



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

November 17, 2025

Licensee

New Perspective - Cloquet & Barnum
3725 Horizon Drive Building 2
Barnum, MN 55707

RE: Project Number(s) SL22197016

Dear Licensee:

On October 16, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on April 30, 2025. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'Tim Hanna'.

Tim Hanna, Supervisor
State Engineering Services Section
Email: Tim.Hanna@state.mn.us
Telephone: 507-208-8982 Fax: 1-866-890-9290

CLN



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

September 22, 2025

Licensee

New Perspective Cloquet & Barnum

3725 Horizon Drive Building 2

Barnum, MN 55707

RE: Project Number(s) SL22197016

Dear Licensee:

On July 29, 2025, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on April 30, 2025. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the April 30, 2025, survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on April 30, 2025, found not corrected at the time of the July 29, 2025, follow-up survey and/or subject to penalty assessment are as follows:

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

0780-Fire Protection And Physical Environment-144g.45 Subd. 2 (a) (1) - \$500.00

The details of the violations noted at the time of this follow-up survey completed on July 29, 2025 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

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

DOCUMENTATION OF ACTION TO COMPLY

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

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.

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.

We urge you to review these orders carefully. If you have questions, please contact Benjamin J. Zwart at 651-201-3715.

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

Sincerely,



Benjamin J. Zwart, Supervisor
State Engineering Services Section
Email: Benjamin.Zwart@state.mn.us
Telephone: 651-201-3715 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 22197	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 07/29/2025
NAME OF PROVIDER OR SUPPLIER NEW PERSPECTIVE - CLOQUET & BA		STREET ADDRESS, CITY, STATE, ZIP CODE 3725 HORIZON DRIVE BLDG 2 BARNUM, MN 55707			
(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 *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been 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: SL#34822015-1 On July 16, 2025, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on April 30, 2025. As a result of the follow-up survey, the following orders were reissued.	{0 000}			
{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:	{0 480}			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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{0 480}	Continued From page 1 (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 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	{0 480}			

Minnesota Department of Health
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Minnesota Department of Health

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{0 680}	Continued From page 3 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 by: Not reviewed during this survey.	{0 680}			
{0 775} SS=E	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the requirements of Minnesota State Fire Code Rules, Chapter 7511.	{0 775}			

Minnesota Department of Health

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{0 775}	Continued From page 4 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 July 16, 2025, at 9:50 a.m., the surveyor toured the facility with executive director (ED)-M. During the facility tour, the surveyor observed the following: Obstructed Egress - In cottage 4, the evacuation floor plan labeled the door from the sunroom leading out to the exterior patio as an exit. This patio was enclosed by a fence with a locked gate. The gate lock required a key to open. A keybox was installed at the gate that required a code to open. The gate key was stored inside the keybox. During the tour interview, ED-M stated the local fire official reviewed and approved this installation. - In occupied resident sleeping room 206, cottage 2, the egress window was obstructed by the storage of personal belongings in front of the window. During the tour interview, ED-M verified the obstructed egress observation. Smoke Alarm Maintenance The smoke alarm installed in occupied resident sleeping room 209, cottage 2, was discolored, indicating it was not new. During the previous	{0 775}			

Minnesota Department of Health

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{0 775}	Continued From page 5 survey on April 29, 2025, in occupied resident sleeping room 209, cottage 2, the date on the back of the hardwired smoke alarm listed a manufacture date of 2011. During the tour interview, ED-M verified the smoke alarm had not been replaced since the previous survey. Smoke alarms are required to be maintained with a manufacture date of ten years or less in accordance with MSFC in Minnesota Rules Chapter 7511. Controlled Egress Door Locking System Procedures Electromagnetic locks with keypads were installed on the emergency exit doors in cottage 4. On July 16, 2025, ED-M provided instructions for installation of the controlled egress locking system. Record review indicated the instructions did not include employee procedures to operate and unlock the controlled egress door locking system. During an interview on July 16, 2025, at approximately 1:30 p.m., ED-M verified these controlled egress door locking system procedures were lacking.	{0 775}			
{0 780} SS=E	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a	{0 780}			

Minnesota Department of Health

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{0 780}	Continued From page 6 dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that complied with fire protection requirements. 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 July 16, 2025, at 9:50 a.m., the surveyor toured the facility with executive director (ED)-M.	{0 780}			

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{0 780}	Continued From page 7 During the facility tour, the surveyor observed the following in cottage 4: When the smoke alarm installed in resident sleeping room 410 was tested by ED-M, the smoke detector sounder bases installed outside of the sleeping units were not actuated. During the facility tour interview, ED-M verified the above listed observations. Smoke alarms are required to be installed outside and in the immediate vicinity of resident sleeping units. All dwelling unit smoke alarms must be interconnected throughout the facility so that actuation of one alarm causes all alarms to operate.	{0 780}			
{0 790} SS=C	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: Not reviewed during this survey.	{0 790}			
{0 800} SS=D	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including	{0 800}			

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{0 800}	Continued From page 8 walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{0 800}			
{0 810} SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to	{0 810}			

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 22197	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 07/29/2025
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{01890}	Continued From page 10 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: Not reviewed during this survey.	{01890}			
{01910} SS=D	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. (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: Not reviewed during this survey.	{01910}			
{01960} SS=D	144G.72 Subd. 5 Documentation of	{01960}			

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{01960}	Continued From page 11 administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{01960}			
{02310} SS=D	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{02310}			
{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	{02320}			

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{02320}	Continued From page 12 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: Not reviewed during this survey.	{02320}			
{02410} SS=D	144G.91 Subd. 13 Personal and treatment privacy (a) Residents have the right to consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being. Staff must respect the privacy of a resident's space by knocking on the door and seeking consent before entering, except in an emergency or unless otherwise documented in the resident's service plan. (b) Residents have the right to have and use a lockable door to the resident's unit. The facility shall provide locks on the resident's unit. Only a staff member with a specific need to enter the unit shall have keys. This right may be restricted in certain circumstances if necessary for a resident's health and safety and documented in the resident's service plan. (c) Residents have the right to respect and privacy regarding the resident's service plan. Case discussion, consultation, examination, and treatment are confidential and must be conducted discreetly. Privacy must be respected during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{02410}			

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June 9, 2025

Licensee

New Perspective Cloquet & Barnum
3725 Horizon Drive Building 2
Barnum, MN 55707

RE: Project Number(s) SL22197016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 30, 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.

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 for widespread violations;

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

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

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

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - \$500.00

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,

A handwritten signature in cursive script that reads "Jessie Chenze".

