Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

March 13, 2025

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

RE: Project Number(s) SL27607016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on February 13, 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 . . ."

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility**.

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

INFORMAL CONFERENCE
In accordance with Minn. Stat. § 144A.475, Subd. 8 OR Minn. Stat. § 144G.20, Subd. 20, the Commissioner of Health is authorized to hold a conference to exchange information, clarify issues, or resolve issues. The Department of Health staff would like to schedule a conference call with Jaris M 'Pokey' Paro Assisted Living. Please contact Jessie Chenze at 218-332-5175 on or before Wednesday, March 26, 2025, to schedule the conference call.

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,

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Jessie Chenze, Supervisor
State Rapid Response Team
Email: Jessie.Chenze@state.mn.us
Telephone: 218-332-5175 Fax: 1-800-337-9238

HHH

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 _____	02/13/2025

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 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: SL27067016-0 On February 11, 2025, through February 13, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were six resident(s); six receiving services under the Assisted Living Facility 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.	
0 100 SS=F	144G.10 Subdivision 1 License required (a)(1)Beginning August 1, 2021, no assisted living	0 100		

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0 100	Continued From page 1 facility may operate in Minnesota unless it is licensed under this chapter. (2) No facility or building on a campus may provide assisted living services until obtaining the required license under paragraphs (c) to (e). (b)The licensee is legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. Nothing in this chapter shall in any way affect the rights and remedies available under other law. (c) Upon approving an application for an assisted living facility license, the commissioner shall issue a single license for each building that is operated by the licensee as an assisted living facility and is located at a separate address, except as provided under paragraph (d) or (e). (d) Upon approving an application for an assisted living facility license, the commissioner may issue a single license for two or more buildings on a campus that are operated by the same licensee as an assisted living facility. An assisted living facility license for a campus must identify the address and licensed resident capacity of each building located on the campus in which assisted living services are provided. (e) Upon approving an application for an assisted living facility license, the commissioner may: (1) issue a single license for two or more buildings on a campus that are operated by the same licensee as an assisted living facility with dementia care, provided the assisted living facility for dementia care license for a campus identifies the buildings operating as assisted living facilities with dementia care; or (2) issue a separate assisted living facility with dementia care license for a building that is on a campus and that is operating as an assisted living facility with dementia care.	0 100		

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0 100	Continued From page 2 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to demonstrate legal responsibility for the control and operation of the facility when the licensee allowed use of the facility space to operate a home health care agency out of the assisted living facility. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to 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: During the entrance conference on February 11, 2025, at 9:14 a.m., licensed assisted living director (LALD)-A stated the licensee was familiar with current minimum assisted living requirements. During a facility tour on February 11, 2025, at 10:06 a.m., with interim clinical nurse supervisor (ICNS)-B, the surveyor observed a sign indicating Home Care Office on the door of room 169 located in the main entrance of the assisted living building and a sign on room door 173 in a hallway indicating Home Care Staff. In the main entrance of the lobby of the assisted living, the surveyor observed two licenses, consisting of a home care	0 100		

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0 100	Continued From page 3 comprehensive license with a different license number issued by the Minnesota Department of Health and the license of the assisted living. Registered nurse (RN)-B stated the home care agency was owned by the same organization as the assisted living license, the home care agency had their own employees, occupied an office space in the assisted living and shared the same entrance. On February 12, 2025, at 9:46 a.m., LALD-A stated both the home care agency and the assisted living were owned by the same organization and was not aware the licensee was required to apply for a variance to operate the home care agency out of the assisted living building. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 100		
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;	0 470		

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0 470	Continued From page 4 (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 clinical nurse supervisor (CNS) developed and implemented a staffing plan to determine staffing levels to meet the needs of all residents, which included reviewing the staffing plan at least twice a year. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee held an assisted living facility licensed for a capacity of 10 residents and had a current census of six residents.	0 470		

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0 470	Continued From page 5 During entrance conference on February 11, 2025, at 9:14 a.m., licensed assisted living director (LALD)-A stated the licensee was familiar with the current minimum assisted living requirements. On February 11, 2025, at 12:14 a.m., LALD-A stated they talk about staffing needs at every meeting; however, had not developed in writing or implemented a staffing plan 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 that 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		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (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	0 480		

