Electronically Delivered

November 5, 2025

Licensee
New Perspective - Faribault
828 1st Street Northeast
Faribault, MN 55021

RE: Project Number(s) SL30225016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on October 15, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

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

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

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

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00
St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $500.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $1,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

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

factor.

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

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

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

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

If you have any questions, please contact me.

Sincerely,

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

CLN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30225	A. BUILDING: _____ B. WING _____	10/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE - FARIBAULT	828 1ST STREET NE FARIBAULT, MN 55021

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0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL30225016-0 On October 13, 2025, through October 15, 2025, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were 50 residents; 48 receiving services under the Assisted Living Facility with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. 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.	
0 420 SS=F	144G.40 Subdivision 1 Responsibility for housing and services	0 420		

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0 420	Continued From page 1 The facility is directly responsible to the resident for all housing and service-related matters provided, irrespective of a management contract. Housing and service-related matters include but are not limited to the handling of complaints, the provision of notices, and the initiation of any adverse action against the resident involving housing or services provided by the facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide sufficient management, control, and operation of the housing and services provided by the facility. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee had an assisted living with dementia care license, effective March 1, 2025. The licensee's renewal "Application for Assisted Living License", section titled "Official Verification of Owner or Authorized Agent", (page four and five of the application), identified an affirmative checkmark next to the statement, "I declare that, as the owner or authorized agent, I attest that I	0 420		

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0 420	Continued From page 2 have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659, governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract." Another checkmark was noted at the statement, "I have examined this application and all attachments, and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct and complete. I will notify MDH, in writing, of any changes to this information as required." Page six was electronically signed by the authorized agent on December 23, 2024. As a result of this survey, the following orders were issued under 0480, 0510, 0630, 0660, 0680, 0690, 0730, 0775, 0800, 0810, 0830, 0970, 1380, 1540, 1640, 1650, 1730, 1790, 1940, 1960, 1970, 2170, which indicated the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.01 to 144G.95. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 420		
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 3 (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 4 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) 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 document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated October 14, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.	0 480		

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0 480	Continued From page 5 TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program that complies with accepted health care, medical and nursing standards for infection control related to glove use and handwashing during blood sugar checks by one of two employees (unlicensed personnel (ULP)-E). This had the potential to affect all residents receiving blood sugar checks. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic	0 510		

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0 510	Continued From page 6 failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On October 14, 2025, at 7:44 a.m., the surveyor observed ULP-E prepare R3's medications and gather R3's diabetic supplies and brought them to R3's room. ULP-E prepared R3's glucometer (device that measures the concentration of glucose (sugar) in a person's blood), wiped R3's left ring finger with an alcohol prep pad, pricked R3's fingertip with a lancet, squeeze R3's finger and placed a drop of blood onto the test strip. ULP-E then administered R3's medications. ULP-E did not wear gloves when she checked R3's blood sugar and did not perform hand hygiene after checking R3's blood sugar. ULP-E brought R3's blood sugar supplies back to the medication cart, disposed of the test strip with blood on it and started to document the blood sugar results and medication administration but was interrupted when another resident called for assistance from down the hallway. ULP-E approached the other resident and assisted her with her wheelchair pedals and escorted her to the dining room for breakfast. ULP-E did not perform hand hygiene during the entire observation noted above. On October 15, 2025, at 10:53 a.m., clinical nurse supervisor (CNS)-B stated staff were expected to wear gloves when performing any task that involved blood and bodily fluids. CNS-B stated the staff were also expected to perform hand hygiene between tasks and in between resident cares. The licensee's Use of Gloves policy dated	0 510		

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0 510	Continued From page 7 November 5, 2021, indicated gloves are to be worn whenever there may be direct contact between a team member's hands and blood, bodily fluids, secretions, feces, or contaminated items. The licensee's Hand Washing policy dated October 14, 2024, team members will wash hands between resident care and whenever direct physical contact with a resident takes place. Use of gloves dos does not replace hand washing. No other information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 630 SS=F	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 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 observation, interview, and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to	0 630		

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0 630	Continued From page 8 include the required content for three of three residents (R1, R2, and 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 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: R1 R1 was admitted on February 19, 2024, with diagnoses that included Alzheimer's disease. On October 14, 2025, at 8:36 a.m., the surveyor observed unlicensed personnel (ULP)-E administer medications to R1. R1's service plan dated September 17, 2025, indicated R1 received services to include vital signs, weights, oxygen saturation checks, oxygen, modified diet, incontinence care, mobility and transfer assistance, dressing, grooming, and bathing. The service plan did not include medication management services. R1's IAPP dated April 30, 2025, included the following information under the category "Risk of Abuse by Others": 1. History of Abuse: Does resident have a history of abuse from others? a. Answer: No 2. Diagnoses Impacting Communication of Abuse: Does resident have diagnoses that make	0 630		

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0 630	Continued From page 9 it difficult to communicate abuse to others? b. Answer: No 3. Dependency on Others for activities of daily living (ADL)s: Does resident receive community assistance with the activities of daily living? c. Answer: Yes 4. Third Parties and ADLs: Does resident receive assistance with the activities of daily living from a non-community third party? d. Answer: No 5. Financial Decision-Making Support: Does resident have others to support with making financial decision? e. Answer: Yes 6. Social Support System: Does resident have a social support system? f. Answer: Yes R1's IAPP did not indicate if R1 was susceptible to abuse by another individual, including other vulnerable adults R2 R2 was admitted on June 28, 2023, with diagnoses that included diabetes. On October 14, 2025, at 7:03 a.m., the surveyor observed ULP-D administer medications to R2. R2's service plan dated August 5, 2025, indicated R2 received services to include vital signs, weights, blood glucose checks, simple dressing change, incontinence care, escorts, dressing, grooming and bathing. The service plan did not include medication management services. R2's IAPP dated April 1, 2025, included the following information under the category "Risk of Abuse by Others":	0 630		

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0 630	Continued From page 10 1. History of Abuse: Does resident have a history of abuse from others? a. Answer: No 2. Diagnoses Impacting Communication of Abuse: Does resident have diagnoses that make it difficult to communicate abuse to others? b. Answer: No 3. Dependency on Others for activities of daily living (ADL)s: Does resident receive community assistance with the activities of daily living? c. Answer: Yes 4. Third Parties and ADLs: Does resident receive assistance with the activities of daily living from a non-community third party? d. Answer: No 5. Financial Decision-Making Support: Does resident have others to support with making financial decision? e. Answer: Yes 6. Social Support System: Does resident have a social support system? f. Answer: Yes R2's IAPP did not indicate if R2 was susceptible to abuse by another individual, including other vulnerable adults. In addition, R2's IAPP indicated R2 had a history of verbal or physical abuse towards others but did not include interventions to minimize abuse to others from R2. R3 R3 was admitted on February 14, 2025, with diagnoses that included Alzheimer's disease. On October 14, 2025, at 7:39 a.m., the surveyor observed ULP-E administer medications to R3. R3's service plan dated September 9, 2025,	0 630		

