DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

March 17, 2023

Licensee
New Perspective - Highland Park
750 Mississippi River Boulevard
Saint Paul, MN 55116

RE: Project Number(s) SL20168015

Dear Licensee:

On February 16, 2023, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the December 9, 2022, evaluation were corrected. This follow-up evaluation verified that the facility is in substantial compliance.

It is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. You are encouraged to retain this document for your records.

Please feel free to call me with any questions.

Sincerely,

Jess Schoenecker, Supervisor
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-3789 Fax: 651-281-9796

JMD

Electronically Delivered

January 9, 2023

Licensee
New Perspective - Highland Park
750 Mississippi River Boulevard
Saint Paul, MN 55116

RE: Project Number(s) SL20168015

Dear Licensee:

The Minnesota Department of Health completed an evaluation on December 9, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

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

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

St - 0 - 1640 - 144g.70 Subd. 4 (a-e) - Service Plan, Implementation And Revisions - $3,000.00

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

The total amount you are assessed is $6000.00. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up evaluations. The licensee is not required to submit a plan of correction for approval.

The correction order documentation should include the following:

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

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

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

Please address your cover letter for general reconsideration requests to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

Free from Maltreatment reconsideration requests should be addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both.

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

Sincerely,

Jess Gallmeier, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jess.gallmeier@state.mn.us
Phone: 651-201-3789 Fax: 651-215-9697

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20168	A. BUILDING: _____ B. WING _____	12/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE - HIGHLAND PAR	750 MISSISSIPPI RIVER BLVD SAINT PAUL, MN 55116

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(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: SL20168015 On, December 5, through December 9, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 82 residents; 79 of whom received services under the provider's Assisted Living with Dementia Care license. On December 5, and December 8, 2022, immediate orders were issued for 1640 and 2310, respectively. The immediacy was removed on and December 6, 2022, for 2310 and December 9, 2022, for 1640 prior to the time of exit on December 9, 2022.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and 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 had the potential to affect all 79 residents receiving services. 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 the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report, dated December 6, and December 9, 2022, for	0 480		

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0 480	Continued From page 2 the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post the required information related to the grievance procedure. This had the potential to 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:	0 550		

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0 550	Continued From page 3 On December 5, 2022, at 11:59 a.m., the surveyors toured the facility with licensed assisted living director (LALD)-D. The licensee had a wall mounted sign holder containing the grievance procedure, but the grievance procedure lacked the name, telephone number, and e-mail contact information for the individuals who were responsible for handling resident grievances. The posting was found at main entrance vestibule and right inside memory care. On December 5, 2022, at 12:00 p.m., LALD-D confirmed the posting lacked the above required content and would look into why it wasn't posted. The licensee's Resident Grievances policy dated November 5, 2021, indicated the licensee would provide each resident and/or legal representative the name or title of the person or persons to contact with a grievance/complaint and the method of submitting a grievance to the licensee. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 550		
0 650 SS=E	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training	0 650		

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0 650	Continued From page 4 and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. (b) Each employee record must be retained for at least three years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the employee record contained the required annual performance reviews for one of two employees (director of nursing (DON)-A) and documentation of required training and competency testing for two of three unlicensed employees (unlicensed personnel (ULP)-B, ULP-F). 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 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	0 650		

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0 650	Continued From page 5 occurred repeatedly; but is not found to be pervasive). The findings include: DON-A DON-A was hired on June 5, 2018, and provided supervisory and direct care services to the residents of the facility. DON-A's employee record lacked past and current annual performance reviews. DON-A's employee record included one annual performance review dated January 31, 2020, which was approximately 22 months past due. On December 7, 2022, at 9:23 a.m., licensed assisted living director (LALD)-D stated they were trying to locate annual performance reviews for DON-A. ULP-B ULP-B was hired October 21, 2020, and provided direct care services to residents. ULP-B's employee record lacked the following documentation of required competency training completed by a registered nurse (RN): -documentation requirements for all services provided; -reports of changes in the resident's condition to the supervisor designated by the facility; -basic infection control, including blood-borne pathogens; -maintenance of a clean and safe environment; -appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices;	0 650		

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0 650	Continued From page 6 (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; -training on the prevention of falls; -standby assistance techniques and how to perform them; -basic nutrition, meal preparation, food safety, and assistance with eating; -preparation of modified diets as ordered by a licensed health professional; -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; -awareness of confidentiality and privacy; -understanding appropriate boundaries between staff and residents and the resident's family; -procedures to use in handling various emergency situations; -awareness of commonly used health technology equipment and assistive devices; -observing, reporting, and documenting resident status; -basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; -reading and recording temperature, pulse, and respirations of the resident; -recognizing physical, emotional, cognitive, and developmental needs of the resident; -safe transfer techniques and ambulation; and -range of motioning and positioning. ULP-F ULP-F was hired June 21, 2022, and provided direct care services to residents. ULP-F's employee record included a Care Skills Assessment dated June 21, 2022, but lacked the following documentation of required competency	0 650		