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0 480	Continued From page 6 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 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.	0 480		

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0 480	Continued From page 7 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated February 12, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email 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 notice must also have the contact information for the 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. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. 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 licensee's 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 February 11, 2025, at 10:06 a.m., the surveyor observed and confirmed with interim clinical nurse supervisor (ICNS)-B, 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 9 On February 11, 2025, at 11:18 a.m., licensed assisted living director (LALD)-A stated the licensee's grievance procedure should have been posted and was aware of the requirement. The licensee's Complaint/Grievance Posting procedure 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		
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by:	0 580		

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0 580	Continued From page 10 Based on interview and record review, the licensee failed to implement and maintain a quality management program appropriate to the size of the facility and relevant to the type of services provided. 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 the residents). The findings include: During the entrance conference on February 11, 2025, at 9:14 a.m., licensed assisted living director (LALD)-A stated the licensee did not have a formal quality management program for the assisted living with documented meeting minutes. LALD-A stated they met as an organization for quality management; however, meetings were not specific to the assisted living. On February 12, 2025, at 2:10 p.m., LALD-A provided the surveyor with Continuous Quality Improvement (COI) agenda and meeting minutes for August 7, 2024, and November 6, 2024, that indicated each department should have an ongoing COI project and have one written up for each department supervisor. The above noted COI meeting minutes did not include any projects or topics related to the licensee. The licensee's Quality Management Project policy dated August 2021, indicated the licensee would have at least one documented quality	0 580		

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0 580	Continued From page 11 improvement project in place at all times, and retain records of such projects for at least two years. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 580		
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. (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	0 680		

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(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 12 by: Based on observation, 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 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 the entrance conference on February 11, 2025, at 9:14 a.m., licensed assisted living director (LALD)-A was identified as responsible for the development and maintaining the licensee's emergency preparedness plan. LALD-A stated the licensee's EPP was available on-line to review. During the facility tour on February 11, 2025, at 10:06 a.m., with interim clinical nurse supervisor (ICNS)-B, the licensee's emergency preparedness plan was not observed in the facility or readily available to residents, staff and visitors. The licensee's electronic Emergency Preparedness Plan dated October 13, 2023, lacked an emergency preparedness plan (EPP) with the following requirements: -annual review of the EPP; -quarterly review of the missing resident policy; -subsistence needs for staff and patients to	0 680		

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	27607	A. BUILDING: _____ B. WING _____	02/13/2025

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0 680	Continued From page 13 include food, medical supplies, sewage and waste disposal; -arrangements with other facilities to include copies of written arrangement agreements; -alternate means of communication; and -emergency prep testing requirements of the licensee's emergency preparedness plan with documentation of the facility's analysis and response. On February 13, 2025, at 9:49 a.m., LALD-A stated the licensee's emergency preparedness was a work in progress. LALD-A stated the licensee had purchased a template and was currently working on individualizing the EPP specifically to the licensee. LALD-A stated the licensee was working along side other departments within the organization in developing the licensee's EPP. LALD-A stated the licensee's EPP was only available electronically and not readily available to staff, residents and visitors. The licensee's Emergency Response Plan policy dated August 2021, indicated the licensee would have in place a general emergency preparedness plan, that was in alignment with facility's requirement to also comply with Centers for Medicare and Medicare Services State Operation Manual Appendix Z. The licensee's emergency plan would include all required elements of appendix Z. The plan would be in writing and reviewed annually. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		

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0 775	Continued From page 14	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 keep the facility in compliance with Minnesota State Fire Code under Minnesota Rule Chapter 7511. The deficient condition has the ability to affect all staff and 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 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 a facility tour on February 11, 2025, between 09:45 a.m. and 12:45 p.m. with the maintenance director (DM)-C, the surveyor observed the following conditions: SMOKE ALARMS: The DM-C checked a few smoke alarms in the resident rooms, they were over 10 years old from date of manufacture. All smoke alarms over 10 years old from date of manufacture shall be replaced with like type	0 775		

