Electronically Delivered

March 10, 2025

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

RE: Project Number(s) SL24718016

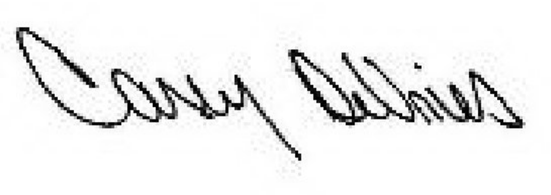
Dear Licensee:

On February 7, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the November 22, 2024, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,



Casey DeVries, Supervisor
State Evaluation Team
Email: casey.devries@state.mn.us
Telephone: 651-201-5917 Fax: 1-866-890-9290

JMD

Electronically Delivered

January 2, 2025

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

RE: Project Number(s) SL24718016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on November 22, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

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

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

St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $3,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

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

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

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

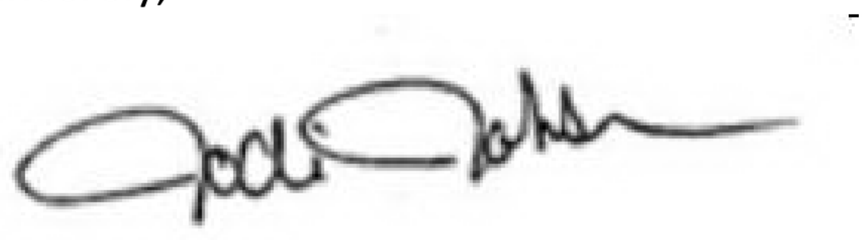
the website listed above.

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

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

If you have any questions, please contact me.

Sincerely,



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

HHH

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 _____	11/22/2024

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 ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL24718016 On November 18, 2024, through November 22, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 120 residents; 80 receiving services under the Assisted Living Facility with Dementia Care license. 2310: An immediate correction order was issued on November 20, 2024, at a level 3/Isolated (G). The licensee took action during the survey to mitigate the risk; however, the citation remains at a G.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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

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0 480	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated November 20, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer	0 480		

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0 480	Continued From page 3 to the FBEIR for any compliance dates.	0 480		
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: Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program that complies with accepted health care, medical and nursing standards for infection control related to glove use and handwashing by one of two unlicensed personnel (ULP-D) observed during medication administration. 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).	0 510		

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0 510	Continued From page 4 The findings include: On November 21, 2024, at 11:20 a.m., ULP-D was observed performing a blood glucose check for R3 in the resident's apartment on the first floor. The surveyor did not observe ULP-D perform hand hygiene prior to entering R3's apartment. ULP-D donned gloves prior to performing the blood glucose check. Once the task was completed, ULP-D exited R3's apartment still wearing the gloves, and returned to the medication cart. ULP-D disposed of the lancet and testing strip in a sharps container and doffed gloves into a waste container. ULP-D did not perform hand hygiene after removing the gloves. ULP-D then documented R3's blood glucose result in the electronic medication administration record (eMAR) and stated would next go to R6's apartment on the second floor to administer medication and check blood sugar. At 11:30 a.m., ULP-D went to the second floor medication cart, and without performing hand hygiene, set up R6's scheduled medication and obtained R6's blood glucose testing supplies. ULP-D entered R6's apartment, administered his medication, then donned gloves and obtained the resident's blood sugar. R6 stated he had not eaten yet; ULP-D then stated she would hold his insulin until after he had eaten. ULP-D exited R6's apartment upon completion and returned to the second floor medication cart still wearing the gloves. ULP-D disposed of the lancet and test strip into a sharps container and doffed the gloves into a waste container. ULP-D documented the medication administration and blood glucose level in the eMAR, then stated she would return to R6's apartment and encourage him to eat lunch. The surveyor asked ULP-D at what point she would wash her hands or perform hand hygiene. ULP-D stated she should have	0 510		

