Electronically Delivered

March 21, 2025

Licensee
New Perspective Cloquet & Barnum
1909 Tall Pine Lane
Cloquet, MN 55720

RE: Project Number(s) SL25969016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on February 20, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

The correction order documentation should include the following:

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

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

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

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

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

If you have any questions, please contact me.

Sincerely,

Jessie Chenze

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

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25969	A. BUILDING: _____ B. WING _____	02/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE - CLOQUET & BA	1909 TALL PINE LANE CLOQUET, MN 55720

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL25969016-0 On February 18, 2025, through February 20, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were seven residents; seven residents receiving services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 110 SS=F	144G.10 Subdivision 1a Assisted living director license required	0 110		

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0 110	Continued From page 1 Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the licensed assisted living director (LALD) was listed as the Director of Record for the licensee. This had the potential to affect all the licensee's 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 February 4, 2025, at 1:33 p.m., the surveyor reviewed the Board of Executives for Long-Term Services and Support (BELTSS) website. The BELTSS website indicated the licensee did not have a current assisted living director (LALD) listed for the licensee. During entrance conference on February 18, 2025, a.m., at 9:17 a.m., LALD-A stated LALD-A was the current LALD for the licensee. The surveyor and LALD-A reviewed the BELTSS website and LALD-A was not indicated as the Director of Record for the licensee. LALD-A stated LALD-A had a shared LALD license and	0 110		

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0 110	Continued From page 2 was unaware he was not listed as the Director of Record for this licensee. During the facility tour on February 18, 2025, at 10:27 a.m., the surveyor and LALD-A observed LALD-A's licensee displayed in the fan folder located on the wall at the main entrance of the facility. LALD-A's license indicated LALD-A had a shared license and included health facility identification number (HFID) 22197, another assisted living owned by the same company at a different location; however, did not include the licensee's HFID 25979. The licensee's Communication and Delegation of Authority policy dated December 27, 2024, indicted accurate, up-to-date information for the licensed assisted living director would be available to residents, families, and team members and would be displayed at the Community. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with	0 480		

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0 480	Continued From page 3 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 and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part	0 480		

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0 480	Continued From page 4 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 February 19, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and	0 640		

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0 640	Continued From page 5 suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post the 911 emergency number near house phones provided by the facility as required. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the facility tour on February 18, 2025, at 10:27 a.m., with licensed assisted living director (LALD)-A, the 911 emergency number was observed posted on a wall in the staff office; however, was not observed posted by the public phones located on the medication cart and in the laundry room. LALD-A stated they were aware of the requirement and would add the required 911 postings.	0 640		

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0 640	Continued From page 6 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 640		
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 facility tour with licensed assisted living director (LALD)-A on February 18, 2025, 10:27 a.m., the surveyor observed the facility's layout included the main entrance, a large common area, dining room, two hallways that provided access to resident rooms, a laundry room, mechanical room and managerial and nursing office. In the main entry, the surveyor observed an accordion style file system on the wall in clear plastic sleeves included a facility evacuation plan; however, there was no evidence of the emergency disaster plan posted prominently in the building, as required. LALD-A confirmed the emergency disaster plan was not posted prominently, and the emergency preparedness binder was kept in an enclosed pantry area on a shelf. The licensee's Emergency Preparedness Program (EPP) red binder dated October 1, 2025, was observed in the kitchen pantry on the first shelf. The licensee's EPP respectfully lacked the following: -documentation of a quarterly review of missing resident policy;	0 680		

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0 680	Continued From page 8 -arrangements with other facilities/providers to receive residents; -an 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 February 20, 2025, at 11:11 a.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 and written agreements with other facilities/providers in the event of an evacuation or relocation of residents and staff. The licensee's Emergency Preparedness Program revised January 5, 2024, indicated copies of the Emergency Preparedness and Response Program would be maintained and kept near the front entrance of the Community. The licensee's Emergency Preparedness policy dated March 11, 2011, 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;	0 680		

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0 680	Continued From page 9 -staff assignments in the event of a disaster or an emergency; and -post the Community's Disaster Evacuation Plan prominently. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to keep the facility in compliance with Minnesota State Fire Code under Minnesota Rule Chapter 7511. The deficient conditions have the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On a facility tour on February 19, 2025, between 09:00 a.m. and 10:30 a.m. with the licensed	0 775		