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

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 22197	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/30/2025
NAME OF PROVIDER OR SUPPLIER NEW PERSPECTIVE - CLOQUET & BA		STREET ADDRESS, CITY, STATE, ZIP CODE 3725 HORIZON DRIVE BLDG 2 BARNUM, MN 55707			
(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: SL22197016-0 On April 28, 2025, through April 30, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 18 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			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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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			

Minnesota Department of Health

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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 April 29, 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	0 480			

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0 480	Continued From page 3 to the FBEIR for any compliance dates.	0 480			
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an infection control program to comply with acceptable health care, medical nursing standards for infection control during medication administration for one of one unlicensed personnel, (ULP)-G. 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:	0 510			

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0 510	Continued From page 4 During the entrance conference on April 28, 2025, at 10:16 a.m., clinical nurse supervisor (CNS)-B stated employees received infection control training upon hire and annually. ULP-G was hired March 1, 2023, to provide direct care services to the residents of the licensee. ULP-G's employee record indicated ULP-G completed infection control training on March 28, 2023, and January 3, 2025, and completed a skill assessment and deemed competent by the registered nurse (RN) on medication administration on all routes on May 20, 2023. On April 29, 2025, at 6:59 a.m., the surveyor observed ULP-G enter Cottage House two and stated ULP-G had to go to Cottage House four and get orange juice for the morning. ULP-G put the orange juice away in the kitchen and began to prepare R7's morning medications. Without performing hand hygiene, ULP-G dispensed each pill directly into ULP-G's ungloved hand then put the pills into a disposable medication cup. ULP-G entered R7's room and administered R7's medications. ULP-G exited R7's room and without performing hand hygiene, gathered R4's pre-filled insulin pens and entered R4's room. ULP-G stated ULP-G would be right back because ULP-G forgot to grab alcohol prep pads and left the room. ULP-G entered R4's room, and without performing hand hygiene or wearing gloves, ULP-G injected R4's Humalog and Lantus insulins into R4's left upper thigh. ULP-G exited R4's room, disposed of the insulin needles into a sharps container and documented R4's insulin administration in R4's electronic medical record. Without performing hand hygiene, ULP-G prepared R6's medications by dispensing each	0 510			

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0 510	Continued From page 5 pill directly into ULP-G's ungloved hand then put each pill into a medication cup. ULP-G entered R6's room and without performing hand hygiene or wearing gloves, ULP-G administered R6's eye drops and administered medications. ULP-G exited R6's room and directly enter R8's room, made R8's bed, exited the room, documented R6's administration of medications then began to pour orange juice in preparation for breakfast. During the surveyor's observation of ULP-G's medication, insulin and eye drop administration, ULP-G failed to perform hand hygiene in preparing and administering resident's medication and failed to wear gloves during the administration of eye drops and insulin. On April 30, 2025, at 12:40 p.m., CNS-B stated staff should perform hand hygiene before and after medication administration and wear gloves when administering insulin and eye drops per licensee's policy and procedure. The licensee's Infection Control policy dated October 15, 2024, indicated hands would be washed between resident care and whenever direct physical contact with a resident took place. The licensee's Medication Administration Insulin policy dated November 21, 2024, indicted staff would perform hand hygiene and apply gloves before each mediation administration and perform hand hygiene again after the removal of gloves. The licensee's Medication Administration Eye Drops/Ointment policy dated November 21, 2024, indicated staff would perform hand hygiene, apply gloves, administer the eye drop, remove gloves and perform hand hygiene.	0 510			

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0 510	Continued From page 6 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510			
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 by: Based on observation, interview, and record review, the licensee failed to develop and post an emergency preparedness plan prominently with	0 680			

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0 680	Continued From page 7 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, 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 April 28, 2025, at 10:16 a.m., licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-B stated they were familiar with the assisted living laws and regulations. During the facility tour with licensed sales director (SD)-F on April 28, 2025, at 11:16 a.m., and 11:26, the surveyor observed Cottage House four and Cottage House two layouts. The cottage layouts included a main entrance, common areas, and two hallways that provided access to resident rooms, a laundry room, mechanical room and offices. In the main entry, the surveyor observed an accordion style file system on the wall and in a clear plastic sleeve included a facility evacuation plan; however, there was no evidence of the emergency disaster plan posted prominently in the buildings, as required. SD-F confirmed the emergency disaster plan was not posted prominently, and the emergency preparedness binders were kept in an enclosed pantry area on a shelf in the kitchens of each house.	0 680			

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0 680	Continued From page 8 The licensee's [name of license] Emergency Preparedness and Response Program (EPP) dated October 2024, was observed on a shelf in the kitchen pantries in Cottage House two and Cottage House four. The licensee's EPP respectfully lacked the following: -emergency prep testing requirements to include: -participation in an annual full-scale exercise that is community based or conduct an annual, individual, facility-based functional exercise; and -an additional annual exercise that may include a second full-scale exercise or mock disaster drill or table-top exercise and analyze the facility's response to and maintain documentation of all drills, tabletop exercises and emergency events & revise plan as needed. On April 30, 2025, at approximately 2:30 p.m., LALD-A stated they were unable to find documentation of conducting and analysis of a full-scale and/or tabletop exercises of the licensee's emergency plan as required, quarterly review of missing resident policy The licensee's Emergency Preparedness policy dated March 11, 2022, indicted the Community would develop a written preparedness plan (called the Emergency Preparedness and Response Program) that meets the health, safety, and security needs of residents and team members, and requirements set for in applicable law and includes at least: -a plan for evacuation; -elements of sheltering in place; -temporary relocation sites; and -staff assignments in the event of a disaster or an emergency. No further information was provided.	0 680			

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0 680	Continued From page 9	0 680			
0 775 SS=E	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, interview, and record review, the licensee failed to comply with the requirements of Minnesota State Fire Code Rules, Chapter 7511. 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 April 29, 2025, at 9:50 a.m., the surveyor toured the facility with environmental services director (ESD)-J and maintenance assistant (MA)-K. During the facility tour, the surveyor observed the following: Obstructed Egress - In cottage 4, the evacuation floor plan labeled the door from the sunroom leading out to the exterior patio as an exit. This patio was enclosed by a fence with a locked gate. The gate lock required a key to unlock.	0 775			

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0 775	Continued From page 10 - In occupied resident sleeping room 206, cottage 2, the egress window was obstructed by the storage of personal belongings in front of the window. Carbon Monoxide Alarms In cottage 4, carbon monoxide alarms were not installed within 10 feet of resident sleeping rooms 405 and 410. When carbon monoxide alarms are not tied into the building fire alarm system, carbon monoxide alarms are required to be installed within ten feet of all sleeping rooms. Smoke Alarm Maintenance In occupied resident sleeping room 209, cottage 2, the date on the back of the hardwired smoke alarm indicated a manufacture date of 2011. Smoke alarms are required to be maintained with a manufacture date of ten years or less in accordance with MSFC in Minnesota Rules Chapter 7511. Clothes Dryer Maintenance In the cottage 4 laundry room, the exhaust duct for the clothes dryer was partially disconnected, creating a fire hazard. Smoking Material Disposal A plastic bottle was provided for smoking material disposal in the designated outdoor smoking area for cottage 4. The plastic bottle contained burnt cigarettes, creating a fire hazard. During the facility tour interview, ESD-J and MA-K verified the above listed observations. Controlled Egress Door Locking System Procedures Electromagnetic locks with keypads were installed on the emergency exit doors in cottage 4. On April 29, 2025, licensed assisted living director (LALD)-A and sales director (SD)-F provided emergency evacuation plan documents. Record review indicated the emergency plan did not include procedures to operate and unlock the controlled egress door locking system. During an	0 775			

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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
0 775	Continued From page 11 interview on April 29, 2025, at approximately 1:30 p.m., LALD-A and SD-F verified these instructions were not included in the emergency plan provided. SD-F stated these procedures would be emailed to the surveyor if located. No further information was received. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775			
0 780 SS=E	144G.45 Subd. 2 (a) (1) Fire protection and physical environment for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced	0 780			