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0 775	Continued From page 15 alarms. EXTENSION CORD: The surveyor observed extension cords being used permanently in offices 108, 110 and 111. Electrical cords shall not be routed through walls/doors and shall not be used for permanent use. CARBON MONOXIDE: The surveyor did not observe carbon monoxide protection in the building. Carbon monoxide protection shall be provided in the building as discussed. EMERGENCY/EXIT LIGHTS: The surveyor observed that a few emergency lights inside the resident rooms failed to operate when push button tested. All exit/emergency lights shall be fixed and that all the lights shall push button tested monthly and the 30-minute test completed annually. This shall be documented. MEANS OF EGRESS: The surveyor observed snow blocking the west exit door. Exit doors shall always be openable, snow shall be removed in a timely manner. LINT:	0 775		

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0 775	Continued From page 16 The surveyor observed excessive lint accumulation on a few bathroom fan vent covers. The vent fan/covers shall be cleaned periodically. STORAGE: The surveyor observed combustible storage on top of the boilers in the mechanical room. No storage is allowed on top of the boilers/water heaters/furnaces. The deficient conditions were visually verified by DM-C accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 775		
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.	0 810		

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0 810	Continued From page 17 (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and the licensee failed to document required fire safety evacuation training for employees and residents as well as the required fire drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: A record review and interview were conducted on February 11, 2025, at approximately 12:15 p.m.	0 810		

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0 810	Continued From page 18 with maintenance (DM)-C on the fire safety and evacuation plan for the facility, fire drills and training records for the employees and residents. FIRE/EVACUATION PLAN: Record review indicated the fire safety and evacuation plan shall be updated. It was last updated on August 2021. The plan did not have the facility floor plan inserted in it, was not accessible, did not show resident movement or capabilities. The plan was generic. TRAINING: Record review indicated the licensee failed to complete and document fire safety and evacuation training for the employees at a minimum of twice a year and offer the residents the training at least once a year. FIRE DRILLS: Record review indicated that three fire drills were completed and documented in 2024. They are required to be completed two times per year on each shift and documented. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination.	01060		

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01060	Continued From page 19 (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on observation, interview and record	01060		

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01060	Continued From page 20 review, the licensee failed to provide written notice with required content to the resident, legal representative, and/or designated representative, and failed to provide the notification to the Office of Ombudsman for Long-Term Care (OOLTC) when the resident did not return from the emergency relocation within four days for one of one resident (R4) reviewed for a hospitalization. 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: R4's diagnoses included congestive heart failure, diabetes type II, coronary artery disease, stage III chronic kidney disease, high blood pressure, depression and bipolar disorder. R4's Service Plan dated January 13, 2025, indicated R4 received assistance with medication management, blood glucose and vital signs monitoring, safety checks, meals, housekeeping and laundry. On February 12, 2025, at 7:26 a.m., the surveyor observed unlicensed personnel (ULP)-D administering R4's morning scheduled medications. R4's progress notes entered December 26, 2024, indicated R4 had a fall on December 22, 2024, was sent to the emergency room and was	01060		

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01060	Continued From page 21 admitted for severe hyponatremia (low sodium level in the blood). R4's progress notes dated December 26, 2024, indicated R4 returned from the hospital December 26, 2024, at 2:00 p.m. R4's Hospital Summary dated December 26, 2024, indicated R4 was admitted on December 22, 2024, and was discharged on December 26, 2024, back to the assisted living. R4's record lacked evidence a written notice, including the following required content was provided to R4's representative: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. In addition, R2's record lacked notification was provided to the Office of Ombudsman for Long-Term Care for R2's hospitalization of four days or longer: In addition, R4's record lacked notification was provided to the Office of Ombudsman for Long-Term Care for R4's hospitalization of four	01060		