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0 775	Continued From page 10 assisted living director (LALD)-A and the environmental services director (ESD)-F, the surveyor observed the following conditions: RESIDENT ROOM EMERGENCY ESCAPE WINDOWS: The surveyor observed a cable connected to the window that would not allow it to open fully. At least one compliant emergency escape and rescue opening is required within each resident sleeping room. Existing emergency escape and rescue openings are required to meet a minimum clear opening area of 648 square inches and have a minimum opening dimension of 20 inches in height and a minimum opening dimension of 20 inches in width. The windowsill height from the floor to the clear opening shall be not more than 48 inches. LINT: The surveyor observed excessive lint accumulation on the bathroom fan vent covers. The vent fan/covers shall be cleaned periodically. The deficient conditions were visually verified by LALD-A and the ESD-F accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 775		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment	0 780		

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0 780	Continued From page 11 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 by: Based on observation and interview, the licensee failed to provide smoke alarms that functioned and are interconnected so that the actuation of one alarm causes all alarms in the dwelling unit to actuate. Also, there were a few smoke alarms missing. The deficient condition has the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	0 780		

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0 780	Continued From page 12 was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On a facility tour on February 19, 2025, between 09:00 a.m. and 10:30 a.m. with the licensed assisted living director (LALD)-A and the environmental services director (ESD)-F, the surveyor observed the following conditions: SMOKE ALARMS: The ESD-F checked the interconnection of the smoke alarms and the one outside of resident room 101 did not operate when the rest of the smoke alarms in the facility were tested. All smoke alarms in the facility shall be interconnected. The deficient condition was visually verified by the LALD-A and the ESD-F accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		
01290 SS=F	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring	01290		

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01290	Continued From page 13 self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study (BGS) was submitted and a clearance received in affiliation with the assisted living licensee's current health facility identification (HFID) for one of eight employees (unlicensed personnel (ULP)-D). This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During entrance conference on February 18, 2025, at 9:18 a.m., the surveyor requested a copy of the Minnesota Department of Human Services (MN DHS) NetStudy employee roster and a list of the licensee's current employees including hire dates and titles.	01290		

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01290	Continued From page 14 ULP-D had a hire date of January 27, 2021, to provide direct are services to the licensee's residents. ULP-D's BGS clearance letter dated January 27, 2021, was cleared; however, was affiliated through HFID 21972, a sister facility of the licensee. ULP-D's record lacked evidence ULP-D's BGS had been affiliated with the licensee's HFID 25969. On February 18, 2025, at 12:17 p.m., clinical nurse supervisor (CNS)-B provided the surveyor with a copy the DHS NetStudy employee roster. Upon review of the NetStudy roster with CNS-B and Director of Operations (DOO)-G, CNS-B stated ULP-D was a full-time employee of the licensee; however, ULP-D was not listed as an employee on the NetStudy employee roster. DOO-G stated all employees from the corporate owned assisted livings should have been affiliated with each of the assisted livings HFID licensed numbers. DOO-G stated human recourses had been working with DHS on tying to affiliate ULP-D's BGS with the licensee's HFID 25969 and there have been delays with the process. The licensee's Background Checks policy dated February 14, 2022, candidates would undergo background checks via Verified Credentials and the Minnesota Department of Human Services. Each community (assisted living facilities) must establish and maintain an account with the Minnesota Department of Services (MN DHS). No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		

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

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01500	Continued From page 16 subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employees performing direct care services completed the required annual training for one of two employees (unlicensed personnel (ULP)-C). 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 entrance conference on February 18, 2025, at 9:17 a.m., clinical nurse supervisor	01500		

