DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

September 15, 2022

Administrator
Jaris M 'Pokey' Paro Assisted Living
1571 Airport Road
Cloquet, MN 55720

RE: Project Number(s) SL27607015

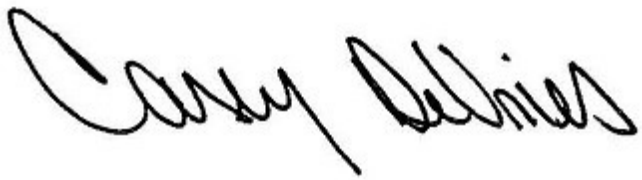
Dear Administrator:

On September 12, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the July 14, 2022, evaluation were corrected. This follow-up evaluation verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,



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

PMB

Electronically Delivered

August 2, 2022

Administrator
Jaris M 'Pokey' Paro Assisted Living
1571 Airport Road
Cloquet, MN 55720

RE: Project Number(s) SL2760715

Dear Administrator:

The Minnesota Department of Health completed an evaluation on July 14, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

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

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

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

St - 0 - 2310 - 144g.91 Subd. 4 - Appropriate Care And Services = $3,000

The total amount you are assessed is $3,000. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

Please address your cover letter for general reconsideration requests to:	Free from Maltreatment reconsideration requests should be addressed to:

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

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

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

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

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

Sincerely,

Jessie Chenze, RN, BSN
Interim HFE Supervisor 1 | State Evaluations Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Office: 218-332-51751 | Mobile: 651-508-2791| Fax: 218-332-5196

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27607	A. BUILDING: _____ B. WING _____	07/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JARIS M 'POKEY' PARO ASSISTED	1571 AIRPORT ROAD CLOQUET, MN 55720

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL2760715 On, July 11, 2022, through July 14, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were five (5) residents, all of whom received services under the provider's Assisted Living license. Immediate correction orders were identified on July 11, 2022, issued for SL#27607015, tag identification 0110 and 2310. On July 14, 2022, the immediacy of correction order 2310 was removed, however, non-compliance remained at a scope and level of I. Immediacy of correction order 0110 remained.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 110 SS=F	144G.10 Subdivision 1a Assisted living director license required	0 110		

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0 110	Continued From page 1 Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports (BELTSS). This had a potential to affect all of the licensee's five (5) residents receiving Assisted Living services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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). This resulted in an immediate correction order on July 11, 2022. The findings include: The licensee lacked evidence of a licensed assisted living director (LALD) as required, in general administrative charge of the facility. On July 11, 2022, at approximately 8:43 a.m., during the entrance conference, associate director (AD)-D stated that registered nurse (RN)-A was in the process of becoming the	0 110		

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0 110	Continued From page 2 licensee's LALDs. On July 11, 2022, at approximately 11:15 a.m., the surveyor checked the BELTSS website for verification of the assisted living director licensure. RN-A was not listed as having a current LALD license. The surveyor emailed BELTSS and was informed the licensee was not in their database, so no LALD or residency permit was associated with that location. BELTSS also indicated RN-A had not completed the process for the residency permit. On July 11, 2022, at approximately 3:04 p.m., RN-A stated she had been doing online training for becoming an LALD but had not yet completed the training. RN-A also stated she had been unsuccessful in finding a mentor to be able to move forward in completing the process. The licensee's Assisted Living Director policy dated August 1, 2021, indicated the LALD would maintain a current and active license or permit with BELTSS. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate As of survey exit on July 14, 2022, immediacy remained. On July 20, 2022 evaluation supervisor received correspondence that RN-A had a valid assisted living director in residence (ALD-IR) permit on BELTSS.	0 110		
0 430 SS=C	144G.40 Subd. 2 Uniform checklist disclosure of services	0 430		

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0 430	Continued From page 3 (a) All assisted living facilities must provide to prospective residents: (1) a disclosure of the categories of assisted living licenses available and the category of license held by the facility; (2) a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and (3) an oral explanation of the services offered under the contract. (b) The requirements of paragraph (a) must be completed prior to the execution of the assisted living contract. (c) The commissioner must, in consultation with all interested stakeholders, design the uniform checklist disclosure form for use as provided under paragraph (a). This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the uniform checklist disclosure of services was provided to one of one resident (R1) with records reviewed. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include:	0 430		