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0 510	Continued From page 5 cleansed her hands after removing gloves for each of the resident's blood glucose checks. On November 22, 2024, at 10:21 a.m., clinical nurse supervisor (CNS)-B stated staff were expected to wash hands or use hand sanitizer when removing gloves following a blood glucose check. The licensee's Hand Washing policy dated October 14, 2024, indicated: Team members will wash hands between resident care and whenever direct physical contact with a resident takes place. The licensee's Use of Gloves policy dated October 14, 2024, indicated: Team members will follow proper glove changing protocols to include: Performing hand hygiene between glove changes. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person	0 630		

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0 630	Continued From page 6 and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan was updated with a change of condition for one of four residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 was admitted to the assisted living with dementia care facility on February 28, 2024, with diagnoses including dementia. R2's Individual Abuse Prevention Plan (IAPP) dated September 4, 2024, indicated the resident was not at risk to abuse other vulnerable adults. Review of R2's progress notes revealed the following: - October 14, 2024, 2:53 p.m., Staff report resident was calling another resident names like "the little demon". She yells at the other resident and says she has no manner and does not belong here. - October 22, 2024, 8:50 a.m., Staff report resident tried hitting another resident when she	0 630		

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0 630	Continued From page 7 walked by her. On November 22, 2024, at 10:21 a.m., clinical nurse supervisor (CNS)-B stated R2's IAPP had not been updated to reflect the risk of abuse to other vulnerable adults, and should have. The licensee's Maltreatment of a Resident policy revised February 28, 2023, indicated: 3. Vulnerable adult assessment a. The individual abuse prevention plan will contain an individual assessment of: i. The person's susceptibility to abuse by other individuals, including other vulnerable adults; ii. The person's risk of abusing other vulnerable adults; and iii. Statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms;	0 780		

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0 780	Continued From page 8 (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the current Minnesota Fire Code Provisions. This had the potential to directly affect all 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) 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 facility tour on November 21, 2024, from 9:45 a.m. through 11:30 a.m., with environmental services director (ESD)-I, the surveyor observed the following:	0 780		

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0 780	Continued From page 9 Trash chute doors in the following locations did not self-close and latch: third floor by fitness area did not self-close or latch, trash chute A2 did not self-close, trash chute B2 did not latch, trash chute B1 did not self-close, kitchen trash chute did not self-close, trash chute A1 did not self-close or latch. Trash chute doors are required to self-close and latch to prevent the spread of fire and smoke into adjoining building areas or floor levels. ESD-I verified the findings and stated they would have the trash chute doors repaired. The two sets of double doors on the second floor by stair C2 and the double doors leading into the second-floor employee break room were labeled as fire-resistant rated for 1 ½ hours and were equipped with magnetic hold-open devices and automatic door closers. When released from the magnets the doors did not automatically close and latch. Fire-resistant rated doors are required to self-close and latch to prevent the spread of fire and smoke into adjoining building areas. ESD-I verified the findings and stated they would adjust the doors. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		
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) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for	0 810		

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0 810	Continued From page 10 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) Staff 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 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. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to conduct the required drills. This had the potential to directly affect all 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) 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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0 810	Continued From page 11 The findings include: On November 21, 2024, at 11:35 a.m., environmental services director (ESD)-I, provided documentation on the fire safety and evacuation training, and evacuation drills for the facility. Record review indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month. During interview on November 21, 2024, at 11:50 a.m., ESD-I stated that the facility conducts evacuation drills every six months. ESD-I stated that they train employees every month. The surveyor explained that evacuation drills are required every other month so employees can practice what they have been trained. ESD-I stated they understood the requirements for conducting evacuation drills. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01060 SS=D	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the	01060		

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01060	Continued From page 12 location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation and failed to notify the Office of Ombudsman for Long-Term Care of the emergency relocation for one of one resident (R2).	01060		