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01500	Continued From page 17 (CNS)-B stated they were aware of the required content for employee training. CNS-B stated corporate human resources (HR) was responsible for assigning employee training. ULP-C had a hire date of April 9, 2019, to provide direct care services to the residents of the facility. On February 19, 2025, at 8:32 a.m., the surveyor observed ULP-C administering R2's scheduled morning medications. ULP-C's employee record lacked evidence ULP-C successfully completed annual training as required to include: -review of provider's policies and procedures. On February 20, 2025, at 9:47 a.m., CNS-B stated HR was responsible for assigning annual training for employees through their computer-based learning program and each employee received notifications when trainings were due. CNS-B reviewed ULP-C's training records and stated ULP-C had not completed the required annual review of the provider's policies and procedures in 2024 because HR had not assigned ULP-C the required training topic. The licensee's Team Member Orientation and Training policy dated January 27, 2023, indicated all team members performing direct services will receive at least eight hours of annual training for each 12 months of employment. Continuing education shall be relevant to the job responsibilities and would include, at a minimum, each of the following: -review of infection control techniques and implementation of infection control standards including: -review of hand washing techniques;	01500		

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01500	Continued From page 18 -the need for and use of protective gloves, gowns, and masks; -appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; -disinfecting reusable equipment and environmental surfaces; and -reporting communicable diseases. -effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; -review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and -the principles of person-centered planning and service delivery and how they apply to direct support services provided by the team member. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		
01700 SS=D	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include	01700		

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01700	Continued From page 19 an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure residents were assessed for self-administration of medications for one of one resident (R2) who self-administered insulin after set up. 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: R2's diagnoses included diabetes type II, vascular dementia, hearing loss, and history of a	01700		

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01700	Continued From page 20 cerebrovascular accident (stroke). R2's 90-Day Assessment dated December 4, 2024, indicated R2 received assistance with medication administration services; however, did not include an assessment of R2's ability to self-administer medications. R2's Service Plan dated December 14, 2024, indicated R2 received medication administration services. R2's prescriber orders dated February 4, 2025, included an order for Lantus SoloStar insulin pen (long-acting insulin) to inject eight units daily. Ok for resident to self-administer after staff set up and watch resident administer. R2's Medication and Treatment and Therapies Management Plan dated February 5, 2025, indicated R2 elected medication administration services including subcutaneous administration (insertion of medications beneath the skin by injection or infusion). R2's February 2025, Medication Administration Record (MAR) indicated R2 received Lantus SoloStar insulin 8 units daily. Ok for resident or self-administer after staff set up and watch resident administer. On February 18, 2025, at 8:32 a.m., the surveyor observed unlicensed personnel (ULP)-C prime R2's Lantus insulin pen two unit then dial eight units of insulin. ULP-C entered R2's room, check R2's blood glucose with the results of 112 milligrams per deciliter (mg/dl). ULP-C handed R2's Lantus Solostar insulin pen and R2 self-administered into right lower abdomen.	01700		

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01700	Continued From page 21 On February 19, 2025, at 10:52 a.m., clinical nurse supervisor (CNS)-B stated R2 was able to administer own insulin after set up and R2 had an order from R2's provider. CNS-B stated after residents were deemed competent by the registered nurse and signed a Negotiated Risk Agreement, residents were able to self-administer medications. CNS-B stated they were unable to find a singed Negotiated Risk Agreement for R2 for self-administration of insulin. CNS-B stated the licensee did not complete a separate self-medication assessment and it was not included in the 90-Day Assessments. The licensee's Self-Administration of All Medications policy dated, November 20, 2024, indicted in accordance with requirements of applicable law, for residents who elect to self-administer their medications and treatments or maintain at bedside for self-administration, the health and wellness director (HWD) or licensed nurse designee would request a primary care provider order for resident self-administration of medication and treatments or maintain an as needed medication at bed-side for self-administration and execute a Negotiated Risk Agreement. Residents deemed safe to self-administer their medications would acknowledge and agree that they would independently manage medication orders, processing, and delivery, and any medication or treatment. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700		

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01730	Continued From page 22	01730		
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes.	01730		

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01730	Continued From page 23 (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure an individual medication management plan was followed for one of one resident (R2) whose medications were managed and stored by the licensee. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: R2's diagnoses included diabetes type II, hypertension (high blood pressure), hearing loss, and vascular dementia. R2's Individual Medication Management and Treatment Plan dated February 5, 2025, indicated R2's medications were stored in locked medication carts. On February 19, 2025, at 8:42 a.m., the surveyor observed unlicensed personnel (ULP)-C prepare and administer R2's scheduled morning medications. During R2's medication observation, the surveyor observed three bottles of medications on a table next to R2's recliner	01730		