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0 430	Continued From page 4 R1's diagnoses included diabetes, insulin dependent, left above the knee amputation, mild cognitive impairment, and depression. R1's Service Agreement dated February 18, 2022, indicated R1 received services including medication management, treatment services, assistance with bathing, grooming, laundry, and housekeeping. R1's record contained the Statement of Home Care Services Comprehensive Home Care Provider form dated February 18, 2022, and lacked a uniform checklist disclosure of services to include: - a disclosure of the categories of assisted living licenses available and the category of license held by the facility; - a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and - an oral explanation of all services offered under the contract. On July 12, 2022, at approximately 10:00 a.m., registered nurse (RN)-B confirmed all of the licensee's residents had not received the UDALSA and confirmed the licensee was using the Statement of Home Care Services Comprehensive Home Care Provider form. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 430		

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0 470	Continued From page 5	0 470		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the required staffing plan was developed, implemented, and evaluated for appropriateness of staffing levels as required. This had the potential to affect all current five (5) residents, staff, and visitors.	0 470		

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0 470	Continued From page 6 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents The findings include: The licensee held an assisted living facility licensed for a capacity of 10 residents and had a current census of five (5) residents. During entrance conference on July 11, 2022, at approximately 9:22 a.m., the surveyor requested a copy of the licensee's staffing plan. On July 13, 2022, at approximately 8:16 a.m., registered nurse (RN)-A confirmed a staffing plan had not developed or implemented to determine staffing hours based on resident care needs. The licensee's Staffing and Scheduling policy dated August 2021, indicated the supervisor would develop and implement a written staffing plan the provided an adequate number of qualified direct-care staff to meet the residents' needs 24-hours a day, seven days a week. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 470		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment	0 550		

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0 550	Continued From page 7 All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post the required information related to the grievance procedure. This had the potential to affect all current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During a facility tour on July 11, 2022, at approximately 10:17 a.m., the surveyor observed and confirmed with registered nurse (RN)-A, RN-B and Associate Director (AD)-D the main entrance and/or common areas lacked the required posting of the grievance procedure to include the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances.	0 550		

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0 550	Continued From page 8 The licensee's Complaint-Grievance posting dated August 1, 2021, indicated the licensee would post, in a conspicuous place, information about the complaint/grievance procedure, and the name, telephone number, and email contact information for the individual(s) who are responsible for handling resident complaint/grievances. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 550		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not	0 680		

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0 680	Continued From page 9 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 develop and post a written emergency disaster plan with all the required content. This had the potential to affect all five (5) current 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During entrance conference on July 11, 2022, at approximately 9:22 a.m., the surveyor made a request to view the licensee's emergency preparedness plan, which was provided and later reviewed by the surveyor. The licensee's 2022 Safety Policies and Procedures lacked an emergency preparedness (EP) plan with the following required content: - a description of the facilities approach to meeting the health/safety/security needs of the staff and residents; - process for EP cooperation with state and local EP officials/organizations; - a thoroughly completed risk assessment;	0 680		

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0 680	Continued From page 10 - a description of the population served by the licensee; - development of policies/procedures to address: - procedure for tracking staff and residents; - subsistence needs for staff and residents during an emergency; - a medical record documentation system to preserve resident information, security, and availability; - emergency staffing strategies to include volunteers; - development of arrangements with other facilities and providers to receive residents if needed; and - the facilities role in providing care and treatment at alternative sites. - a communication plan that included: - arrangement with other facilities; - names and contact information for staff, resident physicians, other facilities; - contact information for federal, state, tribal, local EP staff, ombudsman; - a method of sharing information and medical documentation for residents; and - a means to provide information regarding the facility's needs, and its ability to provide assistance to include information about their occupancy. On July 13, 2022, at approximately 8:13 a.m., registered nurse (RN)-A stated the licensee had emergency preparedness policies and procedures available via electronic records, and verified the emergency preparedness manual had not been developed to meet the required content noted above. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One	0 680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27607	A. BUILDING: _____ B. WING _____	07/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JARIS M 'POKEY' PARO ASSISTED	1571 AIRPORT ROAD CLOQUET, MN 55720

(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
0 680	Continued From page 11 (21) days	0 680		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced	0 810		