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0 780	Continued From page 12 by: Based on observation and interview, the licensee failed to provide smoke alarms that complied with fire protection requirements. 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 April 29, 2025, at 9:50 a.m., the surveyor toured the facility with environmental services director (ESD)-J and maintenance assistant (MA)-K. During the facility tour, the surveyor observed the following: - A smoke alarm was not installed outside resident sleeping room 410, in cottage 4. - A smoke alarm was not installed outside resident sleeping room 210, in cottage 2. During the facility tour interview, ESD-J and MA-K verified the above listed smoke alarm observations. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780			
0 790 SS=C	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,	0 790			

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0 790	Continued From page 13 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 and interview, the licensee failed to install and maintain the portable fire extinguishers as required by statute. This deficient condition had the potential to affect all residents, staff, and visitors. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On April 29, 2025, at 9:50 a.m., the surveyor toured the facility with environmental services director (ESD)-J and maintenance assistant (MA)-K. During the facility tour, the surveyor observed the following: - Monthly inspections were not recorded on the back of the tags attached to the portable fire extinguishers, indicating monthly inspections had not been completed. Fire extinguisher inspections must be conducted every month to ensure each extinguisher is in its designated place, that it has not been tampered with, and there is no obvious physical damage or condition that would interfere with its use or operation. During the facility tour interview, ESD-J and MA-K verified monthly inspections had not been completed and stated they were not aware of this requirement.	0 790			

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0 790	Continued From page 14 - The fire extinguisher in the mechanical room of cottage 2 was not mounted. Fire extinguishers must be available in an emergency and properly installed to prevent them from being moved or damaged. During the facility tour interview, ESD-J and MA-K verified the above listed fire extinguisher observation. TIME PERIOD FOR CORRECTION: Two (2) days	0 790			
0 800 SS=D	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the 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 an isolated scope (when one or a limited number of residents are affected or one or	0 800			

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0 800	Continued From page 15 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On April 29, 2025, at 9:50 a.m., the surveyor toured the facility with environmental services director (ESD)-J and maintenance assistant (MA)-K. During the facility tour, the surveyor observed the following: - The exterior patio was designated as an outdoor activity space for residents in cottage 4. Areas of this concrete patio floor were uneven and chipped, creating a trip/fall hazard. - In occupied resident room 201, cottage 2, the window opening hardware was stripped for one of the casement windows, making it difficult to open. During the facility tour interview, ESD-J and MA-K verified the above listed maintenance observations and stated these items required repair. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800			
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and	0 810			

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0 810	Continued From page 16 (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at 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 required content, make all parts of the plan readily available, and provide required training and 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	0 810			

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0 810	Continued From page 17 the residents). The findings include: On April 29, 2025, licensed assisted living director (LALD)-A, sales director (SD)-F, environmental services director (ESD)-J and maintenance assistant (MA)-K provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. On April 29, 2025, at 9:50 a.m., the surveyor toured the facility with environmental services director (ESD)-J and maintenance assistant (MA)-K. During the facility tour, the surveyor observed emergency floor plans were posted in cottages 2 and 4, but the fire safety and evacuation plan procedures were not readily available in either cottage. The fire safety and evacuation plans were kept in the emergency preparedness binders. The emergency preparedness binder for cottage 2 was stored in cottage 4. The emergency preparedness binder for cottage 4 was stored in cottage 2. The fire safety and evacuation plans were not readily available. Evacuation procedures for individualized unique needs of residents had been identified, but the licensee failed to maintain these procedures as readily available for all staff accessibility. Record review indicated the fire safety and evacuation plans in the emergency preparedness binders did not include these identified resident needs for evacuation. During an interview on April 29, 2025, at 1:09 p.m., LALD-A stated residents requiring staff assistance in an emergency had been identified, and these procedures were maintained electronically on the computer. During an interview on April 29, 2025, at 1:30 p.m., LALD-A verified all parts of the FSEP were not maintained as readily available. FIRE SAFETY AND EVACUATION PLAN	0 810			

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0 810	Continued From page 18 COTTAGE 2 The licensee failed to develop and maintain a site specific FSEP for cottage 2 evident by a review of the fire response plan. Record review indicated the fire response plan was a New Perspectives template. The template referenced neighborhoods or hallways directly below or above the fire origin, especially if the sprinklers have discharged. Cottage 2 did not have fire sprinklers or a fire alarm system installed. These life safety systems were inaccurately referenced as part of the FSEP for cottage 2. The FSEP included standard employee procedures, but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks evident by a lack of these procedures in the plan. Additionally, the plan inappropriately directed employees to evacuate residents from the smoke/fire compartment to the opposite smoke/fire compartment (i.e., between sets of fire doors) in a building without smoke/fire compartment doors. The FSEP did not identify specific fire protection actions for residents evident by inappropriate instructions for residents to remain in their apartments if the fire alarms activate in a building without fire sprinklers or fire-resistant construction. The FSEP included standard resident evacuation procedures, but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency, evident by a lack of these site specific procedures in the plan. FIRE SAFETY AND EVACUATION PLAN COTTAGE 4 The licensee failed to develop and maintain a site specific FSEP for cottage 4, evident by a review of the fire response plan. Record review indicated	0 810			

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0 810	Continued From page 19 the fire response plan was a New Perspectives template. The template referenced neighborhoods or hallways directly below or above the fire origin and cottage 4 is a one story building with no basement. The FSEP included standard employee procedures, but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks evident by a lack of these procedures in the plan. Additionally, the plan inappropriately directed employees to evacuate residents from the smoke/fire compartment to the opposite smoke/fire compartment (i.e., between sets of fire doors) in a building without smoke/fire compartment doors. The FSEP included standard resident evacuation procedures, but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency evident by a lack of these site specific procedures in the plan. During an interview on April 29, 2025, at 1:30 p.m., LALD-A and SD-F verified the licensee FSEP required revision. TRAINING During an interview on April 29, 2025, at 1:30 p.m., LALD-A and SD-F stated resident and employee FSEP training records for the past year were not available and these would be emailed to the surveyor by 4:00 p.m. The surveyor received an email from SD-F on April 29, 2025, at 4:00 p.m. This email included attachments for resident and employee training. Record review indicated the licensee failed to provide fire safety and evacuation training to the residents in house 4 at least once per year, evident by training documentation lacking the required frequency. One training record for residents was provided, dated January 24, 2025.	0 810			

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0 810	Continued From page 20 The description of this training listed house 2. No training records were provided for house 4. Record review indicated the licensee failed to provide training to employees on the FSEP at least twice per year evident by training documentation lacking the required frequency. One training record was provided, dated January 9, 2025, for emergency preparedness and fire safety and evacuation. The training sign in sheet was signed by 5 employees and the documentation indicated this training was for the Cloquet and Barnum communities. No additional training records were provided. DRILLS Record review indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift, with at least one evacuation drill every other month evident by a review of completed fire drill logs. Twelve fire drills were recorded in 2024. These 2024 drills were completed during May, June, July, and November. No evacuation drill records for 2025 were provided. During an interview on April 29, 2025, at 1:30 p.m., LALD-A and SD-F verified the evacuation drill frequency was not met. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810			
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a	0 970			

