Electronically Delivered

February 24, 2026

Licensee
New Perspective - Cloquet and Barnum
701 Horizon Circle
Cloquet, MN 55720

RE: Project Number(s) SL24315016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on January 22, 2026, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

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

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

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

St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $500.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

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

factor.

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

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

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

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

If you have any questions, please contact me.

Sincerely,

Jessie Chenze

Jessie Chenze, Supervisor
State Evaluation Team
Email: Jessie.Chenze@state.mn.us
Telephone: 218-332-5175 Fax: 1-866-890-9290

KKM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24315	A. BUILDING: _____ B. WING _____	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE - CLOQUET & BA	701 HORIZON CIRCLE 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: SL24315016-0 On January 20, 2026, through January 22, 2026, the Minnesota Department of Health conducted a change of ownership (CHOW) survey at the above provider. At the time of the survey, there were 46 residents; 46 receiving services under the Assisted Living Facility with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24315	A. BUILDING: _____ B. WING _____	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE - CLOQUET & BA	701 HORIZON CIRCLE 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
0 480	Continued From page 1 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are	0 480		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24315	A. BUILDING: _____ B. WING _____	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE - CLOQUET & BA	701 HORIZON CIRCLE 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
0 480	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated January 21, 2026, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.	0 480		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24315	A. BUILDING: _____ B. WING _____	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE - CLOQUET & BA	701 HORIZON CIRCLE 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
0 480	Continued From page 3 TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure services were provided according to accepted health care, medical, or nursing standards in regard to infection control during medication and treatment administration for one of four employees (unlicensed personnel (ULP)-D). In addition, the licensee failed to ensure infection control standards were followed to disinfect shared reusable medical equipment for one of one employee (ULP-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when	0 510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24315	A. BUILDING: _____ B. WING _____	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE - CLOQUET & BA	701 HORIZON CIRCLE 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
0 510	Continued From page 4 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: ULP-D had hire date of August 12, 2024, to provide care and services to the residents of the licensee. ULP-D's employee record indicated ULP-D completed medication training November 14 and 15, 2024, and annual infection control training November 6, 2025. On January 21, 2026, at 7:25 a.m., the surveyor observed ULP-D prepare R3's medications, gather R3's blood glucose meter and insulins and placed in the blood pressure basket directly on the blood pressure cuff. ULP-D entered R3's room, removed the blood glucose meter and insulins from the blood pressure basket and placed the blood pressure cuff around R3's left arm and obtained a blood pressure reading of 152/57 and pulse 72. ULP-D monitored R3's blood glucose by poking R3's right finger collecting a blood sample on the test strip and obtained a blood glucose reading of 294. ULP-D administered R3's insulins into R3's abdomen then placed the blood glucose meter, used supplies and insulin pens back into the basket directly on the blood pressure cuff. ULP-D removed gloves, exited R3's room, tossed used disposable blood glucose supplies into the garbage, placed insulin pens and blood glucose meter back into the medication cart and documented in R3's electronic medication administration record (eMAR) medications were administered. The surveyor did not observe ULP-D perform hand hygiene after the removal of	0 510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24315	A. BUILDING: _____ B. WING _____	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE - CLOQUET & BA	701 HORIZON CIRCLE 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
0 510	Continued From page 5 gloves or disinfect the blood pressure cuff or equipment where R3's insulin pens and blood glucose meter were placed after use. -At 7:45 a.m., the surveyor observed ULP-D prepare R8's medications. ULP-D stated R8's blood pressure needs to be checked before administering R8's lisinopril (used to treat high blood pressure). ULP-D gathered R8's insulin, blood glucose meter and supplies and placed in the basket directly on the shared blood pressure cuff. At 7:52 a.m., ULP-D entered R8's room and obtained R8's blood pressure with the shared automatic blood pressure machine for a reading of 149/72; pulse 64. ULP-D stated R8 was able to take all medications. ULP-D proceeded and monitored R8's blood glucose. ULP-D cleansed R8's right pointer finger, poked R8's finger and obtained a blood sample onto the test strip and received a blood glucose reading of 112. ULP-D administered R8's insulin and medications, gathered used blood glucose supplies and insulin pen and placed in the basket of the blood pressure machine directly on the blood pressure cuff. ULP-D removed gloves, exited room, returned to the medication cart, disposed of used blood glucose supplies and placed the automatic blood pressure machine in the corner of the room. The surveyor did not observe ULP-D perform hand hygiene or disinfect the shared blood pressure cuff or equipment after use. -At 8:14 a.m., the surveyor observed ULP-D prepare and administer R7's inhaler and medications at the dining room table. ULP-D removed gloves, documented in eMAR and did not perform hand hygiene. -At 8:22 a.m., the surveyor observed ULP-D monitor R6's blood glucose and administered	0 510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24315	A. BUILDING: _____ B. WING _____	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE - CLOQUET & BA	701 HORIZON CIRCLE 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
0 510	Continued From page 6 R6's insulin at the dining table. ULP-D removed gloves, documented in eMAR and did not perform hand hygiene. On January 21, 2026, at 8:30 a.m., ULP-D stated ULP-D did not disinfect the blood pressure cuff or equipment after resident use because there were no disinfecting wipes or hand sanitizer available in Cottage 8. On January 22, 2026, at 12:41 p.m., registered nurse (RN)-B stated staff should perform hand hygiene before preparing medications, after administration of medications and after the removal of gloves. RN-B stated staff should be using Sani-Cloth disinfecting wipes to wipe down shared equipment after use. RN-B stated disinfecting wipes and hand hand sanitizer had been replenished in all of the buildings. The licensee's Medication Administration policy dated November 21, 2024, indicated performing hand hygiene and donning gloves is required if touching any medication while removing it from the bottle/packaging; in this scenario, gloves are to be removed and discarded, and hand hygiene performed after preparing the medication and before entering the resident's apartment. The licensee's Use of Gloves policy dated October 14, 2024, indicated after the use of gloves, perform hand hygiene in accordance with the Hand Washing and Use of Hand Sanitizers policies and procedures. The licensee's Hand Washing policies dated October 14, 2024, indicated team members would wash hands between resident care and whenever direct physical contact with a resident. Use of gloves do not replace hand washing.	0 510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24315	A. BUILDING: _____ B. WING _____	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE - CLOQUET & BA	701 HORIZON CIRCLE 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
