Electronically Delivered

October 27, 2025

Licensee
New Perspective  Prior Lake
4685 Park Nicollet Avenue
Prior Lake, MN  55372

RE:  Project Number(s) SL22094016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on September 25, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

MDH concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

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

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

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

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

**St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $500.00**

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

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

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

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

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

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

If you have any questions, please contact me.

Sincerely,

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

KKM

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 22094 | A. BUILDING: _____ B. WING _____ | 09/25/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| NEW PERSPECTIVE PRIOR LAKE | 4685 PARK NICOLLET AVENUE PRIOR LAKE, MN 55372 |

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| 0 000 | Initial Comments<br><br>*****ATTENTION*****<br><br>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S)<br><br>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey.<br><br>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.<br><br>INITIAL COMMENTS:<br><br>SL22094026-0<br><br>On September 22, 2025, through September 25, 2025, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were 119 residents; 110 receiving services under the Assisted Living Facility with Dementia Care license. | 0 000 | Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction.<br><br>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.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.<br><br>THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3. | |
| 0 480 SS=F | 144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services | 0 480 | | |

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

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| 0 480 | Continued From page 2<br><br>existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition;<br>(6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and<br>(7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code.<br><br>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).<br><br>The findings include:<br><br>Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated September 23, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee | 0 480 | | |

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| 0 480 | Continued From page 3<br>within 24 hours of the inspection.<br><br>TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates. | 0 480 | | |
| 0 510 SS=D | 144G.41 Subd. 3 Infection control program<br><br>(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.<br>(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.<br>(c) The facility must maintain written evidence of compliance with this subdivision.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to establish and maintain an infection control program that complies with accepted health care, medical and nursing standards for infection control during medication administration for one of three unlicensed personnel (ULP-E).<br><br>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 | 0 510 | | |

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| 0 510 | Continued From page 4<br>situation has occurred only occasionally).<br><br>The findings include:<br><br>On September 23, 2025, at 7:16 a.m., ULP-E was at the medication cart in the facility hallway. ULP-E was dishing up R5's medications for administration. During the process, ULP-E tipped over the medication cup, one pill spilling out onto the medication cart and another pill fell to the floor. ULP-E picked up the pills and placed them back into the medication cup. ULP-E then went into R5's room and administered the medications.<br><br>On September 24, 2025, at 3:24 p.m., clinical nurse supervisor (CNS)-B stated if staff drop a pill on the floor, they should notify the nurse, take a new pill from the end of the roll of the pill packs and use that to administer to the resident. CNS-B would then request a replacement pack from the pharmacy.<br><br>The licensee's Medication Management Lost or Spilled Medication policy dated November 18, 2024, indicated the following:<br>3. A medication that is dropped or spilled will be treated as hazardous waste for disposition purposes and discarded according to the Medication Disposition policy and procedure.<br>4. If needed, the health and wellness director (HWD) or licensed nurse designee will contact the pharmacy to have the medication timely replaced.<br>5. To replace the dose of a dropped multi-dose packaged medication:<br>a. Pull a replacement dose from the last dated package in the strip that matches the administration time of the dropped medication, leaving the package attached to the strip; | 0 510 | | |

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| 0 510 | Continued From page 5<br><br>b. Seal the medication package from which the replacement dose was pulled with tape;<br>c. Initial and date the resealed package; and<br>d. Place the dropped medication back into the multi-dose package from which it originally came, seal the package with tape, initial and date the package, and provide the resealed package to the nurse for follow up and ordering of replacement medication.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 510 | | |
| 0 640 SS=F | 144G.42 Subd. 7 Posting information for reporting suspected c<br><br>The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by:<br>(1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility;<br>(2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and<br>(3) providing reasonable accommodations with information and notices in plain language.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee failed to support protection and safety by posting the 911 emergency number in a common area and near telephones provided by the assisted living facility. This had the potential to affect all | 0 640 | | |

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| 0 640 | Continued From page 6<br>residents, staff, and visitors.<br><br>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).<br><br>The findings include:<br><br>On September 22, 2025, at approximately 2:00 p.m. during a facility tour with sales director (SD)-I, the surveyor observed postings in the entry way of the facility. There was no posting for 911. SD-I stated the 911 number was not posted in public areas or by all facility phones; 911 was posted by the resident public phones in common areas and at the front desk. The surveyor did not observe a posting by the front desk.<br><br>On September 23, 2025, at 8:43 a.m., the surveyor observed a facility phone on a table in the common area of the memory care unit. 911 was not posted on or near the phone.<br><br>On September 24, 2025, at 9:33 a.m., licensed assisted living director (LALD)-A stated she was unaware the posting did not have 911 on them and was unaware the front desk and memory care phone did not have 911 posted by them. LALD-A further stated it had been posted but must have come down.<br><br>No further information was provided. | 0 640 | | |