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0 630	Continued From page 11 indicated R3 received services to include vital signs, weights, blood glucose checks, and simple dressing change. The service plan did not include medication management services. R3's IAPP dated April 9, 2025, included the following information under the category "Risk of Abuse by Others": 1. History of Abuse: Does resident have a history of abuse from others? a. Answer: No 2. Diagnoses Impacting Communication of Abuse: Does resident have diagnoses that make it difficult to communicate abuse to others? b. Answer: No 3. Dependency on Others for activities of daily living (ADL)s: Does resident receive community assistance with the activities of daily living? c. Answer: Yes 4. Third Parties and ADLs: Does resident receive assistance with the activities of daily living from a non-community third party? d. Answer: No 5. Financial Decision-Making Support: Does resident have others to support with making financial decision? e. Answer: No 6. Social Support System: Does resident have a social support system? f. Answer: Yes R3's IAPP did not indicate if R3 was susceptible to abuse by another individual, including other vulnerable adults On October 15, 2025, at 1:10 p.m., clinical nurse supervisor (CNS)-B stated R2's IAPP did not include interventions for the risk of R2 abusing others due to her history of aggression. CNS-B	0 630		

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0 630	Continued From page 12 stated the same IAPP was used for all residents and thought it included the required content including the resident's risk of abuse by others. The licensee's Assessments and Evaluations policy dated June 24, 2025, indicated assessments, reassessments, and evaluations will be conducted by a licensed nurse in accordance with the Assessments and Evaluations schedule. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
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 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	0 660		

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0 660	Continued From page 13 licensee failed to maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included a two-step TST (tuberculin skin test) or other evidence of tuberculosis (TB) screening such as a blood test for two of two employees (unlicensed personnel (ULP)-D and ULP-E). This practice resulted in a level two violation (a violation that did no 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: ULP-D ULP-D was hired on April 24, 2024, to provide direct care and services to the licensee's residents. ULP-D's employee record included a TB Screening dated April 24, 2024; however, it lacked evidence of a two-step TST or other evidence of TB screening such as a blood test. ULP-E ULP-E was hired on September 24, 2024, to provide direct care and services to the licensee's residents. ULP-E's employee record included a TB Screening dated September 24, 2025; however, it lacked evidence of a two-step TST or other evidence of TB screening such as a blood test.	0 660		

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0 660	Continued From page 14 On October 15, 2025, at 10:44 a.m., licensed assisted living director (LALD)-A stated ULP-D and ULP-E's records lacked evidence of a two-step TST or other other evidence of TB screening such as a blood test. The licensee's Communicable Disease-Tuberculosis policy dated March 13, 2023, indicated the licensee would ensure baseline communicable disease screening is completed for new team members and endure TB test and communicable disease screening results are maintained in team members personnel files. 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; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents.	0 680		

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0 680	Continued From page 15 (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency preparedness (EP) plan with all the required content. This had the potential to affect all residents, staff, and visitors of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's Emergency Preparedness and Response Program dated June 5, 2025, was reviewed and lacked the following: - arrangement with other faculties (including sister facilities); - Missing resident policy and evidence the licensee reviewed their Missing Resident plan on a quarterly basis	0 680		

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0 680	Continued From page 16 - policy and procedure that address development of arrangements with other facilities/providers to receive residents in the event of limitations/cessation of operations to maintain the continuity of services to residents; - policy and procedure for a system to track the location of on duty staff and sheltered residents and if on duty staff and sheltered residents are relocated, the facility must document the specific name/location of the receiving facility or other location; - policy and procedure addressing the role of facility under waiver declared by the Secretary in accordance with section 1135 of the ACT; - communication plan must include contact information for the following: MN Office of Ombudsman for LTC, and resident physicians On October 15, 2025, at 1:21 p.m., regional director of operations (RDOO)-C stated the licensee had the missing content listed above and would email them to the surveyor. On October 15, 2025, at 2:22 p.m., RDOO-C emailed the surveyor a copy of the licensee's Missing Residents and Elopement policy dated October 27, 2023; however, it did not include documentation of a quarterly review as required. On October 15, 2025, at 7:22 p.m., licensed assisted living director (LALD)-A emailed the surveyor a copy of the licensee's Mutual Aid Memorandum of Understanding for Evacuation Assistance; however, the document was dated October 15, 2025, which was after the start of survey. The surveyor did not receive any additional documents from the licensee.	0 680		

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0 680	Continued From page 17 The licensee's Emergency Preparedness policy dated February 28, 2022, indicated in an effort to maintain a safe living space for residents and working space for team members, the community will develop a written emergency preparedness plan that meets the health, safety, and security needs of residents and team members, and meets requirements set forth in applicable law. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 690 SS=C	144G.43 Subdivision 1 Resident record (a) Assisted living facilities must maintain records for each resident for whom it is providing services. Entries in the resident records must be current, legible, permanently recorded, dated, and authenticated with the name and title of the person making the entry. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure entries in the resident records were authenticated by the name and title of the person making the entry for three of three residents (R1, R2, R3). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of	0 690		

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0 690	Continued From page 18 the residents). The findings include: R1 R1 was admitted on February 19, 2024, with diagnoses that included Alzheimer's disease. R1's service plan dated September 17, 2025, indicated R1 received services to include vital signs, weights, and oxygen saturation checks. R1's Monthly Weight and Vital Signs record dated September 2025, lacked staff initials, staff names/signature and credentials/title. R2 R2 was admitted on June 28, 2023, with diagnoses that included diabetes. R2's service plan dated August 5, 2025, indicated R2 received services to include vital signs and weights. R2's Monthly Weight and Vital Signs record dated September 2025, included staff initials but lacked staff names/signature and credentials/title. R3 R3 was admitted on February 14, 2025, with diagnoses that included Alzheimer's disease. R3's weight record dated September 2025, lacked staff initials, staff names/signature and credentials/title. On October 15, 2025, at 11:14 a.m., clinical nurse supervisor (CNS)-B stated the staff initials, names and credentials were not included in the	0 690		

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0 690	Continued From page 19 vital sign and weight documents as listed above. CNS-B stated she would add an area to each document to ensure staff authenticated each document as required. The licensee's Health Record Standards policy dated May 9, 2024, indicated documentation entries would include the date (month, day, and year) time of entry (include a.m. or p.m. or use of military time), and the writer's full signature, license designation, as applicable, and title. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 690		
0 730 SS=D	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; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships;	0 730		

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0 730	Continued From page 20 (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 record review, the licensee failed to ensure the resident record included the required documentation of all provided services for one of three 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	0 730		

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0 730	Continued From page 21 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 was admitted on February 19, 2024, with diagnoses that included Alzheimer's disease. R1's service plan dated September 17, 2025, indicated R1 received services to include fall mitigation interventions: check on resident every 2 hours. R1's resident monthly assignment reported dated October 2025, did not include every two-hour safety checks. R1's record lacked documentation of every two-hour safety checks. On October 15, 2025, at 11:11 a.m., clinical nurse supervisor (CNS)-B reviewed R1's record and stated it did not include documentation of safety checks. CNS-B stated she would add this service to R1's tasks to be completed by the staff. The licensee's Health Record Standards policy dated May 9, 2024, indicated the health record will contain all healthcare documentation pertaining to the resident's stay in the community. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		

