Electronically Delivered

August 12, 2022

Administrator
Barnes Care
154 East Highway 61
Esko, MN 55733

RE: Project Number SL29535015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on July 21, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

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

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

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, no immediate fines are assessed.

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

The correction order documentation should include the following:

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

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

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

Please address your cover letter for general reconsideration requests to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

Free from Maltreatment reconsideration requests should be addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

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

Sincerely,

Jessie Chenze, Interim Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: Jessica.Chenze@state.mn.us
Phone: 218-332-5175| Fax: 218-332-5196

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29535	A. BUILDING: _____ B. WING _____	07/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BARNES CARE	154 EAST HIGHWAY 61 ESKO, MN 55733

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL#2935015 On July 18, 2022, through July 21, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 13 residents, all of whom received services under the provider's Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 250 SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a	0 250		

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0 250	Continued From page 1 provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the	0 250		

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0 250	Continued From page 2 commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to show they met the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations understood applicable statutes and rules; nor developed and/or implemented current policies and procedures as required with records reviewed. 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 July 18, 2022, at approximately 10:35 a.m.., licensed assisted living director (LALD)-A stated the licensee's employees in charge of the facility were familiar	0 250		

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0 250	Continued From page 3 with the assisted living regulations and the licensee provided medication and treatment management services. The licensee's Application for Assisted Living License, section titled Official Verification of Owner or Authorized Agent, (page four and five of the application), identified, I certify I have read and understand the following: [a check mark was placed before each of the following]: - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45, my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17. - I have read and fully understand Minn. Stat. sect. 144G.80, 144G.81. and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22, my building(s) must comply with these sections if applicable. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G. - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659. - Reporting of Maltreatment of Vulnerable Adults. - Electronic Monitoring in Certain Facilities. - I understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data, the Commissioner will use information provided in this application, which may include an in-person or telephone conference, to determine if the applicant meets	0 250		

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0 250	Continued From page 4 requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying a license. I understand that information submitted to the commissioner in this application may, in some circumstances, be disclosed to the appropriate state, federal or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices. - I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons (opens in a new window), all data submitted on this application shall be classified as public information upon issuance of a provisional license or license. All data submitted are considered private until MDH issues a license. - I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659 governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. - I have examined this application and all attachments and checked the above boxes indicating my review and understanding of	0 250		

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0 250	Continued From page 5 Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct, and complete. I will notify MDH, in writing, of any changes to this information as required. - I attest to have all required policies and procedures of Minn. Stat. chapter 144G and Minn. Rules chapter 4659 in place upon licensure and to keep them current as applicable. Page five was electronically signed by Justin Barnes on May 17, 2022. The licensee had an assisted living license issued on August 1. 2021, with an expiration date of July 31, 2022. The licensee failed to ensure the following policies and procedures were developed and/or implemented: (1) requirements in section 626.557, reporting of maltreatment of vulnerable adults; (2) conducting and handling background studies on employees; (3) orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; (4) orientation to and implementation of the assisted living bill of rights; (5) medication and treatment management; (6) delegation of tasks by registered nurses or licensed health professionals; and (7) supervision of unlicensed personnel performing delegated tasks. On July 20, 2022, at 3:23 p.m., LALD-A confirmed the licensee provided assisted living services but failed to implement corresponding policies and	0 250		

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0 250	Continued From page 6 procedures, as required. As a result of this survey, the following orders were issued 0430, 0470, 0485, 0550, 0620, 0630, 0640, 0660, 0680, 0800, 0810, 0920, 0930, 0940, 0970, 1470, 1640, 1650, 1760, 1890, 1950, 3030, 3090, indicating the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 250		
0 430 SS=C	144G.40 Subd. 2 Uniform checklist disclosure of services (a) All assisted living facilities must provide to prospective residents: (1) a disclosure of the categories of assisted living licenses available and the category of license held by the facility; (2) a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and (3) an oral explanation of the services offered under the contract. (b) The requirements of paragraph (a) must be completed prior to the execution of the assisted living contract. (c) The commissioner must, in consultation with all interested stakeholders, design the uniform checklist disclosure form for use as provided under paragraph (a).	0 430		

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0 430	Continued From page 7 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a copy of the uniform checklist disclosure of services (UDALSA) with the required content for two of two residents (R1, R2) with records reviewed. This had the potential to affect all 13 residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 R1's diagnoses included congestive heart failure, cerebral infarction (stroke), dementia, and anxiety. R1's Rental Agreement was signed March 28, 2022. R1's Service Plan dated March 28, 2022, indicated R1 received services which included medication administration, dressing, grooming, bathing, incontinence care, housekeeping, and laundry. R1's record lacked a written acknowledgement of receiving the licensee's UDALSA. R2	0 430		