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0 650	Continued From page 7 training completed by a RN: -documentation requirements for all services provided; -reports of changes in the resident's condition to the supervisor designated by the facility; -basic infection control, including blood-borne pathogens; -maintenance of a clean and safe environment; -training on the prevention of falls; -basic nutrition, meal preparation and food safety; -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; -awareness of confidentiality and privacy; -understanding appropriate boundaries between staff and residents and the resident's family; -procedures to use in handling various emergency situations; -observing, reporting, and documenting resident status; -basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; and -recognizing physical, emotional, cognitive, and developmental needs of the resident. On December 6, 2022, at 11:02 a.m., an email was sent to licensed assisted living director (LALD)-D requesting competency training documentation for ULP-B. On December 6, 2022, at 3:36 p.m., an email was sent to LALD-D requesting competency training documentation for ULP-B. On December 7, 2022, at 9:23 a.m., director of nursing (DON)-A stated the trainings were done on a corporate level and they were trying to locate	0 650		

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0 650	Continued From page 8 the documentation. DON-A stated they were aware it was required documentation. On December 7, 2022, at 11:54 a.m., ULP-F stated they had received training in the required competencies by a nurse when hired. On December 8, 2022, at 9:50 p.m., DON-A was shown the missing competencies for ULP-B and ULP-F and confirmed they were missing and were still trying to locate additional documentation. On December 8, 2022, at 11:00 a.m., ULP-B stated she had received training in the required competencies by a nurse when hired. The licensee's Team Member Orientation and Training policy dated November 5, 2021, indicated, " All team members responsible for providing assistance with activities of daily living must complete training prior to assuming their job and delivering services to residents. If any volunteers provide assisted living services to Community residents, they will also receive an orientation to the Community." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by	0 660		

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0 660	Continued From page 9 the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included baseline testing and screening for two of two employees (unlicensed personnel (ULP)-B, director of nursing (DON)-A), further ULP-B lacked TB training required upon hire and annually thereafter. This had the potential to affect all residents, staff and visitors at the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: The facility TB Risk Assessment last completed on January 1, 2022, indicated the facility's risk	0 660		

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0 660	Continued From page 10 level to be low. DON-A DON-A was hired June 5, 2018, and provided direct care services to the residents of the facility. DON-A's employee record lacked required TB documentation for: -TB history and symptom screening: -baseline screening by two-step Mantoux (skin test), blood serum draw, or x-ray; and -TB training upon hire. ULP-B ULP-B was hired October 21, 2021, and provided direct care services to the residents of the facility. ULP-B's employee record lacked required TB documentation for: -TB history and symptom screening; -baseline screening by two-step Mantoux (skin test), blood serum draw, or x-ray; and -TB training upon hire and annually thereafter. On December 7, 2022, at 9:23 a.m., licensed assisted living director (LALD)-D stated they were unable to locate requested TB documentation for DON-A and ULP-B. The licensee's Communicable Disease - Tuberculosis policy dated July 22, 2020, indicated: "-TB training is required at the time of hire for all team members and is provided in the Team Member Orientation (TMO); -TB training is conducted annually for all team members; -conducting baseline communicable disease screening on new team members; -ensuring that TB tests and communicable	0 660		

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NEW PERSPECTIVE - HIGHLAND PAR	750 MISSISSIPPI RIVER BLVD SAINT PAUL, MN 55116

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0 660	Continued From page 11 disease screening results are maintained in team member personnel files and resident TB tests and communicable disease screening results are maintained in the resident health record; -each team member will be tested for TB using the Two-Step Tuberculin Skin Test - Team Members/Volunteers form. -a two-step skin test or single interferon gamma release assay (IGRA) for M. tuberculosis (e.g., QuantiFERON Â® TB Gold or TB Gold-InTube, T-SPOTÂ®.TB) will be administered unless the team member's medical history indicates that a tuberculin skin test is contraindicated. See Tuberculosis Gold Testing- MD Order Request form or other approved form for use as applicable to Community for approved cases only; and -if the team member has been tested using one (1) of the above measures within the previous ninety (90) days, and can provide documentation to support the testing, the Community will not test the team member at that time." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency;	0 680		

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0 680	Continued From page 12 (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to perform an annual review of their written emergency preparedness (EP) plan and failed to post the EP plan prominently. In addition, the licensee failed to perform the monthly load test runs and weekly inspections of the emergency power generator to meet the requirements outlined under NFPA 110, (referenced under the Code of Federal Regulations, title 42, section 483.73) as part of the facility's emergency plan required under Minnesota Rules, Part 4659.0100, to ensure proper performance of the generator. This had the potential to 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, but was not likely to	0 680		

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0 680	Continued From page 13 cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee's Emergency Preparedness and Response Program policy/procedure dated September 14, 2021, lacked the following required content: POSTING On December 5, 2022, at 11:54 a.m., during the entrance tour with licensed assisted living director (LALD)-D, the surveyor observed the EP plan behind the front desk of the lobby. LALD-D stated the EP plan could be requested by anyone to view and was also in the nursing office which was on the 3rd floor. LALD-D acknowledged it was not prominently posted and available for anyone. In addition, LALD-D stated the front desk was only staffed during business hours. LALD-D stated the EP plan was also available in the nursing office. EMERGENCY GENERATOR On December 5, 2022, at approximately 4:45 p.m., survey staff requested records relating to the emergency generator inspections, maintenance, and load test runs for review from the maintenance director (DES)-I. Further document review indicated the licensee failed to provide the required minimum frequency of weekly inspection records and the monthly load test runs of the emergency power generator as outlined under NFPA 110 as part of the facility's emergency plan to ensure proper performance of the generator. The DES-I provided a "TEL"	0 680		