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0 775	Continued From page 22	0 775		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the current State Fire Code in Minnesota Rules, chapter 7511. 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, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). Findings include: On October 14, 2025, from 11:30 a.m. to 3:30 p.m., the surveyor toured the facility with environmental services director (ESD)-G and licensed assisted living director (LALD)-A. During the tour, the surveyor observed: ESCUTCHEON: It was observed that several sprinkler heads in the 1st floor common hallway, basement common area and Garden memory care were missing escutcheon covers or had open areas around the sprinkler heads. Escutcheon covers	0 775		

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0 775	Continued From page 23 are required to cover the gap between the sprinkler and the ceiling or wall to prevent heat from escaping in other spaces which can delay sprinkler activation and/or spread the fire. FIRE RATED DOORS: Resident rooms, at the facility had fire rated assemblies and rated fire doors. The doors and rated assemblies all show evidence that automatically closing mechanism had been removed. Swinging fire doors shall close from the full-open position and latch automatically. SMOKE ALARMS: Facility has installed hard-wired smoke alarms in each resident room. In the 25+ surveyed rooms alarms were over 10 years past the manufacturer date. Per MN State Fire Code and manufacturer's instructions, single-and multiple-station smoke alarms shall be replaced when they exceed ten years from the date of manufacture. All smoke alarms shall be replaced with smoke alarms having the same type of power supply. CARBON MONOXIDE ALARM: Facility didn't have carbon monoxide alarms in the resident rooms or alarms connected to the fire alarm panel at the source of fuel fire appliances. Mechanical rooms that have fuel fired appliances will be equipped with a carbon monoxide detector connected to the fire alarm panel or each resident living area will have a carbon monoxide alarm in accordance with MN State fire code. CONTROLLED EGRESS: Controlled egress doors in both memory care areas, facility-controlled egress system had a	0 775		

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0 775	Continued From page 24 separate de-activate system that failed to operate. Facility had recently installed a new "fob" entry system that wasn't working with existing override for controlled egress doors. MN Fire code states, egress control locking systems shall have the capability of being unlocked by a signal or switch from the fire command center, a nursing station, or other approved location. The signal or switch shall directly break power to the lock. EXIT OBSTRUCTION: Memory care (Patio) secured patio exit gate was locked with a key-lock. The personnel gate should provide egress to the public way. Gate from the patio failed to lead to the public way During a facility tour on October 14, 2025, at 1:30 p.m., LALD-A and ESD-G, verified the above listed observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Two (2) day.	0 775		
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.	0 800		

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0 800	Continued From page 25 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain 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. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On October 14, 2025, from 11:30 a.m. to 3:30 p.m., the surveyor toured the facility with environmental services director (ESD)-G and licensed assisted living director (LALD)-A. The following was observed: HOLES: Back hall stairwell, basement elevator lobby, basement storage area, attic in memory care electrical room all had areas where drywall was cut and missing from water damage or other projects. Holes can reduce the fire separation allowing the spread of fire. ELECTRICAL PANEL:	0 800		

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NEW PERSPECTIVE - FARIBAULT	828 1ST STREET NE FARIBAULT, MN 55021

(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
0 800	Continued From page 26 Electrical panels in the "patio" memory care area were unlocked. This allowed residents to access breakers and turn on appliances which are normally secured for resident safety reasons. On October 14, 2025, at 1:30 p.m., ESD-G and LALD-A, verified the above listed observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) 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) staff 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) 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	0 810		

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0 810	Continued From page 27 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 observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training. This had the potential to directly affect all residents, staff, and visitors. 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). The findings include: October 14, 2025, Environmental services director (ESD)-G and licensed assisted living director (LALD)-A provided documents on the FSEP, fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP, titled "Fire", undated, failed	0 810		

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0 810	Continued From page 28 to include the following: STAFF ACTIONS: The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate). The provided FSEP was from the corporate office and not written to represent the specific facility. RESIDENT ACTIONS: The FSEP did not identify specific fire protection actions for residents. There was no section in the plan that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. Facility has resident actions in a handbook that they receive upon move in. LALD-A stated they will add those procedures to the FSEP. UNIQUE AND UNUSUAL RESIDENT NEEDS: The facility uses an electronic care plan website for standard resident evacuation procedures. Facility also has resident evacuation status in a separate binder due to HIPAA violations. The FSEP does not include instructions on how to use care plan website or what to do in the loss of power/internet event not was it a staff action to evacuate with binder containing resident information for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. On October 14, 2025, at 1:30 p.m., LALD-A stated they understood the areas of their policy	0 810		

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0 810	Continued From page 29 that were incomplete and would work on bringing them into compliance. TRAINING: The licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. LALD-A stated they use a web-based training for staff upon hire and yearly afterwards, they also use am emergency checklist that ESG-G goes over new staff members. No other training documentation was provided. On October 14, 2025, at 1:30 p.m., LALD-A stated they understood the requirements for training staff and would implement a training program that was compliant with statute requirements. DRILLS The licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month. LALD-A/ ESD-G stated drills had not consistently taken place in the last two years. LALD-A and ESD-G provided documentation for a fire drill on August 7, 2024, November 8, 2024, January 30, 2025, March 3, 2025, April 30, 2025, and September 26, 2025. On October 14, 2025, at 1:30 p.m., LALD-A and ESD-G stated there were no additional documented drills for the facility and would implement fire drills that comply with statute requirements TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		

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0 830	Continued From page 30	0 830		
0 830 SS=F	144G.45 Subd. 3 Local laws apply Assisted living facilities shall comply with all applicable state and local governing laws, regulations, standards, ordinances, and codes for fire safety, building, and zoning requirements, except a facility with a licensed resident capacity of six or fewer is exempt from rental licensing regulations imposed by any town, municipality, or county. This MN Requirement is not met as evidenced by: Based on observation, record review and interview, the licensee failed to comply with all state and local governing laws, and codes for fire safety, building, and zoning requirements. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On October 14, 2025, from 11:30 a.m. to 3:30 p.m., the surveyor toured the facility with environmental services director (ESD)-G and licensed assisted living director (LALD)-A. At the	0 830		

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0 830	Continued From page 31 time of the survey, several rooms in the "Garden" memory care area were under construction along with exterior concrete work. On October 17, 2025, at 10:00 a.m., the surveyor called the City of Faribault building department and confirmed the licensee did not have a recent building permit on file, only an electrical permit. Under MN Statue 144G.45 Subd 6, all new construction beginning on or after August 1, 2021, must submit plans to MDH. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 830		
0 970 SS=C	144G.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 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 affect all residents. This practice resulted in a level one violation (a	0 970		

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0 970	Continued From page 32 violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's Assisted Living Residency Agreement included a clause that indicated the resident would waive the licensee's liability for health, safety, or personal property of the resident. -Page 28 of the agreement indicated: "Force Majeure: Resident shall indemnify and hold harmless Community and all entities and persons affiliated with Community, including its owners, managers, employees, attorneys, vendors, and contractors, from liability, loss, damages, cost, claims, or expenses, including reasonable attorneys' fees, incurred, alleged, or threatened as a result of or in connection with: (i) Resident's actions or omissions that cause injury or damage to any person or property, (ii) Resident's violation of law or this agreement, or (iii) claims asserted by Resident's guest, invitees, or representatives". On October 15, 2025, at 10:47 a.m., licensed assisted living director (LALD)-A reviewed the licensee's Residency agreement and stated it included the above content, and further stated the same contract was utilized for all residents at the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	0 970		