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0 430	Continued From page 8 R2's diagnoses included diabetes, atrial fibrillation (irregular heartbeat), cardiomyopathy (a disease of the heart muscle that makes it harder for the heart to pump blood to the rest of the body), and hyperlipidemia (high cholesterol). R2's Rental Agreement was signed September 21, 2017. R2's Service Plan dated August 31, 2022, indicated R2 received services which included medication administration, blood glucose monitoring, housekeeping, laundry, and monitoring and assist with dressing, grooming toileting, and bathing. R2's record included an undated signed written acknowledgement; however, the written acknowledgment did not include the UDALSA. On July 19, 2022, licensed assisted living director (LALD)-A confirmed R1's record did not include a written acknowledgement of receiving the licensee's UDALSA. LALD-A confirmed R2's written acknowledgment did not include the licensee's UDALSA. LALD-A stated he was unaware the licensee was required to provide the UDALSA to all residents and confirmed the residents had not received the UDALSA. The licensee's Uniform Checklist Disclosure of Assisted Living Services and Amenities dated August 1, 2022, indicated the licensee would provide UDALSA to prospective residents prior to signing an Assisted Living Contract and would obtain written acknowledgement from the resident or resident representative. No further information was provided.	0 430		

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0 430	Continued From page 9 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 430		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the required	0 470		

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0 470	Continued From page 10 staffing plan was developed, implemented, and evaluated for appropriateness of staffing levels as required. This had the potential to affect all current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents The findings include: The licensee held an assisted living facility licensed for a capacity of 14 residents and had a current census of 13 residents. During entrance conference on July 18, 2022, at approximately 10:35 a.m., licensed assisted living director (LALD)-A stated the licensee had developed a staffing plan which was reviewed a minimal of twice a year. During a facility tour on July 18, 2022, at approximately 11:52 a.m., the surveyor confirmed with registered nurse (RN)-B, the licensee did not have the daily staff schedule posted. On July 19, 2022, at approximately 12:13 p.m., RN-B provided the surveyor with the licensee's staffing plan which consisted of the licensee's Staffing and Scheduling policy and July's 24 hour daily staffing schedule. On July 20, 2022, at approximately 4:12 p.m., LALD-A confirmed the licensee had not developed or implemented a staffing plan to	0 470		

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0 470	Continued From page 11 determine staffing hours based on resident care needs. The licensee's Staffing and Scheduling Policy dated August 1, 2021, indicated the clinical nurse supervisor or house lead would develop and implement a written staffing plan that provided an adequate number of qualified direct-care staff to meet the residents' needs 24-hours a day, seven-days a week and the daily staff schedule would be posted. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 470		
0 485 SS=C	144G.41 Subd 1. (13) (i) (A) and (C) Minimum Requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (A) menus must be prepared at least one week in advance, and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; (C) the facility cannot require a resident to include	0 485		

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	29535	A. BUILDING: _____ B. WING _____	07/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BARNES CARE	154 EAST HIGHWAY 61 ESKO, MN 55733

(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
0 485	Continued From page 12 and pay for meals in their contract; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to post a menu a week in advance that was made available to all residents. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the initial facility tour on July 18, 2022, at approximately 11:52 a.m., with registered nurse (RN)-B, menus were not posted in the dining or main areas of the facility. RN-B confirmed menus were not posted to made available for the residents and was unaware of the requirement. The licensee's Food Service policy dated August 1, 2021, indicated menus would be prepared at least one week in advance and made available to all residents. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		

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0 550	Continued From page 13	0 550		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post the required information related to the grievance procedure. This had the potential to affect all 13 current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During a facility tour on July 18, 2022, at approximately 11:52 a.m., the surveyor observed, and confirmed with registered nurse (RN)-B, the licenses' grievance procedure was posted on the office doors; however, the grievance procedure posting lacked the required content to include the	0 550		

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0 550	Continued From page 14 e-mail contact information for the individuals who are responsible for handling resident grievances and contact information for the Office of Ombudsman for Mental Health and Developmental Disabilities. On July 21, 2022, at approximately 10:38 a.m., RN-B confirmed the licensee's grievance procedure posted on the office doors was not a conspicuous place for everyone to see. The licensee's Complaint/Grievance Posting policy dated August 1, 2021, indicated the licensee would post, in a conspicuous place, information about the licensee's complaint/grievance procedure, and the name, telephone number, and email contact information for the individual(s) who were responsible for handling resident complaint/grievances. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 550		
0 620 SS=D	144G.42 Subd. 6 (a) Compliance with requirements for reporting ma 144G.42 Subd. 6. Compliance with requirements for reporting maltreatment of vulnerable adults; abuse prevention plan. (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. This MN Requirement is not met as evidenced	0 620		