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0 970	Continued From page 21 lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for health, safety, or personal property of a resident. This had the potential to affect all 18 residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: During the entrance conference on April 28, 2025, at 10:16 a.m., license assisted living director (LALD)-A stated the licensee's Residency Agreement was the same contract used for all residents. The licensee's Residency Agreement (assisted living contract) dated January 11, 2024, included the following clauses: -page 27, section 15. Indemnification: Community shall not be liable whatsoever for lost, stolen, or damaged property of any property loss or bodily injury or death due to fire, windstorms, hurricanes, tornados, or any other natural or man-made hazards or incidents. Resident herein promises to indemnify and hold harmless Community, and all entities and persons affiliated	0 970			

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0 970	Continued From page 22 with Community, its owner, managers, employees, attorneys, vendors, and contractors from liability, loss, damages, costs, claims, or expenses, including attorney's fees, incurred, alleged, or threatened as a result of, in connection with, arising out of, or relating to, Resident and/ or Community relating to any terms of this Agreement that may result in harm, death, to Resident or damage to Resident's property or to any other individual or entity beginning on the date of the signing of the Agreement until the end of time. By signing this Agreement, the parties specifically acknowledge that they understand the terms of this section. This section survives the termination of this agreement. -page 27, section 16. Waiver of Subrogation: To the extent allowed by law, Resident waives their right of recovery against Community for any damages caused by an occurrence insured against the Resident. Resident, if allowed under law or policy coverage, also waives the rights of their respective insurance carriers to subrogate against Community under any applicable policy. Resident agrees to add Community as additional insured and obtain consent from Resident's Insurance carriers to waive their subrogation in accordance with this paragraph. On April 30, 2024, at 1:37 p.m., LALD-A stated they were familiar with the waiver of liability language from previous surveyed facilities owned by the licensee. LALD-A stated they created an addendum to the resident agreement with changes to the liability clause. LALD-A reviewed R4's contract signed May 1, 2025, and the licensee's electronic resident agreement template and stated both agreements included the liability clauses noted above and stated LALD-A could not find and addendum to the licensee's	0 970			

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0 970	Continued From page 23 agreement reflecting the changes of the liability clause. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 970			
01890 SS=E	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 ensure medications were maintained bearing the original prescription label with information regarding the direction for use, medication name, medication dosage, resident's name, and the pharmacy in which it had been issued. In addition, the licensee failed to ensure medications were maintained to include information including the opened date and expiration date for time sensitive medications stored and managed by the licensee in one of two 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 was issued at a pattern scope (when more than a	01890			

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01890	Continued From page 24 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 April 28, 2025, at 10:16 a.m., licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-B stated the licensee provided secured medication storage to the residents of the facility. PRESCRIPTION LABEL On April 28, 2025, at 3:42 p.m., the surveyor reviewed Cottage House two's medication cart with unlicensed personnel (ULP)-D and observed a signed posted above the medication cart with pictures of medications directing to date insulin, eye drops, inhalers, creams, bottles, glucometer test strips, and nebulizer solutions when opened. The surveyor and ULP-D observed the following: -an opened albuterol inhaler(used to treat difficulty breathing) attached to a spacer (a chamber-like device attached to the mouthpiece of the inhaler), lacked an original prescription label with information regarding the direction for use, medication name, medication dosage, resident name, and pharmacy. ULP-D confirmed the albuterol inhaler did not have a label on the inhaler, original packaging, or date the inhaler had been opened. ULP-D stated the albuterol inhaler belonged to R6. TIME SENSITIVE MEDICATIONS -R1's opened budesonide formoterol inhaler (used to treat asthma) lacked the date the inhaler had been opened and when the inhaler would expire; -R6's opened bottle of olopatadine hydrochloride	01890			

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NAME OF PROVIDER OR SUPPLIER NEW PERSPECTIVE - CLOQUET & BA			STREET ADDRESS, CITY, STATE, ZIP CODE 3725 HORIZON DRIVE BLDG 2 BARNUM, MN 55707		
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01890	Continued From page 25 0.1% eye drop (used to treat pink eye) lacked the date the eye drop had been opened and when the eye drop would expire; and -R7 had three opened bottles of Refresh tears (used to treat dry eyes) that lacked the date the eye drops had been opened and when the eye drops would expire. ULP-D stated R1 was no longer a resident at the facility and was discharge in December 202,4 and R1's inhaler should have been removed from the medication cart. ULP-D stated staff should be writing the date on the medication when the medication was opened. On April 30, 2025, at 12:40 p.m., CNS-B stated they posted signs above each medication cart with instructions on labeling medications when opened and continue to educate staff. CNS-B stated the ULPs who passed medications were assigned to go through the medication carts weekly looking for expired medications, ensuring active medications had opened dates and reordered any needed medications and the nurses went through the medication carts monthly. On April 29, 2025, at 7:16 a.m., the surveyor observed ULP-G administering R2's olopatadine 0.1% eye drop, one drop into each eye. R2's eye drop lacked the date the eye drop had been opened and when the eye drop would expire. The manufacturer's instructions for budesonide formoterol inhaler (Symbicort) dated August 2019, directed to throw away the inhaler three months after removed from its foil pouch. The manufacturer's instruction for olopatadine hydrochloride eye drop dated September 20, 2023, directed to throw away the eye drop bottle	01890			

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01890	Continued From page 26 at the end of the treatment or four weeks after opening whichever comes first. The manufacturer's instructions for Refresh tears dated 2024, indicted to discard eye drop 90 days after opening. The licensee's Medication Storage policy, dated June 28, 2024, indicated medications that were managed by the Community (assisted living) would be securely stored in original pharmacy-labeled containers per pharmacy instructions and organized by resident, in accordance with applicable law. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890			
01910 SS=D	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. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name,	01910			

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01910	Continued From page 27 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, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's diagnoses included cerebral vascular accident (stroke) type 2 diabetes, and hypertension (high blood pressure). R1's October 2024 Medication Administration Record indicated R1 was scheduled and received the following medications: -acetaminophen 500 milligrams (mg) two tablets three times a day for pain; -calcium 600 mg with vitamin D 20 micrograms (mcg) one tablet twice a day for supplementation; -ferrous sulfate 325 mg one tablet every morning for iron deficiency; -fluoxetine 20 mg one capsule daily for anxiety; -Lantus Solostar insulin 100 units (u)/milliliter (ml)	01910			

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01910	Continued From page 28 inject 54 u daily for diabetes; -loratadine 10 mg one table daily for allergies; -magnesium oxide 400 mg one tablet daily for supplementation; -omeprazole 40 mg one capsule daily for gastric reflux; and -potassium chloride 10 milliequivalents (mEq) one tablet with food for supplementation. R1's prescriber orders dated August 8, 2024, included the above noted medications. R1's Discharge Summary/Post Discharge Plan dated February 6, 2025, indicated R1's services started September 2, 2021, and R1 was discharged to a higher level of care facility on December 7, 2024. R1's discharge summary indicated R1 received medication management and R1's medications were sent with R1 and or R1's legal representative at discharge. R1's record lacked the required documentation for R1's disposition of medications noted above to include the medication's name, strength, medication prescription number, as applicable, and quantity. On April 30, 2025, at 10:08 a.m., clinical nurse supervisor (CNS)-B stated they were unable to find documentation in R1's record of the disposition of R1's medications. CNS-B stated a contracted nurse completed R1's discharge and was no longer working for the licensee. CNS-B stated CNS-B was unsure if the contracted nurse completed a medication disposition form for R1's medications. The licensee's Medication Deposition policy dated July 16, 2024, indicated medication disposition would be appropriately documented using the	01910			