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0 810	Continued From page 12 by: Based on document review and interview, the licensee failed to provide the required training and drills for fire safety and evacuation. This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a 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 July 12, 2022, at approximately 3:40 p.m., the facilities coordinator (FC)-G provided documents for review. Documents were reviewed by survey staff on July 12, 2022, between 3:40 p.m. and 4:10 p.m. 1. The FDL Assisted Living Residence Emergency Response Plan failed to include the identification of unique or unusual resident needs for movement or evacuation. 2. Documentation was requested but not provided for employee training on fire safety and evacuation. The FC-G stated during an interview on July 12, 2022, at approximately 3:45 p.m., that employees were trained upon hire and then annually. The licensee failed to provide the required employee training frequency for fire safety and evacuation, Training was not required at least twice per year after hire. 3. Documentation was requested but not provided for resident training on fire safety and evacuation. 4. The plans included a policy on evacuation drills, but no evacuation drill logs or schedules were included in the documentation. The FC-G stated during an interview, at approximately 3:45 p.m., that evacuation drills were completed twice	0 810		

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0 810	Continued From page 13 a year. The licensee failed to provide the required frequency for evacuation drills of twice per year per shift with at least one evacuation drill every other month. The FD-G explained during an interview, on July 12, 2022, at approximately 4:10 p.m., that the safety officer was unavailable and would email follow-up documentation for review. As of July 18, 2022, no further information was submitted. Survey staff provided an Assisted Living Facility Checklist for Existing Facilities on 144G.45, which included training and evacuation drill frequency requirements. Survey staff also discussed with the FD-G that additional evacuation maps should be posted within the facility at the entrance and within the hallways. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 920 SS=C	144G.50 Subd. 2 (c) Contract information (c) The contract must include: (1) a disclosure of the category of assisted living facility license held by the facility and, if the facility is not an assisted living facility with dementia care, a disclosure that it does not hold an assisted living facility with dementia care license; (2) a description of all the terms and conditions of the contract, including a description of and any limitations to the housing or assisted living services to be provided for the contracted amount; (3) a delineation of the cost and nature of any other services to be provided for an additional fee;	0 920		

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0 920	Continued From page 14 (4) a delineation and description of any additional fees the resident may be required to pay if the resident's condition changes during the term of the contract; (5) a delineation of the grounds under which the resident may be discharged, evicted, or transferred or have services terminated; (6) billing and payment procedures and requirements; and (7) disclosure of the facility's ability to provide specialized diets. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to execute a written contract with the required content for one of one resident (R1) with records reviewed. This had the potential to affect all five (5) residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R1's diagnoses included diabetes, insulin dependent, left above the knee amputation, mild cognitive impairment, and depression. R1's Service Agreement dated February 18, 2022, indicated R1 received services including medication management, treatment services, assistance with bathing, grooming, laundry, and housekeeping.	0 920		

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0 920	Continued From page 15 R1's signed Assisted Living rental Agreement dated February 22, 2021, lacked the following content: -a disclosure of the category of assisted living facility license held by the facility and, if the facility was not an assisted living facility with dementia care, a disclosure that it does not hold an assisted living facility with dementia care license. On July 11, 2022, at approximately 11:52 a.m., the surveyor observed unlicensed personnel (ULP)-E administering R1's insulin. On July 13, 2022, at approximately 8:51 a.m., registered nurse (RN)-A and RN-B verified the licensee's above contract language and confirmed the same Assisted Living Rental Agreement was used for all residents at the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 920		
0 930 SS=C	144G.50 Subd. 2 (d-e; 1-4) Contract information (d) The contract must include a description of the facility's complaint resolution process available to residents, including the name and contact information of the person representing the facility who is designated to handle and resolve complaints. (e) The contract must include a clear and conspicuous notice of: (1) the right under section 144G.54 to appeal the termination of an assisted living contract; (2) the facility's policy regarding transfer of	0 930		

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0 930	Continued From page 16 residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent is required for a transfer; (3) contact information for the Office of Ombudsman for Long-Term Care, the Ombudsman for Mental Health and Developmental Disabilities, and the Office of Health Facility Complaints; (4) the resident's right to obtain services from an unaffiliated service provider; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to execute a written contract with the required content for one of one resident (R1) with records reviewed. This had the potential to affect all five (5) residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R1's diagnoses included diabetes, insulin dependent, left above the knee amputation, mild cognitive impairment, and depression. R1's Service Agreement dated February 18, 2022, indicated R1 received services including medication management, treatment services, assistance with bathing, grooming, laundry, and housekeeping.	0 930		

