about taking resident blood sugars and when to call the nurse if a blood sugar was abnormal. ULP-D stated a reading below 70 "raises my concern," and "too high for me" would be 300, and I would contact

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01940	Continued From page 43	01940		

the nurse. ULP-D said typically the resident's blood sugar parameters were written in the MAR, and verified there were no parameters in the MAR for R4. ULP-D stated, "we would just need to add", and said, "it should be there."

On December 14, 2021, at approximately 1:32 p.m., registered nurse (RN)-A acknowledged R4's instruction regarding taking of the resident's blood sugar did not include any parameters that may indicate a blood sugar that is either too low or high. RN-A said that although R4 typically did not need to get insulin after taking blood sugar, she did not feel comfortable just adding parameters to the doctor's order. RN-A stated she would obtain better parameters for R4's blood sugars.

R5
R5's diagnoses included type 2 diabetes, congestive heart failure, Alzheimer's dementia and hypertension.

R5's Medication & Treatment Management Plan, dated November 12, 2021, indicated nursing staff would provide treatment services in accordance with a physician's order and also indicated R5 had a physician's order for glucose monitoring. R5's treatment plan indicated licensed nurses and unlicensed personnel would follow resident-specific instructions for treatments as noted in the resident service plan or eMAR (electronic medication administration record).

R5's prescriber's orders, dated November 17, 2021, included "OneTouch Verio Reflect" (brand name of glucometer/blood sugar testing device) and directed to check blood sugar once daily, alternating fasting in the morning and 2 hours postprandial (after a meal). The prescriber's order contained no further information about R5's blood

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	24718	A. BUILDING: _____ B. WING _____	12/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01940	Continued From page 44 sugar testing. R5's MAR for December 2021 indicated R5's blood glucose (sugar) was tested twice daily. Instructions in the MAR directed to test blood glucose once daily alternating fasting in the morning and 2 hours postprandial. The MAR did indicate the testing was for monitoring. However, the directions lacked any further instructions, or information such as when to call a nurse if the blood sugars were too low or too high, and specifically what those parameters were. On December 15, 2021, at approximately 7:51 a.m., ULP-I stated he would notify a nurse if a blood sugar was, "below 80 and above 180", and would do that, "especially if that was my first time", checking the resident. ULP-I said it would be helpful to know what a resident's "baseline" was and added that "it's different" for each resident. ULP-I verified R5 had blood sugar testing but stated R5 did not get insulin but he did not know why the resident would have blood sugar testing if he did not get insulin. ULP-I stated he thought the residents' parameters usually were on the MAR. During a subsequent interview on December 15, 2021, at approximately 1:59 p.m., RN-A acknowledged R5 also had no parameters regarding blood sugars, but emphasized R5's readings were "for information purposes only." RN-A acknowledged that it was usually unlicensed staff who obtained resident blood sugars and stated they do need to be aware of when blood sugars may be out of range. RN-A stated each medication cart had information about when to call the nurse and also stated parameters were needed as part of the treatment plan. RN-A also mentioned the licensee's policy	01940		

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01940	Continued From page 45 directed if a blood sugar was below 70 or above 450, to recheck blood sugar and notify the nurse. The licensee's Treatment or Therapy Management Services policy, revised/updated November 5, 2021, indicated the Community provided treatment and therapy services within the scope of the provider license. The policy indicated further, the RN would develop and maintain a current individualized treatment and therapy management plan for each resident to include, among a list of other items: documentation of specific resident instructions relating to the treatment or therapy service administration. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01970 SS=D	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 obtain a prescriber's order for a treatment provided for one of five residents (R4) with records reviewed.	01970		

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01970	Continued From page 46	01970		

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:
During the entrance conference on December 13, 2021, at approximately 11:18 a.m., registered nurse (RN)-A confirmed the licensee provided various treatment services to residents.
R4's diagnoses included hypertension, atrial fibrillation, chronic kidney disease and type 2 diabetes.
R4's record lacked a prescriber's order for TED (thromboembolism-deterrent) hose, (compression stockings worn around the leg to prevent or deter edema and blood clots).
R4's Resident Service Agreement, effective August 31, 2021, indicated R4 received among other services, to apply TED stockings: on in the "AM" (morning) and off in "PM" (evening). R4's Medication & Treatment Management Plan, dated September 28, 2021, also indicated nursing staff would provide treatment services in accordance with a physician's order, and indicated R4 had a physician's order for TED stockings.
On December 14, 2021, at approximately 8:01 a.m., unlicensed personnel (ULP)-L placed TED stockings on R4. At about 8:10 a.m., ULP-L verified R4 wore the special stockings, which were put on by the staff daily.
R4's Service Checkoff List for December 2021 was reviewed, and the documentation indicated R4 received the service of TED stocking application every day in December.
On December 14, 2021, at approximately 1:54