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0 620	Continued From page 15 by: Based on interview and record review, the licensee failed to timely submit a report to the Minnesota Adult Abuse Reporting Center (MAARC) for one of one resident (R4) who had an altercation with another resident (R5) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at 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: The licensee failed to report timely the July 16, 2022, altercation incident between R4 and R5 to MAARC. On July 18, 2022, at approximately 10:35 a.m., the surveyor requested the licensee's MAARC reports for the past six months and was only provided a MAARC report submitted March 18, 2022. R4 R4's diagnoses included Alzheimer's. R4's Service Plan dated August 30, 2021, indicated R4 received assistance with bathing, medications, meals, laundry, and housekeeping. R4's Resident Care Plan dated July 8, 2020, indicated R4 had behaviors that required regular interventions.	0 620		

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0 620	Continued From page 16 R4's July 2022, Daily Behavior Observation form indicated R4's targeted behavior included refusing medications, eating, showering, and throwing stuff. R4's had 12 observed behaviors documented. R5 R5's diagnoses included epilepsy (seizures), anxiety and depression. R5's Service Plan dated April 21, 2022, indicated R5 received assistance with dressing, grooming, bathing, medications, meals, laundry, and housekeeping. R5's Resident Care Plan dated April 25, 2022, indicated R5 had no behaviors that needed interventions. R5's July 2022, Daily Behavior Observation form indicated R5 had no identified targeted behaviors and had no behaviors observed. The licensee's Resident/Visitor Unusual Occurrence Report dated July 16, 2022, indicated R5 was trying to redirect R4 into a new area, R4 became agitated and slapped R5 across the face. The report indicated there was no visible injury. Staff notified RN-B and R4's family and did not notify R5's family per R5's request. The licensee's communication book dated July 16, 2022, had an entry indicating R4 slapped R5 across the face and be aware of R4's behaviors becoming aggressive. On July 19, 2022, at approximately 8:47 a.m., licensed assisted living director (LALD)-A confirmed the incident between R4 and R5 had	0 620		

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0 620	Continued From page 17 not been reported to MAARC and should have been reported within 24 hours after known incident. LALD-A stated he was not the RN on-call at the time of the incident and was just made aware of the altercation. RN-B stated she was on call that weekend and had received the call from staff reporting R4 slapped R5 across the face. RN-B stated staff notified both families of the incident. RN-B confirmed she did not file a report with MAARC. On July 19, 2022, at approximately 10:07 a.m., LALD-A informed the surveyor, he filed a report to MAARC regarding the altercation between R4 and R5. The licensee's Vulnerable Adult Maltreatment-Prevention & Reporting policy, dated August 1, 2021, defined maltreatment as neglect, abuse and exploitation. The policy noted the director of nursing and ED were responsible for investigating and reporting incidents (no later than 24 hours after the maltreatment was first suspected) any incident of suspected maltreatment. The investigation will begin as soon as a report is received. As part of the internal investigation, the director of nursing and ED will: - interview witnesses or persons who may have information concerning the incident - document the witness statements concerning the incidents - review the resident's care plan and relevant chart records and agency policies - review the witness statements, resident records, resident's individual abuse protection plan, and agency policies to determine whether abuse, neglect has occurred, including standards of care, that may have been violated.	0 620		

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0 620	Continued From page 18 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 620		
0 630 SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for one of two residents (R1) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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:	0 630		

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0 630	Continued From page 19 R1's diagnoses included congestive heart failure, cerebral infarction (stroke), dementia, and anxiety. R1's Service Plan dated March 28, 2022, indicated R1 received services which included medication administration, dressing, grooming, bathing, incontinence care, housekeeping, and laundry. R1's Assessment For Client Vulnerability and Safety dated March 30, 2022, lacked a review of self-abuse. R1's unsigned and undated IAPP, identified areas of vulnerability with interventions and lacked a review of the resident's susceptibility to be abused by another individual, including other vulnerable adults, potential risk of self-abuse and resident's risk of abusing other vulnerable adults. On July 18, 2022, at approximately 3:35 p.m., licensed assisted living director (LALD)-A stated R1's Assessment for Client Vulnerability and Safety was the licensee's old form which did not address self-abuse. LALD-A confirmed not all residents had the new IAPP in place and was in the process of updating resident records. LALD-A confirmed R1's IAPP had not been fully completed to review areas noted above and had not been authenticated by the staff who completed the form. The licensee's Individual Abuse Prevention Plan policy dated August 1, 2021, noted the IAPP would contain an individualized review or assessment of the person's susceptibility to abuse by another individual including other vulnerable adults, and the person's risk of	0 630		