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0 680	Continued From page 14 system printout of the monthly generator exercise entries from the logbook and the records noted as "(with no load test)". In addition, the documentation showed monthly routine inspection checks were performed rather than weekly inspections. At approximately 5:30 p.m., LALD-D and the DES-I acknowledged the findings. REVIEWED ANNUALLY On December 8, 2022, at 11:43 a.m., LALD-D was emailed questioning if the EP plan's front page dated September 14, 2021, was the last date of annual review. On December 8, 2022, at 12:20 p.m., LALD-D stated they had just completed the annual review last week and provided an updated EP plan front page dated November 28, 2022. LALD-D confirmed the annual review date provided was more than two (2) months overdue. UPDATED LALD INFORMATION On December 8, 2022, the EP plan was reviewed and was not updated with the current LALD's information. The licensee's Emergency Preparedness policy dated March 11, 2022, indicated: "Review the emergency preparedness plan annually and make appropriate updates in the event changes are required before the annual review," and "Post the Community's Disaster Evacuation Plan prominently." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		

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0 700	Continued From page 15	0 700		
0 700 SS=F	144G.43 Subdivision 1 Resident record (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. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure resident records were protected against unauthorized disclosure of written records. This had the potential to affect all residents at the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: On December 5, 2022, at 11:54 a.m., during the entrance tour with licensed assisted living director (LALD)-D, the EP plan was observed behind the front desk of the lobby. LALD-D stated the EP plan could be requested by anyone to view and was also in the nursing office which was on the 3rd floor.	0 700		

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0 700	Continued From page 16 On December 7, 2022, the licensees EP plan was reviewed and protected resident information was identified near the front of the EP plan in plastic sleeves. The forms titled, "Current Resident by Apartment," contained resident names, apartment numbers and the date of birth off all facility residents. Some resident names were highlighted in yellow which indicated, "When name is highlighted, redirect them from going outside without an escort." The licensee's Personal and Privacy Rights policy dated March 16, 2022, indicated, "The community will protect and keep confidential personal information for each resident." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 700		
0 730 SS=E	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records;	0 730		

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0 730	Continued From page 17 (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to ensure records included documentation of services provided as identified in the service plan for three of five residents (R6, R8, R10). This practice resulted in a level two violation (a	0 730		

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0 730	Continued From page 18 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R6 R6's diagnoses included memory deficit following nontraumatic subarachnoid hemorrhage (stroke). R6's records indicated R6 received assistance with bed mobility, bathing, toileting and transfers. R6's record lacked documentation of services provided for all services during the evening shifts of November 12-13, all services during the morning shift of November 22, all services during the overnight shifts of November 3,18 and 27 and all services during the evening shift of December 3, 2022. R8 R8's diagnosis included Alzheimer's Disease. R8's service plan dated July 7, 2022, indicated R8 received assistance with dressing, bowel management, catheter care, skin monitoring and mobility. R8's record lacked documentation of services provided including but not limited to assistance with dressing, bowel management, catheter care, skin monitoring, falls management, cognition cues and mobility on the following dates: November 3, 5, 12-13, 18, 25, 28, and December	0 730		

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0 730	Continued From page 19 4, 2022, on various shifts. R10 R10's diagnoses included Parkinson's Disease. R10's service plan dated July 21, 2022, indicated R10 received assistance with reminders to use walker, dressing, grooming, toileting and transfer assistance. R10's record lacked documentation of services provided including but not limited to assistance with bowel tracking, dressing, grooming, transfer assistance, skin monitoring and mobility: November 4-5, 7, 11-13, 19, and 26, 2022, on various shifts. On December 7, 2022, at 9:23 a.m., licensed assisted living director (LALD)-D and director of nursing (DON)-A both stated they get notifications from their documentation software if services were not documented, they then follow up with staff to find out why the documentation had not occured. LALD-D and DON-A both stated the documentation software should have notified them of the missed documentation. The licensee's Health Record Standards policy dated November 5, 2021, indicated, "Have documentation entries that include the date (month, day, and year) time of the entry (to include am or pm or use of military time), and the writer ' s full signature, license designation, as applicable, and title (e.g., Susie Simon, RN, HWD)." Further, "A late entry should be documented in the health record, either electronically in the paper chart if EHR is unavailable, as soon as possible after identifying an omission in documentation"	0 730		

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0 730	Continued From page 20 TIME PERIOD FOR CORRECTION: Seven (7) days	0 730		
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; (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 provide working smoke alarms in resident apartment units 103 and 228 and the interconnection of the required smoke alarms for the one-bedroom and two-bedroom apartment units located throughout the facility. This has the	0 780		

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0 780	Continued From page 21 potential to directly affect 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: On December 5, 2022, approximately from 12:45 p.m. to 4:45 p.m. survey staff toured the facility with the director of environmental services (DES)-I. During the tour, survey staff observed and the DES-I verified the following: 1) Inside the resident living unit 103, the smoke alarm located inside the bedroom failed to sound when the DES-I tested the alarm. 2) The smoke alarms in each apartment unit (one-bedroom and two-bedroom apartment units) throughout the facility were not interconnected so the actuation of one alarm causes all alarms in the unit to sound. The finding was evident as the DES-I tested each smoke alarm in each of the one-and two-apartment units and each alarm sounded local and failed to sound the other smoke alarm in the unit for proper notification. The DES-I verified the finding and stated that smoke alarms inside the sleeping rooms were installed later based on the wires and conduits routing to the floor rather than the ceiling. On December 5, 2022, at approximately 5:30 p.m., during the exit interview, the DES-I and the licensed assisted living director (LALD)-D	0 780		