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| 0 640 | Continued From page 7<br>TIME PERIOD FOR CORRECTION: Twenty-One (21) days | 0 640 | | |
| 0 700 SS=E | 144G.43 Subdivision 1 Resident record<br><br>(b) Resident records, whether written or electronic, must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable relevant federal and state laws. The facility shall establish and implement written procedures to control use, storage, and security of resident records and establish criteria for release of resident information.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure resident records were protected against unauthorized disclosure of both electronic and written records.<br><br>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).<br><br>The findings include:<br><br>On September 22, 2025, at 4:29 p.m., unlicensed personnel (ULP)-D set up medications for R6. ULP-D left the medication cart and walked into a nursing office. The computer on the medication | 0 700 | | |

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| 0 700 | Continued From page 8<br><br>cart was left open and R6's medical information was visible to any person who would walk past the cart. An unidentified staff walked past the medication cart and closed the computer screen.<br><br>On September 23, 2025, at 7:22 a.m., the surveyor observed ULP-E setting up medications for R4. ULP-E administered oral medications. ULP-E the brought R4 into a laundry room leaving the computer screen open with R4's medication information and other personal information on the screen.<br><br>On September 24, 2025, at 3:24 p.m., regional director of clinical services (RDCS)-H stated staff should close or lock the computer screen whenever they walk away from it.<br><br>The licensee's Personal and Privacy Rights policy dated January 2, 2025, indicated resident medical, financial, or other records will be protected and kept confidential.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 700 | | |
| 0 775 SS=F | 144G.45 Subd. 2. (a) Fire protection and physical environment<br><br>Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and:<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee failed to comply with the current State Fire Code | 0 775 | | |

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| 0 775 | Continued From page 9<br><br>in Minnesota Rules, chapter 7511. This had the potential to directly affect all residents, staff, and visitors.<br><br>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 the potential to affect a large portion or all of the residents).<br><br>Findings include:<br><br>On September 23, 2025, from 10:30 a.m. to 2:30 p.m., the surveyor toured the facility with environmental services director (ESD)-G. During the tour, the surveyor observed:<br><br>FIRE RATED DOORS:<br>Resident rooms, utility/mech rooms and laundry rooms at the facility had fire rated assemblies and rated fire doors that didn't close and latch automatically. Per MN State Fire Code, swinging fire doors shall close from the full-open position and latch automatically.<br><br>SMOKE ALARMS:<br>Facility has installed hard-wired smoke alarms in each resident room. In the 25+ surveyed rooms alarms were over 10 years past the manufacturer date. Per MN State Fire Code and manufacturer's instructions, single-and multiple-station smoke alarms shall be replaced when they exceed ten years from the date of manufacture. All smoke alarms shall be replaced with smoke alarms having the same type of | 0 775 | | |

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| 0 775 | Continued From page 10<br>power supply.<br><br>LIQUID OXYGEN<br>In resident room 205, 3 containers of liquid oxygen containing more than 31.6 gallons (120L) in total was found; resident was filling smaller oxygen tanks to use with machine. Local area fire marshal was contacted and informed about resident filling and quantity.<br><br>EMERGENCY EXIT LIGHT<br>Emergency exit lights in the memory care, dining hall and other area didn't work when tested. Per MN State Fire Code, interior exit passageways shall automatically illuminate.<br><br>During a facility tour on September 23, 2025, at 12:30 p.m., ESD-G, verified the above listed observations while accompanying on the tour.<br><br>TIME PERIOD FOR CORRECTION: Two (2) day. | 0 775 | | |
| 0 810 SS=F | 144G.45 Subd. 2 (b-f) Fire protection and physical environment<br><br>(b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to:<br>(1) location and number of resident sleeping rooms;<br>(2) staff actions to be taken in the event of a fire or similar emergency;<br>(3) fire protection procedures necessary for residents; and<br>(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 | 0 810 | | |