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01910	Continued From page 29 Medication Disposition Record form to include the following: -date of disposition; -medication name, dosage, and prescription number; -method of disposition; -quantity dispositioned; -signatures of applicable team members; and -the disposition record would be uploaded to the resident's electronic health record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910			
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a resident treatment plan was followed and any follow up procedure was provided to meet the resident's needs for one of three residents (R3) who received blood glucose monitoring.	01960			

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01960	Continued From page 30 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 April 28, 2025, at 10:16 a.m., licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-B stated the licensee provided treatment and therapy services including blood glucose (sugar) monitoring. R3's diagnosis included diabetes type II. R3's 90-Day Assessment dated April 1, 2025, indicted R3 received assistance with blood glucose monitoring by ULPs. R3's Medication and Treatment/Therapies Management Plan dated December 19, 2024, included blood glucose monitoring. R3's April 2025 Medication Administration Record (MAR) included staff initials indicating staff assisted and recorded R3's blood glucose monitoring once daily. R3's MAR indicated to notify nurse if R3's blood glucose reading was below 70 milligrams per deciliter (mg/dl) or above 450 mg/dl. R3's blood glucose report from February 1, 2025, to April 28, 2025, indicated:	01960			

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01960	Continued From page 31 -On February 28, 2025, at 12:55 p.m., blood glucose result of 464; -On February 28, 2025, at 3:26 p.m., blood glucose result of 474; -On March 4, 2025, at 3:11 p.m., blood glucose result of 478; -On March 11, 2025, at 3:28 p.m., blood glucose result of 457; and R3's Progress Notes from February 1, 2025, through April 28, 2025, lacked documentation the registered nurse (RN) had been notified of the above noted out of range blood glucose readings; furthermore, R3's record lacked documentation any follow up treatment or procedure was provided. On April 29, 2025, at 1:59 p.m., RN-H reviewed R3's blood glucose readings and progress notes and verified R3's blood glucose readings were above 400, and stated they were unable to find documentation in R3's record the RN was notified as directed. The licensee's Treatment or Therapy Management Services policy dated February 20, 2025, indicated team members to include ULPs trained in treatment and therapy services administration would document in the electronic medication administration record (eMAR) or service plan their name, title, and the date and time treatment or therapy was administered. When treatment or therapy services are not administered as ordered or prescribe, the applicable team member would document the reason why the treatment or therapy was not administered, and any follow-up procedures to meet the resident's needs. No further information was provided.	01960			

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01960	Continued From page 32	01960			
	TIME PERIOD FOR CORRECTION: Seven (7) days				
02310 SS=D	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the care and services were provided according to acceptable health care and medical, or nursing standards with regards to safely storing oxygen. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: During the facility tour with sales director (DS)-F on April 28, at 11:50 a.m., the surveyor observed one tall oxygen cylinder stored in a small closet located in an office in Cottage 2 house. The oxygen cylinder was stored in an upright position; however, was not stored securely in a rack or by chains preventing from falling over.	02310			

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02310	Continued From page 33 On April 30, 2025, at 12:40 p.m., clinical nurse supervisor (CNS)-B stated oxygen cylinders should be securely stored in an oxygen rack. CNS-B stated they were in the process of determining what resident the oxygen cylinder belong to and what oxygen management company provided the oxygen cylinder to pick it up. The licensee's Oxygen Use, Safety, and Storage policy dated November 20, 2024, indicted oxygen cylinders would be stored as follows: -with all tank valves closed; -in an area that was well ventilated; -away from electrical panels and cords; -away from radiators, open flames, and other heat sources; and -in an upright position in an oxygen cylinder storage cage. The Minnesota Department of Health (MDH) Oxygen Cylinder Storage Requirements dated April 16, 2020, based on the National Fire Protection Association, Standard 99 (NFPA 99), indicated a common hazard in a health care facility is storing and handling compressed oxygen in cylinders. When storing oxygen cylinders, they must be secured in racks or by chains to prevent them from falling over. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310			
02320 SS=D	144G.91 Subd. 4 (b) Appropriate care and services	02320			

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02320	Continued From page 34 (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 to ensure the steps of insulin administration process was followed by unlicensed personnel (ULP)-G for one of one resident (R4). In addition, the licensee failed to ensure a treatment and therapy management plan was followed for one of one resident (R5). 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: ULP-G ULP-G was hired March 1, 2023, to provide direct care services to the residents of the licensee. ULP-G's employee records indicated ULP-G completed annual infection control training January 3, 2025, and deemed competent by the registered nurse (RN) on medication	02320			

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02320	Continued From page 35 administration on May 20, 2023, for initial training and on February 13, 2025, for annual medication administration training. In addition, ULP-G's training transcript indicted ULP-G completed one-hour HIPPA (Health Insurance Portability and Accountability Act) training on protecting health information including logging off medication cart laptops when not in use. R4 R4's diagnosis included diabetes type II. R4's prescriber orders dated January 17, 2025, included Accu-Check (a brand name of a blood glucose monitor) four times a day, Humalog Kwik pen (fast-acting) insulin five units three times a day, and Lantus Solostar (long-lasting) insulin inject 36 units once daily. R4's Service Plan dated January 29, 2025, indicated R4's services included medication and treatment services and to refer to R4's medication and treatment plan. R4's Medication and Treatment and Therapies Management Plan dated January 22, 2025, indicated R4 received oral and subcutaneous medication administration and blood glucose monitoring. In addition, R4's medication and treatment plan indicated medication passers were trained to report changes of condition to the nurse. R4's April 2025 Medication Administration Record (MAR), indicated on April 29, 2024, ULP-G administered R4's scheduled morning Humalog and Lantus insulin and recorded R4's blood glucose of 160 milligrams (mg) per deciliter (dl). R4's record lacked documentation R4 had a	02320			

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02320	Continued From page 36 continuous blood glucose monitor or was able to self-monitor own blood glucose and report results for staff to record in R4's record. On April 29, 2025, at 6:55 a.m., the surveyor entered Cottage House two and observed R4's Humalog and Lantus insulin pens that were pre-dialed to dose to be administered on the top of the medication cart. The laptop on the medication cart was opened and displayed residents' information on the computer screen. R5 was sitting at the breakfast table with a cup coffee, a blood glucose meter and a disposable paper cup of medications. R5 stated ULP-G had gone to Cottage House four to get supplies. At 6:59 a.m., ULP-G entered Cottage House two and stated ULP-G had to run to Cottage House four to get orange juice for the morning. At 7:09 a.m., ULP-G gathered R4's insulin pens, placed in ULP-G's pocket and entered R4's room. ULP-G reached inside ULP-G's pocket and put the insulin pens on R4's recliner arm rest and stated ULP-G forgot an alcohol prep pad and exited R4's room leaving the insulin pens in R4's room. ULP-G re-entered R4's room, opened the alcohol prep pad and cleansed the top of R4's left thigh, removed the insulin cap and injected five units of Humalog insulin into R4's left thigh and immediately withdrew the insulin pen needle. ULP-G cleansed a separate area of R4's left upper thigh with an alcohol prep pad, removed the cap of the needle, injected of 36 units of Lantus insulin and immediately withdrew the insulin pen needle. ULP-G asked R4 what R4's blood glucose was that morning and R4 reported 160 mg/dl. Immediately following R4's insulin administration, ULP-G stated R4 no longer used a blood glucose meter and recently received a new continuous glucose monitor. ULP-G stated R4 independently scanned the sensor to obtain	02320			