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0 930	Continued From page 17 R1's signed Assisted Living rental Agreement dated February 22, 2021, lacked the following content: -the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent was required for a transfer; and -contact information for ombudsman for Mental Health and Development Disabilities and Office of Health Facility Complaints (OHFC). On July 11, 2022, at approximately 11:52 a.m., the surveyor observed unlicensed personnel (ULP)-E monitoring R1's blood glucose (sugar) and administering R1's insulin. On July 13, 2022, at approximately 8:51 a.m., registered nurse (RN)-A and RN-B verified the licensee's above contract language and confirmed the same assisted living rental agreement was used for all residents at the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 930		
0 970 SS=C	144.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a	0 970		

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0 970	Continued From page 18 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 facility's liability for health, safety, or personal property of a resident. This had the potential to affect all five (5) residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On July 11, 2022, at approximately 9:22 a.m., during entrance conference, the surveyor requested a copy of the licensee's assisted living contract and was provided. The assisted living contract included two clauses that indicated the resident would waive the facility's liability for health, safety, or personal property of the resident. On page 10, section H. the contract noted the following: -the tenant shall not make claim against the Landlord or any of its representatives or employees for or on account of loss or injury or damage sustained by or from insects, pests, fire, water, deluge, overflow, sewer back-up, or from malfunction or breakdown of appliances in rental units, heating and cooling equipment, and laundry	0 970		

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0 970	Continued From page 19	0 970		

room equipment;
-the tenant shall not make claim for any loss to articles by theft or from any other cause. It is expressly agreed that Tenant shall be solely responsible for the security of Tenant's possessions regardless of whether said building shall have any form of security system;
-it is highly recommended that Tenant obtain Renter's Insurance to protect personal belongings. Tenant shall look to Tenant's own insurance for reimbursement for any loss from fire, wind, vandalism, theft, or any loss, and hereby waives any and all claims of any nature against Landlord, Owner, or any of its representatives or employees on behalf of Tenant, its insurers, and all other persons claiming through Tenant;
- Landlord is not responsible for the actions or for any damages, injury, or harm caused by third parties (such as other tenants, guests, intruders, or trespassers), who are not under Landlord's control; and
-Tenant is responsible for any actions of Tenant's guests or when agents are acting on behalf of Tenant.

In addition, on page 10, section I, the contract noted the Tenant shall reimburse landlord for the following:
-any loss, property damage, or cost of repair service, including plumbing problems, caused by negligence or improper use by Tenant or Tenant's guests or agents;
-any loss or damage caused by doors or windows being left open;
-any costs incurred by Tenant because of services or repairs executed without prior written approval from Landlord;
-costs of reconditioning the premises, including, but not limited to carpets and hard floor cleaning,

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0 970	Continued From page 20 along with damages in excess of normal wear and tear caused by Tenant and Tenant's guests or agents; -all costs Landlord has because of abandonment or other violations of the Rental Agreement by Tenant, such as costs for advertising the rental unit; and -all court costs, attorney fees, serving fees, and administrative costs Landlord has in any suit for eviction, unpaid rent, or any other debt or change. On July 13, 2022, at approximately 8:51 a.m., registered nurse (RN)-A and RN-B verified the licensee's above contract language and confirmed the same assisted living rental agreement was used for all residents at the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 970		
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC);	01470		

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01470	Continued From page 21 (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual	01470		

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01470	Continued From page 22 and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure two of two employees registered nurse (RN)-B and unlicensed personnel (ULP)-E received orientation to assisted living facility licensing to include all the required topics with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: RN-B RN-B had a hire date of August 20, 2020, under the comprehensive home care license, and began providing services under the licensee's Assisted Living license on August 1, 2021. RN-B's transcript indicted RN-B completed Home Care Orientation on May 18, 2020. RN-B's employee record lacked the following required orientation content: - an overview of the 144G statutes; -policies and procedures related to the provision of assisted living services by the individual staff person; - the principles of person-centered planning and	01470		

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01470	Continued From page 23	01470		

service delivery and how they apply to direct support services provided by the staff person; and
- a review of the types of assisted living services the employee will be providing and the facility's category of licensure.

ULP-E
ULP-E had a hire date of July 14, 2016, under the comprehensive home care license, and began providing services under the licensee's Assisted Living license on August 1, 2021.