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01730	Continued From page 24 where R2 was sitting. Immediately following the medication administration, ULP-C stated the nurses were aware R2 had medications in her room. ULP-C stated the nurses would remove the medications from R2's room and R2 would purchase more. ULP-C stated R2's electronic medication administration record (EMAR) did not include any medications R2 kept in her room and staff were not managing those medications. On February 20, 2025, at 9:10 a.m., R2 stated the licensee assisted R2 with medication and insulin administration and stored of medications. The surveyor observed one opened bottle of vitamin B12 (supplement) XX micrograms (mcg), one opened bottle of Melatonin (sleep aid) 12 milligrams (mg) and one opened bottle ibuprofen (pain reliever) 200 mg in R2's room. R2 stated she took the vitamin B12 when she remembered, the Melatonin if she needed it at night to help her sleep and the ibuprofen for headaches. R2 stated she did not know why she was able to keep certain medications in her room but wasn't able to keep her insulin and the rest of her medications in her room that were being stored by the licensee. R2's prescriber orders dated January 4, 2025, did not include vitamin B12, Melatonin, or ibuprofen. R2's February 2025, Medication Administration Record (MAR) did not include R2's vitamin B12, Melatonin, or ibuprofen, which were being stored in R2's room. On February 20, 2025, at 9:47 a.m., clinical nurse supervisor (CNS)-B stated the nurses would educate R2 about purchasing over the counter medications without notifying the nurse and storing in room. CNS-B stated the nurses would	01730		

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01730	Continued From page 25 remove medications found in R2's room and R2 would keep purchasing more medications on her own. CNS-B stated she was unable to find documentation in R2's record about medications found in R2's room, any education provided to R2 or if R2's provider had been updated. The licensee's Medication Management/Medication Storage policy dated June 28, 2024, indicated medication that was managed by the Community would be securely stored in the original pharmacy-labeled containers per pharmacy instructions and organized by resident, in accordance with applicable law. Medications would be centrally stored in locked medication carts, secure medication rooms, or secured medication refrigerators located in the Community. The licensee's Non-Community Administration of Medication policy dated November 20, 2024, indicated the Community offers medication and treatment services to its assisted living residents. Assisted living residents may elect to self-manage medication and treatments in accordance with applicable law. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who	01960		

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NEW PERSPECTIVE - CLOQUET & BA	1909 TALL PINE LANE CLOQUET, MN 55720

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01960	Continued From page 26 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 treatment or therapies were administered as directed and failed to document the reason they were not administered for one of one resident (R2) with treatment and/or therapies. 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: R2's diagnoses included vascular dementia, hypertension (high blood pressure) and history of a cerebrovascular accident (stroke). R2's prescriber orders dated February 4, 2025, included an order to start amlodipine 5 milligrams (mg) (used to treat high blood pressure) daily and to monitor R2's blood pressure weekly for four weeks. R2's Service Plan dated December 14, 2024,	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25969	A. BUILDING: _____ B. WING _____	02/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE - CLOQUET & BA	1909 TALL PINE LANE CLOQUET, MN 55720

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01960	Continued From page 27 directed to monitor and record R2's blood pressure weekly on Thursdays for one-month effective January 8, 2025. In addition, R2's Service Plan directed to monitor R2's blood pressure in the electronic medical administration record (EMAR) for four weeks for medication monitoring of a new blood pressure drug effective February 10, 2025. R2's Medication and Treatment and Therapies Management Plan dated February 5, 2025, indicated R2's treatment or therapy instructions were in R2's EMAR or R2's service plan. R2's February 2025, EMAR indicated R2 was administered amlodipine 5 mg daily from February 5, through February 19, 2025, and R2's EMAR instructed to take R2's blood pressure weekly for four weeks for monitoring of a new blood pressure medications. R2's EMAR lacked documentation of R2's weekly blood pressure readings or why R2's blood pressure was not monitored as directed. R2's Blood Pressure reading printed February 19, 2025, indicated R2's blood pressure was monitored on January 1, 2025, and February 1, 2025; however, R2's record did not include evidence R2's blood pressure was monitored weekly as instructed for January or February. On February 19, 2025, at 9:54 a.m., clinical nurse supervisor (CNS)-B stated R2's provider instructed R2's blood pressure to be monitored weekly for four weeks for monitoring a new blood pressure medication. CNS-B stated R2's EMAR directed to monitor R2's blood pressure weekly for four weeks and staff did not follow the written instructions. CNS-B stated usually there was a separate task created on the EMAR for special	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25969	A. BUILDING: _____ B. WING _____	02/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE - CLOQUET & BA	1909 TALL PINE LANE CLOQUET, MN 55720