0 510	Continued From page 7 Hands would be washed: -before and after direct care of a resident; -after contact with surfaces or equipment in the immediate vicinity of the resident; and -before applying and after removing personal protective equipment. The licensee's Use of Hand Sanitizers policy dated October 14, 2024, indicated Soap and water must be used when hands appear dirty, after using the bathroom, and prior to preparing food. In other situations, alcohol-based hand sanitizers may be used instead of soap and water to sanitize hands. Hand sanitizer may only be used three (3) times before hands must be washed with soap and water. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
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, record review, and interview, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 775		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24315	A. BUILDING: _____ B. WING _____	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE - CLOQUET & BA	701 HORIZON CIRCLE 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
0 775	Continued From page 8 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, Physical Environment Inspection Report (PEIR) dated January 21, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775		
0 790 SS=D	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to ensure the	0 790		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24315	A. BUILDING: _____ B. WING _____	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE - CLOQUET & BA	701 HORIZON CIRCLE 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
0 790	Continued From page 9 physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. 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: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated January 21, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
0 810 SS=E	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	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24315	A. BUILDING: _____ B. WING _____	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE - CLOQUET & BA	701 HORIZON CIRCLE 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
0 810	Continued From page 10 emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. 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	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24315	A. BUILDING: _____ B. WING _____	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE - CLOQUET & BA	701 HORIZON CIRCLE 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
0 810	Continued From page 11 found to be pervasive). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated January 21, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twnety-one (21) days	0 810		
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 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: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) prepared in writing specific instructions for one of one resident (R2) who received medication management services. This practice resulted in a level two violation (a violation that did not harm a resident's health or	01750		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24315	A. BUILDING: _____ B. WING _____	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE - CLOQUET & BA	701 HORIZON CIRCLE 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 12 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 January 20, 2026, at 10:25 a.m., licensed assisted living director (LALD)-A stated the licensee provided medication management services to residents at the facility. R2's diagnoses included type two diabetes, dementia, hypertension (high blood pressure), shortness of breath and osteoporosis. R2's Service Plan effective date January 5, 2026, included assistance with medication management and administration. R2's hospice orders dated January 20, 2026, included order for: -hydromorphone 2 milligrams (mg) one tablet by mouth every four hours as needed for pain. R2's January 2026 Medication Administration Record (MAR) indicated R2 was scheduled and received hydromorphone 2 mg one tablet by mouth every four hours as needed for pain or shortness of breath. R2's MAR indicated able to crush medications; however, did not indicate to mix crushed medications, mix with water and administer medication mixture through a syringe. On January 20, 2026, at 12:16 p.m., the surveyor observed unlicensed personnel (ULP)-C prepare	01750		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24315	A. BUILDING: _____ B. WING _____	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE - CLOQUET & BA	701 HORIZON CIRCLE 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 13 R2's unscheduled hydromorphone 2 mg. ULP-C crushed hydromorphone 2 mg pill into a powder substance, obtained a one milliliter (ml) syringe, filled it with water, and mix the crushed medication with the water in a clear plastic medication cup. ULP-C drew the medication mixture into the syringe and administered directly into R2's mouth. Immediately following R2's medication administration, ULP-C documented in R2's MAR medication was administered. R2's MAR's indicated "may crush meds", however, did not indicate to mix crushed medication with water and administer with a syringe. ULP-C stated they were trained how to administer crushed medication through a syringe in initial medication training. ULP-C stated R2's record did not include written instructions to crush medications and administer through a syringe. ULP-C stated ULP-C knew R2 did not like to take her crushed medications mixed with yogurt or applesauce and that was why ULP-C mixed with water and administered through a syringe. On January 20, 2026, at 3:53 p.m., registered nurse RN-B stated if there were any specific directions for administering medications, the written instructions should be on the residents MAR. RN-B stated R2's record indicated it was okay to crush R2's medications; however, did not include instructions to crush medication, mix with water and administer through a syringe. The licensee's Medication Administration policy dated November 21, 2024, indicated prior to administering medication, the med passer would be appropriately licensed or, where allowable by law, would have been trained, evaluated for competency, and delegated/authorized by a licensed nurse to administer medication in accordance with applicable policy and procedure.	01750		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24315	A. BUILDING: _____ B. WING _____	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE - CLOQUET & BA	701 HORIZON CIRCLE 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 14 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the registered nurse (RN) failed to ensure medications were administered per prescriber orders for one of seven residents (R3) observed during medication administration. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24315	A. BUILDING: _____ B. WING _____	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE - CLOQUET & BA	701 HORIZON CIRCLE 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
01760	Continued From page 15 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on January 20, 2026, at 10:25 a.m., licensed assisted living director (LALD)-A stated the licensee provided medication management services to residents at the facility. R3's diagnoses included cognitive communication deficit, mild cognitive impairment, and type 1 diabetes. R3's Resident Service Agreement dated December 17, 2025, indicated R3 received medication management services. On January 21, 2026, at 7:25 a.m., the surveyor observed unlicensed personnel (ULP)-D prepare R3's scheduled medications and gathered R3's Humalog (rapid-acting) and Lantus (long-acting) insulins and supplies from the medication cart. ULP-D entered R3's room and ULP-D obtained R3's blood glucose with a reading of 294. ULP-D stated R3 would get a total of 12 units of Humalog insulin which included the sliding scale dose. ULP-D dialed 12 units of Humalog insulin and administered into R3's left upper abdomen. ULP-D prepared R3's Lantus insulin pen and dialed 13 units of Lantus insulin and injected into R3's right upper abdomen. During the insulin administration observation, ULP-D did not have R3's medical record to ensure correct insulin doses were administered including Humalog sliding scale which was based on R3's blood glucose results. Immediately following R3's insulin administration, ULP-D documented in R3's electronic medication administration record	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24315	A. BUILDING: _____ B. WING _____	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE - CLOQUET & BA	701 HORIZON CIRCLE 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