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0 780	Continued From page 22 acknowledged the above findings. On December 7, 2022, at approximately 9:30 a.m. nurse survey staff interviewed resident R9 in room 228 and observed a smoke alarm sitting on the resident ' s dresser. Survey staff notified the LALD-D. In addition, survey staff also followed up with the DES-I and he confirmed it has re-installed the smoke alarm back up. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty (21) days	0 780		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment of the facility in a continuous state of good repair and operation. This has the potential to directly affect the health, safety, and well-being of all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a	0 800		

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0 800	Continued From page 23 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). On December 5, 2022, approximately from 12:45 p.m. to 4:45 p.m. survey staff toured the facility with the director of environmental services (DES)-I. During the tour, survey staff observed and the DES-I verified the following: 1) In apartment unit 309 (employee breakroom), the carpet flooring was soiled and dirty. 2) In unoccupied unit 330, the toilet trap was completely dried out which would allow sewer gas to enter the building environment creating unsafe and health risks to residents and employees. 3) The ceiling in the housing-keeping room for the third floor had penetrations that need to be sealed. 4) The ceiling in the memory care mechanical room had penetrations that need to be sealed to maintain the fire rating of the room. 5) In resident units 115 and 226, the bathroom exhaust fans were not working. 6) A portion of the corridor wall sheetrock located near the blue pull station (NW door) was compromised and needed to be repaired to maintain the smoke rating of the corridor. 7) Apartment unit 228 and the 1st-floor sunroom located under the 2nd-floor balcony were closed off due to extensive water damage from the balcony. The DES-I explained they had water intrusion from the 2nd-floor balcony that caused significant water damage to unit 228 and the sunroom which is located beneath the balcony. The DES-I also stated that they have received bids from contractors and that the repair was underway. 8) The exhaust fan located in the 2nd-floor	0 800		

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0 800	Continued From page 24 laundry room was not working. 9) In resident apartment unit 222, the kitchen faucet had a slow drip. On December 5, 2022, at approximately 5:30 p.m., during the exit interview, the DES-I and the licensed assisted living director-D acknowledged the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the	0 810		

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NEW PERSPECTIVE - HIGHLAND PAR	750 MISSISSIPPI RIVER BLVD SAINT PAUL, MN 55116

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0 810	Continued From page 25 proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on document review and interview, the licensee failed to provide all required content on the fire safety and evacuation plan. This has the potential to directly affect the safety of all residents receiving care, 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: On December 5, 2022, at approximately 4:45 p.m., survey staff received and reviewed the fire safety and evacuation documentation, evacuation drill, and training documentation provided by the licensed assisted living director (LALD)-D and director of environmental services (DES)-I. A documentation review and interview were performed with the LALD-D and DES-I at approximately 4:45 p.m. indicating the plan documentation lacked complete procedures to	0 810		

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0 810	Continued From page 26 include employee actions to be taken in the event of a fire or similar emergency by calling 911. In addition, the documentation did not have the identification of unique or unusual resident needs for movement or evacuation for resident movement, evacuation, or relocation during a fire or similar emergency. Survey staff explained to the LALD-D and the DES-I that unique resident situations must be considered during an evacuation including residents with mobility limitations, cognitive impairment, deaf or blind, or any residents needing assistance including movement and evacuation that must be addressed in the fire safety and evacuation plan. Additional resident handbook documentation was provided via email on December 6, 2022, at 11:39 a.m. from the LALD-D. On December 5, 2022, at approximately 5:30 p.m., during the exit interview, the LALD-D and DES-I acknowledged the above findings and agreed to update their fire safety and evacuation plan to reflect the requirements. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 970 SS=C	144.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a	0 970		

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0 970	Continued From page 27 lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the licensee's liability for health, safety, or personal property of a resident. This had the potential to effect five of five residents (R2, R3, R4, R5, R6) receiving services. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On December 6, 2022, Resident Agreements were reviewed for R2, R3, R4, R5, and R6 which contained waivers of liability. On December 7, 2022, at 9:23 a.m., licensed assisted living director (LALD)-D stated the waiver reviewed was their old waiver and the Resident Agreements contain an addendum with a change of language. The licensee's Resident Agreement addendum, "Section VI: General Terms," included the following language indicating waivers of liability: "Hold Harmless. Resident understands and agrees to assume the risks inherent in this Agreement and to hold Community, and its	0 970		

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0 970	Continued From page 28 associates and agents harmless for any damages, injury, or other loss resulting from: (1) reasonable omissions or acts made in good faith; (2) theft or other action by a third-party; (3) damages caused by fire, water, or the elements; and (4) loss of personal property." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01470 SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of	01470		

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01470	Continued From page 29 Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology 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 one of two employees (unlicensed personnel (ULP)-B) received orientation to all required assisted living regulation content. This practice resulted in a level two violation (a	01470		

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01470	Continued From page 30	01470		

violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally).

The findings include:

ULP-B was hired October 21, 2020, and provided direct care services to the residents of the facility.