ULP-E's transcript indicated ULP-E completed Home Care Orientation on July 15, 2016.

ULP-E's employee record lacked the following required orientation content:
- an overview of the 144G statutes;
-policies and procedures related to the provision of assisted living services by the individual staff person; and
- a review of the types of assisted living services the employee will be providing and the facility's category of licensure.
- the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; and
- a review of the types of assisted living services the employee will be providing and the facility's category of licensure.

On July 12, 2022, at approximately 11:05 a.m., RN-B confirmed she had not completed the required training and ULP-E's employee records lacked the above noted required orientation content. RN-B stated the EduCare training's were assigned by ULP-E.

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01470	Continued From page 24 On July 11, 2022, at approximately 11:52 a.m., the surveyor observed ULP-E administering insulin to R1. On July 12, 2022, at approximately 2:40 p.m., ULP-E stated she was unaware of the requirements for staff to complete orientation to assisted living and confirmed the licensee's staff completed Home Care Orientation. The licensee's Orientation of Staff and Supervisors and Content policy dated August 2021, indicated all licensee's employees must complete the orientation to assisted living facility requirements before providing assisted living services to residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01470		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must	01620		

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	27607	A. BUILDING: _____ B. WING _____	07/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JARIS M 'POKEY' PARO ASSISTED	1571 AIRPORT ROAD CLOQUET, MN 55720

(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
01620	Continued From page 25	01620		

be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review.
(e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed ongoing resident reassessments not to exceed 90 days for one of one resident (R1) with records reviewed.

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

The findings include:

R1's diagnoses included diabetes, insulin dependent, left above the knee amputation, mild cognitive impairment, and depression.

R1's Service Agreement dated February 18, 2022, indicated R1 received services including medication management, treatment services, assistance with bathing, grooming, laundry, and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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JARIS M 'POKEY' PARO ASSISTED	1571 AIRPORT ROAD CLOQUET, MN 55720

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01620	Continued From page 26 housekeeping. R1's record indicated the RN completed an Initial Assessment on February 18, 2022, and a 90-day assessment May 25, 2022, which exceeded 90 days from the previous completed assessment by six (6) days. On July 12, 2022, at approximately 10:33 a.m., RN-B verified R1's 90 assessment had not been completed within 90 days from R1's previous assessment as required. The licensee's Assessments, Reviews, and Monitoring policy dated August 2021, indicated resident monitoring and reviews must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01780 SS=F	144G.71 Subd. 10 Medication management for residents who will (a) An assisted living facility that is providing medication management services to the resident must develop and implement policies and procedures for giving accurate and current medications to residents for planned or unplanned times away from home according to the resident's individualized medication management plan. The policies and procedures must state that: (1) for planned time away, the medications must be obtained from the pharmacy or set up by the	01780		

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	27607	A. BUILDING: _____ B. WING _____	07/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JARIS M 'POKEY' PARO ASSISTED	1571 AIRPORT ROAD CLOQUET, MN 55720

(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
01780	Continued From page 27 licensed nurse according to appropriate state and federal laws and nursing standards of practice; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to implement policies and procedures for giving accurate and current medications for those residents who received medication management services during planned times away from home. This has the potential to affect all six (6) 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During entrance conference on July 11, 2022, at approximately 9:22 a.m., registered nurse (RN)-B confirmed the licensee provided medication management services to the residents at the facility. RN-B confirmed (unlicensed personnel) ULP would prepare and send medications with residents for planned and unplanned times away. On July 12, 2022, at approximately 11:48 a.m., RN-B confirmed for planned time away, ULP prepared and sent medications with the resident or the resident's representative even if there was a licensed nurse available. RN-B confirmed she had not read the licensee's policy Medication Management-Planned and Unplanned Time Away policy.	01780		

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JARIS M 'POKEY' PARO ASSISTED	1571 AIRPORT ROAD CLOQUET, MN 55720

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01780	Continued From page 28 On July 12, 2022, at approximately 2:37 p.m., ULP-F confirmed ULP who was responsible for medications would prepare the medications to send with the resident the day the resident was leaving whether it was planned or unplanned timed away, even if the nurse was present. The licensee's Medication Management - Planned and Unplanned Time Away policy dated August 2021, indicated for planned time away, the medications must be obtained by the pharmacy or set up by a licensed nurse. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01780		
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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JARIS M 'POKEY' PARO ASSISTED	1571 AIRPORT ROAD CLOQUET, MN 55720