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0 970	Continued From page 33 (21) days	0 970		
01380 SS=F	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 was completed for two of two employees (unlicensed personnel (ULP)-D) and ULP-E to include all required content. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to	01380		

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01380	Continued From page 34 affect a large portion or all of the residents). The findings include: ULP-D ULP-D was hired on April 24, 2024, to provide direct care and services to the facility's residents. ULP-D's employee record lacked evidence of training and competency evaluation for the following topics: -range of motion ULP-E ULP-E was hired on September 24, 2024, to provide direct care and services to the facility's residents. ULP-E's employee record lacked evidence of training and competency evaluation for the following topics: -range of motion On October 15, 2025, at 11:20 a.m., clinical nurse supervisor (CNS)-B reviewed ULP-D and ULP-E's record and stated it did not include training and competency evaluation for range of motion. On October 15, 2025, at 1:17 p.m., regional director of clinical services (RDOCS)-F stated the licensee did not train or competency test any of the employees as the licensee does not offer or provide range of motion services to residents. The licensee's Team Member Orientation and Training policy dated January 27, 2023, indicated training and competency evaluations to be completed prior to team members providing care	01380		

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01380	Continued From page 35 services included range of motion. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		
01540 SS=D	144G.64 (a) (3) Training in Dementia, Mental Illness, and De- (3) for assisted living facilities with dementia care, direct-care staff 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, the staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure two of two employees (unlicensed personnel (ULP)-D and ULP-E	01540		

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01540	Continued From page 36 received the required amount of mental illness, and de-escalation training in the required time frame. 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: The licensee provided services under an Assisted Living with Dementia Care Facility license. ULP-D ULP-D was hired on April 24, 2024, to provide direct care and services to the facility's residents. ULP-D's employee record lacked evidence of completing any mental illness and de-escalation training. ULP-E ULP-E was hired on September 24, 2024, to provide direct care and services to the facility's residents. ULP-E's employee record lacked evidence of completing any mental illness and de-escalation training. On October 15, 2025, at 11:40 a.m., licensed assisted living director (LALD)-A reviewed ULP-D	01540		

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01540	Continued From page 37 and ULP-E's record and stated it did not include the required mental illness and de-escalation training. The licensee's Team Member Orientation and Training policy dated January 27, 2023, indicated per applicable law, all team members providing and supervising direct services must complete their orientation to the community requirements and applicable regulations before providing assisted living services to residents. Evidence that each team member has completed training, to include a copy of results of any testing, will be maintained in team member's personnel file. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01540		
01640 SS=F	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	01640		

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01640	Continued From page 38 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 observation, interview, and record review, the licensee failed to ensure a written service plan was revised to reflect the current services provided for three of three residents (R1, R2, and R3). This practice resulted in a level two violation (a violation that did no 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: R1 R1 was admitted on February 19, 2024, with diagnoses that included Alzheimer's disease. On October 14, 2025, at 8:36 a.m., the surveyor observed unlicensed personnel (ULP)-E administer medications to R1. R1's service plan dated September 17, 2025, indicated R1 received services to include vital signs, weights, oxygen saturation checks, oxygen, modified diet, incontinence care, mobility	01640		

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01640	Continued From page 39 and transfer assistance, dressing, grooming, and bathing. The service plan did not include medication management services. R2 R2 was admitted on June 28, 2023, with diagnoses that included diabetes. On October 14, 2025, at 7:03 a.m., the surveyor observed ULP-D administer medications to R2. R2's service plan dated August 5, 2025, indicated R2 received services to include vital signs, weights, blood glucose checks, simple dressing change, incontinence care, escorts, dressing, grooming and bathing. The service plan did not include medication management services. R3 R3 was admitted on February 14, 2025, with diagnoses that included Alzheimer's disease. On October 14, 2025, at 7:39 a.m., the surveyor observed ULP-E administer medications to R3. R3's service plan dated September 9, 2025, indicated R3 received services to include vital signs, weights, blood glucose checks, and simple dressing change. The service plan did not include medication management services. On October 15, 2025, at 10:55 a.m., clinical nurse supervisor (CNS)-B reviewed R1, R2 and R3's service plans and stated it did not include an area for medication management services. CNS-B stated they used the same service plan template for all residents. The licensee's Resident Service Plan policy	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE - FARIBAULT	828 1ST STREET NE FARIBAULT, MN 55021

(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
01640	Continued From page 40 dated December 29, 2024, indicated the service plan, including any revisions, is maintained in the resident health record. The service plan is revised and 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 needs or preferences, and any tie the community's fee schedule changes. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE - FARIBAULT	828 1ST STREET NE FARIBAULT, MN 55021

(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
01650	Continued From page 41 authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the service plan included all required content for three of three residents (R1, R2, and 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 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: R1 R1 was admitted on February 19, 2024, with diagnoses that included Alzheimer's disease. R1's service plan dated September 17, 2025, indicated R1 received services to include vital signs, weights, oxygen saturation checks, oxygen, modified diet, incontinence care, mobility and transfer assistance, dressing, grooming, and bathing. The service plan did not include medication management services.	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE - FARIBAULT	828 1ST STREET NE FARIBAULT, MN 55021

(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
01650	Continued From page 42 R1's service plan lacked the following content: - the fees for services, frequency of each service; - the schedule and methods of monitoring assessments of the resident; - the schedule and methods of monitoring staff providing services; and - contingency plan that includes: - the action to be taken if the scheduled service cannot be provided; - information and method to contact the facility: - the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency and - the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters R2 R2 was admitted on June 28, 2023, with diagnoses that included diabetes. R2's service plan dated August 5, 2025, indicated R2 received services to include vital signs, weights, blood glucose checks, simple dressing change, incontinence care, escorts, dressing, grooming and bathing. The service plan did not include medication management services. R2's service plan lacked the following content: - the fees for services, frequency of each service; - the schedule and methods of monitoring assessments of the resident; - the schedule and methods of monitoring staff	01650		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE - FARIBAULT	828 1ST STREET NE FARIBAULT, MN 55021

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01650	Continued From page 43 providing services; and - contingency plan that includes: - the action to be taken if the scheduled service cannot be provided; - information and method to contact the facility: - the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency and - the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters R3 R3 was admitted on February 14, 2025, with diagnoses that included Alzheimer's disease. R3's service plan dated September 9, 2025, indicated R3 received services to include vital signs, weights, blood glucose checks, and simple dressing change. The service plan did not include medication management services. R3's service plan lacked the following content: - the fees for services, frequency of each service; - the schedule and methods of monitoring assessments of the resident; - the schedule and methods of monitoring staff providing services; and - contingency plan that includes: - the action to be taken if the scheduled service cannot be provided; - information and method to contact the facility: - the names and contact information of	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NEW PERSPECTIVE - FARIBAULT	828 1ST STREET NE FARIBAULT, MN 55021

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01650	Continued From page 44 persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency and - the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters On October 15, 2025, at 11:06 a.m., clinical nurse supervisor (CNS)-B stated when a resident was admitted to the licensee and received services, she completed the "Acknowledgment | MN" which included most of the required service plan content (does not include the names and contact information of persons the resident wishes to have notified in an emergency). CNS-B stated the "Acknowledgment | MN" document was only completed at the time of admission/start of services or if a resident transferred from Assisted Living to Memory Care. CNS-B stated when a resident's services changed, she would revise the service plan which did not include the required content as noted above. The licensee's Resident Service Plan policy dated December 29, 2024, indicated 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;	01650		