01760	Continued From page 16 (eMAR), R3's blood glucose was 289 milligrams per deciliter (mg/dl). The surveyor asked ULP-D how ULP-D knew what R3's blood glucose was, and ULP-D stated from ULP-D's memory. The surveyor asked ULP-D to pull the memory recall on R3's blood glucose meter to confirm R3's blood glucose results. R3's blood glucose meter indicated R3's most recent blood glucose was 294, not 289 as ULP-D initially documented. ULP-D changed R3's blood glucose reading in the eMAR to 294 and stated it did not change the amount of Humalog insulin R3 would receive. The surveyor asked ULP-D how ULP-D knew how much Humalog sliding scale insulin R3 was to receive without having R3's MAR at the time ULP-D administered R3's insulins. ULP-D stated R3's sliding scale insulin had not changed and ULP-D reviewed R3's insulin instructions before entering R3's room. ULP-D proceeded and documented in R3's eMAR R3 received a total of 12 units of Humalog insulin, 10 units of Humalog sliding scale and 13 units of Lantus insulin. R3's January 2026 Medication Administration Record (MAR), indicated R3 received the following medications and treatments: -blood sugar checks four times a day; -Humalog insulin three units daily with meals and hold if blood sugar was less than 120 mg/dl; -Lantus insulin 13 units once daily in the morning; -Humalog insulin inject with meals per sliding scale three times a day as follows: 161-190=2 units; 191-220=4 units; 221-250=6 units; 251-280=8 units; 281-310=10 units; 311-340=12 units; 341-370=14 units	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24315	A. BUILDING: _____ B. WING _____	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE - CLOQUET & BA	701 HORIZON CIRCLE 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
01760	Continued From page 17 371-400=16 units; 401-430=18 units; 431-460=20 units; 461-490=22 units; 491-520=24 units; 521-550=26 units; 551-580=28 units; 581-610=30 units; >610=32 units. R3's prescriber orders dated December 29, 2025, included the orders noted above. On January 22, 2026, at 12:17 p.m., RN-B and RN-G stated if a resident received insulin based on a sliding scale, staff were expected to first check the residents blood glucose then record the results in the eMAR and determine if the resident was to receive any sliding scale insulin. If the resident was to receive sliding scale insulin, staff were expected to prepare the insulin at the medication cart while referring to the directions in the resident's eMAR. RN-B stated staff should not prepare the dosage of sliding scale insulin in the resident's room without having the instructions to refer to. RN-B and RN-G reviewed R3's MAR and stated R3 should have received four units of scheduled Humalog and 10 units of sliding scale Humalog insulin for a total of 14 units; instead of 12 units of Humalog and 10 units of Humalog sliding scale as ULP-D documented in R3's record. RN-B stated they would have to into it further as it may an issue how ULP-D is documenting insulin dosages administered. RN-B stated either way, it looks like ULP-D did not administer the correct dose of insulin. The licensee's Medication Administration/Insulin and Insulin Derivatives dated November 21, 2024, indicated for each administration of	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24315	A. BUILDING: _____ B. WING _____	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE - CLOQUET & BA	701 HORIZON CIRCLE 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
01760	Continued From page 18 medication, med passers will follow the seven (7) rights: -Right resident; -Right medication; -Right dose; -Right route; -Right time and day; -Right reason; and -Right documentation. The licensed nurse or med passer (for tasks that may be delegated per applicable law) would: -Following the seven (7) rights, with the eMAR open to the resident's medications: -Compare the medication order in the eMAR to the label on the medication container; -Check the expiration date on the insulin pen to verify the medication has not expired; -Identify the appropriate site for the insulin injection, rotating injection sites upon each administration; -Gather needed supplies for insulin administration. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01890 SS=F	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	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24315	A. BUILDING: _____ B. WING _____	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE - CLOQUET & BA	701 HORIZON CIRCLE 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
01890	Continued From page 19 by: Based on observation, interview, and record review, the licensee failed to ensure medications were maintained bearing the original prescription label with legible information including the expiration date for time sensitive medications for four of four medication carts. 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 the entrance conference on January 20, 2026, at 10:25 a.m., licensed assisted living director (LALD)-A stated the licensee provided medication storage for residents at the facility. COTTAGE #8 MEDICATION CART On January 20, 2026, at 12:02 p.m., the surveyor reviewed the medication cart in Cottage 8 with unlicensed personnel (ULP)-C and observed the following: -R2's opened Lantus (long-acting) pre-filled insulin pen lacked the date the insulin had been opened and when the insulin would expire; -R3's opened Lantus pre-filled insulin pen lacked the date the insulin had been opened and when the insulin would expire. -R6's opened Lantus pre-filled insulin pen lacked the date the insulin had been opened and when the insulin would expire; -R7's opened Combivent inhaler (for chronic	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24315	A. BUILDING: _____ B. WING _____	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE - CLOQUET & BA	701 HORIZON CIRCLE 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
01890	Continued From page 20 pulmonary disease) lacked the date the inhaler had been opened and when the inhaler would expire; and -R8's opened albuterol inhaler (used to treat bronchospasms) included a date sticker, however, lacked the date the inhaler had been opened and when the inhaler would expire. COTTAGE #5 MEDICATION CART On January 20, 2026, at 12:47 p.m., the survey reviewed the medication cart in Cottage 5 with ULP-F and observed the following: -R10's opened Dorzolamide hydrochloride and brimonidine/timolol eye drops (used to treat high pressure in the eyes) lacked the date the eye drops had been opened and when the eye drops would expire; During the medication cart observation, ULP-F stated she thought the afternoon shift was assigned to go through the medication cart but was unsure how often. COTTAGE #6 MEDICATION CART On January 20, 2026, at 1:26 p.m., the surveyor reviewed the medication cart in Cottage 6 with ULP-E and observed the following: -R12's two opened Advair HFA (used to treat asthma symptoms) inhalers lacked the dates the inhalers had been opened and when the inhalers would expire. During the medication cart observation, ULP-E stated they go through the medication carts on Monday and Thursdays looking for expired medications and making sure mediations were dated when opened. On January 20, 2026, at 3:53 p.m., registered nurse (RN)-B stated the ULP assigned to the medication cart goes through the medication carts every Monday and Thursday looking for	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24315	A. BUILDING: _____ B. WING _____	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE - CLOQUET & BA	701 HORIZON CIRCLE 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
01890	Continued From page 21 expired medications and the nurses complete routine audits. Clinical nurse supervisor (CNS)-B stated when insulin, eye drops, inhalers, creams, bottles of medications were opened, staff have been instructed to put the date the medication had been opened and for time-sensitive medications, put the date the medication would expire. COTTAGE #7 MEDICATION CART On January 21, 2026, at 11:22 a.m., the surveyor reviewed the medication cart in Cottage 7 with ULP-G and observed the following: -R13's opened Novolog pre-filled (rapid-acting) insulin lacked the date the insulin had been opened and when the insulin would expire. The manufacturer's instructions for use of Lantus dated June 2022, indicated to discard the Lantus insulin pen 28 days after opening, even if the insulin pen still contains Lantus. The manufacturer's instruction for use of Combivent inhaler dated January 2020, indicated to use within 28 days after opening. The manufacturer's instructions for use of Dorzolamide hydrochloride eye drops dated January 2020, indicated to use within 28 days after opening the bottle. The manufacturer's instructions for the use of brimonidine/timolol eye drops dated December 14, 2022, indicated to discard unused portion 28 days after opening. The manufacturer's instructions for use of Ventolin inhaler dated 2011, indicated to throw away when the counter reads 000 or 12 months after removed from the foil package.	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24315	A. BUILDING: _____ B. WING _____	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE - CLOQUET & BA	701 HORIZON CIRCLE 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