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01060	Continued From page 13 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 was admitted to the assisted living with dementia care facility on February 28, 2024, with diagnoses including dementia. R2's Resident Service Agreement dated September 9, 2024, indicted R2 received services which included medication administration, assistance with bathing, dressing, grooming, toileting, transfers, housekeeping, laundry, and behavior management. R2's After Visit Summary dated July 31, 2024, indicated the resident was hospitalized from July 17, 2024, to July 31, 2024 (14 days). R2's After Visit Summary dated August 7, 2024, indicated the resident was hospitalized from August 3, 2024, to August 7, 2024. R2's progress note dated August 7, 2024, indicated R2 was transferred from the hospital to a skilled nursing facility for short term rehabilitation. R2 returned to the licensee on September 4, 2024 (32 days later). R2's record lacked a written notice that contains, at a minimum: - the reason for the relocation;	01060		

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01060	Continued From page 14 - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for the Office of Ombudsman for Long-Term Care; - if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. In addition, R2's record lacked notification to the Office of Ombudsman for Long-Term Care the resident had been relocated and had not returned to the facility within four days. On November 21, 2024, at 9:36 a.m., licensed assisted living director (LALD)-A stated being unable to find evidence a written notice related to R2's emergency relocations had been completed and provided, and further lacked notification to the Office of Ombudsman for Long-Term Care that the resident had been relocated and had not returned to the facility within four days. The licensee's Transfer and Termination policy revised March 13, 2023, indicated: When a resident is temporarily relocated (transferred) to a hospital or other healthcare setting, the health and wellness director (HWD) or licensed nurse designee will complete and deliver to the resident (their legal representative, designated representative, and/or case worker as applicable) a Notice of Emergency Relocation form as soon as practical. Where possible, the	01060		

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01060	Continued From page 15 Notice of Emergency Relocation form will be sent to these individuals via email. The HWD or designee will also notify the Office of Ombudsman if any resident transferred outside the Community remains out of the community for more than four days. Notice to the Office of Ombudsman is done by faxing completed copies of the Notice of Emergency Relocation and Cover Sheet for Notices to the Office of Ombudsman to the fax number provided in the Cover Sheet for Notices to the Office of Ombudsman. No further information was provided. TIME PERIOD TO CORRECT: Twenty-one (21) days	01060		
01370 SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to	01370		

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01370	Continued From page 16 perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency evaluations were completed as required prior to providing direct care for one of two unlicensed personnel (ULP-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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:	01370		

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01370	Continued From page 17 ULP-D was hired September 27, 2023, to provide direct care services. ULP-D's record lacked evidence of the following competencies had been completed prior to providing direct cares: - appropriate and safe techniques in personal hygiene and grooming, including: -hair care and bathing; -care of teeth, gums, and oral prosthetic devices; -care and use of hearing aids; -dressing and assisting with toileting; and - standby assistance techniques and how to perform them. On November 22, 2024, at 10:21 a.m., licensed assisted living director (LALD)-A reviewed ULP-D's education/competency training form and stated the above trainings were documented as verbal training completed; however, the return demonstration was not. The licensee's Team Member Orientation and Training policy revised January 27, 2023, indicated: Training and competency evaluations to be completed prior to team members providing care services include: Appropriate and safe techniques in personal hygiene and grooming, including: - Hair care and bathing; - Care of teeth, gums, and oral prosthetic devices; - Care and use of hearing aides; and - Dressing and assisting with toileting. Standby assistance techniques and how to perform them. No further information was provided.	01370		

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01370	Continued From page 18 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01380 SS=D	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency evaluations were completed as required prior to providing direct care for one of two unlicensed personnel (ULP-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a	01380		