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|---|---|---|---|
| | 22094 | A. BUILDING: _____ B. WING _____ | 09/25/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NEW PERSPECTIVE PRIOR LAKE | 4685 PARK NICOLLET AVENUE PRIOR LAKE, MN 55372 |

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|---|---|---|---|---|
| 0 810 | Continued From page 11<br><br>evacuation.<br>(c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter.<br>(d) Fire safety and evacuation plans shall be readily available at all times within the facility.<br>(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.<br>(f) Evacuation drills are required for staff 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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training. This had the potential to directly affect all residents, staff, and visitors.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). | 0 810 | | |

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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|---|---|---|---|---|
| 0 810 | Continued From page 12<br><br>The findings include:<br><br>September 25, 2025, LALD-A and ESD-G provided documents on the FSEP, fire safety and evacuation training, and evacuation drills for the facility.<br><br>FIRE SAFETY AND EVACUATION PLAN:<br>The licensee's FSEP, failed to include the following:<br><br>STAFF ACTIONS:<br>The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate). The provided FSEP was from a third-party provider and had not been updated to the specific facility.<br><br>On September 25, 2025, at 12:30 p.m., ESD-G/LALD-A stated they understood the areas of their policy that were incomplete and would work on bringing them into compliance.<br><br>TRAINING:<br>The licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. ESF-G stated that he continually educates during fire drill activities. No other training documentation was provided.<br><br>On September 25, 2025, at 12:30 p.m., ESD-G/LALD-A stated they understood the requirements for training residents and staff and would implement a training program that was | 0 810 | | |

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|---|---|---|---|---|
| 0 810 | Continued From page 13<br>compliant with statute requirements.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 0 810 | | |
| 01290 SS=F | 144G.60 Subdivision 1 Background studies required<br><br>(a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information.<br>(b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12.<br>(c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure a background study was submitted and received in affiliation with the assisted living license for one of one employee (unlicensed personnel (ULP)-C. This had the potential to affect all residents living in the assisted living facility.<br><br>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 | 01290 | | |

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|---|---|---|---|
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|---|---|
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|---|---|---|---|---|
| 01290 | Continued From page 14<br><br>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).<br><br>The findings include:<br><br>ULP-C was hired on May 6, 2025, to provide direct care services to the facility's residents.<br><br>On September 23, 2025, at 10:00 a.m., the surveyor observed ULP-C putting compression stockings on R3 and then transferred R3 using a mechanical lift.<br><br>ULP-C had a background study completed May 2, 2025, affiliated with health facility identification number (HFID) 30649, which was another licensee owned by the same company. ULP-C's background study was not affiliated with this licensee's HFID (22094).<br><br>On September 24, 2025, at 3:03 p.m., regional director of clinical services (RDCS)-H stated ULP-C's background study was not affiliated to the licensee and they should have been affiliated.<br><br>The licensee's Background Checks policy dated February 14, 2022, indicated staff soul have a background study completed and cleared prior to working with facility residents.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Two (2) days | 01290 | | |

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|---|---|---|---|
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| 01500 | Continued From page 15 | 01500 | | |
| 01500 SS=D | 144G.63 Subd. 5 Required annual training<br><br>(a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include:<br>(1) training on reporting of maltreatment of vulnerable adults under section 626.557;<br>(2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights;<br>(3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases;<br>(4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders;<br>(5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and<br>(6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person.<br>(b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. | 01500 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 22094 | A. BUILDING: _____ B. WING _____ | 09/25/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NEW PERSPECTIVE PRIOR LAKE | 4685 PARK NICOLLET AVENUE PRIOR LAKE, MN 55372 |

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|---|---|---|---|---|
| 01500 | Continued From page 16<br><br>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:<br>(1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication;<br>(2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or<br>(3) information about strategies and technology 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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure annual training included all required topics for each 12 months of employment for one of one unlicensed personnel (ULP-E).<br><br>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).<br><br>The findings include: | 01500 | | |

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| 01500 | Continued From page 17<br><br>ULP-E was hired on October 6, 2020, and began providing assisted living services on August 1, 2021.<br><br>On September 23, 2025, at 7:00 a.m., the surveyor observed ULP-E administering medications to residents.<br><br>ULP-E's employee record lacked evidence the following required annual training had been completed in 2024 or 2025:<br>- training on reporting of maltreatment of vulnerable adults under section 626.557;<br>- review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights;<br>- review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases;<br>- review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and<br>- the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person.<br><br>On September 24, 2025, at 3:03 p.m., regional director of clinical services (RDCS)-H stated ULP-E did not have the required annual training.<br><br>The licensee's Team Member Orientation and | 01500 | | |