01890	Continued From page 22 The manufacturer's instructions for use of Advair HFA inhaler dated December 2014, indicated to throw away inhaler when counter reads 000 or by the expiration date on the package. The manufacturer's instructions for use of Novolog dated February 2023, indicated to discard the Novolog insulin pen 28 days after opening, even if the insulin pen still contains insulin. The licensee's Medication Management/ Medication Storage policy dated June 27, 2024, indicated medications managed by the licensee would be securely stored in original-labeled container per pharmacy instructions and organized by resident, in accordance with applicable law. Each container stored by the licensee would carry the following information to include the expiration date of the medication. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) day	01890		
01950 SS=D	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24315	A. BUILDING: _____ B. WING _____	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE - CLOQUET & BA	701 HORIZON CIRCLE 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
01950	Continued From page 23 personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record for one of two residents (R4) who received treatment and therapy services. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a 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 January 20, 2026, at 10:25 a.m., licensed assisted living director (LALD)-A stated the licensee provided treatment and therapy services to residents at the facility. R4's diagnosis included diabetes type II.	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24315	A. BUILDING: _____ B. WING _____	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE - CLOQUET & BA	701 HORIZON CIRCLE 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
01950	Continued From page 24 On January 21, 2026, at 11:41 a.m., unlicensed personnel (ULP)-F informed the surveyor ULP-F was going to check R4's blood glucose (sugar). ULP-F stated R4's blood glucose supplies were stored in R4's room. ULP-F enter R4's room and inform R4 it was time to check R4's blood glucose. R4's blood glucose meter and supplies were in R4's room. R4 checked own blood glucose and obtained a blood glucose reading of 247. ULP-F exited R4's room leaving R4's blood glucose meter and supplies in R4's room and ULP-F documented blood glucose results in R4's electronic medication administration record (eMAR). R4's Service Plan dated January 16, 2026, indicated R4 received blood glucose monitoring and R4 was able to poke own finger to obtain blood glucose and staff were to observe procedure. R4's Medication and Treatment and Therapies Management Plan dated December 15, 2025, indicated R4 received blood glucose monitoring and R4's treatment, or therapy instructions were in the eMAR and treatment supplies would be securely stored in a locked medication cart. R4's January 2026 Medication Administration Record (MAR) indicated R4 was scheduled and received blood glucose monitoring four times a day. R4's MAR did not indicate R4 was able to self-monitor blood glucose with staff supervision or R4's blood glucose supplies could be kept in R4's room. On January 22, 2026, at 12:27 p.m., registered nurse (RN)-B stated R4's blood glucose supplies should be kept in the locked medication cart.	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24315	A. BUILDING: _____ B. WING _____	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE - CLOQUET & BA	701 HORIZON CIRCLE 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
01950	Continued From page 25 RN-B stated R4 was able to check own blood glucose with staff supervision and R4's blood glucose supplies should not be stored in R4's room unless indicated otherwise. RN-B stated R4's MAR did not include written instructions R4 was able to monitor own blood glucose under the supervision of staff and what method was used or R4's blood glucose supplies could be stored in R4's room. The licensee's Treatment or Therapy Management services policy dated March 21, 2023, indicated after assessment or orders received for treatment or therapy services, the licensed nurse would develop and maintain a current individualized treatment and therapy management plan for each resident to include: -a statement of the type of treatment or therapy services would be provided; and -any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed and monitoring of treatment or therapy in an effort to prevent possible complications or adverse reactions. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		
02320 SS=E	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	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24315	A. BUILDING: _____ B. WING _____	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE - CLOQUET & BA	701 HORIZON CIRCLE 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 26 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 ensure privacy was maintained for two of two residents (R6, R7) while receiving medication and treatment 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 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: During the entrance conference on January 20, 2026, at 10:25 a.m., licensed assisted living director (LALD)-A stated the licensee provided medication and treatment management services to residents at the facility. Unlicensed personnel (ULP)-D had hire date of August 12, 2024, to provide care and services to the residents of the licensee. ULP-D's employee record indicated ULP-D completed the following trainings: -insulin administration and blood glucose monitoring November 14, 2024; -medication administration November 15, 2024; and -Assisted Living Bill or Rights-Minnesota on	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24315	A. BUILDING: _____ B. WING _____	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE - CLOQUET & BA	701 HORIZON CIRCLE 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 27 August 14, 2024, and January 1, 2026. On January 21, 2026, at 8:14 a.m., the surveyor observed ULP-D prepare R7's medications and administer R7's inhaler at the dining table while R7 was eating breakfast and other residents were present eating breakfast. -At 8:22 a.m., the surveyor observed ULP-D monitor R6's blood glucose (sugar) and administer R6's insulin and while R6 was sitting at the dining table during breakfast with other residents present. ULP-D cleansed R6's right pointer finger, poked R6's finger, collected a blood sample and obtained a blood glucose reading of 98 milligrams per deciliter (mg/dl). ULP-D prepared eight units of Lantus (long-acting) insulin and administered into R6's right abdomen at the dining table. During ULP-D's medication and treatment administration observations noted above, the surveyor did not observe ULP-D offer residents to move to a more private setting before administering resident's insulins, inhaler, or blood glucose monitoring. In addition, the surveyor did not observe ULP-D ask other residents that were at the dining table, if they were comfortable with having insulin or blood glucose monitoring completed in the same area where the residents were sitting. On January 22, 2026, at 12:43 p.m., registered nurse (RN)-B stated all treatments and therapy services should be provided in a private area to maintain dignity and respect for the residents receiving the service and other residents that may be present. The licensee's undated Minnesota Assisted Living	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24315	A. BUILDING: _____ B. WING _____	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE - CLOQUET & BA	701 HORIZON CIRCLE 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 28 Bill of Rights, indicated case discussion, consultation, examination, and treatments are confidential and must be conducted discretely. The licensee's Medication Administration/Blood Glucose Testing policy dated December 25, 2024, indicated when testing blood glucose levels, the licensed nurse or med passer (for tasks that may be delegated per applicable law) would introduce self, explain that they would be testing blood sugar, instruct resident to wash hands, assist resident to sit in a comfortable chair and provide privacy as warranted. The licensee's Medication Administration/Inhalants policy dated November 21, 2024, the licensed nurse or med passer (for tasks that may be delegated per applicable law) would introduce self, explain that they would be administering an inhaler and provide privacy as warranted. The licensee's Medication Administration/Insulin and Insulin Derivatives policy dated November 21, 2024, indicated the licensed nurse or med passer (for tasks that may be delegated per applicable law) would introduce self, explain that they would be administering insulin and provide privacy as warranted. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) day	02320		