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0 630	Continued From page 20 abusing other vulnerable adults, and potential risk of self-abuse. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
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 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 required content in common areas to include: posting the 911 emergency number and contact information for Minnesota Adult Abuse Reporting Center (MAARC) in common areas and near telephones provided by the assisted living facility. This had the potential to affect all residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 640		

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0 640	Continued From page 21 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 a facility tour on July 18, 2022, at approximately 11:52 a.m., the surveyor confirmed with registered nurse (RN)-B, the licensee did not have the required postings for 911 emergency number or MAARC contact information and was unaware of the requirement. The licensee's Vulnerable Adult Maltreatment-Prevention and Reporting policy dated August 1, 2021, indicated the licensee would post the 911 emergency number in common areas and near telephones provided by the licensee and post the reporting number for MAARC. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 640		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity	0 660		

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0 660	Continued From page 22 and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the provider established and maintained a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included completion of a facility risk assessment. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on July 18, 2022, at 10:35 a.m., the surveyor requested the licensee's facility TB risk assessment, which was provided and later reviewed by the surveyor. The licensee's facility TB risk assessment had been completed by registered nurse and was dated July 19, 2012. The facility had been identified as low risk.	0 660		

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0 660	Continued From page 23 On July 20, 2022, at 4:12 p.m., licensed assisted living director (LALD)-A stated he reviewed the facility TB plan annually and confirmed the facility's TB risk assessment was not being completed every two years and was last completed 2012. The licensee's TB Plan updated March 2011, indicated the facility TB risk assessment would be updated every two years at a low risk setting and annually at a high-risk setting. The licensee's Tuberculosis Screening dated August 1, 2021, indicated the licensee would maintain a current community TB risk assessment and would update annually, using the data and form provided by the Minnesota Department of Health. The Minnesota Department of Health (MDH) guidelines "Regulations for Tuberculosis Control in Minnesota Health Care Settings" dated July 2013, and based on CDC guidelines, indicated a TB risk assessment should be completed initially and then for low-risk settings the risk assessment should be updated every other year; each agency should have written TB infection control procedures. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness	0 680		

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0 680	Continued From page 24 (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not 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 have a written emergency preparedness plan with all the required content and failed to post an emergency preparedness plan prominently. This had the potential to affect all 13 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	0 680		

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0 680	Continued From page 25 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 July 18, 2022, at approximately 10:35 a.m., the surveyor requested the licensee's emergency preparedness plan, which was later reviewed by the surveyor. During the initial facility tour on July 18, 2022, at approximately 11:52 a.m., with registered nurse (RN)-B, the main entrance and common areas of the facility lacked signage posted or information regarding the licensee's emergency preparedness plan. RN-B stated she was unfamiliar with the requirement. The licensee's Emergency Action Plan lacked the following content and/or policies and procedures to address: - a completed risk assessment; - policies and procedures to address natural and man-made disasters - a description of the facilities approach to meeting the health/safety/security needs of the staff and residents; - process for EP cooperation with state and local EP officials/organizations; - a missing resident plan that was reviewed quarterly (last reviewed October 18, 2017); - arrangements/contracts to re-establish utility services; - a description of the population served by the licensee; - development of policies/procedures to address:	0 680		

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0 680	Continued From page 26 - procedure for tracking staff and residents; - subsistence needs for staff and residents during an emergency to include (food, water, medical supplies, pharmacy supplies, sewer and waste disposal, emergency lighting, fire detection, extinguishing and alarm systems); - evacuation plan which included staff responsibilities during an evacuation and transporting services for residents being evacuated; - shelter in place; - a medical record documentation system to preserve resident information, security, and availability; - emergency staffing strategies to include volunteers; - development of arrangements with other facilities and providers to receive residents if needed; and - the facilities role in providing care and treatment at alternative sites under a 1135 waiver; - a communication plan that included: - arrangement with other facilities; - names and contact information for staff, resident physicians, other facilities, volunteers; - contact information for federal, state, tribal, local EP staff, ombudsman, state licensing and certification agencies; - primary and alternative means for communicating with facility staff, federal, state, regional and local emergency management agencies; - a method of sharing information and medical documentation for residents; - a means to provide information regarding the facility's needs, and its ability to provide assistance to include information about their occupancy; and - a method of sharing information from the EPP with residents and their families.	0 680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29535	A. BUILDING: _____ B. WING _____	07/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BARNES CARE	154 EAST HIGHWAY 61 ESKO, MN 55733