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01970	Continued From page 47 a.m., registered nurse (RN)-A was unable to locate an order for R4's TED stockings in the resident's record. RN-A stated such an order would typically be on the admission dictation and it was likely that R4 was wearing TED hose before becoming a resident of the facility. RN-A stated she would have to follow up and added, "there needed to be" an order for all treatments. The licensee's Treatment or Therapy Management Services policy, dated July 22, 2020, indicated the licensee provided treatment and therapy services within the scope of its provider license and according to applicable law. Further, the RN was responsible for requesting and receiving orders or prescriptions for treatments and therapy service, and maintaining an individualized resident treatment or therapy services record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced	02040		

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02040	Continued From page 48 by: Based on interview and record review, the licensee failed to provide hazard vulnerability assessment or safety risk assessment that indicated how identified hazards would be mitigated of the physical environment on and around the property for the facility. This deficient practice had the ability to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: Record review indicated that the licensee had performed a hazard vulnerability assessment on and around the property but had not prescribed any mitigation factors for any of the hazards associated with the physical environment. During an interview on December 15, 2021 at approximately 12:20 p.m. to 12:55 p.m., Executive Director (ED)-B confirmed that the licensee had a hazard vulnerability assessment in accordance with Appendix Z requirements, which also did identify hazards on or around the property, but did include mitigation factors in the assessment. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	02040		

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02110	Continued From page 49	02110		
02110 SS=F	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in.	02110		

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NEW PERSPECTIVE - MANKATO	100 DUBLIN ROAD MANKATO, MN 56001

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02110	Continued From page 50 This MN Requirement is not met as evidenced by: Based on interview and record review, licensee failed to ensure policies and procedures required in the licensing of assisted living facilities with dementia care were developed and/or implemented, and were provided to each resident and/or the residents legal/designated representative at the time of move-in. This had the potential to affect all dementia care residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee lacked evidence the following required policies and procedures related to dementia care had been developed. - transportation coordination and assistance to and from outside medical appointments; and - safekeeping of residents' possessions. The licensee's Residency Agreement noted they had the above required policies, and upon request the licensee would provide copies. On December 15, 2021, at approximately 2:20 p.m., executive director (ED)-B confirmed the above required policies had not been developed. In addition, ED-B confirmed the required policies had not been provided to the residents unless	02110		

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02110	Continued From page 51 requested, as noted in the contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02110		

Minnesota Department of Health
Food, Pool, & Lodging Services
P.O. Box 64975
Saint Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *12/14/21*
Time: 09:20:50
Report: 1020211162

Food and Beverage Establishment Inspection Report

Location:
New Perspective - Mankato
100 Dublin Road
Mankato, MN56001
Blue Earth County, 07

Establishment Info:
ID #: 0037763
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 5073857080
ID #:

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

The following orders were issued during this inspection.

3-500D Microbial Control: disposition of food

3-501.18A ***** Priority 1 *****

MN Rule 4626.0405A Discard all TCS food prepared in the establishment or opened commercially packaged food when the time exceeds 7 days from the preparation or opening date or if the container or package is not marked.

SPINACH MARKED 12/3/21 IN THE WALK-IN COOLER. DISCUSSED WITH MANAGER. SPINACH WAS DISCARDED.

Corrected on Site

4-500 Equipment Maintenance and Operation

4-501.114A ***** Priority 1 *****

MN Rule 4626.0805A Use the approved sanitizer according to the rule and the EPA approved manufacturer's label.

QUAT SANITIZER BEING USED TO DISINFECT SURFACES IN THE KITCHEN AND THEN SUBSEQUENTLY WASHED WITH WATER IMMEDIATELY AFTER. QUAT SANITIZER LABEL STATES, "DO NOT RINSE." DISCUSSED WITH OPERATOR. QUAT SANITIZER WILL NO LONGER BE RINSED AFTER WITH WATER.

Comply By: 12/14/21

4-500 Equipment Maintenance and Operation

4-501.114C1 ***** Priority 1 *****

MN Rule 4626.0805C1 Provide and maintain an approved chlorine chemical sanitizer solution that has a minimum concentration of 50 ppm and a minimum temperature of 75 degrees F (24 degrees C) for water with a pH of 8 or less or a minimum temperature of 100 degrees F (38 degrees C) for water with a pH of 8.1 to 10.