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|---|---|---|---|
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| 01500 | Continued From page 18<br><br>Training policy dated January 27, 2023, indicated: Per applicable law, all team members performing direct services will receive at least eight (8) hours of annual training for each 12 months of employment. Continuing education shall be relevant to the job responsibilities and will include, at a minimum, each of the following:<br>- Training on reporting of maltreatment of vulnerable adults;<br>- Review of the assisted living bill of rights and team member responsibilities related to ensuring the exercise and protection of those rights;<br>- Review of infection control techniques and implementation of infection control standards including:<br>- Review of hand washing techniques;<br>- The need for and use of protective gloves, gowns, and masks;<br>- Appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades;<br>- Disinfecting reusable equipment and environmental surfaces; and<br>- Reporting communicable diseases.<br>- Review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and<br>- The principles of person-centered planning and service delivery and how they apply to direct support services provided by the team member.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) days | 01500 | | |
| 01530 SS=D | 144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- | 01530 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 22094 | A. BUILDING: _____ B. WING _____ | 09/25/2025 |

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|---|---|
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|---|---|---|---|---|
| 01530 | Continued From page 19<br><br>(a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements:<br>(1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter;<br>(2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 | 01530 | | |

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|---|---|---|---|
| | 22094 | A. BUILDING: _____ B. WING _____ | 09/25/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NEW PERSPECTIVE PRIOR LAKE | 4685 PARK NICOLLET AVENUE PRIOR LAKE, MN 55372 |

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|---|---|---|---|---|
| 01530 | Continued From page 20<br>months of employment thereafter;<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure direct care staff received the required two hours of initial training on mental illness and de-escalation topics for one of two employees (unlicensed personnel lead (ULP)-E). This had the potential to affect all residents and staff.<br><br>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).<br><br>The findings include:<br><br>ULP-E was hired on October 6, 2020, and began providing assisted living services on August 1, 2021.<br><br>On September 23, 2025, at 7:00 a.m., the surveyor observed ULP-E administering medications to residents.<br><br>ULP-E's employee record identified ULP-E had been assigned the required mental health and de-escalation training but had not completed it yet. | 01530 | | |

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|---|---|---|---|
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|---|---|---|---|---|
| 01530 | Continued From page 21<br><br>On September 24, 2025, at 3:03 p.m., regional director of clinical services (RDCS)-H stated ULP-E should have completed the mental illness and de-escalation training.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 01530 | | |
| 01880 SS=F | 144G.71 Subd. 19 Storage of medications<br><br>An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure one of one medication cart was securely locked in substantially constructed compartments and permitted only authorized personnel to have access. This had the potential to affect all residents.<br><br>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).<br><br>The findings include: | 01880 | | |

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|---|---|---|---|
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|---|---|---|---|---|
| 01880 | Continued From page 22<br><br>On September 23, 2025, at 7:22 a.m., the surveyor observed unlicensed personnel (ULP)-E setting up medications for R4 in the dementia care unit. ULP-E administered oral medications. ULP-E the brought R4 into a laundry room to administer topical medications. ULP-E did not lock the medication cart and it was not within ULP-E's visual sight. There were three residents in the area with one of them in close proximity of the medication cart.<br><br>On September 23, 2025, at approximately 2:00 p.m., the surveyor was walking past a medication cart on the second floor assisted living area. The surveyor observed the medication cart was unlocked and there were no staff in the vicinity. The surveyor went to the nursing office and informed them of the unlocked medication cart.<br><br>On September 24, 2025, at 3:24 p.m., regional director of clinical services (RDCS)-H stated medication carts should always be locked when staff are not present.<br><br>The licensee's Medication Management Medication Storage dated June 27, 2024, indicated medications will be centrally stored in locked medication carts, secure medication rooms, or secure medication refrigerators located in the Community.<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01880 | | |
| 01970 SS=D | 144G.72 Subd. 6 Treatment and therapy orders<br><br>There must be an up-to-date written or | 01970 | | |