ULP-B's employee record lacked documentation of orientation for the following:
-review of provider policies and procedures;
-reporting maltreatment and vulnerable adults or minors;
-Assisted Living Bill of Rights;
-handling resident complaints, reporting complaints, where to report;
-consumer advocacy services; and
-review of types of assisted living services the employee will provide and providers scope of license.

On December 6, 2022, at 11:02 a.m., an email was sent to licensed assisted living director (LALD)-D requesting orientation documentation for ULP-B.

On December 6, 2022, at 3:36 p.m., an email was sent to LALD-D requesting orientation documentation for ULP-B.

On December 7, 2022, at 9:23 a.m., LALD-D stated they were trying to locate ULP-B's orientation documentation and were aware it was required.

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01470	Continued From page 31 On December 7, 2022, at 2:15 p.m., additional orientation training documentation was provided by LALD-D for ULP-B but was a duplicate of what had already been provided. On December 8, 2022, at 11:00 a.m., ULP-B stated she had received orientation training when hired. The licensee's Team Member Orientation and Training policy dated November 5, 2022, indicated: "Orientation conducted prior to all team members performing job duties will consist of TMO: NP Orientation, TMO: Care Skills, TMO: Understanding Dementia, role-specific onboarding (to include the team member ' s job description and an organizational chart), and specific resident orientation. It will include: -overview of regulatory training requirements; -introduction and review of the Community ' s policies and procedures related to the provision of assisted living services; -handling of emergencies and use of emergency services; -compliance with and reporting of maltreatment of vulnerable adults to the Minnesota Adult Abuse Reporting Center (MAARC); -assisted living bill of rights and team member responsibilities related to ensuring the exercise and protection of those rights; -principles of person-centered planning and service delivery and how they apply to direct support services provided by the team member; -handling of residents' complaints, reporting of complaints, and where to report complaints; -consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care	01470		

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01470	Continued From page 32 Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and -review of the types of assisted living services the team member will be providing and the Community ' s category of licensure, as documented in the Uniform Disclosure of Assisted Living Services and Amenities." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01500 SS=D	144G.63 Subd. 5 Required annual training (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: (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;	01500		

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01500	Continued From page 33 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 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 employees received at	01500		

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01500	Continued From page 34 least eight (8) hours of annual training for each 12 months of employment for two of two employees (unlicensed personnel (ULP)-B, director of nursing (DON)-A). In addition, the licensee failed to include all required training topics for the annual training. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: DON-A DON-A was hired on June 5, 2018, and provided supervisory and direct care services to the residents of the facility. DON-A's employee record lacked documentation of required annual trainings for the following: -eight (8) hours of annual training in required topics, only two (2) hours were documented; -infection control techniques; and -review of provider policies and procedures. ULP-B ULP-B was hired October 21, 2020, and provided direct care services to the residents of the facility. ULP-B's employee record lacked documentation of required annual trainings for the following: -eight (8) hours of annual training in required topics, only two (2) hours were documented; -infection control techniques; and -review of provider policies and procedures.	01500		

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01500	Continued From page 35 On December 6, 2022, at 11:02 a.m., an email was sent to licensed assisted living director (LALD)-D and requested annual training for infection control and provider policies and procedures for DON-A and ULP-B. On December 6, 2022, at 3:36 p.m., an email was sent to LALD-D and requested annual training for infection control and provider policies and procedures for DON-A and ULP-B. On December 7, 2022, at 9:23 a.m., LALD-D stated they were trying to locate DON-A and ULP-B's annual training documentation and were aware it was required. The licensee's Team Member Orientation and Training policy dated November 5, 2021, indicated: "Per applicable law, all team members performing direct services will receive at least eight (8) hours of annual training per 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: -training on reporting of maltreatment of vulnerable adults; -review of the assisted living bill of rights 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,	01500		

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01500	Continued From page 36 needles, syringes, and razor blades; -disinfecting reusable equipment and environmental surfaces; -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 disorders; -review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; -the principles of person-centered planning and service delivery and how they apply to direct support services provided by the team member; and -evidence that each team member has completed annual training, to include a copy of results of any testing, will be maintained in the team member ' s personnel file, with a copy being given to the team member." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		
01540 SS=F	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial	01540		

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01540	Continued From page 37 eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the required eight (8) hours of dementia care training was completed for direct-care employees within 80 hours of employment start date for one of two employees (unlicensed personnel (ULP)-B). Further, the licensee failed to ensure the required two (2) hours of annual dementia care training for each 12 months of employment was completed for direct-care employees in the required time frame for one of two employees (director of nursing (DON)-A). 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: DON-A DON-A was hired on June 5, 2018, and provided supervisory and direct care services to the	01540		

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01540	Continued From page 38 residents of the facility. DON-A's employee record lacked documentation of the required two (2) hours of annual dementia care training for each 12 months of employment. DON-A's employee record had 1.25 hours of documented annual dementia care training. ULP-B ULP-B was hired October 21, 2020, and provided direct care services to the residents of the facility. ULP-B's employee record lacked documentation of the required eight (8) hours of dementia care training to be completed within 80 hours of employment start date. ULP-B employee record had zero (0) hours of documented annual dementia care training On December 6, 2022, at 11:02 a.m., an email was sent to licensed assisted living director (LALD)-D which requested dementia care training documentation for ULP-B. On December 6, 2022, at 3:36 p.m., an email was sent to LALD-D which requested dementia care training documentation for ULP-B. On December 7, 2022, at 9:23 a.m., LALD-D stated they were trying to locate DON-A and ULP-B's dementia care training documentation and were aware it was required. The licensee's Team Member Orientation and Training policy dated November 5, 2021, indicated: "-direct-care team members will have completed at least eight (8) hours of initial training on the below topics upon hire, within 80 working hours of the employment start date; and	01540		