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0 680	Continued From page 27 On July 20, 2022, at approximately 2:23 p.m., licensed assisted living director (LALD)-A confirmed the emergency plan lacked the required content noted above and was not posted as required. LALD-A confirmed he was not familiar with the Appendix Z (a section of the Centers for Medicare and Medicaid Services [CMS] state operations manual which includes the emergency preparedness guidelines). LALD-A verified the licensee had not fully developed and implemented the facility's emergency preparedness plan/program as required and planned to reach out to the Healthcare Coalitions for assistance. The licensee's Emergency Preparedness Plan-Appendix Z Compliance policy dated August 1, 2021, indicated the licensee would develop and implement and emergency preparedness plan to include all the required elements of appendix Z. The plan would be in writing, reviewed annually and be based on the licensee's assisted living-based community-based risk assessments, utilizing an all-hazards approach. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 800 SS=F	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	0 800		

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0 800	Continued From page 28 residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observations during facility tour, the licensee failed to maintain the laundry room. Excessive dryer lint was observed behind dryers. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On July 18, 2022, between 10:45 a.m. and 12:45 p.m., survey staff toured the facility with unlicensed personnel (ULP)-C. During the facility tour, survey staff observed excessive lint build up in the dryers. ULP-C verbally confirmed survey staff observations during the facility tour. No further information was provided TIME PERIOD FOR CORRECTION: Twenty-one (21) 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	0 810		

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0 810	Continued From page 29 maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop a fire safety and evacuation plan with required elements, failed to provide required employee and resident training on fire safety and evacuation, and failed to conduct required evacuation drills. This had the	0 810		

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0 810	Continued From page 30 potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During interview on July 18, 2022, between 10:45 a.m. and 12:45 p.m., the unlicensed personnel (ULP)-C stated they did not have any documentation for fire safety and evacuation on site and was missing required fire drills and smoking policy. 1) Survey staff requested fire safety training and evacuation plan documentation, but the licensee did not provide the requested documentation. 2) Survey staff requested Fire Drill documentation - licensee could only provide one (1) out of the six (6) required drills. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 920 SS=C	144G.50 Subd. 2 (c) Contract information (c) The contract must include: (1) a disclosure of the category of assisted living facility license held by the facility and, if the facility is not an assisted living facility with dementia	0 920		

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0 920	Continued From page 31 care, a disclosure that it does not hold an assisted living facility with dementia care license; (2) a description of all the terms and conditions of the contract, including a description of and any limitations to the housing or assisted living services to be provided for the contracted amount; (3) a delineation of the cost and nature of any other services to be provided for an additional fee; (4) a delineation and description of any additional fees the resident may be required to pay if the resident's condition changes during the term of the contract; (5) a delineation of the grounds under which the resident may be discharged, evicted, or transferred or have services terminated; (6) billing and payment procedures and requirements; and (7) disclosure of the facility's ability to provide specialized diets. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written assisted living contract with the required content for two of two residents (R1, R2) with records reviewed. This had the potential to affect all 13 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:	0 920		

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0 920	Continued From page 32 R1 R1's diagnoses included congestive heart failure, cerebral infarction (stroke), dementia, and anxiety. R1's Rental Agreement was signed March 28, 2022, lacked a disclosure of the category of assisted living facility license held by the facility and, if the facility was not an assisted living facility with dementia care, a disclosure that it does not hold an assisted living facility with dementia care license. R1's Service Plan dated March 28, 2022, indicated R1 received services which included medication administration, dressing, grooming, bathing, incontinence care, housekeeping, and laundry. R2 R2's diagnoses included diabetes, atrial fibrillation (irregular heartbeat), cardiomyopathy (a disease of the heart muscle that makes it harder for the heart to pump blood to the rest of the body), and hyperlipidemia (high cholesterol). R2's Rental Agreement was signed September 21, 2017, lacked a disclosure of the category of assisted living facility license held by the facility and, if the facility was not an assisted living facility with dementia care, a disclosure that it does not hold an assisted living facility with dementia care license. R2's Service Plan dated August 31, 2022, indicated R2 received services which included medication administration, blood glucose monitoring, housekeeping, laundry, and monitoring and assist with dressing, grooming	0 920		

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0 920	Continued From page 33 toileting, and bathing. On July 20, 2022, at approximately 3:23 p.m., lisensed assisted living director (LALD)-A confirmed the licensee used the same Rental Agreement for all residents and the rental agreement had not been updated to meet the assisted living requirements. LALD-A confirmed the licensee's assisted living contract lacked the required content as noted above. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 920		
0 930 SS=C	144G.50 Subd. 2 (d-e; 1-4) Contract information (d) The contract must include a description of the facility's complaint resolution process available to residents, including the name and contact information of the person representing the facility who is designated to handle and resolve complaints. (e) The contract must include a clear and conspicuous notice of: (1) the right under section 144G.54 to appeal the termination of an assisted living contract; (2) the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent is required for a transfer; (3) contact information for the Office of Ombudsman for Long-Term Care, the Ombudsman for Mental Health and Developmental Disabilities, and the Office of Health Facility Complaints; (4) the resident's right to obtain services from an	0 930		