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01380	Continued From page 19 limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-D was hired September 27, 2023, to provide direct care services. ULP-D's record lacked evidence of the following competencies had been completed prior to providing direct cares: - safe transfer techniques and ambulation - range of motioning and positioning On November 22, 2024, at 10:21 a.m., licensed assisted living director (LALD)-A reviewed ULP-D's education/competency training form and stated the above trainings were documented as verbal training completed; however, the return demonstration was not. The licensee's Team Member Orientation and Training policy revised January 27, 2023, indicated: Training and competency evaluations to be completed prior to team members providing care services include: Safe transfer techniques and ambulation; and Range of motioning and positioning. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must	01500		

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01500	Continued From page 20 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: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (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; (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; (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 (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training 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	01500		

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01500	Continued From page 21 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 challenges it poses to communication; (2) the 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 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 annual training included all required topics for each 12 months of employment for one of one employee (unlicensed personnel (ULP)-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-D was hired September 27, 2023, to provide direct care services.	01500		

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01500	Continued From page 22 On November 19, 2024, at 3:37 p.m., ULP-D was observed administering medication to R8 in the memory care unit. ULP-D's employee record lacked evidence the employee had successfully completed annual training as required, to include the following: - training on reporting of maltreatment of vulnerable adults under section 626.557; - 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; disinfection environmental surfaces; and reporting communicable disease; - 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, and; - the principals of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. On November 22, 2024, at 10:21 a.m., licensed assisted living director (LALD)-A reviewed ULP-D's employee record and stated the above annual trainings had been assigned; however, they had not been completed. The licensee's Team Member Orientation and Training policy revised January 27, 2023, indicated: Per applicable law, all team members performing direct services will receive at least eight hours of annual training for every 12 months of	01500		

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01500	Continued From page 23 employment. Continuing education shall be relevant to the job responsibilities, and will include, at a minimum, each of the following: Training on reporting of maltreatment of vulnerable adults; Review of the assisted living bill of right and team member responsibilities related to ensuring the exercise and protection of those rights; Review of infection control techniques and implementation of infection control standards including; - 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 and environmental surfaces; and - Reporting communicable diseases. 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 disorder; 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 The principles of person-centered planning and service delivery and how they apply to direct support services provided by the team member. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500		

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01530	Continued From page 24	01530		
01530 SS=D	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 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 observation, interview, and record review, the licensee failed to ensure one of one employee (unlicensed personnel (ULP)-C) completed at least two hours of dementia training annually as required. This practice resulted in a level two violation (a violation that did not harm a resident's health or	01530		

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	24718	A. BUILDING: _____ B. WING _____	11/22/2024

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

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01530	Continued From page 25 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: ULP-D was hired September 27, 2023, to provide direct care services. On November 19, 2024, at 3:37 p.m. ULP-D was observed administering medication to R8 in the memory care unit. ULP-D's record lacked at least two hours of training on topics related to dementia for each 12 months of employment as required. On November 22, 2024, at 10:21 a.m., licensed assisted living director (LALD)-A reviewed ULP-D's employee record and stated the above annual dementia training had not been completed. The licensee's Team Member Orientation and Training policy revised January 27, 2023, indicated: Direct-care team members will have at least two hours of annual training for each 12 months of employment on topics related to dementia care. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01530		

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01620	Continued From page 26	01620		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed a comprehensive reassessment not to exceed 90 calendar days from the last assessment, for one of four residents (R4). 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	01620		

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01620	Continued From page 27 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: R4's Resident Service Agreement dated November 16, 2023, indicated R4 received assistance with medication administration, bathing, grooming, dressing, catheter care, laundry, and housekeeping. R1's last three assessments were requested. Assessments dated March 25, 2024, June 26, 2024, and October 3, 2024, were provided. 93 days had passed between the March and June 2024, assessments (3 days late), and 99 days had passed between the June and October 2024, assessments (9 days late). On November 22, 2024, at 10:21 a.m., clinical nurse supervisor (CNS)-B reviewed R4's record and stated the last two comprehensive assessments had been completed late. The licensee's Assessments and Evaluations policy revised September 14, 2023, indicated: 1. A Community registered nurse will conduct an initial individualized and comprehensive assessment, call the Comprehensive Assessment, prior to the initiation of nursing services to determine if the prospective resident's needs can be met by the Community. 2. Additional assessments, reassessments, and evaluations are conducted by a licensed nurse in accordance with the Assessments, Evaluations, and Rosters Schedule: a. Within 14 days of the start of services;	01620		