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01960	Continued From page 28 treatment instructions; however, R2's EMAR did not have a separate blood pressure task assigned to the unlicensed personnel (ULPs) to document R2's weekly blood pressure readings. The licensee's Treatment or Therapy Management Services policy dated March 21, 2023, indicated the Community provides treatment and therapy services within the scope of its provider license and according to applicable law. The registered nurse (RN) is responsible for: -requesting and receiving orders or prescriptions for treatments or therapy services; -implementing treatments or therapy services; -providing or delegating treatments or therapy services to licensed or unlicensed personnel in accordance with applicable delegation practice standards; -overseeing accurate documentation of treatments or therapy services; -maintaining an individualized resident treatment or therapy services record; -monitoring and evaluating treatment or therapy services; -communicating information regarding treatment or therapy services with the prescribing physician; and -educating and communicating with the resident or resident's legal representative about treatments or therapy services they are receiving. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		

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

Type: Full
Date: *02/19/25*
Time: 10:30:00
Report: 1027251020

Food and Beverage Establishment Inspection Report

Location:
New Perspective - Cloquet & Ba
1909 Tall Pine Lane
Cloquet, MN55720
Carlton County, 09

Establishment Info:
ID #: 0038746
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 2188780000
ID #:

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

The following orders were issued during this inspection.

2-200 Employee Health

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

MN Rule 4626.0040C The person in charge must record all reports of diarrhea or vomiting made by food employees and report those illnesses to the regulatory authority.

AT TIME OF INSPECTION STAFF COULD NOT LOCATE AN ILLNESS LOG. AN ILLNESS LOG WAS LEFT WITH MANAGER. COS

Corrected on Site

3-300B Protection from Contamination: cross-contamination, eggs

3-302.11A(1) ***** Priority 1 *****

MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.

AT TIME OF INSPECTION RAW BACON AND BEEF WERE STORED OVER READY TO EAT FOODS IN UPRIGHT COOLER IN LAUNDRY ROOM. STAFF MOVED BOTH ITEMS TO A LOWER SHELF. COS

Corrected on Site

Surface and Equipment Sanitizers

Quaternary Ammonia: = 200PPM at Degrees Fahrenheit
Location: SANITIZER BUCKET
Violation Issued: No

Hot Water: = at 161 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Type: Full
Date: *02/19/25*
Time: 10:30:00
Report: 1027251020
New Perspective - Cloquet & Ba

Food and Beverage Establishment Inspection Report

Food and Equipment Temperatures

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

Process/Item: Upright Cooler
Temperature: 40 Degrees Fahrenheit - Location: MASHED POTATOES
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 41 Degrees Fahrenheit - Location: SLICED CHEESE
Violation Issued: No

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

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

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

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

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

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

I acknowledge receipt of the MN Department of Health inspection report number 1027251020 of 02/19/25.

Certified Food Protection Manager PHYLLIS ASPERHEIM

Certification Number: FM28012 Expires: 02/09/26

Inspection report reviewed with person in charge and emailed.

Signed: _____
TRAVIS SMITKE
MANAGER

Signed: Ian Harrison
Ian H

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

Report #: 1027251020

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

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

No. of RF/PHI Categories Out	2
No. of Repeat RF/PHI Categories Out	0
Legal Authority MN Rules Chapter 4626	

Date 02/19/25
Time In 10:30:00
Time Out

	Address	City/State	Zip Code	Telephone
New Perspective - Cloquet & Ba	1909 Tall Pine Lane	Cloquet, MN	55720	2188780000

License/Permit #	Permit Holder	Purpose of Inspection	Est Type	Risk Category
0038746		Full		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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

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

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

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

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

GOOD RETAIL PRACTICES

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

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

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

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

Food Recalls:

Person in Charge (Signature) **Date:** 02/21/25

Inspector (Signature) Dan Harrison