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02320	Continued From page 37 blood glucose results without poking a finger and reported the results to staff. R5 R5 diagnosis included diabetes type II. R5's Service Plan dated November 19, 2024, indicated R5 received medication and treatment services and to refer to R5's medication and treatment plan. R5's 90-Day Comprehensive Assessment dated March 6, 2025, indicated R5 required assistance with medication administration and blood glucose monitoring. R5's Medication and Treatment Therapies Management Plan dated September 12, 2024, indicated R5 received assistance with medication administration and blood glucose monitoring administered by caregivers, med passers or unlicensed personnel. R5's prescriber orders dated March 11, 2025, included blood glucose monitoring twice a day. R5's April 2025 MAR included staff initials indicating staff assisted and recorded R5's blood glucose monitoring twice a day. R5's record lacked documentation R5 was able to self-administer medications after set-up or monitor own blood glucose. On April 28, 2025, at 2:00 p.m., ULP-G stated ULP-G had prepared R4's insulin earlier that morning for administration and had to run to Cottage House four for orange juice and forgot to lock R4's insulin pens in the medication cart. ULP-G stated locking the computer screen after	02320			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 22197	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/30/2025
NAME OF PROVIDER OR SUPPLIER NEW PERSPECTIVE - CLOQUET & BA			STREET ADDRESS, CITY, STATE, ZIP CODE 3725 HORIZON DRIVE BLDG 2 BARNUM, MN 55707		
(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 38 use was important to protect resident information; however, mornings get busy passing medications, assisting residents and preparing breakfast and sometimes feel rushed and forget. ULP-G stated ULP-G was unsure the required time to wait after administering insulin before removing the insulin pen needle from the injection site and stated ULP-G thought it was a minute. ULP-G stated ULP-G did not wait after administering R4's insulin and withdrew the insulin pen needles from the skin right away. ULP-G stated R5 was able to independently check her own blood glucose and take own medications after setting up. ULP-G stated staff recorded R5's blood glucose results and stored R5's blood glucose meter in the medication cart. On April 30, 2025, at 10:25 a.m., CNS-B stated staff receive training on protecting resident information upon hire and annually that included locking computer screens when not in use. CNS-B stated R5 had a trial period where staff were observing R5 monitor own blood glucose; however, it had been determined by nursing R5 was no longer able to monitor own blood glucose and staff were re-assigned the task. CNS-B stated staff should be following the resident,s plan of care. On April 30, 2025, at 12:58 p.m., RN-H stated they were unaware R4 had a Dexcom (continuous blood glucose monitor). RN-H stated R4 had a regular blood glucose monitor and staff were to check R4's blood glucose and record R4's results. RN-H stated RN-H spoke with R4 and R4 reported she recently received the Dexcom monitor directly from the company and R4 installed it herself and had been using it for a few days. RN-H stated the ULP-G should have reported to the nurse R4 had a new blood	02320			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 22197	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/30/2025
NAME OF PROVIDER OR SUPPLIER NEW PERSPECTIVE - CLOQUET & BA		STREET ADDRESS, CITY, STATE, ZIP CODE 3725 HORIZON DRIVE BLDG 2 BARNUM, MN 55707			
(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 39 glucose monitoring system as it was a change in R4's plan of care. The licensee's Medication Administration/Insulin policy dated November 21, 2024, indicated the appropriately delegated unlicensed medication passer would administer insulin to residents in accordance with provider orders, applicable law, and company policies and procedures and directed the following: -sanitize the injection site with an alcohol wipe and allow to dry; -grasp the skin of the injection site between fingers and thumb in preparation for the injection; -hold the insulin pen at a 90-degree angle and insert pen needle into the injection site; -press the plunger and with a slow and steady push until all the insulin is injected, hold the needle in place for approximately 10 seconds; -remove the needle from the injection site. The licensee's Medication Administration/Supervision of Resident Self-Administration policy dated November 21, 2024, indicated for residents assessed as capable of self-administering medications with supervision, the med passer would provide the following: -follow the resident's electronic medication administration record e(MAR); -provide the medication cup to the resident for self-administration; -observe the resident while self-administering; and -confirm self-administration of all medications. The licensee's Treatment or Therapy Management Services policy dated February 20, 2025, indicated when administration of a treatment or therapy service delegated to	02320			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 22197	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/30/2025
NAME OF PROVIDER OR SUPPLIER NEW PERSPECTIVE - CLOQUET & BA		STREET ADDRESS, CITY, STATE, ZIP CODE 3725 HORIZON DRIVE BLDG 2 BARNUM, MN 55707			
(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 unlicensed personnel, the licence nurse would ensure the unlicensed personnel were instructed in the proper treatment method with respect to each resident and the unlicensed personnel had demonstrated the ability to competently follow the procedures. The licensee's Resident Rights policy dated January 3, 2025, indicated the Community (assisted living) would protect and keep confidential person information for each client including resident medical, financial, or other records. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320			
02410 SS=D	144G.91 Subd. 13 Personal and treatment privacy (a) Residents have the right to consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being. Staff must respect the privacy of a resident's space by knocking on the door and seeking consent before entering, except in an emergency or unless otherwise documented in the resident's service plan. (b) Residents have the right to have and use a lockable door to the resident's unit. The facility shall provide locks on the resident's unit. Only a staff member with a specific need to enter the unit shall have keys. This right may be restricted in certain circumstances if necessary for a resident's health and safety and documented in the resident's service plan. (c) Residents have the right to respect and	02410			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 22197	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/30/2025
NAME OF PROVIDER OR SUPPLIER NEW PERSPECTIVE - CLOQUET & BA			STREET ADDRESS, CITY, STATE, ZIP CODE 3725 HORIZON DRIVE BLDG 2 BARNUM, MN 55707		
(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
02410	Continued From page 41 privacy regarding the resident's service plan. Case discussion, consultation, examination, and treatment are confidential and must be conducted discreetly. Privacy must be respected during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure staff knocked before entering resident rooms for one of four staff (unlicensed personnel (ULP)-G). 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: ULP-G was hired March 1, 2023, to provide direct care services to the residents of the licensee. ULP-G's employee training records indicated ULP-G completed Care Skills training on March 28, 2023, which included resident care interactions and knocking before entering resident rooms. On April 29, 2025, at 7:06 a.m., the surveyor observed ULP-G enter R7's room without knocking prior to entering or announcing self. At 7:09 a.m., ULP-G entered R4's room without	02410			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 22197	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/30/2025
NAME OF PROVIDER OR SUPPLIER NEW PERSPECTIVE - CLOQUET & BA			STREET ADDRESS, CITY, STATE, ZIP CODE 3725 HORIZON DRIVE BLDG 2 BARNUM, MN 55707		
(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
02410	Continued From page 42 knocking or announcing self-prior to entering. At 7:23 a.m., ULP entered R8's room without knocking or announcing self-prior to entering room. On April 29, 2025, at 2:00 p.m., ULP-G stated residents were normally out of their rooms during morning medication pass and ULP-G did not think about knocking before entering resident rooms. On April 30, 2025, at 10:25 a.m., clinical nurse supervisor (CNS)-B stated during employee orientation staff were required to complete Care Skills training which covered training on resident and included prior to entering a resident's room, staff must knock and wait for a response, introduce self and purpose for the interaction. CNS-B stated staff were to knock at least three times and if no response, slowly open the door, peek in and announce your entrance. The licensee's Team Member Orientation Training/Care Skills updated March 1, 2025, included a topic on page five Resident Care Interactions that instructed the following: -If you need to enter a resident's apartment for an interaction, knock before entering and wait for a response: -introduce self; and -explain the purpose of the interaction. The Minnesota Bill of Rights for Assisted Living Residents, undated, was included in the licensee's resident agreement at the time of admission and indicated staff must respect the privacy of a resident's space by knocking on the door and seeking consent before entering, except in an emergency or unless otherwise documented in the resident's service plan. In addition,	02410			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 22197	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/30/2025
NAME OF PROVIDER OR SUPPLIER NEW PERSPECTIVE - CLOQUET & BA			STREET ADDRESS, CITY, STATE, ZIP CODE 3725 HORIZON DRIVE BLDG 2 BARNUM, MN 55707		
(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
02410	Continued From page 43 residents have the right to be treated with courtesy and respect. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02410			