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01620	Continued From page 28 b. After changes in condition of a resident; and c. No more than 90 days from the most recent assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the	01640		

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01640	Continued From page 29 licensee failed to ensure a written service plan was revised to reflect the current services provided for two of four residents (R1, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 R1's diagnoses included Alzheimer's dementia. R1's provider orders dated October 17, 2024, included an order for oxygen 2 Lpm (liters per minute) three times a day for shortness of breath. Apply oxygen via nasal canula if resident exhibits or states they are short of breath. The order further indicated the resident can refuse oxygen administration. R1's medication administration record (MAR) dated November 2024, included the above treatment orders. R1's Resident Service Agreement dated November 12, 2024, did not include the oxygen administration. On November 19, 2024, at 2:45 p.m., clinical nurse supervisor (CNS)-B stated R1's oxygen therapy was not included on the service agreement as they count that as part of the medication administration task.	01640		

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01640	Continued From page 30 R3 R3's diagnoses included type II diabetes mellitus with diabetic chronic kidney disease. R3's provider orders dated October 16, 2024, included blood glucose checks four times a day. R3's MAR dated November 2024, indicated to check blood sugar level before meals and bedtime. Notify nurse if blood sugar reading is below 70 or above 450. R3's Resident Service Agreement dated August 17, 2024, did not include the blood glucose checks. On November 22, 2024, at 10:21 a.m., CNS-B stated R3's blood glucose checks were not included in the service agreement as they look at it as part of the medication administration task. The licensee's Resident Service Plan policy revised January 16, 2024, indicated: 4. The service plan will: a. Identify the program services, frequency, and approaches the Community will provide under applicable law, to include personal care, supervision, activities, health monitoring, medication administration, behavior management, information and referral, and transportation. 6. The service plan, including any revisions, is maintained in the resident heath record. The service plan is revised an signed by a licensed nurse, Community representative, and the resident and/or the resident's legal representative any time services change based on changes in the resident's need or preferences, and any time the Community's fee schedule changes.	01640		

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01640	Continued From page 31 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01640		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to 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.	01940		

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01940	Continued From page 32 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for one of four residents (R1). 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 November 18, 2024, at 9:50 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided treatment management services to residents, including oxygen therapy. R1's diagnoses included Alzheimer's dementia. R1's provider orders dated October 17, 2024, included an order for oxygen 2 Lpm (liters per minute) three times a day for shortness of breath. Apply oxygen via nasal canula if resident exhibits or states they are short of breath. The order further indicated the resident can refuse oxygen administration. R1's medication administration record (MAR) dated November 2024, included the above treatment orders.	01940		

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01940	Continued From page 33 R1's record lacked a treatment management plan to include the following required content: - procedures for notifying a registered nurse when a problem arose with treatments or therapy services. On November 19, 2024, at 2:45 p.m. clinical nurse supervisor (CNS)-B stated R1's treatment plan did not include direction to staff of when to notify a nurse when problems arose with the resident's oxygen therapy. The licensee's Treatment or Therapy Management Services policy revised March 21, 2023, indicated: 4. After assessment or orders received for treatment or therapy services, the HWD (health wellness director) or licensed nurse will develop and maintain a current individualized treatment and therapy management plan for each resident to include: d. Procedures for notifying an RN (registered nurse) or appropriate licensed health professional when a problem arises with treatment or therapy services. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
02310 SS=G	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards.	02310		