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01060	Continued From page 22 days or longer. On February 12, 2025, at 11:49 a.m., licensed assisted living director (LALD)-A and interim clinical nurse supervisor (ICNS)-B stated they were unaware of the requirements and had not been providing a written notice to residents when hospitalized or notifying the ombudsman of a hospital stay four days or longer. The licensee's Emergency Relocation policy dated August 2021, indicated in the event of an emergency relocation, the licensee would provide a written notice that contained at a minimum: -the reason for the relocation; -the name and contact information for the location to which the resident has been relocated and any new service provider; -contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; -if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and -a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal. The facility would provide contact information for the agency to which the resident may submit an appeal. The notice required would be delivered as soon as practicable to the resident, legal representative, and designated representative and to The Office of Ombudsman for Long-Term Care if the resident had been relocated and had not returned to the facility within four days. No further information was provided.	01060		

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01060	Continued From page 23 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01060		
01500 SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct	01500		

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01500	Continued From page 24 support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employees performing direct services completed the required annual training for two of two employees (interim clinical nurse supervisor (ICNS)-B, unlicensed personnel (ULP)-C). 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 was issued at a widespread scope (when problems are pervasive or represent a systemic	01500		

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01500	Continued From page 25 failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During entrance conference on February 11, 2025, at 9:14 a.m., licensed assisted living director (LALD)-A and ICNS-B stated they were familiar with the content of employee training records. ICNS-B ICNS-B had a hire date of September 7, 2022, to supervise and provide direct care to the licensee's residents. On February 11, 2025, through February 13, 2025, the survey observed ICNS-B provide services to the licensee's residents. ICNS-B's employee record lacked evidence ICNS-B successfully completed annual training in 2024 as required to include: -Assisted Living Bill of Rights; -a review of provider's policies and procedures; and -principles of person-centered planning/service delivery. ULP-D ULP-D had a hire date of September 18, 2023, to provide direct care to the licensee's residents. On February 12, 2025, at 10:20 a.m., the surveyor observed ULP-D administering R5's scheduled morning medications. ULP-D's employee record lacked evidence ULP-D successfully completed annual training in 2024 as required to include:	01500		

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01500	Continued From page 26 -review of provider's policies and procedures. On February 13, 2025, at 1:33 p.m., LALD-A stated they were unable to find documentation ICNS-B and ULP-D completed the required annual training noted above. The licensee's Annual Required Staff Training policy dated August 2021, indicated a training record, kept in employee records, would be retained for each employee who performs direct home care services to track compliance with annual training requirements. The following training elements must be included every 12 months to all staff who performs direct care services: -review of Assisted Bill of Rights; -review of the facility's policies and procedures related to the provisions of assisted living services and how to implement those policies and procedures; and -principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		
01750 SS=D	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated	01750		

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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
01750	Continued From page 27 the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Bases on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) prepared in writing specific instructions for each resident and documented those instructions for one of one resident (R4) who self-administered eye drops. 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: R4's diagnoses included dry eyes and diabetes type II. R4's Service Plan dated January 13, 2025, indicated R4 received medication administration services. R4's prescriber orders dated December 26, 2024, included the following eye drops: -olopatadine HCL 0.1% (used to treat dry eyes) instill one drop into both eye two times a day and wait five minutes between different types of eye	01750		

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01750	Continued From page 28 drops; and -carboxymethylcellulose (artificial tears) instill one drop in each eye twice a day for dryness. R4's Medication Assessment of Safety in Self Administration form dated December 20, 2024, indicated R4 was deemed able to partially safely self-administer medications to include topical and eye drops. R4's February 2025, Medication Administration Summary indicated R4 was scheduled and received olopatadine eye drops, one drop into affected eye(s) two times a day for dry, itchy eyes. Wait five minutes between different types of eye drops; and Artificial Tears one drop in each eye twice a day for dryness. R4's Medication Administration Summary did not indicate R4 was able to self-administer own eye drops. On February 12, 2025, at 7:15 a.m., the surveyor observed unlicensed personnel (ULP)-D prepare ULP-D's medications and eyes for administration. ULP-D stated R4 was able to self-administer own eye drops; however, ULP-D stated R4's electronic record did not indicate R4 was able to self-administer eye drops. ULP-D stated she worked full-time and was familiar with ULP-D's medications and plan of care. ULP-D stated new employees would receive verbal instructions R4 was able to self-administered eye drops. On February 12, 2025, at 1:32 p.m., interim clinical nurse supervisor (ICNS)-B stated R4 had a self-administration assessment completed on December 20, 2024, which deemed R4 competent to self-administer topical medications and eye drops. ICNS-B stated R4's Medication Administration Summery did not indicate R4 was able to self-administer eye drops and should	01750		