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	20168	A. BUILDING: _____ B. WING _____	12/09/2022

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NEW PERSPECTIVE - HIGHLAND PAR	750 MISSISSIPPI RIVER BLVD SAINT PAUL, MN 55116

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01540	Continued From page 39 -supervisors of direct-care team members will have at least two (2) hours of annual training per 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	01540		
01640 SS=G	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. (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:	01640		

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01640	Continued From page 40 Based on observation, interview, and record review, the licensee failed to implement and provide all services within the service plan for one of one resident (R8). 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 December 7, 2022, at 9:10 a.m., the surveyor observed R8 lying in bed on left side. Upon R8 rising, unlicensed personnel (ULP)-C removed the catheter leg bag (bag that holds urine which is attached by two elastic straps below knee and around upper ankle) on R8's left leg. The leg bag contained approximately 200 milliliters of dark yellow urine. ULP-C placed a new leg bag to R8'a left lower leg then proceeded to perform morning cares in bathroom. On December 8, 2022, at 8:24 a.m., the surveyor observed R8 lying in bed with the leg bag attached to the lower part of the right leg. R8 admitted to the licensee on July 7, 2022. R8's diagnoses included Alzheimer's disease, Brown-Sequard syndrome (lesion in the spinal cord causing weakness or paralysis), history of urinary tract infections, anxiety, and history of falling.	01640		

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01640	Continued From page 41 R8's signed Resident Service Agreement dated July 7, 2022, indicated R8 received catheter assistance with instructions to "empty catheter 4-7x daily," and "AM change from night bag to day bag. Empty contents, rinse with water/vinegar, drain, rinse, hand in bathroom, and PM change from day bag to night bag. Empty contents, rinse with water/vinegar, rinse, hand in bathroom." R8's Comprehensive Assessment (MN) dated October 6, 2022, identified R8 needed assistance with all activities of daily living including mobility, dressing, toileting, catheter care, and medication management. R8's prescriber's order dated July 21, 2022, indicated R8 was prescribed ciprofloxacin 250 milligram (mg) tablet twice a day for seven days for a urinary tract infection. R8's prescriber's order dated October 6, 2022, indicated R8 was discharged from the hospital with an order for cefpodoxime 200 mg tablet by mouth two times a day for five days for urinary tract infection. R8's prescriber's order dated October 18, 2022, indicated R8 was prescribed cephalexin 250 mg capsule by mouth daily for recurrent urinary tract infection. During an interview with R8 on December 7, 2022, at 8:45 a.m., R8 expressed feeling confused and would repeat questions to the surveyor which were already asked and answered. During an interview on December 7, 2022, at 9:00 a.m., ULP-C and ULP-E (who work the morning	01640		

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01640	Continued From page 42	01640		

shift) observed the leg bag on R8 and were unaware whether the overnight staff changed the bag from an overnight bag to a leg bag prior to the start of their shift.

During an interview on December 7, 2022, at 11:54 a.m., ULP-F (who works the evening shift) indicated when R8 goes to bed, the urine is emptied from the leg bag then R8 is placed into bed without changing the bag to an overnight bag. ULP-F indicated they were trained on the expectations of catheter care.

During an interview on December 7, 2022, at 3:42 p.m., ULP-G (who works the overnight shift) indicated "R8 sleeps with the leg bag on the leg all the time." She had not seen R8's catheter bag hooked to the bed. ULP-G indicated they must wake R8 to bring leg over to edge of bed to empty leg bag. ULP-G indicated they were taught by other ULPs and did not know the requirements of catheter care.

During an interview on December 8, 2022, at 9:40 a.m., director of nursing (DON)-A was unaware that ULP-F was not changing the leg bag to an overnight bag during the evening shift when assisting R8 to bed. DON-A was not notified by any ULP of the issue mentioned above. DON-A later provided the most recent urinary catheter training dated September 2022, where it was not documented that ULP-C, ULP-E, ULP-F, or ULP-G attended.

The licensee's undated Changing Catheter Drainage Bag procedure indicated, "transitioning from bedside (day use) to leg (night use) [sic], and back to bedside bags." (A bedside urinary catheter drainage bag is used when a resident is in bed and is placed at a level below the

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01640	Continued From page 43 resident's bladder to prevent the urine from flowing back into the bladder. A leg bag is used when a resident is out of bed and moving around; it can be easily concealed under clothing to provide dignity and privacy. Use of a leg bag in bed allows for the potential of urine to flow from the bag back into the bladder and can lead to infection.) The licensee's Resident Service Plan policy dated November 5, 2022, indicated team members that are responsible for the delivery of care will sign to attest that the care was completed, and if necessary, any exceptions to care will be documented and communicated immediately to the nurse on duty. TIME PERIOD FOR CORRECTION: Immediate Immediacy is removed as confirmed by review by evaluation supervisor on December 6, 2022, however noncompliance remains at a scope and severity of G. TIME PERIOD FOR CORRECTION: Seven (7) days	01640		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and	02040		