Duluth District Office
Minnesota Department of Health
11 East Superior Street, Suite 290
Duluth, MN 55802
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

NEW PERSPECTIVE CLOQUET & BARN
701 Horizon Circle
Cloquet, MN 55720
Carlton County
Parcel:

Phone:

License Info

License: HFID 24315

Risk:
License:
Expires on:
CFPM: TRAVIS SMITKE
CFPM #: CFPM-16204; Exp: 7/23/2027

Inspection Info

Report Number: F1027261008
Inspection Type: Full - Single
Date: 1/21/2026 Time: 10:30 AM
Duration: minutes
Announced Inspection: Yes
Total Priority 1 Orders: 1
Total Priority 2 Orders: 2
Total Priority 3 Orders: 3
Delivery: Emailed

New Order: 3-300B Protection from Contamination: cross-contamination, eggs
3-302.12 *Priority Level: Priority 3 CFP#: 37*
MN Rule 4626.0240 Properly label all working containers holding food or food ingredients that are removed from original packages with the common name of the food. Label the food in English and any other languages used by employees who handle food.
COMMENT: CONTAINER OF FLOUR IN DRY STORAGE CLOSET OF BUILDING 7 WAS NOT LABELED. STAFF LABELED CONTAINER. COS
Comply By: Complied On Site Originally Issued On: 1/21/2026

New Order: 3-300C Protection from Contamination: equipment/utensils, consumers
3-304.12G *Priority Level: Priority 3 CFP#: 43*
MN Rule 4626.0275G Store the bulk food dispensing utensil in the food with the handle extending out of the food, or in a protective enclosure attached or adjacent to the enclosure with the utensil on a tether of easily cleanable material which is short enough to prevent the utensil from making contact with the floor.
COMMENT: SCOOPS IN FLOUR CONTAINERS HAD HANDLES IN FLOUR IN BUILDINGS 6 AND 7. STAFF REMOVED SCOOPS. COS
Comply By: Complied On Site Originally Issued On: 1/21/2026

! **New Order: 3-500B Microbial Control: hot and cold holding**
3-501.16A2 *Priority Level: Priority 1 CFP#: 22*
MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.
COMMENT: UPRIGHT COOLER IN KITCHEN OF BUILDING 8 WAS MAINTAINING FOODS AT 43-45F. STAFF MOVED FOOD TO ANOTHER COOLER UNTIL COOLER COULD BE REPAIRED/REPLACED. COS
Comply By: Complied On Site Originally Issued On: 1/21/2026