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|---|---|---|---|
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| NEW PERSPECTIVE PRIOR LAKE | 4685 PARK NICOLLET AVENUE PRIOR LAKE, MN 55372 |

| (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 |
|---|---|---|---|---|
| 01970 | Continued From page 23<br><br>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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure treatment orders were renewed at least every 12 months for one of two residents (R2) receiving treatments.<br><br>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).<br><br>The findings include:<br><br>R2 was admitted on February 12, 2018, and began receiving assisted living services on August 1, 2021.<br><br>R2's service plan dated July 30, 2024, indicated R2 received TED (Thrombo-Embolic Deterrent to prevent blood clots) stocking assistance.<br><br>R2's annual physicians order renewal dated July 23, 2025, did not include TED stockings. | 01970 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 22094 | A. BUILDING: _____ B. WING _____ | 09/25/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| NEW PERSPECTIVE PRIOR LAKE | 4685 PARK NICOLLET AVENUE PRIOR LAKE, MN 55372 |

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|---|---|---|---|---|
| 01970 | Continued From page 24<br><br>R2's physician order dated December 20, 2019, included use compression stockings on the legs to decrease swelling.<br><br>On September 25, 2025, at 12:55 p.m., regional director of clinical services (RDCS)-H stated the most current physician order they had for R2's TED stockings was the December 2019 order. The order should have been renewed annually.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01970 | | |
| 02320 SS=E | 144G.91 Subd. 4 (b) Appropriate care and services<br><br>(b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure medications were administered according to policy and accepted standards of practice for two of two residents (R4, R11).<br><br>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 | 02320 | | |

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|---|---|---|---|---|
| 02320 | Continued From page 25<br><br>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).<br><br>The findings include:<br><br>ULP-E<br>On September 23, 2025, at 7:22 a.m., the surveyor observed unlicensed personnel (ULP)-E setting up medications for R4 in the dementia care unit. ULP-E administered oral medications. ULP-E then brought R4 into a laundry room to administer diclofenac gel (pain relief) to R4's hip. ULP-E put on gloves, exposed R4's hip area, put some of the diclofenac gel directly onto her gloved hand and administered it to R4's hip area. ULP-E did not measure the medication using the manufacturer's measuring strip.<br><br>R4's medication administration record (MAR) dated September 2025, included diclofenac gel 1% apply 2 grams topically to right hip twice daily.<br><br>ULP-F<br>On September 23, 2025, at 7:45 a.m., ULP-F set up R11's medications which included a QVAR redihaler. ULP-F brought the medications to the resident, administered the oral medications and assisted R11 with her QVAR inhaler. ULP-F did not provide R11 with water to rinse her mouth and spit out nor did she cue R11 to do it themselves.<br><br>R11's MAR included QVAR redihaler inhale one puff twice a day. | 02320 | | |

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| NEW PERSPECTIVE PRIOR LAKE | 4685 PARK NICOLLET AVENUE PRIOR LAKE, MN 55372 |

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|---|---|---|---|---|
| 02320 | Continued From page 26<br><br>On September 24, 2025, at 9:06 a.m., clinical nurse supervisor stated staff had been trained to use the measuring strip when administering diclofenac gel and staff were trained to have the resident rinse their mouth and spit it out after inhaler use.<br><br>The licensee's Medication Administration policy dated November 22, 2024, indicated staff were to check the medication to the MAR and administer the correct dose indicated.<br><br>The licensee's Medication Administration Inhalents policy dated November 21, 2024, included "Provide the resident with water and instruct resident to rinse their mouth, as the medication can irritate the mucosal membrane of the mouth and cause a burning sensation".<br><br>Diclofenac's patient instructions for use dated July 2009 included the following:<br>- Use Voltaren® Gel exactly how your doctor prescribes it for you. Do not apply Voltaren® Gel anywhere other than where your doctor tells you to.<br>- Do not use more than a total of 32 grams of Voltaren® Gel each day. This means that if you add up the amount of Voltaren® Gel as directed by your doctor, it should not be more than 32 grams in one day. The dose for your hands, elbows or wrists is 2 grams of Voltaren® Gel each time you apply it.<br>- Apply Voltaren® Gel 4 times a day (a total of 8 grams each day ).<br>- Do not apply more than 8 grams each day to any one of your affected hands, wrists or elbows.<br>The dose for your knees, ankles or feet is 4 grams of Voltaren® Gel each time you apply it. | 02320 | | |