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01750	Continued From page 29 identify what medications R4 was able to self-administer. The licensee's Medication Management Individual Plan policy dated August 2021, indicated the licensee would develop and maintain an current individualized medication management record for each resident based on the resident's assessment that must contain the following: -a statement describing the medication management services that would be received; and -documentation of specific resident instructions relating to the administration of medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
01790 SS=D	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	01790		

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01790	Continued From page 30 nurse is not available, the registered nurse may 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,	01790		

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01790	Continued From page 31 including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of two unlicensed personnel (ULP-D) was trained by a registered nurse (RN) and had demonstrated competency to prepare and give medications for residents having unplanned time away. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on February 11, 2025, at 9:14 a.m., licensed assisted living director (LALD)-A stated ULPs were trained by the RN to prepare medications for residents who were going on a leave of absence. ULP-D was hired on September 18, 2023, to provide direct care services to residents of the facility. On February 12, 2025, at 7:15 a.m., the surveyor observed ULP-D administering R4's scheduled morning medications. ULP-D's employee record lacked evidence to indicate ULP-D had demonstrated competency to	01790		

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01790	Continued From page 32 provide medications to residents for unplanned times away from home. On February 13, 2025, at 10:55 a.m., LALD-A stated the RN completed the skills check-off list for Medication Administration for Unplanned of Leave of Absence during medication training and LALD-A stated they were unable to find training and competency records indicating ULP-D completed the required training and competency. The licensee's Medication Management-Planned and Unplanned Time Away policy dated August 2021, indicated the registered nurse would trained the unlicensed staff and determined the unlicensed staff was competent to follow the procedures for giving medications to residents. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to date time-sensitive medications with opened and expiration dates for two of two residents (R2, R4) whose medications	01890		

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01890	Continued From page 33 were stored by the licensee. 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: On February 11, 2025, at 10:18 a.m., the surveyor observed the licensee's medication storage cabinets with interim clinical nurse supervisor (ICNS)-B. ICNS-B stated staff were trained to date insulins, inhalers and eye drops when opened and would expire and stored medications were checked weekly for expired medications. ICNS-B confirmed the following: -R2's opened bottle of latanoprost 0.005% eye drop and R2's opened bottle of brimonidine (Alphagan) 0.15% eye drop, both used to treat glaucoma, lacked the date the eye drops had been opened and when the eye drops would expire; and -R4's opened bottle of olopatadine HCL 0.1% eye drop used to treat dry, irritated eyes, lacked the date the eye drop had been opened and when the eye drop would expire. The manufacturer's instructions for latanoprost eye drop dated August 2011, directed once the eye drop is opened for use, it may be stored at room temperature for six weeks.	01890		

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01890	Continued From page 34 The manufacturer's instructions for brimonidine eye drop dated February 2022, directed to discard bottle 28 days after opening, even if there is solution remaining. The manufacturer's instructions for olopatadine eye drop dated July 2021, directed to write down the date the eye drop was opened in the space on each bottle label and box and throw away the bottle four weeks after first opened to prevent infection. The licensee's Medication Storage policy dated August 2021, indicated when medications were managed and stored by the licensee, medications would be kept securely locked and stored per manufacturer's directions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01910 SS=F	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances.	01910		

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01910	Continued From page 35 (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document in the resident record all of the required content in the disposition of medications for one of one resident (R1) upon discharge. 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: R1's diagnoses included congestive hear failure, type II diabetes, bipolar affective and depressive disorder, and anxiety. R1's December 2024 Medication Administration Summary indicated R1 was scheduled and received the following medications: -hydroxyzine hcl 25 milligrams (mg) one tablet daily for anxiety; -acetaminophen 500 mg two tablets three times a day for pain; -hydroxyzine hcl 25 mg one tablet every six hours for anxiety;	01910		