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01650	Continued From page 45 b. Identify any additional services which are available for purchase by the resident; and c. Identify the activities and social connections the resident will be assisted in maintaining. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650		
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, a registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a registered nurse must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel;	01730		

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01730	Continued From page 46 (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop an individualized medication management plan with the required content for three of three residents (R1, R2, and R3). This practice resulted in a level two violation (a violation that did no 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: During the entrance conference on October 13,	01730		

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01730	Continued From page 47 2025, at approximately 9:30 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to the residents at the facility. R1 R1 was admitted on February 19, 2024, with diagnoses that included Alzheimer's disease. On October 14, 2025, at 8:36 a.m., the surveyor observed unlicensed personnel (ULP)-E administer medications to R1. R1's service plan dated September 17, 2025, indicated R1 received services to include vital signs, weights, oxygen saturation checks, oxygen, modified diet, incontinence care, mobility and transfer assistance, dressing, grooming, and bathing. The service plan did not include medication management services. R1's medication administration record (MAR) dated October 2025, included the following medications: -acetaminophen 500 milligrams (mg); take two tablets by mouth three times daily (pain) -carvedilol 25 mg; take one tablet by mouth twice daily (blood pressure) -guaifenesin 600 mg; take one tablet by mouth every 12 hours (cough) -hydromorphone 1 mg; dissolve one tablet sublingually every six hours (shortness of breath) -DuoNeb 0.5 mg-3 mg/3 milliliters (ml); use one vial via nebulizer four times daily (cough) -Klor-Con 10 milliequivalent (meq); take one tablet by mouth once daily (supplement) -levothyroxine 75 micrograms (mcg); take one tablet by mouth once daily (thyroid) -lorazepam 0.5 mg; dissolve one tablet	01730		

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01730	Continued From page 48 sublingually at bedtime (sleep) -trazodone 100 mg; take one tablet by mouth at bedtime (sleep) -venlafaxine 75 mg; take three capsules by mouth once daily (depression) -acetaminophen suppository 650 mg; unwrap an insert one suppository rectally every six hours as needed for fever -Bisacodyl suppository 10 mg; unwrap and insert one suppository rectally once daily as needed for constipation -haloperidol 0.5 mg; dissolve one tablet sublingually every four hours as needed for agitation/nausea/vomiting -hydromorphone 0.5 mg; take one tablet by mouth every four hours as needed for pain -hyoscyamine 0125 mg; take one tablet by mouth every four hours as needed for secretions -DuoNeb 0.5 mg-3 mg/3 ml; use one vial via nebulizer every four hours as needed for cough or shortness of breath -lorazepam 0.5 mg; dissolve one tablet every four hours as needed for anxiety -prochlorperazine 10 mg; take one tablet by mouth every six hours as needed for nausea or vomiting -senexon plus 8.6-50 mg; take one tablet by mouth once daily as needed for constipation R1's medication management plan dated September 17, 2025, lacked the following required content: -identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis -procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services	01730		

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01730	Continued From page 49 R2 R2 was admitted on June 28, 2023, with diagnoses that included diabetes. On October 14, 2025, at 7:03 a.m., the surveyor observed ULP-D administer medications to R2. R2's service plan dated August 5, 2025, indicated R2 received services to include vital signs, weights, blood glucose checks, simple dressing change, incontinence care, escorts, dressing, grooming and bathing. The service plan did not include medication management services. R2's MAR dated October 2025, included the following medications: -acetaminophen 500 mg; take two tablets by mouth three times daily (pain) -Fiber lax 625 mg; take one tablet by mouth twice daily (constipation) -Genteal Tear solution; instill one drop into affected eye(s) twice daily (dry eye) -Lantus Insulin 100 units/ml; inject 32 units subcutaneously at bedtime (diabetes) -levothyroxine 175 mcg; take one tablet by mouth once daily (thyroid) -lisinopril (hydrochlorothiazide 10-12.5 mg; take two tablets by mouth once daily (blood pressure) -metoprolol succinate 100 mg; take one tablet by mouth once daily (blood pressure) -Nystatin 100,000 units/gram; apply liberally to skin twice daily to groin/coccyx/under armpits (rash) -quetiapine 25 mg; take one tablet by mouth twice daily (anxiety/agitation) -risperidone 2 mg; take one tablet by mouth at bedtime (depression) -Xarelto 20 mg; take one tablet by mouth every	01730		

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01730	Continued From page 50 evening (blood thinner) -guaifenesin liquid 100/5 ml; take two teaspoonful by mouth every four hours as needed for cold symptoms and nonproductive cough -loperamide 2 mg; take two tablets with first loose stool, then take one tablet by mouth after each loose stool as needed -quetiapine 25 mg; take one tablet by mouth once daily as needed for anxiety/agitation R2's medication management plan dated August 5, 2025, lacked the following required content: -identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis -procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services R3 R3 was admitted on February 14, 2025, with diagnoses that included Alzheimer's disease. On October 14, 2025, at 7:39 a.m., the surveyor observed ULP-E administer medications to R3. R3's service plan dated September 9, 2025, indicated R3 received services to include vital signs, weights, blood glucose checks, and simple dressing change. The service plan did not include medication management services. R3's MAR dated October 2025, included the following medications: -acamprosate calcium 333 mg; take two tablets by mouth three times daily (alcohol dependency) -aripiprazole 5 mg; take one tablet by mouth once daily (anxiety/depression)	01730		

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01730	Continued From page 51 -buspirone 30 mg; take one tablet by mouth twice daily (anxiety/depression) -Calcium/Vitamin D 600-400 mg; take one tablet by mouth twice daily (supplement) -escitalopram 20 mg; take one tablet by mouth once daily (depression) -ferrous sulfate 325 mg; take one tablet by mouth once daily (supplement) -folic acid 1 mg; take one tablet by mouth daily (supplement) -gabapentin 300 mg; take two capsules by mouth twice daily (pain) -Lactulose solution 10 grams/15 ml; take 45 ml by mouth four times daily (liver) -loratadine 10 mg; take one tablet by mouth once daily (allergies) -melatonin 3 mg; take one tablet by mouth at bedtime (sleep) -midodrine 10 mg; take one tablet by mouth three times daily -omeprazole 20 mg; take one capsule by mouth daily (heartburn) -Potassium Chloride 20 meq; take one tablet by mouth once daily (supplement) -quetiapine 200 mg; take one tablet by mouth at bedtime (sleep) -quetiapine 25 mg; take one tablet by mouth at bedtime (sleep) -spironolactone 100 mg; take one tablet by mouth once daily -Therapeutic-M; take one tablet by mouth once daily (supplement) -torsemide 20 mg; take two tablets by mouth once daily (diuretic) -Vitamin B1 100 mg; take one tablet by mouth once daily (supplement) -Vitamin B12 1,000 mcg; take one tablet by mouth daily (supplement) -Vitamin C 500 mg; chew one tablet by mouth	01730		