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0 930	Continued From page 34 unaffiliated service provider; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written assisted living contract with the required content for two of two residents (R1, R2) with records reviewed. This had the potential to affect all 13 residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 R1's diagnoses included congestive heart failure, cerebral infarction (stroke), dementia, and anxiety. R1's Rental Agreement was signed March 28, 2022, lacked the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent was required for a transfer. R1's Service Plan dated March 28, 2022, indicated R1 received services which included medication administration, dressing, grooming, bathing, incontinence care, housekeeping, and laundry. R2	0 930		

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0 930	Continued From page 35 R2's diagnoses included diabetes, atrial fibrillation (irregular heartbeat), cardiomyopathy (a disease of the heart muscle that makes it harder for the heart to pump blood to the rest of the body), and hyperlipidemia (high cholesterol). R2's Rental Agreement was signed September 21, 2017, lacked the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent was required for a transfer. R2's Service Plan dated August 31, 2022, indicated R2 received services which included medication administration, blood glucose monitoring, housekeeping, laundry, and monitoring and assist with dressing, grooming toileting, and bathing. On July 20, 2022, at approximately 3:23 p.m., lisensed assisted living director (LALD)-A confirmed the licensee used the same Rental Agreement for all residents and the rental agreement had not been updated to meet the assisted living requirements. LALD-A confirmed the licensee's assisted living contract lacked the required content as noted above. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 930		
0 940 SS=C	144G.50 Subd. 2 (e; 5-7) Contract information (5) a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support	0 940		

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0 940	Continued From page 36 program under chapter 256I, including: (i) whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers; (ii) whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); (iii) whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; (iv) whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; (v) a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; (vi) a statement that residents may be eligible for assistance with rent through the housing support program; and (vii) a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program; (6) the contact information to obtain long-term care consulting services under section 256B.0911; and (7) the toll-free phone number for the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to execute a written assisted living contract with the required content for two of two residents (R1, R2) with records	0 940		

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0 940	Continued From page 37 reviewed. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 R1's diagnoses included congestive heart failure, cerebral infarction (stroke), dementia, and anxiety. R1's Service Plan dated March 28, 2022, indicated R1 received services which included medication administration, dressing, grooming, bathing, incontinence care, housekeeping, and laundry. On July 19, 2022, at approximately 7:55 a.m., unlicensed personal (ULP)-C was observed administering R1's morning scheduled medications. R1's Rental Agreement signed March 28, 2022, lacked the following required content: -whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; -whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of	0 940		

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0 940	Continued From page 38 time that private payment is required; -a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; and -a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program. R2 R2's diagnoses included diabetes, atrial fibrillation (irregular heartbeat), cardiomyopathy (a disease of the heart muscle that makes it harder for the heart to pump blood to the rest of the body), and hyperlipidemia (high cholesterol). R2's Service Plan dated August 31, 2022, indicated R2 received services which included medication administration, blood glucose monitoring, housekeeping, laundry, and monitoring and assist with dressing, grooming toileting, and bathing. R2's Service Plan lacked authentication from the resident or resident's representative. R2's Rental Agreement was signed September 21, 2017, lacked the following required content: -whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; -whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; -a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; and	0 940		

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0 940	Continued From page 39 -a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program. On July 20, 2022, at 3:23 p.m., licensed assisted living director (LALD)-A confirmed the licensee used the same Rental Agreement for all residents. LALD-A confirmed the licensee's assisted living contract lacked the required content as noted above and had not been updated to meet the assisted living license requirements. LALD-A confirmed R1's Rental Agreement had not been signed by the licensee's representative. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 940		
0 970 SS=C	144.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a 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	0 970		

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0 970	Continued From page 40 property of a resident. This had the potential to affect all 13 residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on July 18, 2022, at 10:35 a.m., the surveyor requested a copy of the licensee's assisted living contract, which was provided in the licensee's resident admission packet. The licensee's Rental Agreement in section C, under 9, of the contract included a disclaimer indicating: - personal property, the licensee does not insure, nor does it take responsibility for personal property. The licensee recommends the resident uses proper precautions to guard themselves against possible loss, which may include obtaining renters insurance; - the licensee insures itself against liability losses and does not insure residents for liability losses. The licensee recommends the resident use proper precautions to guard themselves against possible loss. On July 20, 2022, at 3:23 p.m., licensed assisted living director (LALD)-A verified the licensee's above rental agreement language and confirmed the same assisted living rental agreement was used for all residents at the facility.	0 970		