New Order: 4-200 Equipment Design and Construction
4-204.112A *Priority Level: Priority 3 CFP#: 36*
MN Rule 4626.0620A Provide a temperature measuring device located in the warmest part of mechanically refrigerated units and coolest part of hot food storage units that are capable of measuring air temperature or a simulated product temperature.
COMMENT: UPRIGHT COOLER IN BUILDING 8 KITCHEN DID NOT HAVE A THERMOMETER. STAFF PLACED A THERMOMETER IN COOLER DURING INSPECTION. COS
Comply By: Complied On Site Originally Issued On: 1/21/2026

New Order: 4-300 Equipment Numbers and Capacities
4-302.13B *Priority Level: Priority 2 CFP#: 48*
MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.
COMMENT: AT TIME OF INSPECTION THERE WAS NO THERMOMETER FOR MEASURING TEMPERATURE OF HOT WATER DISH MACHINE IN KITCHEN OF BUILDING 6
Comply By: 1/28/2026 Originally Issued On: 1/21/2026

New Order: 6-300 Physical Facility Numbers and Capacities
6-301.12 *Priority Level: Priority 2 CFP#: 10*
MN Rule 4626.1445 Provide and maintain a supply of individual disposable towels, a continuous towel system, a heated-air hand drying device, or an approved ambient air temperature hand drying device at each handwashing sink or group of adjacent handwashing sinks.
COMMENT: AT TIME OF INSPECTION THERE WERE NO PAPER TOWELS AT HANDWASHING SINK IN KITCHEN OF BUILDING 8. STAFF PROVIDED PAPER TOWELS. COS
Comply By: Complied On Site Originally Issued On: 1/21/2026

Food & Beverage General Comment

DISCUSSED EMPLOYEE ILLNESS AND EXCLUSIONS AND REQUIRED SANITIZER STRENGTHS. OBSERVED STAFF WEARING GLOVES WHEN HANDLING READY TO EAT FOODS.

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

I acknowledge receipt of the Duluth District Office inspection report number F1027261008 from 1/21/2026

Ian Harrison

TRAVIS SMITKE
MANAGER

Ian Harrison,
Public Health Sanitarian 3
218-302-6170
ian.harrison@state.mn.us

Duluth District Office
Minnesota Department of Health
11 East Superior Street, Suite 290
Duluth, MN 55802

Temperature Observations/Recordings

Establishment Info

NEW PERSPECTIVE CLOQUET & BARN
Cloquet
County/Group: Carlton County

Inspection Info

Report Number: F1027261008
Inspection Type: Full
Date: 1/21/2026
Time: 10:30 AM

Food Temperature: Product/Item/Unit: MAYO**; Temperature Process:**
Location: Upright Cooler at 43 Degrees F.
Comment: BUILDING 8
Violation Issued?: Yes

Food Temperature: Product/Item/Unit: SLICED CHEESE**; Temperature Process:**
Location: Upright Cooler at 45 Degrees F.
Comment: BUILDING 8
Violation Issued?: Yes

Food Temperature: Product/Item/Unit: PEACHES**; Temperature Process:**
Location: Upright Cooler at 44 Degrees F.
Comment: BUILDING 8
Violation Issued?: Yes

Food Temperature: Product/Item/Unit: BUTTER**; Temperature Process:**
Location: Upright Cooler at 44 Degrees F.
Comment: BUILDING 8
Violation Issued?: Yes

Equipment Temperature: Product/Item/Unit: THERMOMETER**; Temperature Process:**
Location: Upright Cooler at 34 Degrees F.
Comment: BUILDING 7
Violation Issued?: No

Food Temperature: Product/Item/Unit: SLICED HAM**; Temperature Process:**
Location: Upright Cooler at 37 Degrees F.
Comment: BUILDING 7
Violation Issued?: No

Food Temperature: Product/Item/Unit: SLICED CHEESE**; Temperature Process:**
Location: Upright Cooler at 39 Degrees F.
Comment: BUILDING 7
Violation Issued?: No

Equipment Temperature: Product/Item/Unit: THERMOMETER**; Temperature Process:**
Location: Upright Cooler at 39 Degrees F.
Comment: BUILDING 7
Violation Issued?: No

Equipment Temperature: Product/Item/Unit: THERMOMETER**; Temperature Process:**
Location: Upright Cooler at 36 Degrees F.
Comment: BUILDING 7
Violation Issued?: No

Food Temperature: **Product/Item/Unit:** BUTTER**; Temperature Process:**
Location: Upright Cooler at 40 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: **Product/Item/Unit:** ALL FOODS FROZEN**; Temperature Process:**
Location: Upright Freezer at Degrees F.
Comment: BUILDING 7 4 FREEZERS
Violation Issued?: No

Food Temperature: **Product/Item/Unit:** COD**; Temperature Process:** Cooking
Location: Oven at 171 Degrees F.
Comment: BUILDING 7
Violation Issued?: No

Food Temperature: **Product/Item/Unit:** MIXED VEGGIES**; Temperature Process:** Hot-Holding
Location: Steam Table at 151 Degrees F.
Comment: BUILDING 7
Violation Issued?: No

Food Temperature: **Product/Item/Unit:** MIXED VEGGIES**; Temperature Process:** Hot-Holding
Location: Steam Table at 192 Degrees F.
Comment: BUILDING 7
Violation Issued?: No

Equipment Temperature: **Product/Item/Unit:** THERMOMETER**; Temperature Process:**
Location: Upright Cooler at 40 Degrees F.
Comment: BUILDING 8
Violation Issued?: No

Food Temperature: **Product/Item/Unit:** ALL FOODS FROZEN**; Temperature Process:**
Location: Upright Freezer at Degrees F.
Comment: BUILDING 8
Violation Issued?: No