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01910	Continued From page 36 -amiodarone 200 mg one tablet daily for irregular heart beat; -aspirin 81 mg one tablet daily for hear health; -isosorbide ER 30 mg two tablets daily to prevent chest pain; -Jardiance 10 mg one tablet daily for diabetes; -lamotrigine 150 mg one tablet daily for mood disorder; -Lantus Solostar insulin 20 units twice daily for diabetes; -losartan 25 mg one tablet daily for high blood pressure; -multivitamin one tablet daily for supplementation; -Novolog inject 10 units of insulin with a small meal and 20 units with a large meal daily for diabetes; -oxycodone 5 mg one tablet one tablet daily in the morning and once in the evening as needed for pain; -pressure 10 mg one tablet daily to prevent blood clots; -granola ER 500 mg one tablet twice daily for chest pain; -Senna 8.6 mg two tablets daily in the morning for constipation; -spironolactone 25 mg one tablet daily for high blood pressure; -Mona inject 7.5 mg weekly for diabetes; -atorvastatin 40 mg one tablet daily for high cholesterol; -metoprolol succinate ER 25 mg two tablets daily for high blood pressure; -mirtazapine 7.5 mg one tablet daily for depression; -vitamin B-12 500 micrograms (mcg) one tablet daily for supplementation; and -vitamin D3 25 mcg one tablet daily for supplementation. R1's prescriber orders dated September 27,	01910		

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01910	Continued From page 37 2024, included above noted medications. R1's Discharge/Transfer Summary dated December 2, 2024, indicated R1 was admitted October 21, 2024, and discharged to home December 2, 2024. R1's discharge summary indicated R1 received medication management and R1's medications were sent with R1 at discharge. R1's Medication Disposition record dated December 2, 2024, included documentation for the disposition of the medications noted above of the medication's name, strength, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition; however, lacked documentation of the medication prescription number, as applicable. On February 11, 2025, at 3:27 p.m., interim clinical nurse supervisor (ICNS)-B stated they had not been documenting the medication prescription numbers and were unaware the prescription number was required when disposing medications. ICNS-B verified the licensee's Medication Disposition form included a column to document the medication prescription number. The licensee's Medication Disposal policy dated August 2021, indicated current unused medications being managed by the licensee would be returned to the pharmacy for credit, or given to the resident or resident's representative, when the resident's medications were no longer managed by the facility, or the medication have been discontinued by the provider. Upon disposition, the facility must document in the resident's record the disposition of the expired medication including the medications name,	01910		

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01910	Continued From page 38 strength, prescription number as applicable, quantity, date of the disposition, and name of staff (including a witness) and other individuals involved in disposition. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
02320 SS=D	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. 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 medication administration by unlicensed personnel (ULP)-D for one of one resident (R4) whose medications were not administered as directed. 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	02320		

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02320	Continued From page 39 situation has occurred only occasionally). The findings include: During entrance conference on February 11, 2025, at 9:14 a.m., licensed assisted living director (LALD)-A stated the licensee provided medication management services to the licensee's residents. ULP-D had a hire date of September 18, 2023, to provide services to the licensee's residents. ULP-D's employee record indicated ULP-D completed training and skills competency in medication administration routes dated October 3, 2023, to include eye drop administration. R4's prescriber orders dated December 26, 2024, included the following eye drops: -olopatadine HCL 0.1% (used to treat dry eyes) instill one drop into both eye two times a day and wait five minutes between different types of eye drops; and -carboxymethylcellulose (artificial tears) instill one drop in each eye twice a day for dryness. R4's February 2025, Medication Administration Summary indicated R4 was scheduled and received olopatadine eye drops, one drop into affected eye(s) two times a day for dry, itchy eyes. Wait five minutes between different types of eye drops; and Artificial Tears one drop in each eye twice a day for dryness. On February 12, 2025, at 7:15 a.m., the surveyor observed ULP-D prepared R4's medications and eye drops, entered R4's room, administered R4's medications then handed R4 a bottle of Refresh Tears and a bottle of olopatadine eye drops. R4	02320		