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	29535	A. BUILDING: _____ B. WING _____	07/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BARNES CARE	154 EAST HIGHWAY 61 ESKO, MN 55733

(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
0 970	Continued From page 41 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 970		
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and	01470		

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01470	Continued From page 42 (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure two of two employees registered nurse (RN)-B and unlicensed personnel (ULP)-C received orientation to assisted living facility licensing to include all the required topics with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive	01470		

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01470	Continued From page 43 or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: RN-B RN-B had a hire date of June 6, 2014, under the comprehensive home care license, and began providing services under the licensee's Assisted Living license on August 1, 2021. RN-B's transcript indicted RN-B completed All training based on Minnesota Assisted Living Home Care Regulation on June 1, 2014. RN-B's employee record lacked the following required orientation content: - an overview of the 144G statutes; - policies and procedures related to the provision of assisted living services by the individual staff person; - the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; - a review of the types of assisted living services the employee will be providing and the facility's category of licensure; - handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; - consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human	01470		

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01470	Continued From page 44 Services, county-managed care advocates, or other relevant advocacy services; and - a review of the types of assisted living services the employee will be providing and the facility's category of licensure. ULP-C ULP-C had a hire date of June 20, 2014, under the comprehensive home care license, and began providing services under the licensee's Assisted Living license on August 1, 2021. ULP-C's employee record lacked the following required orientation content: - an overview of the 144G statutes; - policies and procedures related to the provision of assisted living services by the individual staff person; - the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; - a review of the types of assisted living services the employee will be providing and the facility's category of licensure; - handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; - consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and - a review of the types of assisted living services the employee will be providing and the facility's	01470		

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01470	Continued From page 45 category of licensure. On July 19, 2022, at approximately 7:18 a.m., the surveyor observed ULP-C administering R2's scheduled medications and insulin. On July 20, 2022, at approximately 2:23 pm licensed assisted living director (LALD)-A stated the licensee was not currently using Educate for employee training and confirmed staff have not received orientation to assisted living as required. The licensee's Orientation of Staff and Supervisors and Content policy dated August 1, 2021, indicated all licensee's employees must complete the orientation to assisted living facility requirements before providing assisted living services to residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01470		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services	01640		

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01640	Continued From page 46 and how to contact the Office of Ombudsman for Long-Term Care. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure two of two residents (R1, R2) service plans were authenticated with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 R1's diagnoses included congestive heart failure, cerebral infarction (stroke), dementia, and anxiety. R1's Rental Agreement was signed March 28, 2022.	01640		

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01640	Continued From page 47 R1's Service Plan dated March 28, 2022, indicated R1 received services which included medication administration, dressing, grooming, bathing, incontinence care, housekeeping, and laundry. R2's updated Service Plan dated June 7, 2022, indicated R1 received included the following additional added services: an increase in safety checks, incontinent cares, and linen changes. R1's updated Service Plan lacked authentication from the resident and/or resident's representative. On July 19, 2022, at approximately 7:55 a.m., unlicensed personal (ULP)-C was observed administering R1's morning scheduled medications. R2 R2's diagnoses included diabetes, atrial fibrillation (irregular heartbeat), cardiomyopathy (a disease of the heart muscle that makes it harder for the heart to pump blood to the rest of the body), and hyperlipidemia (high cholesterol). R2's Rental Agreement was signed September 21, 2017. R2's Service Plan dated August 31, 2022, indicated R2 received services which included medication administration, blood glucose monitoring, housekeeping, laundry, and monitoring and assist with dressing, grooming toileting, and bathing. R2's Service Plan lacked authentication from the resident or resident's representative. On July 19, 2022, at approximately 7:18 a.m., ULP-C was observed monitoring R2's blood glucose and administering R2's morning scheduled insulin.	01640		

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01640	Continued From page 48 On July 19, 2022, at 2:15 p.m., licensed assisted living director (LALD)-A confirmed R1's updated Service Plan and R2's Service plan had not been signed by signed by the resident or resident's representative. No further information was provided. The licensee's Service Plan policy dated August 1, 2021, indicated the service plan and any revisions shall include a signature or other authentication by the licensee and by the resident, or resident representative, documenting agreement on the services provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01640		
01650 SS=E	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons	01650		

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01650	Continued From page 49 the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure service plans included the required content for two of two residents (R1, R2) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 R1's diagnoses included congestive heart failure, cerebral infarction (stroke), dementia, and anxiety. R1's Service Plan dated March 28, 2022, indicated R1 received services which included medication administration, dressing, grooming,	01650		