Food Temperature: **Product/Item/Unit:** PEACHES**; Temperature Process:**
Location: Upright Cooler at 40 Degrees F.
Comment: BUILDING 6
Violation Issued?: No

Food Temperature: **Product/Item/Unit:** ALL FOODS FROZEN**; Temperature Process:**
Location: Upright Freezer at Degrees F.
Comment: BUILDING 6
Violation Issued?: No

Food Temperature: **Product/Item/Unit:** MIXED VEGGIES**; Temperature Process:** Hot-Holding
Location: Steam Table at 177 Degrees F.
Comment: BUILDING 6
Violation Issued?: No

Food Temperature: **Product/Item/Unit:** COD**; Temperature Process:** Hot-Holding
Location: Steam Table at 141 Degrees F.
Comment: BUILDING 6
Violation Issued?: No

Food Temperature: **Product/Item/Unit:** ORANGES**; Temperature Process:**
Location: Upright Cooler at 40 Degrees F.
Comment: BUILDING 5
Violation Issued?: No

Equipment Temperature: **Product/Item/Unit:** THERMOMETER**; Temperature Process:**
Location: Upright Cooler at 41 Degrees F.
Comment: BUILDING 5
Violation Issued?: No

<u>Food Temperature</u>: Product/Item/Unit: ALL FOODS FROZEN**; Temperature Process:**
Location: Chest Freezer at Degrees F.
Comment: BUILDING 5
Violation Issued?: No

<u>Food Temperature</u>: Product/Item/Unit: MIXED VEGGIES**; Temperature Process:** Hot-Holding
Location: Steam Table at 172 Degrees F.
Comment: BUILDING 5
Violation Issued?: No

<u>Food Temperature</u>: Product/Item/Unit: COD**; Temperature Process:** Hot-Holding
Location: Steam Table at 168 Degrees F.
Comment: BUILDING 5
Violation Issued?: No

Duluth District Office
Minnesota Department of Health
11 East Superior Street, Suite 290
Duluth, MN 55802

Sanitizer Observations/Recordings

Establishment Info

NEW PERSPECTIVE CLOQUET & BARN
Cloquet
County/Group: Carlton County

Inspection Info

Report Number: F1027261008
Inspection Type: Full
Date: 1/21/2026
Time: 10:30 AM

Sanitizing Chemical: Product: Quaternary Ammonia**; Sanitizing Process:** Wiping Cloth Bucket
Location: Equal To 200 PPM
Comment: BUILDING 7
Violation Issued?: No

Sanitizing Chemical: Product: Chlorine**; Sanitizing Process:** Dish Machine
Location: Equal To 100 PPM
Comment: BUILDING 7
Violation Issued?: No

Sanitizing Chemical: Product: Quaternary Ammonia**; Sanitizing Process:** Wiping Cloth Bucket
Location: Equal To 400 PPM
Comment: BUILDING 8
Violation Issued?: No

Sanitizing Chemical: Product: Chlorine**; Sanitizing Process:** Dish Machine
Location: Equal To 50 PPM
Comment: BUILDING 8
Violation Issued?: No

Sanitizing Equipment: Product: Hot Water**; Sanitizing Process:** Dish Machine
Location: Equal To 172 Degrees F.
Comment: BUILDING 6
Violation Issued?: No

Sanitizing Chemical: Product: Quaternary Ammonia**; Sanitizing Process:** Wiping Cloth Bucket
Location: Equal To 400 PPM
Comment: BUILDING 5
Violation Issued?: No

Sanitizing Equipment: Product: Hot Water**; Sanitizing Process:** Dish Machine
Location: Equal To 182 Degrees F.
Comment: BUILDING 5
Violation Issued?: No

Minnesota (MDH) Version
EH Manager; RPT: F1027261008

Food Establishment Inspection Report

Duluth District Office
Minnesota Department of Health
11 East Superior Street, Suite 290
Duluth, MN 55802

No. of Risk Factor/Intervention/Violations	2	Date: 1/21/2026
No. of Repeat Risk Factor/Intervention/Violations		Time: 10:30 AM
Score (optional)		Dur: min

Establishment:	Address:	City/State:	Zip:	Phone:
NEW PERSPECTIVE CLOQUET & BARN	701 Horizon Circle	Cloquet, MN	55720	
License/Permit #:	**Permit Holder:**	**Purpose of Inspection:**	**Est. Type:**	**Risk Category:**
HFID 24315		Full		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Designated compliance status (IN, OUT, N/O, N/A) for each numbered item

IN=in compliance **OUT**=not in compliance **N/O**=not observed **N/A**=not applicable

Mark "X" in appropriate box for COS and/or R

COS=corrected on-site during inspection **R**=repeat violation

	Compliance Status		COS	R
	Supervision			
1	IN	Person in charge present, demonstrate knowledge and performs duties		
2	IN	Certified Food Protection Manager		
	Employee Health			
3	IN	knowledge, responsibiities, and reporting		
4	IN	Proper use of restriction and exclusion		
5	IN	Response to vomiting, diarrheal events		
	Good Hygienic Practices			
6	IN	Proper eating, tasting, drinking, tobacco use		
7	IN	No discharge from eyes, nose, and mouth		
	Preventing Contamination by Hands			
8	IN	Hands clean and properly washed		
9	IN	No bare hand contact with RTE foods, alternatives		
10	OUT	Adequate handwashing sinks supplied and access	X	
	Approved Source			
11	IN	Food obtained from approved source		
12	N/O	Food Received at proper temperature		
13	IN	Food in good condition, safe & unadulterated		
14	N/A	Records available: shellstock tags, parasite dest.		
	Protection From Contamination			
15	IN	Food separated and protected		
16	IN	Food-contact surfaces; cleaned & sanitized		
17	IN	Proper Disposition of returned, previously served, reconditioned,& unsafe food		