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01730	Continued From page 52 once daily (supplement) -Vitamin D3 2,000 units; take one capsule by mouth once daily (supplement) -Xifaxan 550 mg; take one tablet by mouth twice daily (liver) -acetaminophen 325 mg; take one tablet by mouth every six hours as needed for pain or fever -hydroxyzine 50 mg; take one capsule by mouth four times daily as needed for anxiety -methocarbamol 750 mg; take one tablet by mouth as needed for muscle spasms -Ventolin HFA Inhaler; inhale two puffs by mouth every six hours as needed for wheezing R3's medication management plan dated June 11, 2025, lacked the following required content: -identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis -procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services On October 15, 2025, at 11:16 a.m., CNS-B reviewed the medication management plans and stated the licensee's medication management plan did not include the required content as listed above. CNS-B stated the licensee used the same medication management plan for all residents at the facility. The licensee's Medication Management Program policy dated May 26, 2025, indicate the community offers medication and treatment management services to it's assisted living residents, which include: -administration of medications;	01730		

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01730	Continued From page 53 -storing and securing medications; -documenting medication administration; -observing for effectiveness of medication administration policies and procedures to verify safety measures are in place; -coordination prescription refills; -managing and effecting changes to prescriptions: -communication with the pharmacy, prescriber, and resident and the resident's legal representative regarding medication management. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01790 SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may	01790		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE - FARIBAULT	828 1ST STREET NE FARIBAULT, MN 55021

(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
01790	Continued From page 54 delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the	01790		

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01790	Continued From page 55 doses of each returned medication. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) developed training and competencies for two of two unlicensed personnel (ULP)-D and ULP-E) providing medications to residents for unplanned time away from home when the licensed nurse was not available. 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: ULP-D ULP-D was hired on April 24, 2024, to provide direct care and services to the licensee's residents. ULP-D's record included Medication Administration Competency Evaluation document signed on September 23, 2024, by ULP-D an RN, indicated ULP-D had been trained and competency tested on the following medication administration tasks: 1. Common administration test 2. Oral medications 3. Oral, cutting 4. Oral, crushing	01790		

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01790	Continued From page 56 5. Sublingual 6. Buccal 7. Liquid 8. Eye drops and ointments 9. Ear drops 10. Nasal sprays 11. Inhalers 12. Nebulizers 13. Topical 14. Medicated patches 15. Rectal 16. Vaginal 17. Blood sugar testing 18. Insulin pen 19. Insulin derivatives (subcutaneous injections) 20. EpiPen ULP-D's record did not include a Med Passer Training Checklist. ULP-D's employee record lacked documentation of training and competencies for unplanned time away when the RN was not available. ULP-E ULP-E was hired on September 24, 2024, to provide direct care and services to the facility's residents. ULP-E's record included Medication Administration Competency Evaluation document signed on September 4, 2025, by ULP-E and an RN, indicated ULP-E had been trained and competency tested on the following medication administration tasks: 1. Common administration test 2. Oral medications 3. Oral, cutting 4. Oral, crushing	01790		

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01790	Continued From page 57 5. Sublingual 6. Buccal 7. Liquid 8. Eye drops and ointments 9. Ear drops 10. Nasal sprays 11. Inhalers 12. Nebulizers 13. Topical 14. Medicated patches 15. Rectal 16. Vaginal 17. Blood sugar testing 18. Insulin pen 19. Insulin derivatives (subcutaneous injections) 20. EpiPen ULP-E's record included a Med Passer Training Checklist dated September 5, 2025. On page two, under "Med Passer Shadowing, Day 1 Learning Focus" had 7 columns with 11 rows. -Column one of Row 6 included the following: Leave of absence: Designation of LOA in the EHR (electronic health record). Med packaging for self-or third-party administration while leave: see leaves of absences policy and procedures. -Column two of Row 6 included a check mark -Column three of Row 6 included a check mark -Column four of Row 6 included a check mark -Column five of Row 6 included ULP-E's initials -Column six of Row 6 included ULP-H's initials -Column seven of Row 6 included the date of September 5, 2025 Page 8 of the checklist had a signature page which was signed by ULP-E and ULP-H on September 5, 2025. Clinical nurse supervisor (CNS)-B signed the checklist on September 8, 2025. Although, CNS-B signed page 8 of the document it did not indicate that CNS-B had	01790		

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01790	Continued From page 58 competency tested ULP-E for unplanned time away. ULP-E's employee record lacked documentation of training and competencies for unplanned time away when the RN was not available. On October 15, 2025, at 1:17 p.m., regional director of clinical services (RDOCS)-F stated the ULP were trained and competency tested on unplanned time away. RDOCS-F stated documentation of the training and competency evaluations were located on either the Medication Administration Competency Evaluations document or the Med Passer Training Checklist. The surveyor inquired where on the documents the competency evaluation was documented. RDOCS-F reviewed the documents and stated the Medication Administration Competency Evaluation did not include unplanned time away. RDOCS-F stated when the RN signed the signature page of the Med Passer Training Checklist it implied that the RN had trained, and competency tested the ULP. The licensee's Medication Management Program policy dated May 26, 2025, indicated where allowed by state law, unlicensed team members may be delegated to administration in the community med passer role. Before commencing work in the med passer role, unlicensed team members will be trained and evaluated to verify they are competent in delegated medication management and administration tasks in accordance with applicable stat law and company policy and procedure. No further information provided.	01790		

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01790	Continued From page 59 TIME PERIOD FOR CORRECTION: Seven (7) days	01790		
01940 SS=E	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by:	01940		

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01940	Continued From page 60 Based on observation, interview, and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for three of three residents (R1, R2, and 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 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: R1 R1 was admitted on February 19, 2024, with diagnoses that included Alzheimer's disease. On October 14, 2025, at 8:36 a.m., the surveyor observed unlicensed personnel (ULP)-E apply oxygen at 2 liters to R1. R1's service plan dated September 17, 2025, indicated R1 received services to include oxygen saturation checks, oxygen, and modified diet. R1's Treatment and Therapy Management Plan included within the comprehensive nursing assessment dated September 17, 2025, indicated R1 received the following treatment services: -Oxygen Saturation Checks -Oxygen -Modified Diet	01940		

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01940	Continued From page 61 The treatment and therapy management plan indicated to "See EHR (electronic health record) for treatment details". R1's resident monthly assignment report dated October 2025, included: -Assist resident with applying and/or removing oxygen cannula or mask. Notify supervisor if resident needs assistance with oxygen supplies. Refrain from applying lubricants (e.g., oil, grease, etc.) to the resident's face. -Modify (or verify kitchen modification of) resident's food in accordance with the selected Modified Diet Instructions. R1's record lacked documentation of oxygen saturation checks. R1's prescriber orders included the following: -Oxygen 3 liters via nasal cannula continuously. Ok if she refuses, order dated September 17, 2025. -Minced and moist diet, order dated October 15, 2025. R1's record lacked prescriber orders for oxygen saturation checks. R1's treatment plan failed to include the following required content: -documentation of specific resident instructions relating to the treatments or therapy administration -procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatment or therapy services -resident specific requirements relating to documentation of treatment and therapy received, verification that all treatment and	01940		