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02040	Continued From page 44 (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on the document review and interview, the licensee failed to develop a hazard vulnerability or safety risk assessment plan to identify hazard vulnerabilities and mitigations on and around the property to protect memory care residents from harm. This has the potential to directly affect staff, visitors, and all memory care residents receiving assisted living services. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client'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 clients). The findings include: On December 5, 2022, at approximately 4:45 p.m., survey staff received and reviewed the facility ' s hazard vulnerability assessment plan (undated) from the licensed assisted living director (LALD)-D and the director of environmental services (DES)-I. Document review indicated the following: 1) The licensee had not performed a site-specific safety risk assessment on and around the property to identify vulnerabilities to protect the memory care residents from harm. This finding was evident as the undated assessment	02040		

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02040	Continued From page 45 documentation did not include site-specific safety risks. 2)The plan documentation did not include mitigations to protect memory care residents from harm. Prevention measures to mitigate risks from the identified potential hazard and vulnerability assessment must be developed and documented in the plan. On December 5, 2022, at approximately 5:30 p.m., during the exit interview, the DES-I and the LALD-D acknowledged the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		
02310 SS=I	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. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care standards, medical or nursing standards for three of three residents (R2, R3, R4) who utilized bed rails. This practice resulted in a level three violation (a violation that harmed a resident's health or safety,	02310		

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02310	Continued From page 46 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 a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R2 On December 5, 2022, at 12:25 p.m., the surveyor observed upper bilateral (two) side rails on R2's hospital bed. Both siderails were raised when bed was unoccupied. R2 admitted January 13, 2022, with diagnoses including fracture to right femur (thigh bone), type two diabetes, weakness, and amnesia. R2's Comprehensive Assessment dated October 31, 2022, indicated R2 utilized shower chair, grab bar, hospital bed, wheelchair and EZ-Stand (lift that lifts resident up and down). R2's Resident Service Agreement signed February 2, 2022, indicated R2 received services including medication management, transfer assistance using EZ-stand, and catheter care. R2's record included a Negotiated Risk Agreement signed on February 4, 2022, by R2's designated representative. R2's medication record but lacked documentation of zone measurements per the Food and Drug Administration (FDA) guidelines for zones of entrapment. On December 5, 2022, at 12:25 p.m., director of	02310		

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02310	Continued From page 47 nursing (DON)-A indicated during nursing assessments, the side rails are not measured to ensure they meet the FDA installation guidelines. R3 On December 5, 2022, at 12:40 p.m., the surveyor observed R3's bed with a grab bar on the right side, which was not attached to the bed and did not have straps to secure it to the bed frame. The grab bar was an upside down "U" shape with rails proceeding between the mattress and box spring. The surveyor grasped the grab bar and noted the grab bar not secured to the bed and was able to pull it out with force. R3 admitted November 19, 2021, with diagnoses including hypo-osmolality and hyponatremia (low sodium levels in the blood), chronic obstructive pulmonary disease (lung disease), spinal stenosis (narrowing of the spine), and alcohol use. R3's Comprehensive Assessment dated September 14, 2022, indicated R3 utilized a grab bar, wheelchair, and scooter. R3's Resident Service Agreement, signed April 6, 2022, indicated R3 received services including medication management, toileting, grooming, bathing and dressing assistance, and transfer with assist of one staff person. The service agreement did not indicate use of grab bar. R3's medical record lacked documentation of education of the risks and benefits associated with the use of grab bar and documentation that R3's grab bar was installed, used, and maintained per manufacturer's guidelines. R4 On December 5, 2022, at 12:35 p.m., the	02310		

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02310	Continued From page 48 surveyor observed a grab bar on the right side of R4's full- or queen-sized bed. The grab bar was in the shape of an upside down "M," shaped with two cross bars in the center of the grab bar. R4 admitted February 23, 2021, with diagnoses of unspecified dementia without behavioral disturbance, restless leg syndrome and reduced mobility. R4's Resident Service Agreement signed July 21, 2022, indicated R4 received services for medication management, activities of daily living, and cognition cues due to periods of confusion. R4's service agreement did not include use of a grab bar. R4's Comprehensive Assessment dated January 7, 2022, indicated R4 utilized a grab bar and front wheeled walker. R4's medical record lacked a side rail assessment, documentation of education of the risks and benefits associated with the use of grab bar, and documentation that R4's grab bar was installed, used, and maintained per manufacturer's guidelines. On December 5, 2022, at approximately 12:40 p.m., DON-A acknowledged bedrails/grab bars are in place for R2, R3, and R4. DON-A stated bedrails are provided by residents' family members and the licensee does not provide grab bars or siderails. DON-A acknowledged the residents' records would not contain measurements of R2's siderail to reduce risk of entrapment or have manufacturers installation guidelines to ensure grab bars are installed, maintain, or used correctly for R3 and R4.	02310		