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01790	Continued From page 29	01790		

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

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01790	Continued From page 30 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 written procedures with all the required content for unlicensed personnel (ULP) providing medications for residents having unplanned time away when the licensed nurse was not available. In addition, the licensee failed to ensure the RN followed the licensee's Medication Management-Planned and Unplanned Time Away policy. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During entrance conference on July 11, 2022, at approximately 9:22 a.m., registered nurse (RN)-B confirmed the licensee provided medication management services to the residents at the facility. RN-B confirmed ULP would prepare and send medications with residents for unplanned times away. On July 12, 2022, at approximately 11:48 a.m., RN-B provided the surveyor with the licensee's Medication Management-Planned and Unplanned Time Away Policy and an untitled form ULP completed when medications were sent with the	01790		

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01790	Continued From page 31	01790		

resident for both planned and unplanned time away. RN-B confirmed ULP prepare the medications for residents for both planned and unplanned time away even if there is an RN available. RN-B stated ULP are trained upon hire on the procedure and follow the instructions on the form that is sent with the resident with all the information and instructions for the medications. RN-B confirmed she had not read the licensee's policy Medication Management-Planned and Unplanned Time Away policy.

On July 12, 2022, at approximately 2:37 p.m., ULP-F confirmed ULP who was responsible for medications would prepare the medications to send with the resident the day the resident was leaving whether it was planned or unplanned timed away, even if the nurse was present.

The licensee's lacked a written procedure for unplanned and planned time away to include:
- the type of container or containers to be used for the medications appropriate to the provider's medication system;
- how the containers should be labeled:
- how the RN would be notified that medications have been provided and whether the RN needs to be contacted before the medications are given to the resident or designated representative;
- review by the RN of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and
- how the ULP must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication.

The license's undated Medication Management-Planned and Unplanned Time Away

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01790	Continued From page 32 policy indicated the RN would develop written procedures of the unlicensed personnel, including any specific instructions or procedures regarding controlled substances that are prescribed for that resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790		
02310 SS=J	144G.91 Subd. 4 Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards for one of one resident (R1) with bedrails who lacked a comprehensive bedrail assessment to include measurements of the bedrails to determine compliance with Food and Drug Administration (FDA) guidelines for bedrails. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the	02310		

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02310	Continued From page 33 situation has occurred only occasionally). This resulted in an immediate correction order issued on July 11, 2022. The findings include: On July 11, 2022, at approximately 11:52 a.m., the surveyor observed unlicensed personnel (ULP)-E administer insulin to R1. The surveyor observed bilateral bedrails in the upright position, securely attached to R1's hospital bed. R1's diagnoses included diabetes, mild cognitive impairment, and left below the knee amputation. R1's Service Agreement dated February 18, 2022, indicated R1 received the following services: medication management, treatment services, assistance with bathing, grooming, laundry, and housekeeping. R1's Bed Safety Assessment and 90 Day Comprehensive Assessment completed May 25, 2022, lacked measurements of R1's bedrails. R1's nurse's note dated July 20, 2021, indicated R1 received a hospital bed that day and R1 was educated on the risks of entrapment, restraint and safety of bedrails. On July 11, 2022, at approximately 1:01 p.m., R1 stated she used the bedrails to help assist herself in getting in and out of bed. R1 further stated she has had the hospital bed with the bedrails since she moved in about a year and a half ago. On July 11, 2022, at approximately 3:04 p.m., registered nurse (RN)-B stated she had not measured R1's bedrails and the current	02310		

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02310	Continued From page 34 assessment did not include a place to document bedrail measurements. RN-B confirmed R1's chart lacked evidence R1's bedrails were measured. The licensee's Side rails policy dated August 2021, indicated when the licensee was aware a resident was utilizing side rails (a medical device) on a bed, the licensee would assess the use, educate the resident, and when appropriate, the responsible person, regarding the risks and benefits of the side rails, and verify that the side rail in use was a safe design and utilized consistent with the manufacturer's directions. The policy further indicated the licensee's staff would determine the side rail to be safe by following the FDA's 2006 recommended dimensional measurements to reduce entrapment. The FDA, "A Guide to Bed Safety" revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." TIME PERIOD FOR CORRECTION: Immediate On July 12, 2022, the immediacy of correction order 2310 was removed, however, non-compliance remains at an isolated level three (G).	02310		