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01940	Continued From page 62 therapy was administered as prescribed and monitoring of treatment or therapy to prevent possible complications or adverse reactions. R2 R2 was admitted on June 28, 2023, with diagnoses that included diabetes. On October 14, 2025, at 9:15 a.m., the surveyor observed ULP-D check R2's blood glucose. R2's service plan dated August 5, 2025, indicated R2 received services to include vital signs, weights, blood glucose checks, and simple dressing change. R2's Treatment and Therapy Management Plan included within the comprehensive nursing assessment dated August 5, 2025, indicated R2 received the following treatment services: -Blood Glucose -Simple dressing change -Specimen collection The treatment and therapy management plan indicated to "See EHR (electronic health record) for treatment details". R2's record lacked documentation of simple dressing changes and specimen collection. R2's prescriber orders dated August 26, 2025, decrease glucose checks from three times a day to twice a day. R2's record lacked prescriber orders for simple dressing changes and specimen collection. R2's treatment plan failed to include the following required content:	01940		

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01940	Continued From page 63 -documentation of specific resident instructions relating to the treatments or therapy administration -procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatment or therapy services -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. R3 R3 was admitted on February 14, 2025, with diagnoses that included Alzheimer's disease. On October 14, 2025, at 7:44 a.m., the surveyor observed ULP-E check R3's blood glucose. R3's service plan dated September 9, 2025, indicated R3 received services to include vital signs, weights, blood glucose checks, and simple dressing change. The service plan did not include medication management services. R3's Treatment and Therapy Management Plan included within the comprehensive nursing assessment dated September 9, 2025, indicated R3 received the following treatment services: -Blood glucose -Simple dressing change -Specimen collection The treatment and therapy management plan indicated to "See EHR (electronic health record) for treatment details". R3's vitals report dated September 14, 2025, through October 14, 2025, indicated R3's blood	01940		

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01940	Continued From page 64 glucose was checked four times a day (7:00 a.m., 11:00 a.m., 4:00 p.m., and 9:00 p.m.). R3's record lacked documentation of simple dressing changes and specimen collection. R3's record lacked prescriber orders for simple dressing changes, specimen collection and blood glucose checks. R3's treatment plan failed to include the following required content: -documentation of specific resident instructions relating to the treatments or therapy administration -procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatment or therapy services -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. On October 15, 2025, at 11:26 a.m., clinical nurse supervisor (CNS)-B stated R2 and R3 did not have simple dressing changes or specimen collection treatments. CNS-B stated she had added them to the treatment plan in case they ever needed those services. CNS-B stated she was directed to remove any treatments that the resident does not have scheduled and had not updated R2 and R3's treatment plans yet. CNS-B stated R1, R2 and R3's treatment plans did not include the required content as noted above. CNS-B stated the licensee is changing to a new EHR system soon and believed that system included the required content for treatment plans.	01940		

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01940	Continued From page 65 The licensee's Treatment or Therapy Management Services policy dated February 20, 2025, indicated the licensee would develop and maintain a current individualized treatment and therapy management plan for each resident to include: a. a statement of the type of treatment or therapy services that will be provided: b. documentation of specific resident instructions relating to the treatment or therapy service administration; c. identification of treatments or therapy tasks that will be delegated to unlicensed personnel in accordance with current standards of delegation practice; d. procedures for notifying an RN or appropriate licensed health professional when a problem arises with treatment or therapy services; and e. any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administer as prescribed and monitoring of treatment or therapy in an effort to prevent possible complications or adverse reactions No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who	01960		

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01960	Continued From page 66 administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure treatment or therapies were administered as prescribed, or to document the reason they were not provided, for one of three 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: R1 was admitted on February 19, 2024, with diagnoses that included Alzheimer's disease. On October 14, 2025, at 8:36 a.m., the surveyor observed unlicensed personnel (ULP)-E apply oxygen at 2 liters to R1. R1's service plan dated September 17, 2025, indicated R1 received services to include oxygen saturation checks, oxygen, and modified diet.	01960		

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01960	Continued From page 67 R1's prescriber orders included the following: -Oxygen 3 liters via nasal cannula continuously. Ok if she refuses, order dated September 17, 2025. R1's record lacked prescriber orders for oxygen saturation checks R1's resident monthly assignment report dated October 2025, included: -Assist resident with applying and/or removing oxygen cannula or mask. Notify supervisor if resident needs assistance with oxygen supplies. Refrain from applying lubricants (e.g., oil, grease, etc.) to the resident's face. R1's record lacked documentation of oxygen saturation checks. On October 15, 2025, at 11: 30 a.m., clinical nurse supervisor (CNS)-B stated R2's record lacked documentation of oxygen saturation checks. CNS-B stated she would add this to R2's tasks record so that it is documented going forward. The licensee's Treatment or Therapy Management Services policy dated February 20, 2025, indicated team members trained in treatment or therapy services administration will document in the electronic medication administration record or service plan their name, title, and the date and time treatment or therapy was administered. When treatment or therapy services are not administered as ordered or prescribed, the applicable team member will document the reason why the treatment or therapy was not administered, and any follow-up procedures provided to meet the resident's	01960		

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NEW PERSPECTIVE - FARIBAULT	828 1ST STREET NE FARIBAULT, MN 55021

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01960	Continued From page 68 needs. . No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure up-to-date written or electronically recorded orders were maintained for two of three residents (R1, and R3) receiving treatments. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and 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:	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30225	A. BUILDING: _____ B. WING _____	10/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE - FARIBAULT	828 1ST STREET NE FARIBAULT, MN 55021

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01970	Continued From page 69 R1 R1 was admitted on February 19, 2024, with diagnoses that included Alzheimer's disease. On October 14, 2025, at 8:36 a.m., the surveyor observed unlicensed personnel (ULP)-E apply oxygen at 2 liters to R1. R1's service plan dated September 17, 2025, indicated R1 received services to include oxygen saturation checks, oxygen, and modified diet. R1's resident monthly assignment report dated October 2025, included: -Assist resident with applying and/or removing oxygen cannula or mask. Notify supervisor if resident needs assistance with oxygen supplies. R1's record lacked documentation of oxygen saturation checks. R1's prescriber orders included the following: -Oxygen 3 liters via nasal cannula continuously. Ok if she refuses, order dated September 17, 2025. -Minced and moist diet, order dated October 15, 2025, which was obtained after the start of survey. R1's record lacked prescriber orders for oxygen saturation checks. R3 R3 was admitted on February 14, 2025, with diagnoses that included Alzheimer's disease. On October 14, 2025, at 7:44 a.m., the surveyor observed ULP-E check R3's blood glucose.	01970		

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	30225	A. BUILDING: _____ B. WING _____	10/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE - FARIBAULT	828 1ST STREET NE FARIBAULT, MN 55021

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01970	Continued From page 70 R3's service plan dated September 9, 2025, indicated R3 received services to include vital signs, weights, blood glucose checks, and simple dressing change. R3's vitals report dated September 14, 2025, through October 14, 2025, indicated R3's blood glucose was checked four times a day (7:00 a.m., 11:00 a.m., 4:00 p.m., and 9:00 p.m.). R3's record lacked prescriber orders for blood glucose checks. On October 15, 2025, at 12:18 p.m., clinical nurse supervisor (CNS)-B stated she could not locate prescriber orders for oxygen saturation checks for R1 or blood glucose checks for R3. On October 15, 2025, at 6:04 p.m., CNS-B emailed the surveyor a prescriber order for blood glucose checks four times a day for R3, which was dated October 15, 2025, which was obtained after the start of survey. The licensee's Treatment or Therapy Management Services policy dated February 20, 2025, indicated the nurse would request, receive, and record orders or prescriptions for treatments or therapy services. The written or electronically recorded order will contain the name of the resident, a description of the treatment or therapy services to be administered, and the frequency and other information needed to provide the treatment or therapy services. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30225	A. BUILDING: _____ B. WING _____	10/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE - FARIBAULT	828 1ST STREET NE FARIBAULT, MN 55021