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| 02320 | Continued From page 27<br>- Apply Voltaren® Gel 4 times a day (a total of 16 grams each day).<br>- Do not apply more than 16 grams each day to any one of your affected knees, ankles or feet.<br><br>QVAR's prescribing information dated September 2017, included in the directions for use, "After inhalation, the patient should rinse his/her mouth with water without swallowing to help reduce the risk of oropharyngeal candidiasis (yeast infection in the mouth and throat)".<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 02320 | | |
| 02410 SS=E | 144G.91 Subd. 13 Personal and treatment privacy<br><br>(a) Residents have the right to consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being. Staff must respect the privacy of a resident's space by knocking on the door and seeking consent before entering, except in an emergency or unless otherwise documented in the resident's service plan.<br>(b) Residents have the right to have and use a lockable door to the resident's unit. The facility shall provide locks on the resident's unit. Only a staff member with a specific need to enter the unit shall have keys. This right may be restricted in certain circumstances if necessary for a resident's health and safety and documented in the resident's service plan.<br>(c) Residents have the right to respect and privacy regarding the resident's service plan. | 02410 | | |

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|---|---|---|---|---|
| 02410 | Continued From page 28<br><br>Case discussion, consultation, examination, and treatment are confidential and must be conducted discreetly. Privacy must be respected during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to provide privacy for two of two residents (R5, R4) during topical medication administration.<br><br>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).<br><br>The findings include:<br><br>R5<br>On September 23, 2025, at 7:16 a.m., unlicensed personnel (ULP)-E set up medications for R5, including a Icy Hot topical cream (pain). ULP-E approached R5 in the common area of the secured unit. There were three other residents in the area at the time. ULP-E gave R5 her oral medications. ULP-E then put on gloves, lifted up R5's shirt exposing her back to above her bra line, and applied the Icy Hot to the lower back. ULP-E then lowered her shirt and returned to the medication cart. | 02410 | | |

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|---|---|---|---|---|
| 02410 | Continued From page 29<br><br>R5 was admitted on September 27, 2016, and their diagnoses included history of stroke, cognitive impairment, atrial fibrillation (irregular heart beat), and osteoporosis (condition that weakens bones, making them more prone to fractures). R5 resided in the secured unit within the facility.<br><br>R5's service plan dated December 26, 2024, indicated R5's services included assistance with activities of daily living (ADLs), activities, behavior management, and medication administration.<br><br>R5's Minnesota Assisted Living Bill of Rights was signed by R5's power of attorney (POA) on October 3, 2022, which included "Residents have the right to respect and privacy regarding the resident's service plan. Case discussion, consultation, examination, and treatment are confidential and must be conducted discreetly. Privacy must be respected during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance."<br><br>The licensee failed to ensure R5 was provided privacy during medication administration.<br><br>R4<br>On September 23, 2025, at 7:22 a.m., ULP-E set up medications for administration for R4, which included a lidocaine patch (pain patch) and diclofenac gel (pain gel). R4 was standing next to the medication cart in the common area with three other residents present; one of which was sitting on a couch watching ULP-E and R4. ULP-E gave R4 her oral medications, and then | 02410 | | |

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| 02410 | Continued From page 30<br><br>lifted R4 shirt exposing her back up to the bra line and placed the lidoderm patch on the lower back. ULP-E then asked R4 to go into the laundry room to apply the diclofenac to R4's hip.<br><br>R4 was admitted on July 28, 2025, and their diagnoses included dementia, anxiety, fibromyalgia (chronic disorder characterized by widespread pain and other symptoms such as fatigue), and osteoarthritis (a degenerative joint disease that causes pain in the joints). R4 resided in the secured unit within the facility.<br><br>R4's service plan dated July 29, 2025, indicated R4's services included assistance with ADLs, activities, and medication administration.<br><br>R4's Minnesota Assisted Living Bill of Rights was signed by R4's POA on July 23, 2025, which included "Residents have the right to respect and privacy regarding the resident's service plan. Case discussion, consultation, examination, and treatment are confidential and must be conducted discreetly. Privacy must be respected during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance."<br><br>The licensee failed to ensure R4 was provided privacy during medication administration.<br><br>On September 24, 2025, at 3:24 p.m., regional director of clinical services (RDCS)-H stated staff should have provided the residents with privacy when administering the cream and patch.<br><br>The licensee's Medication Administration Topical policy dated November 21, 2024, indicated staff were to provide privacy before administration. | 02410 | | |