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02310	Continued From page 34 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the care and services were provided according to acceptable health care, medical or nursing standards for one of three residents (R3) with a bed rail. This resulted in an immediate correction order on November 20, 2024. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On November 20, 2024, at 11:47 a.m., R3 stated she had a bedrail attached to her bed. R3 further stated the bedrail helped her get out of bed, and she wouldn't be able too without it. The surveyor and R3's family member (FM)-F (with R3's permission), went into R3's bedroom to observe the bedrail. R3's room was observed to have an upside-down U-shaped assist bar at the head of the bed on the exit side facing towards the door. The bed was near the window but at an angle, so it was not against the wall. The bedrail was slid between the mattress and the bed frame. The mattress was observed to not be flush with the rail and there was approximately a 6-8 inch gap between the mattress and the rail. FM-F stated the mattress would shift, and at times R3 would get caught between the mattress and the rail and	02310		

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02310	Continued From page 35 have to use her pendant to call for staff to help her get up. FM-F then walked around the bed to the side near the window and pushed the mattress over so it was flush against the bedrail. FM-F stated she would need to talk to staff about ensuring the mattress was against the rail. R3's diagnoses included type II diabetes mellitus with chronic kidney disease and history of left hip fracture. R3's Service Plan dated August 17, 2024, indicated R3 received services including medication administration, housekeeping, laundry, toileting, bathing, dressing, and grooming. R3's record included a Negotiated Risk Agreement - Bed Rails/Bed Mobility Devices form signed by R3's power of attorney (POA) on April 25, 2024. R3's record also included an Individualized Bed Rail Assessment dated April 24, 2024. The assessment indicated R3 had a Medline 77301 Halo Safety Ring on the upper right side of the bed. The assessment further indicated the consumer bed rail was installed by a third-party without advance community notification. R3's record also included the manufacturer's instructions for the Halo Safety Ring, which was not the same bedrail that was currently attached to R3's bed. R3's last two Comprehensive Assessments dated August 1, 2024, and August 16, 2024, indicated R3 did not have a bed rail or other device attached to the bed. R3's record lacked: - an assessment for the current bed rail use; - documentation of risk vs. benefits discussion	02310		

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02310	Continued From page 36 with R3 or R3's responsible party; - documentation R3's bed rail was used, installed, and maintained per manufacturer's instructions; and - documentation R3's bed rail was checked for recalls with the Consumer Product Safety Commission (CPSC). On November 20, 2024, at 3:59 p.m., the surveyor and clinical nurse supervisor (CNS)-B entered R3's bedroom to observe the bedrail. CNS-B stated the rail on R3's bed was not the same rail indicated in the assessment that had been completed by the previous CNS. CNS-B asked R3 if she had obtained a different bedrail since moving into her apartment and the resident denied. The Food and Drug Administration's (FDA) A Guide to Bed Safety Bed Rails in Hospitals Nursing Homes and Home Health Care dated June 21, 2006, indicated the following information: "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) last updated April 3, 2024, indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for	02310		

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02310	Continued From page 37 entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, "Documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail; - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Installation and use according to manufacturer's guidelines; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements". Additionally, the MDH website indicated for hospital-style bed rails, the licensee must include in their documentation, the bed rail measurements and that the bed rail has not shifted and is securely attached to the bed frame per manufacturer recommendations. The MDH website also indicated for consumer bed rails, the licensee should refer to the CPSC for the most up-to-date information related to portable bed rail recall information. The licensee's Bed Rails policy revised June 22, 2023, indicated: The Community will perform an assessment of a bed rail: Prior to installation of a bed rail on a resident's	02310		