(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
02170 SS=F	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following: (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to: (1) occupation or chore related tasks; (2) scheduled and planned events such as entertainment or outings; (3) spontaneous activities for enjoyment or those that may help defuse a behavior; (4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities; (6) sensory stimulation activities; (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and (8) outdoor activities. This MN Requirement is not met as evidenced	02170		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30225	A. BUILDING: _____ B. WING _____	10/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE - FARIBAULT	828 1ST STREET NE FARIBAULT, MN 55021

(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
02170	Continued From page 72 by: Based on interview and record review, the licensee failed to conduct an evaluation for activities that addressed all provisions and failed to develop an individualized activity plan based on the evaluation for two of two residents (R1 and R2) who resided in an assisted living with dementia care facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: The licensee had an Assisted Living with Dementia Care (ALFDC) license effective March 1, 2025. R1 R1 was admitted on February 19, 2024, with diagnoses that included Alzheimer's disease. R1's service plan dated September 17, 2025, indicated R1 received services to include vital signs, weights, oxygen saturation checks, oxygen, modified diet, incontinence care, mobility and transfer assistance, dressing, grooming, and bathing. R1's record included an undated, Resident Personal History document which included R1's hobbies and interests.	02170		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30225	A. BUILDING: _____ B. WING _____	10/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE - FARIBAULT	828 1ST STREET NE FARIBAULT, MN 55021

(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
02170	Continued From page 73 R1's record lacked an evaluation to include the following: - current abilities and skills; - emotional and social needs and patterns; - physical abilities and limitations; - adaptations necessary for the resident to participate; and - identification of activities for behavioral interventions. R1's record did not include evidence of an individualized activity plan based on the resident's activity assessment. R2 R2 was admitted on June 28, 2023, with diagnoses that included diabetes. R2's service plan dated August 5, 2025, indicated R2 received services to include vital signs, weights, blood glucose checks, simple dressing change, incontinence care, escorts, dressing, grooming and bathing. R2's record included an undated, Resident Personal History document which included R1's hobbies and interests. R2's record lacked an evaluation to include the following: - current abilities and skills; - emotional and social needs and patterns; - physical abilities and limitations; - adaptations necessary for the resident to participate; and - identification of activities for behavioral interventions.	02170		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30225	A. BUILDING: _____ B. WING _____	10/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE - FARIBAULT	828 1ST STREET NE FARIBAULT, MN 55021

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02170	Continued From page 74 R2's record did not include evidence of an individualized activity plan based on the resident's activity assessment. On October 15, 2025, at 11:31 a.m., licensed assisted living director (LALD)-A stated the licensee used the Resident Personal History as the activity assessment; however, it did not include the required content. LALD-A stated the licensee developed a new document and would be implementing it in the near future which would include the required content and then used to create an activity plan. The licensee's Developing the Life Engagement Program policy dated December 30, 2024, indicated the community will strive to discover what interest, residents and provide them with a program that includes both planned and unplanned activities and experiences that together create a culture of engagement that results in Living Life on Purpose. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02170		

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

Food & Beverage Inspection Report

Establishment Info

NEW PERSPECTIVE FARIBAULT
828 1ST STREET NE
Faribault, MN 55021
Rice County
Parcel:

Phone:

License Info

License: HFID 30225

Risk:
License:
Expires on:
CFPM: Lisa Ann Seifert
CFPM #: 59472; Exp: 6/20/2028

Inspection Info

Report Number: F7990251013
Inspection Type: Full - Single
Date: 10/14/2025 Time: 10:30:36 AM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 3
Delivery:

New Order: 4-900 Protecting Clean Items

4-903.11B *Priority Level: Priority 3 CFP#: 44*

MN Rule 4626.0955B Store all clean equipment and utensils in a self-draining position that permits air drying and covered and inverted.

COMMENT: DISCONTINUE STACKING DISHES THAT ARE STILL WET WITH SANITIZER / WATER. ALLOW ALL DISHES TO DRY COMPLETELY BEFORE STACKING.

Comply By: 10/14/2025 Originally Issued On: 10/14/2025

New Order: 6-200 Physical Facility Design and Construction

6-202.11A *Priority Level: Priority 3 CFP#: 56*

MN Rule 4626.1375A Provide effective shielding, coated or shatter-resistant light bulbs for all light fixtures where there is exposed food, clean equipment, utensils and linens, or unwrapped single-service or single-use articles.

COMMENT: REPLACE MISSING LIGHT SHIELDS IN THE KITCHEN OVER THE PREP / COOKING AREA AND IN THE DRY STORAGE ROOM.

Comply By: 11/14/2025 Originally Issued On: 10/14/2025

New Order: 6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.12A *Priority Level: Priority 3 CFP#: 55*

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

COMMENT: CLEAN AND MAINTAIN CLEAN THE CEILING AND CEILING VENTS IN THE KITCHEN THAT ARE DIRTY ABOVE THE COOKING / PREP AREAS.

Comply By: 10/21/2025 Originally Issued On: 10/14/2025

Food & Beverage General Comment

WE DISCUSSED EMPLOYEE ILLNESS, HANDWASHING, BAREHAND CONTACT PREVENTION, AND NOROVIRUS.

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

I acknowledge receipt of the Mankato District Office inspection report number F7990251013 from 10/14/2025

Benjamin D. Ische

Lisa Seifert

Ben Ische,

Public Health Sanitarian Supervisor
507-344-2710
ben.ische@state.mn.us

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

Temperature Observations/Recordings

Establishment Info

NEW PERSPECTIVE FARIBAULT
Faribault
County/Group: Rice County

Inspection Info

Report Number: F7990251013
Inspection Type: Full
Date: 10/14/2025
Time: 10:30:36 AM

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

Food Temperature: Product/Item/Unit: Soup**; Temperature Process:** Hot-Holding
Location: Steam Table at 176 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Turkey Hotdish**; Temperature Process:** Cooking
Location: Oven at 192 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Ham**; Temperature Process:** Cold-Holding
Location: Under Counter Cooler at 40 Degrees F.
Comment:
Violation Issued?: No

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

Sanitizer Observations/Recordings

Establishment Info

NEW PERSPECTIVE FARIBAULT
Faribault
County/Group: Rice County

Inspection Info

Report Number: F7990251013
Inspection Type: Full
Date: 10/14/2025
Time: 10:30:36 AM

Sanitizing Chemical: **Product:** Quaternary Ammonia**; Sanitizing Process:** Wiping Cloth Bucket
Location: 3-Comp Sink **Equal To** 400 PPM
Comment:
Violation Issued?: No

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Dishwashing Area **Equal To** 168 Degrees F.
Comment:
Violation Issued?: No