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|---|---|---|---|---|
| 02410 | Continued From page 31<br><br>The licensee's Personal and Privacy Rights policy dated January 2, 2025, identified:<br>- "All residents have the right to personal and privacy rights at all times, especially during care and treatment. Team members will respect these rights at all times."<br>- "Treatments will not be provided in a common area. Oral medications may be passed in common areas if requested by the resident."<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION:<br>Twenty-One (21) days | 02410 | | |

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164
Phone: 651-201-4500

# Food & Beverage Inspection Report



## Establishment Info

NEW PERSPECTIVE PRIOR LAKE
4685 PARK NICOLLET AVENUE
Prior Lake, MN 55372
Parcel:

Phone:

## License Info

License: HFID 22094

Risk:
License:
Expires on:
CFPM: Michael David Herstine
CFPM #: CFPM-36435; Exp: 03/13/2028

## Inspection Info

Report Number: F1047251179
Inspection Type: Full - Single
Date: 9/23/2025 Time: 10:00 am
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 1
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery: Emailed

! **New Order: 4-700 Sanitizing Equipment and Utensils**
4-703.11B *Priority Level: Priority 1 CFP#: 16*
*MN Rule 4626.0905B* Sanitize food contact surfaces of equipment and utensils after cleaning by using mechanical hot water operations that achieve a utensil surface temperature of 160 degrees F (71 degrees C) and are set up and maintained in accordance with the specifications of NSF International and the manufacturer's data plate.
COMMENT: DISHMACHINE WAS NOT REACHING A UTENSIL SURFACE TEMPERATURE OF 160F- THE HIGHEST TEMPERATURE REACHED AFTER SEVERAL ATTEMPTS WAS 158F. FACILITY STATED THEY ARE GOING TO SPEAK WITH THE CHEMICAL COMPANY AND SEE IF THE MACHINE CAN BE CONVERTED TO A CHEMICAL DISHWASHER INSTEAD OF A HIGH TEMP DISHWASHER.
*Comply By: 9/23/2025 Originally Issued On: 9/23/2025*

# Food & Beverage General Comment

Inspection conducted with operator M. Herstine and reviewed with MDH Nurse Evaluator S. Haag.

The facility has a main commerical kitchen and a small bisto area used only for resident activities.

Discussed hand washing, ware washing, employee illness policy, temperature control, final cook, temperatures, cleaning, serving highly susceptible populations, and food handling procedures.

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

**I acknowledge receipt of the Metro District Office inspection report number F1047251179 from 9/23/2025**

Mike Herstine
Culinary Services Director

Holly Sievers,
Public Health Sanitarian 2
651-201-5946
holly.sievers@state.mn.us

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164

# Temperature Observations/Recordings



## Establishment Info

NEW PERSPECTIVE PRIOR LAKE
Prior Lake
County/Group:

## Inspection Info

Report Number: F1047251179
Inspection Type: Full
Date: 9/23/2025
Time: 10:00 am

**Food Temperature: Product/Item/Unit:** Pasta Salad**; Temperature Process:** Cold-Holding
**Location:** Walk-in Cooler at 40 Degrees F.
Comment:
*Violation Issued?: No*

**Food Temperature: Product/Item/Unit:** Cooked Eggs**; Temperature Process:** Cold-Holding
**Location:** Prep Cooler at 39 Degrees F.
Comment:
*Violation Issued?: No*

**Food Temperature: Product/Item/Unit:** Soup**; Temperature Process:** Hot-Holding
**Location:** Warmer at 192 Degrees F.
Comment:
*Violation Issued?: No*

**Food Temperature: Product/Item/Unit:** Cheese**; Temperature Process:** Cold-Holding
**Location:** Walk-in Cooler at 37 Degrees F.
Comment:
*Violation Issued?: No*

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164

# Sanitizer Observations/Recordings



## Establishment Info

NEW PERSPECTIVE PRIOR LAKE
Prior Lake
County/Group:

## Inspection Info

Report Number: F1047251179
Inspection Type: Full
Date: 9/23/2025
Time: 10:00 am

**Sanitizing Chemical**: **Product:** Quaternary Ammonia**; Sanitizing Process:** Wiping Cloth Bucket
**Location:** Kitchen **Equal To** 400 PPM
Comment:
*Violation Issued?: No*

**Sanitizing Equipment**: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
**Location:** Dishwashing Area **Equal To** 158 Degrees F.
Comment:
*Violation Issued?: No*