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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
02310	Continued From page 38 bed; Upon discovery of a new bed rail previously unknown to the Community, to include delivery of a hospital bed with attached bed rails for a resident receiving hospice services; When the type of bed rail is changed or if the bed rail is observed not to maintain a consistent secure attachment to the bed frame; upon a resident's change of condition, and At least every 90 days while bed rail remains in place. Whether installed onto a consumer bed or hospital bed, the Community's assessment of a bed rail will include: The resident's physical and cognitive status as they pertain to the bed rail - to determine the intended purpose of the bed rail and extent of risk for entrapment or falls; The resident's incontinence needs, pain, uncontrolled body movement, and/or ability to transfer in and out of bed without assistance; Consideration of any identified contraindications of resident use set forth in the manufacturer's manual such as resident height, weight, age, and mattress, bed frame set up, etc.; An evaluation of the risk and benefits of the resident's use of the bed rails; and The bed rail's status regarding manufacturer recalls; and whether the bed rail has the effect of being an improper restraint. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate During the survey, the licensee took action to mitigate the immediate risk. However, noncompliance remained, and the scope and level remain unchanged.	02310		

Minnesota Dept. of Health
Division of Environmental Health
Food, Pools, and Lodging
12 Civic Center Plaza, # 2105
Mankato, MN

Type: Full
Date: *11/20/24*
Time: 11:06:28
Report: 1028241039

Food and Beverage Establishment Inspection Report

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

Establishment Info:
ID #: 0019913
Risk: Medium
Announced Inspection: No

License Categories:

Expires on: / /

Operator:
Mankato Ops, LLC

Phone #: 5073857080
ID #: 43909

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.

5-200C Plumbing: Maintenance, fixture location

5-205.11AB ***** Priority 2 *****

MN Rule 4626.1110AB The handwashing sink must be accessible at all times for employee use, and must be used only for handwashing.

The sink in the front area service center of the kitchen must either be designated as a handwashing sink only or the handsoap dispenser must be removed so that employees do not confuse the sink for a handwashing sink when it is not.

Comply By: 11/21/24

4-600 Cleaning Equipment and Utensils

4-601.11C

MN Rule 4626.0840C Clean non-food contact surfaces of equipment and maintain free of accumulations of dust, dirt, food residue, and other debris.

The shelving in the Walk-In Cooler and the shelving in holding utensils just outside of the Walk-In Cooler must be cleaned to remove food residue and grime accumulation.

Comply By: 11/21/24

Surface and Equipment Sanitizers

Hot Water: = at 180 Degrees Fahrenheit
Location: Dish Machine - Rinse
Violation Issued: No

Quaternary Ammonia: = 200ppm at Degrees Fahrenheit
Location: Wiping Cloth Bucket
Violation Issued: No

Type: Full
Date: *11/20/24*
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New Perspective - Mankato

Food and Beverage Establishment Inspection Report

Food and Equipment Temperatures

Process/Item: Upright Cooler
Temperature: 40 Degrees Fahrenheit - Location: True - Ambient
Violation Issued: No

Process/Item: Cold Holding
Temperature: 38 Degrees Fahrenheit - Location: Hot Dogs
Violation Issued: No

Process/Item: Hot Holding
Temperature: 145 Degrees Fahrenheit - Location: Mashed Potatoes
Violation Issued: No

Process/Item: Walk-In Cooler
Temperature: 39 Degrees Fahrenheit - Location: Sliced Tomatoes
Violation Issued: No

Process/Item: Cooling
Temperature: 45 Degrees Fahrenheit - Location: Beef
Violation Issued: No

Process/Item: Hot Holding
Temperature: 165 Degrees Fahrenheit - Location: Vegetable Soup
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	0	1	1

This Inspection was conducted in conjunction with HRD.

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

I acknowledge receipt of the Minnesota Dept. of Health inspection report number 1028241039 of 11/20/24.

Certified Food Protection Manager: Jeffrey M. Morris

Certification Number: FM74603 Expires: 08/16/26

Inspection report reviewed with person in charge and emailed.

Signed: _____

Mariann McCormick
Culinary Services Director

Signed: Ryan Miller

Ryan Miller
Environmental Health Specialist
MDH - Mankato
507-995-7672
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