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

Risk factors are improper practices or procedures identified as the most prevalent contributing factors of foodborne illness or injury. Public Health Interventions 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" or OUT 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	N/A	Pasteurized eggs used where required		
31		Water & ice from approved source		
32	N/A	Variance obtained for specialized processing methods		
		Food Temperature Control		
33		Proper cooling methods used; adequate equipment for temperature control		
34	N/O	Plant food properly cooked for hot holding		
35	IN	Approved thawing methods used		
36	X	Thermometers provided & accurate	X	
		Food Identification		
37	X	Food properly labeled; original container	X	
		Prevention of Food Contamination		
38		Insects, rodents, & animals not present; no unauthorized person		
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	X	In-use utensils; Properly stored	X	
44		Utensils, equipment & linens; properly stored, dried, handled		
45		Single-use & single-service articles, properly stored and used		
46		Gloves used properly		
		Utensils, 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 and plan review		

Person in Charge (signature)

Inspector (signature) [redacted]

Follow-up: Follow-up Date:

DEPARTMENT OF HEALTH

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL24315016-0	**Date:** January 21, 2026
Facility Name: NEW PERSPECTIVES CLOQUET	
Facility Address: 701 HORIZON CIRCLE, CLOQUET, MN 55720	

☒ **TAG IDENTIFICATION: 0775**

SCOPE/ SEVERITY: Level 2; Widespread **TIME PERIOD OF CORRECTION:** Seven (7) days

1. Each assisted living facility must comply with the provisions of the Minnesota State Fire Code (MSFC) in Minnesota Rules chapter 7511. [Minn. Stat. 144G.45 subd. 2]

2. Where used in Group I-2 (ALFDC) and ambulatory care facilities, portable, electric space heaters shall only be used in nonsleeping staff and employee areas. [Minn. Stat. 144G.45 subd. 2; MSFC 604.10.5]

   Comments: A portable space heater was in use and producing heat in resident room three of cottage eight. This resident room was unoccupied at the time of the tour.

3. Egress doors shall be readily operable from the egress side without the use of a key or special knowledge. [Minn. Stat. 144G.45 subd. 2; MSFC 1010.2]

   Comments:
   - A battery operated keypad lock was installed on an emergency exit door leading into the link from cottage seven. During the tour, a code was not required to unlock this door. Environmental services director stated the keypad lock was not currently used.
   - In the sunrooms of cottages six and eight, thumbturn deadbolt locks and keyless electronic unlocking systems were installed on the delayed egress emergency exit doors.

4. The means of egress shall be maintained free of obstructions or impediments to full instant use in case of fire or other emergency. [Minn. Stat. 144G.45 subd. 2; MSFC 1031.2]

   Comments: The exterior egress paths were partially covered in snow outside the emergency exit doors on the back of the buildings for cottages seven and eight. Clear continuous egress paths from these doors to the public right of way were not maintained free of snow.

5. Extension cords and flexible cords shall not be a substitute for permanent wiring. [Minn. Stat. 144G.45 subd. 2; MSFC 604.5]

   Comments: To supply power to personal electronics, extension cords were used in occupied resident room eight in cottage seven, and in occupied resident room one in cottage five. Improper use of extension cords creates a fire hazard.

6. Emergency lighting shall be continuously maintained. [Minn. Stat. 144G.45 subd. 2; MSFC 1031.10]

   Comments: The emergency lights labeled #5, #7, and #12 did not work when tested by environmental services director (ESD). ESD stated the licensee had recently identified these non-functional emergency lights during the monthly tests and work orders were in place to make the necessary repairs. Emergency lighting shall be maintained as operable.

☒ **TAG IDENTIFICATION: 0790**

SCOPE/ SEVERITY: Level 2; Isolated **TIME PERIOD OF CORRECTION:** Seven (7) days

---

1. Portable fire extinguishers installed and maintained to MN State Fire Code. [Minn. Stat. 144G.45 subd.2]

Comments:

- In the kitchen of cottage five, a portable fire extinguisher was installed inside the pantry closet. When fire extinguishers are not immediately visible, the installation location needs to be identified with signage.

- One monthly inspection was recorded in the past seven months on the back of the tag attached to the class K fire extinguisher. Fire extinguisher inspections must be completed every month to ensure each extinguisher is in its designated place, it has not been tampered with, and there is no obvious physical damage or condition that would interfere with its use or operation.

- A portable fire extinguisher was stored on the floor inside a closet with an annual maintenance tag dated 2021, in the link between cottages seven and eight. Annual maintenance performed by certified service personnel shall be completed on all fire extinguishers provided in the facility. Portable fire extinguishers must be properly installed to prevent them from being damaged.

☒ **TAG IDENTIFICATION: 0810**

SCOPE/ SEVERITY: Level 2; Pattern **TIME PERIOD OF CORRECTION:** Twenty One (21) days

---

1. Each assisted living facility shall develop and maintain fire safety and evacuation plans that are readily available at all times within the facility. [Minn. Stat. 144G.45 subd.2]

   Comments: Evacuation procedures for the individualized needs of residents were stored electronically. Printed readily available copies of these procedures were not maintained as part of the fire safety and evacuation plan.

2. Each assisted living facility shall develop and maintain fire safety and evacuation plans that include employee actions to be taken in the event of a fire or similar emergency. [Minn. Stat. 144G.45 subd.2]

   Comments: The fire safety and evacuation plan inaccurately instructed employees to evacuate neighborhoods below or above the fire origin, in a one story building.

3. 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. [Minn. Stat. 144G.45 subd.2]

   Comments: The surveyor requested records for evacuation drills completed between April 2025 and January 2026. Eight fire drill reports were provided. Two fire drills had been conducted in each cottage during January 2026. The environmental services director (ESD)-E stated they had not been able to locate records for drills completed by the employee previously responsible for conducting these drills. The licensee failed to meet the evacuation drill frequency as required by statue.