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JARIS M 'POKEY' PARO ASSISTED	**1571 AIRPORT ROAD CLOQUET, MN 55720**

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

Type: Full
Date: *07/11/22*
Time: 13:00:00
Report: 1027221072

Food and Beverage Establishment Inspection Report

Location:
Jaris M 'Pokey' Paro Assisted
1571 Airport Road
Cloquet, MN55720
Carlton County, 09

Establishment Info:
ID #: 0039285
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 2188781227
ID #:

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

The following orders were issued during this inspection.

4-300 Equipment Numbers and Capacities

4-302.13B ** Priority 2 **

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

PROVIDE IRREVERSIBLE THERMOMETER OR THERMAL LABELS FOR MEASURING THE HOT WATER TEMP IN DISH MACHINE.

Comply By: 07/25/22

4-300 Equipment Numbers and Capacities

4-302.14 ** Priority 2 **

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

PROVIDE TEST STRIPS FOR MEASURING QUATERNARY AMMONIA SANITIZER STRENGTH.

Comply By: 07/25/22

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

EMPLOY AT LEAST ONE CERTIFIED FOOD PROTECTION MANAGER.

Comply By: 08/11/22

2-100 Supervision

2-102.12DMN

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

POST CERTIFIED FOOD PROTECTION MANAGER CERTIFICATE WHEN STAFF HAS RECEIVED ONE.

Comply By: 08/11/22

Surface and Equipment Sanitizers

Quaternary Ammonia: = 400PPM at Degrees Fahrenheit
Location: 3 COMP SINK
Violation Issued: No

Quaternary Ammonia: = 400PPM at Degrees Fahrenheit
Location: DISPENSER
Violation Issued: No

Hot Water: = at 163 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Upright Freezer
Temperature: Degrees Fahrenheit - Location: ALL FOODS FROZEN
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 39 Degrees Fahrenheit - Location: MILK
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 38 Degrees Fahrenheit - Location: ROAST BEEF
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 39 Degrees Fahrenheit - Location: SLICED CHEESE
Violation Issued: No

Process/Item: Prep Cooler
Temperature: 37 Degrees Fahrenheit - Location: TOP-AMBIENT
Violation Issued: No

Process/Item: Prep Cooler
Temperature: 38 Degrees Fahrenheit - Location: BOTTOM-CHICKEN SALAD
Violation Issued: No

Process/Item: Prep Cooler
Temperature: 35 Degrees Fahrenheit - Location: BOTTOM-SAUSAGE PATTY
Violation Issued: No

Type: Full
Date: *07/11/22*
Time: 13:00:00
Report: 1027221072
Jaris M 'Pokey' Paro Assisted

Food and Beverage Establishment Inspection Report

Process/Item: Upright Cooler
Temperature: 37 Degrees Fahrenheit - Location: DOMESTIC KITCHEN UPRIGHT-SLICED TURKEY
Violation Issued: No

Process/Item: Upright Freezer
Temperature: Degrees Fahrenheit - Location: DOMESTIC KITCHEN UPRIGHT FREEZER-ALL FOODS FROZEN
Violation Issued: No

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

DISCUSSED EMPLOYEE ILLNESS AND EXCLUSIONS, REQUIRED SANITIZER LEVELS, COOLING PROCESS, AND HOW TO LIMIT BARE HAND CONTACT WITH KITCHEN MANAGER.

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

I acknowledge receipt of the MN Department of Health inspection report number 1027221072 of 07/11/22.

Certified Food Protection Manager: SEE ORDERS

Certification Number: _____ Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed: _____
KIM HOULE
MANAGER

Signed: Ian Harrison
Ian H

651-201-4500
health.foodlodging@state.mn.us

Report #: 1027221072

Food Establishment Inspection Report

MN Department of Health
Food, Pools, & Lodging Services
P.O. Box 64975
Saint Paul, MN 55164-0975

No. of RF/PHI Categories Out	1	Date 07/11/22
No. of Repeat RF/PHI Categories Out	0	Time In 13:00:00
Legal Authority MN Rules Chapter 4626		Time Out