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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
02320	Continued From page 40 proceeded and self-administered both eye drops one right after the other, not waiting five minutes between administration of each eye drop. ULP-D did not instruct R4 to wait five minutes in between eye drops as directed. On February 12, 2025, at 1:32 p.m., interim clinical nurse supervisor (ICNS)-B stated R4 had a self-administration assessment completed on December 20, 2024, which deemed R4 competent to self-administer own topical medications and eye drops. Registered nurse (RN)-F stated staff should notify the nurse if a resident inappropriately self-administered their medications. RN-F stated staff should give R4 one eye bottle, wait five minutes then give R4 the other eye drop bottle to self-administer to ensure R4 waited five minutes between each eye drops. ICNS-B and RN-F stated ULP-D did not notified them R4 was incorrectly administering her eye drops. On February 12, 2025, at 2:02 p.m., ULP-D stated she was aware R4 did not wait five minutes between self-administrating both eye drops as directed on R4's medications administration summary. ULP-D stated R4 had the right to choose not to follow the directions when administering her eye drops. ULP-D stated one of R4's eye drops could be purchased without a doctor's prescription, so it had different guidelines than an eye drop prescribed by a physician. ULP-D stated she had not notified the nurse R4 incorrectly administered her eye drops because the nurses were already aware. The manufacturer's instructions for olopatadine 0.1% solution dated July 2021, indicated if using other eye drops or eye ointment medicines, leave at least five minutes between each eye drop.	02320		

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 _____	02/13/2025

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
02320	Continued From page 41 The licensee's Eye Drops and Eye Ointment policy dated August 1, 2021, indicated only properly trained staff of the licensee may provide medication assistance or administration. ULP must be trained, and competency tested by a RN (registered nurse), with documentation on file. Eye drop and eye ointment medications must be administered according to the prescriber's orders. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		

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

Type: Full
Date: *02/12/25*
Time: 10:15:00
Report: 1027251015

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 previously issued on 07/11/22 have NOT been corrected.

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.
Issued on: 07/11/22 *Comply By: 07/25/22*

The following orders were issued during this inspection.

2-200 Employee Health

2-201.11C ***** Priority 1 *****

MN Rule 4626.0040C The person in charge must record all reports of diarrhea or vomiting made by food employees and report those illnesses to the regulatory authority at the specific request of the regulatory authority.
AT TIME OF INSPECTION ILLNESS LOG DID NOT HAVE ANY REPORTED ILLNESSES FOR A YEAR. MANAGER STATED THEY WOULD RECORD STAFF ILLNESSES MOVING FORWARD. COS

Corrected on Site

Surface and Equipment Sanitizers

Hot Water: = at 162 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

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

Type: Full
Date: *02/12/25*
Time: 10:15:00
Report: 1027251015
Jaris M 'Pokey' Paro Assisted

Food and Beverage Establishment Inspection Report

Food and Equipment Temperatures

Process/Item: Prep Cooler
Temperature: 34 Degrees Fahrenheit - Location: BOTTOM-THERMOMETER
Violation Issued: No

Process/Item: Prep Cooler
Temperature: 39 Degrees Fahrenheit - Location: BOTTOM-NOODLES
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 35 Degrees Fahrenheit - Location: THERMOMETER
Violation Issued: No

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

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

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

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

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

DISCUSSED EMPLOYEE ILLNESS AND EXCLUSIONS, REQUIRED SANITIZER STRENGTHS, AND AVOIDING BARE HAND CONTACT WITH READY TO EAT FOODS.

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 1027251015 of 02/12/25.

Certified Food Protection Manager: DENISE HOULE

Certification Number: FM112693 Expires: 06/24/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
DENISE HOULE
MANAGER

Signed: Ian Harrison
Ian H

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

Report #: 1027251015

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

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

No. of RF/PHI Categories Out	1
No. of Repeat RF/PHI Categories Out	0
Legal Authority MN Rules Chapter 4626	

Date 02/12/25
Time In 10:15:00
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
Surpervision							
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	X	
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		X
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:** 02/12/25

Inspector (Signature) Dan Harrison