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02310	Continued From page 49 The FDA "A Guide to Bed Safety" revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe". The licensee's Mobility Assistance/Bed Mobility Devices policy, last reviewed November 5, 2021, indicated the licensed nurse will conduct an initial assessment and re-assessments, via the Resident Bed Mobility Device Evaluation, that will include an evaluation of a resident's ability to safely use any assistive supportive device. The policy also indicates the device must comply with FDA Hospital Bed Guidelines, to include all gaps between the device and mattress not exceeding FDA-approved measurements, or the resident must have a Negotiated Risk Agreement on file pertaining to the device. Additionally, the use of device must be documented in the resident's service plan. No further information provided. TIME PERIOD FOR CORRECTION: Immediate Immediacy is removed as confirmed by review by evaluation supervisor on December 9, 2022, however noncompliance remains at a scope and severity of I. TIME PERIOD FOR CORRECTION: Seven (7)	02310		

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02310	Continued From page 50 days	02310		

Minnesota Department of Health
Division of Environmental Health, FPLS
PO Box 64975
Saint Paul, 55164-0975
651-201-4500

Type: Full
Date: *12/06/22*
Time: 13:22:27
Report: 1023221250

Food and Beverage Establishment Inspection Report

Location:
New Perspective - Highland Par
750 Mississippi River Blvd
St Paul, MN55116
Ramsey County, 62

Establishment Info:
ID #: 0038749
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6516981111
ID #:

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

The following orders were issued during this inspection.

3-300B Protection from Contamination: cross-contamination, eggs

3-302.11A(1) ** Priority 1 **

MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.

OBSERVED RAW ANIMAL FOODS STORED ABOVE READY TO EAT FOODS. RAW FISH WAS STORED OVER COOKED CHICKEN IN THE WALK IN COOLER.

Comply By: 12/06/22

4-500 Equipment Maintenance and Operation

4-501.114C1 ** Priority 1 **

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

MEASURED CHLORINE CONCENTRATION OF DISH MACHINE TOO LOW. SERVICE MACHINE SO THAT IT EFFECTIVELY SANITIZES DISHWARE.

Comply By: 12/06/22

4-300 Equipment Numbers and Capacities

4-302.13B ** Priority 2 **

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

HIGH TEMP DISH MACHINE IN USE BUT NO WAY OF VERIFYING SANITIZATION TEMPERATURE AVAILABLE. DEVICE PRESENT BUT WOULD NOT TURN ON.

Comply By: 12/06/22

4-600 Cleaning Equipment and Utensils

4-601.11A ** Priority 2 **

MN Rule 4626.0840A Equipment food-contact surfaces and utensils must be clean to sight and touch.

OBSERVED ACCUMULATION OF DRIED FOOD DEBRIS ON TABLE MOUNTED CAN OPENER. EQUIPMENT MUST BE WASHED/RINSED/SANITIZED AFTER USE AND STORED CLEAN.

Comply By: 12/06/22

2-100 Supervision

2-102.12DMN

MN Rule 4626.0033D Post the certified food protection manager certificate.

NO CFPM CERTIFICATE POSTED.

Comply By: 12/06/22

Surface and Equipment Sanitizers

Hot Water: = at 164 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Chlorine: = 100PPM at Degrees Fahrenheit
Location: 3 COMP DISPENSER
Violation Issued: No

Chlorine: = 10PPM at Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: Yes

Food and Equipment Temperatures

Process/Item: Cold Hold/CUT TOMATO
Temperature: 39 Degrees Fahrenheit - Location: PREP COOLER
Violation Issued: No

Process/Item: Cold Hold/MILK
Temperature: 41 Degrees Fahrenheit - Location: REACH IN COOLER
Violation Issued: No

Process/Item: Cold Hold/FISH
Temperature: 39 Degrees Fahrenheit - Location: WALK IN COOLER
Violation Issued: No

Process/Item: Cold Hold/BUTTER
Temperature: 40 Degrees Fahrenheit - Location: REACH IN COOLER (MEMORY CARE)
Violation Issued: No

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

THIS INSPECTION WAS CONDUCTED IN CONJUNCTION WITH MDH HEALTH REGULATORY DIVISION (HRD) SURVEY. INSPECTION CONDUCTED IN PRESENCE OF THE PERSON IN CHARGE. ALL VIOLATIONS WERE DISCUSSED WITH PERSON IN CHARGE AND HRD EVALUATOR DURING INSPECTION. FOR CORRECT BY DATES REFER TO COMPLETE REPORT ISSUED BY HRD.

Food and Beverage Establishment Inspection Report

THIS FACILITY CONSISTS OF A MAIN KITCHEN AREA WITH TYPE I HOOD/ANSUL AND PREP SINK. FOOD SERVICE IS PROVIDED BY FACILITY STAFF.

THESE TOPICS WERE DISCUSSED WITH THE PERSON IN CHARGE:
- EMPLOYEE ILLNESS EXCLUSION
- HAND WASHING PROCEDURE
- NO BARE HAND CONTACT WITH RTE FOOD
- FOOD COOLING METHODS
- VOMIT CLEAN UP PROCEDURE
- FULLY COOKING FOOD FOR HIGH RISK POPULATIONS
- PASTEURIZED SHELL EGGS

RAW SHELL EGGS MUST BE FULLY COOKED. IF EGGS ARE SERVED UNDERCOOKED PASTEURIZED EGGS MUST BE USED.

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1023221250 of 12/06/22.

Certified Food Protection Manager: HABETMARIAM DESTA

Certification Number: 111049 Expires: 12/30/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
HABETMARIAM DESTA
PERSON IN CHARGE

Signed: Gregory T Nelson
Gregory T. Nelson
Public Health Sanitarian
Freeman Building
651-201-4259
greg.nelson@state.mn.us