Jaris M 'Pokey' Paro Assisted	Address: 1571 Airport Road	City/State: Cloquet, MN	Zip Code: 55720	Telephone: 2188781227
License/Permit #: 0039285	Permit Holder	Purpose of Inspection: Full	Est Type	Risk Category

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item. Mark "X" in appropriate box for COS and/or R

IN= in compliance **OUT=** not in compliance **N/O=** not observed **N/A=** not applicable **COS=** corrected on-site during inspection **R=** repeat violation

Compliance Status		COS	R
Supervision			
1	IN OUT — PIC knowledgeable; duties & oversight		
2	IN OUT N/A — Certified food protection manager, duties		
Employee Health			
3	IN OUT — Mgmt/Staff;knowledge,responsibilities&reporting		
4	IN OUT — Proper use of reporting, restriction & exclusion		
5	IN OUT — Procedures for responding to vomiting & diarrheal events		
Good Hygenic Practices			
6	IN OUT N/O — Proper eating, tasting, drinking, or tobacco use		
7	IN OUT N/O — No discharge from eyes, nose, & mouth		
Preventing Contamination by Hands			
8	IN OUT N/O — Hands clean & properly washed		
9	IN OUT N/A N/O — No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed		
10	IN OUT — Adequate handwashing sinks supplied/accessible		
Approved Source			
11	IN OUT — Food obtained from approved source		
12	IN OUT N/A N/O — Food received at proper temperature		
13	IN OUT — Food in good condition, safe, & unadulterated		
14	IN OUT N/A N/O — Required records available; shellstock tags, parasite destruction		
Protection from Contamination			
15	IN OUT N/A N/O — Food separated and protected		
16	IN OUT N/A — Food contact surfaces: cleaned & sanitized		
17	IN OUT — Proper disposition of returned, previously served, reconditioned, & unsafe food		

Compliance Status		COS	R
Time/Temperature Control for Safety			
18	IN OUT N/A N/O — Proper cooking time & temperature		
19	IN OUT N/A N/O — Proper reheating procedures for hot holding		
20	IN OUT N/A N/O — Proper cooling time & temperature		
21	IN OUT N/A N/O — Proper hot holding temperatures		
22	IN OUT N/A — Proper cold holding temperatures		
23	IN OUT N/A N/O — Proper date marking & disposition		
24	IN OUT N/A N/O — Time as a public health control: procedures & records		
Consumer Advisory			
25	IN OUT N/A — Consumer advisory provided for raw/undercooked food		
Highly Susceptible Populations			
26	IN OUT N/A — Pasteurized foods used; prohibited foods not offered		
Food and Color Additives and Toxic Substances			
27	IN OUT N/A — Food additives: approved & properly used		
28	IN OUT — Toxic substances properly identified, stored, & used		
Conformance with Approved Procedures			
29	IN OUT N/A — Compliance with variance/specialized process/HACCP		

Risk factors (RF) are improper practices or proceedures identified as the most prevalent contributing factors of foodborne illness or injury. **Public Health Interventions** (PHI) are control measures to prevent foodborne illness or injury.

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" in box if numbered item is **not** in compliance. Mark "X" in appropriate box for COS and/or R. **COS=** corrected on-site during inspection **R=** repeat violation

			COS	R
Safe Food and Water				
30		IN OUT N/A — Pasteurized eggs used where required		
31		Water & ice obtained from an approved source		
32		IN OUT N/A — Variance obtained for specialized processing methods		
Food Temperature Control				
33		Proper cooling methods used; adequate equipment for temperature control		
34		IN OUT N/A N/O — Plant food properly cooked for hot holding		
35		IN OUT N/A N/O — Approved thawing methods used		
36		Thermometers provided & accurate		
Food Identification				
37		Food properly labled; original container		
Prevention of Food Contamination				
38		Insects, rodents, & animals not present		
39		Contamination prevented during food prep, storage & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

			COS	R
Proper Use of Utensils				
43		In-use utensils: properly stored		
44		Utensils, equipment & linens: properly stored, dried, & handled		
45		Single-use/single service articles: properly stored & used		
46		Gloves used properly		
Utensil Equipment and Vending				
47		Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48	X	Warewashing facilities: installed, maintained, & used; test strips		
49		Non-food contact surfaces clean		
Physical Facilities				
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		Physical facilities installed, maintained, & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature) **Date:** 07/12/22

Inspector (Signature) Dan Harrison