INITIAL CHLORINE SANITIZER CONCENTRATION OF DISHWASHER 0 PPM. DISCUSSED WITH MANAGER. THE LINE WAS ADJUSTED AND AFTER 3 PASSES, THE CONCENTRATION WAS 50 PPM. TEST DISHWASHER SANITIZER CONCENTRATION DAILY TO ENSURE IT MEETS REQUIREMENTS.

Corrected on Site

4-300 Equipment Numbers and Capacities

4-302.14 ***** Priority 2 *****

MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.

CHLORINE SANITIZER USED FOR THE DISHWASHER AT THE ESTABLISHMENT. PROVIDED CHLORINE TEST STRIPS TO MEASURE THE CONCENTRATION OF THE CHLORINE SANITIZER. DISCUSSED WITH MANAGER.

Comply By: 12/28/21

7-100 Toxic Labeling

7-102.11 ***** Priority 2 *****

MN Rule 4626.1595 Clearly label all working containers used for storing poisonous or toxic materials from bulk supplies such as sanitizers and cleaners, with the common name of the product.

SPRAY BOTTLE OF SANITIZER UNLABLED. DISCUSSED WITH MANAGER. THE SPRAY BOTTLE WAS LABELED.

Corrected on Site

3-300C Protection from Contamination: equipment/utensils, consumers

3-304.12E

MN Rule 4626.0275E Store food preparation or dispensing utensils that are used with non-TCS foods, such as ice, in a clean, protected location.

ICE SCOOP BEING STORED ON TOP OF THE ICE MACHINE. DISCUSSED WITH MANAGER. ICE SCOOP WAS WASHED AND WILL BE PLACED IN A FOOD GRADE CONTAINER ON TOP OF THE ICE MACHINE.

Corrected on Site

4-900 Protecting Clean Items

4-903.11D

MN Rule 4626.0955D Discontinue storing items in open packages less than 6 inches above the floor on dollies, pallets, racks, and skids.

BOXES OF OPEN SINGLE USE CUPS BEING STORED ON THE FLOOR IN THE BEVERAGE AREA. DISCUSSED WITH PERSON IN CHARGE. ITEMS TO BE MOVED TO ANOTHER LOCATION TO BE STORED UP OFF OF THE FLOOR.

Comply By: 12/14/21

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.12A

MN Rule 4626.1520A Clean and maintain all physical facilities clean.

VENT FILTER IN DISHWASHER HOOD DUSTY; CLEAN. DISCUSSED WITH MANAGER. VENT FILTER WAS REMOVED FOR CLEANING.

Comply By: 12/16/21

Surface and Equipment Sanitizers

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

Quaternary Ammonia: = 200 PPM at Degrees Fahrenheit
Location: 3 COMPARTMENT SINK
Violation Issued: No

Chlorine: = 0 PPM at Degrees Fahrenheit
Location: DISHWASHER
Violation Issued: Yes

Chlorine: = 0 PPM at Degrees Fahrenheit
Location: DISHWASHER AFTER 3 PASSES AFTER LINE WAS ADJUSTED
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: <0 Degrees Fahrenheit - Location: FOODS FIRM - WALK-IN FREEZER
Violation Issued: No

Process/Item: Cold Holding
Temperature: 40 Degrees Fahrenheit - Location: TUNA - WALK-IN COOLER
Violation Issued: No

Process/Item: Cold Holding
Temperature: 38 Degrees Fahrenheit - Location: VEGETABLE BEEF - WALK-IN COOLER
Violation Issued: No

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: SLICED TOMATOES - TOP OF PREP COOLER
Violation Issued: No

Process/Item: Cold Holding
Temperature: 38 Degrees Fahrenheit - Location: CHICKEN BREAST - BOTTOM OF PREP COOLER
Violation Issued: No

Type: Full
Date: *12/14/21*
Time: 09:20:50
Report: 1020211162
New Perspective - Mankato

Food and Beverage Establishment Inspection Report

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

GENERAL COMMENTS:

DISCUSSED CURRENT COVID-19 AND GENERAL EMPLOYEE ILLNESS POLICIES AND PROCEDURES.

DISCUSSED COOLING AND RE-HEATING PROCEDURES.

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1020211162 of 12/14/21.

Certified Food Protection Manager: Joleen Sandstrom

Certification Number: FM107671 Expires: 07/22/24

Inspection report reviewed with person in charge and emailed.

Signed: _____
Establishment Representative

Signed: _____
Ashley B

651-201-4500