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

Food & Beverage Inspection Report

Page: 1

Establishment Info

New Perspective
3725 Horizon Drive Bldg 2
Barnum, MN 55707
Carlton County
Parcel:

Phone:

License Info

License: HFID 22197

Risk:
License:
Expires on:
CFPM:
CFPM #: ; Exp:

Inspection Info

Report Number: F1027251001
Inspection Type: Full - Single
Date: 5/1/2025 Time: 12:20:52 PM
Duration: 60 minutes
Announced Inspection: No
Total Priority 1 Orders: 0
Total Priority 2 Orders: 1
Total Priority 3 Orders: 0
Delivery: Emailed

New Order: 5-200C Plumbing: Maintenance, fixture location

5-205.11AB *Priority Level: Priority 2 CFP#: 10*

MN Rule 4626.1110AB The handwashing sink must be accessible at all times for employee use, and must be used only for handwashing.

COMMENT: AT TIME OF INSPECTION A CONTAINER OF SHRIMP WAS PLACE IN HANDWASHING SINK. STAFF REMOVED CONTAINER FROM HANDWASHING SINK. COS

Comply By: Complied On Site Originally Issued On: 5/1/2025

Food & Beverage General Comment

COTTAGE 4 KITCHEN:

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

RECOMMEND MOVING SOAP DISPENSER AND HAND TOWEL DISPENSER FROM PREP SINK TO NEXT TO HANDWASHING SINK.

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 F1027251001 from 5/1/2025

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

Page: 1

Establishment Info

New Perspective
Barnum
County/Group: Carlton County

Inspection Info

Report Number: F1027251001
Inspection Type: Full
Date: 5/1/2025
Time: 12:20:52 PM

Food Temperature: Product/Item/Unit: THERMOMETER; Temperature Process: Cold-Holding

Location: Upright Cooler at 36 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: Product/Item/Unit: MILK; Temperature Process: Cold-Holding

Location: Upright Cooler at 39 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: Product/Item/Unit: THERMOMETER; Temperature Process: Cold-Holding

Location: Upright Cooler at 33 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: Product/Item/Unit: ALL FOOD FROZEN; Temperature Process: Cold-Holding

Location: Freezer at Degrees F.

Comment:

Violation Issued?: No

Food Temperature: Product/Item/Unit: ALL FOODS FROZEN; Temperature Process: Cold-Holding

Location: Freezer at Degrees F.

Comment:

Violation Issued?: No



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

Sanitizer Observations/Recordings

Page: 1

Establishment Info

New Perspective
Barnum
County/Group: Carlton County

Inspection Info

Report Number: F1027251001
Inspection Type: Full
Date: 5/1/2025
Time: 12:20:52 PM

Sanitizing Chemical: **Product:** Quaternary Ammonia; **Sanitizing Process:** Manual Mix

Location: Wiping Cloth Bucket **Equal To** 200 PPM

Comment:

Violation Issued?: No

Sanitizing Equipment: **Product:** Hot Water; **Sanitizing Process:** High Temp Dishwasher

Location: Dishwashing Area **Equal To** 161 Degrees F.

Comment:

Violation Issued?: No

Minnesota (MDH) Version EH Manager; RPT: F1027251001			Food Establishment Inspection Report			Page <u>1</u> of <u>1</u>			
 Duluth District Office Minnesota Department of Health 11 East Superior Street, Suite 290 Duluth, MN 55802			No. of Risk Factor/Intervention/Violations		0	Date: 5/1/2025			
			No. of Repeat Risk Factor/Intervention/Violations			Time: 12:20:52 PM			
			Score (optional)			Dur: 6 min			
Establishment: New Perspective		Address: 3725 Horizon Drive Bldg 2		City/State: Barnum, MN		Zip: 55707		Phone:	
License/Permit #: HFID 22197		Permit Holder:		Purpose of Inspection: Full		Est. Type:		Risk Category:	
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	Compliance Status			COS	R
Supervision					Time/Temperature Control for Safety				
1	IN	Person in charge present, demonstrate knowledge and performs duties			18	N/O	Proper cooking time & temperatures		
2	IN	Certified Food Protection Manager			19	N/O	Proper reheating procedures for hot holding		
Employee Health					20	N/A	Proper cooling time and temperature		
3	IN	knowledge, responsibilities, and reporting			21	IN	Proper hot holding temperatures		
4	IN	Proper use of restriction and exclusion			22	IN	Proper cold holding temperatures		
5	IN	Response to vomiting, diarrheal events			23	IN	Proper date marking & disposition		
Good Hygienic Practices					24	N/A	Time as public health control;procedures & record		
6	IN	Proper eating, tasting, drinking, tobacco use			Consumer Advisory				
7	IN	No discharge from eyes, nose, and mouth			25	N/A	Consumer advisory provided for raw or undercooked foods		
Preventing Contamination by Hands					Highly Susceptible Populations				
8	IN	Hands clean and properly washed			26	IN	Pasteurized foods used; prohibited foods not offered		
9	N/O	No bare hand contact with RTE foods, alternatives			Food/Color Additives and Toxic Substances				
10	IN	Adequate handwashing sinks supplied and access			27	N/A	Food additives; approved & properly used		
Approved Source					28	N/A	Toxic substances properly identified;stored;used		
11	IN	Food obtained from approved source			Conformance with Approved Procedures				
12	N/O	Food Received at proper temperature			29	N/A	Compliance with variance, specialized processes & HACCP plan		
13	IN	Food in good condition, safe & unadulterated			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				
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							
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				COS	R
Safe Food and Water					Proper Use of Utensils				
30	IN	Pasteurized eggs used where required			43		In-use utensils; Properly stored		
31		Water & ice from approved source			44		Utensils, equipment & linens; properly stored, dried, handled		
32	N/A	Variance obtained for specialized processing methods			45		Single-use & single-service articles, properly stored and used		
Food Temperature Control					46		Gloves used properly		
33		Proper cooling methods used; adequate equipment for temperature control			Utensils, Equipment and Vending				
34	N/O	Plant food properly cooked for hot holding			47		Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
35	N/O	Approved thawing methods used			48		Warewashing facilities: installed, maintained, used; test strips		
36		Thermometers provided & accurate			49		Non-food contact surfaces clean		
Food Identification					Physical Facilities				
37		Food properly labeled; original container			50		Hot & cold water available; adequate pressure		
Prevention of Food Contamination					51		Plumbing installed; proper backflow devices		
38		Insects, rodents, & animals not present; no unauthorized person			52		Sewage & waste water properly disposed		
39		Contamination prevented during food prep, storage, & display			53		Toilet facilities; properly constructed, supplied & cleaned		
40		Personal cleanliness			54		Garbage & refuse properly disposed; facilities maintained		
41		Wiping cloths: properly used & stored			55		Physical facilities installed, maintained & clean		
42		Washing fruits & vegetables			56		Adequate ventilation & lighting; designated areas used		
Person in Charge (signature)					57		Compliance with MCIAA		
					58		Compliance with licensing and plan review		
Inspector (signature)					Follow-up: Follow-up Date:				



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

Food & Beverage Inspection Report

Page: 1

Establishment Info	License Info	Inspection Info
New Perspective 3725 Horizon Drive Bldg 2 Barnum, MN 55707 Carlton County Parcel: Phone:	License: HFID 22197 Risk: License: Expires on: CFPM: TRAVIS SMITKE CFPM #: FM61676; Exp: 7/23/2027	Report Number: F1027251002 Inspection Type: Full - Single Date: 5/1/2025 Time: 1:27:32 PM Duration: 60 minutes Announced Inspection: No <u>Total Priority 1 Orders: 0</u> <u>Total Priority 2 Orders: 0</u> <u>Total Priority 3 Orders: 0</u> <u>Delivery: Emailed</u>

No orders were issued for this inspection report.

Food & Beverage General Comment

COTTAGE 2 KITCHEN:

DISCUSSED EMPLOYEE ILLNESS AND EXCLUSIONS, REQUIRED SANITIZER STRENGTHS, AND AVOIDING BARE HAND CONTACT WITH 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 F1027251002 from 5/1/2025

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

Page: 1

Establishment Info

New Perspective
Barnum
County/Group: Carlton County

Inspection Info

Report Number: F1027251002
Inspection Type: Full
Date: 5/1/2025
Time: 1:27:32 PM

Food Temperature: Product/Item/Unit: THERMOMETER; Temperature Process: Cold-Holding

Location: Upright Cooler at 36 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: Product/Item/Unit: MILK; Temperature Process: Cold-Holding

Location: Upright Cooler at 39 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: Product/Item/Unit: THERMOMETER; Temperature Process: Cold-Holding

Location: Upright Cooler at 33 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: Product/Item/Unit: ALL FOOD FROZEN; Temperature Process: Cold-Holding

Location: Freezer at Degrees F.

Comment:

Violation Issued?: No

Food Temperature: Product/Item/Unit: ALL FOODS FROZEN; Temperature Process: Cold-Holding

Location: Freezer at Degrees F.

Comment:

Violation Issued?: No



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

Sanitizer Observations/Recordings

Page: 1

Establishment Info

New Perspective
Barnum
County/Group: Carlton County

Inspection Info

Report Number: F1027251002
Inspection Type: Full
Date: 5/1/2025
Time: 1:27:32 PM

Sanitizing Chemical: **Product:** Quaternary Ammonia; **Sanitizing Process:** Manual Mix

Location: Wiping Cloth Bucket **Equal To** 200 PPM

Comment:

Violation Issued?: No

Sanitizing Equipment: **Product:** Hot Water; **Sanitizing Process:** High Temp Dishwasher

Location: Dishwashing Area **Equal To** 161 Degrees F.

Comment:

Violation Issued?: No

 Duluth District Office Minnesota Department of Health 11 East Superior Street, Suite 290 Duluth, MN 55802	No. of Risk Factor/Intervention/Violations		0	Date: 5/1/2025
	No. of Repeat Risk Factor/Intervention/Violations			Time: 1:27:32 PM
	Score (optional)			Dur: 60 min
Establishment: New Perspective	Address: 3725 Horizon Drive Bldg 2	City/State: Barnum, MN	Zip: 55707	Phone:
License/Permit #: HFID 22197	Permit Holder:	Purpose of Inspection: Full	Est. Type:	Risk Category:

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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	Compliance Status			COS	R
Supervision					Time/Temperature Control for Safety				
1	IN	Person in charge present, demonstrate knowledge and performs duties			18	N/O	Proper cooking time & temperatures		
2	IN	Certified Food Protection Manager			19	N/A	Proper reheating procedures for hot holding		
Employee Health					20	N/A	Proper cooling time and temperature		
3	IN	knowledge, responsibilities, and reporting			21	N/O	Proper hot holding temperatures		
4	IN	Proper use of restriction and exclusion			22	IN	Proper cold holding temperatures		
5	IN	Response to vomiting, diarrheal events			23	IN	Proper date marking & disposition		
Good Hygienic Practices					24	N/A	Time as public health control;procedures & record		
6	IN	Proper eating, tasting, drinking, tobacco use			Consumer Advisory				
7	IN	No discharge from eyes, nose, and mouth			25	N/A	Consumer advisory provided for raw or undercooked foods		
Preventing Contamination by Hands					Highly Susceptible Populations				
8	IN	Hands clean and properly washed			26	IN	Pasteurized foods used; prohibited foods not offered		
9	N/O	No bare hand contact with RTE foods, alternatives			Food/Color Additives and Toxic Substances				
10	IN	Adequate handwashing sinks supplied and access			27	N/A	Food additives; approved & properly used		
Approved Source					28	N/A	Toxic substances properly identified;stored;used		
11	IN	Food obtained from approved source			Conformance with Approved Procedures				
12	N/O	Food Received at proper temperature			29	N/A	Compliance with variance, specialized processes & HACCP plan		
13	IN	Food in good condition, safe & unadulterated			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				
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							

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				COS	R
Safe Food and Water					Proper Use of Utensils				
30	IN	Pasteurized eggs used where required			43		In-use utensils; Properly stored		
31		Water & ice from approved source			44		Utensils, equipment & linens; properly stored, dried, handled		
32	N/A	Variance obtained for specialized processing methods			45		Single-use & single-service articles, properly stored and used		
Food Temperature Control					46		Gloves used properly		
33		Proper cooling methods used; adequate equipment for temperature control			Utensils, Equipment and Vending				
34	N/O	Plant food properly cooked for hot holding			47		Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
35	N/O	Approved thawing methods used			48		Warewashing facilities: installed, maintained, used; test strips		
36		Thermometers provided & accurate			49		Non-food contact surfaces clean		
Food Identification					Physical Facilities				
37		Food properly labeled; original container			50		Hot & cold water available; adequate pressure		
Prevention of Food Contamination					51		Plumbing installed; proper backflow devices		
38		Insects, rodents, & animals not present; no unauthorized person			52		Sewage & waste water properly disposed		
39		Contamination prevented during food prep, storage, & display			53		Toilet facilities; properly constructed, supplied & cleaned		
40		Personal cleanliness			54		Garbage & refuse properly disposed; facilities maintained		
41		Wiping cloths: properly used & stored			55		Physical facilities installed, maintained & clean		
42		Washing fruits & vegetables			56		Adequate ventilation & lighting; designated areas used		
Person in Charge (signature)					57		Compliance with MCIAA		
					58		Compliance with licensing and plan review		

Inspector (signature)	Follow-up: Follow-up Date:
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