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01650	Continued From page 50 bathing, incontinence care, housekeeping, and laundry. R2's updated Service Plan dated June 7, 2022, indicated R1 received additional services which included an increase in safety checks, incontinent cares, and linen changes; however, R1's Service Plan lacked the following required content: -frequency of each service being provide; and -the schedule and methods of monitoring staff providing services. On July 19, 2022, at approximately 7:55 a.m., unlicensed personal (ULP)-C was observed administering R1's morning scheduled medications. R2 R2's diagnoses included diabetes, atrial fibrillation (irregular heartbeat), cardiomyopathy (a disease of the heart muscle that makes it harder for the heart to pump blood to the rest of the body), and hyperlipidemia (high cholesterol). R2's Service Plan dated August 31, 2022, indicated R2 received services which included medication administration, blood glucose monitoring, housekeeping, laundry, and monitoring and assist with dressing, grooming toileting, and bathing; however, R2's Service Plan lacked the following required content: -frequency of services being provided; -the names and contact information of persons the resident wishes to have notified in an emergency of if there is a significant change in the resident's condition. On July 19, 2022, at approximately 7:18 a.m., ULP-C was observed monitoring R2's blood glucose and administering R2's morning scheduled insulin	01650		

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01650	Continued From page 51 On July 20, 2022, at approximately 4:12 p.m., licensed assisted living director (LALD)-A confirmed the services plans for R1 and R2 lacked the above required content. The licensee's Service Plan policy date August 1, 2021, indicated the licensee's care plan would include the following: -a description and frequency of services that are to be provided; -schedule and method for the next planned monitoring of staff providing services; and -a contingency plan to include the names and contact information the resident wishes to be notified in an emergency. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan.	01760		

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01760	Continued From page 52 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure medications were administered as prescribed and administered according to manufacturer's instructions for two of two residents (R1, R2) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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 R1's diagnoses included congestive heart failure, cerebral infarction (stroke), dementia, and anxiety. R1's Service Plan dated March 28, 2022, indicated R1 received services which included medication administration. R2's hospice orders dated July 15, 2022, included morphine concentrate 100 milligrams (mg)/milliliters (ml) oral solution 0.5 ml by mouth every hour and 0.5 ml every hour as needed for pain and lorazepam 0.5 mg one tablet by mouth every two hours for anxiety. R1's July 2022, medication administration record (MAR) indicated R1 received morphine 0.5 ml by	01760		

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mouth every two hours and lorazepam 0.5 mg by mouth every two hours. R1's MAR did not include instructions to crush lorazepam tablet and mix with liquid morphine for administration.

On July 19, 2022, at approximately 7:55 a.m., unlicensed personnel (ULP)-C was observed preparing R1's scheduled morning medications. ULP-C crushed R1's lorazepam tablet into a powder consistency then proceeded to dispense the prefilled syringe of liquid morphine into a paper medication cup, mix the medications together and re-draw the mixed medication into the syringe and administer into the right side of R1's mouth.

On July 19, 2022, at approximately 8:02 a.m., ULP-C confirmed R1 did not have specified written instructions or prescriber orders to crush R1's lorazepam and mix with liquid morphine. ULP-C stated she was given verbal directions from R1's hospice nurse the day before. ULP-C confirmed she never received education or training on procedure.

On July 19, 2022, at approximately 1:34 p.m., RN-B stated she was unaware staff were crushing R1's lorazepam and mixing with R1's liquid morphine. RN-B further stated if the hospice nurse gave staff verbal instructions if was the expectation of staff to call and inform the RN. RN-B confirmed R1 did not have orders or written instructions to crush medications and mix with liquid morphine and staff had not been trained on technique. RN-B stated she planned on contacting hospice to obtain appropriate orders.

On July 20, 2022, at approximately 10:54 a.m., hospice RN (HRN)-E stated prior to RN-B requesting an order, HRN-E confirmed R1 did not

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have orders or written instructions to crush R1's lorazepam and mix with liquid morphine for administration. Hospice nurse stated it was not an uncommon practice for residents who are not able to swallow pills and most likely the hospice nurse gave verbal directions to staff.

R2
R2's diagnoses included diabetes, atrial fibrillation (irregular heartbeat), cardiomyopathy (a disease of the heart muscle that makes it harder for the heart to pump blood to the rest of the body), and hyperlipidemia (high cholesterol).

R2's Service Plan dated August 31, 2022, indicated R2 received services which included medication administration and blood glucose monitoring.

R2's prescriber orders dated May 25, 2022, included Lantus Solostar (long acting insulin) 100 units/ml to inject 10 units subcutaneous (underneath the skin) daily and artificial tears two drops in both eyes twice a day.

On July 19, 2022, at approximately 7:18 a.m., the surveyor observed ULP-C prepare R2's scheduled morning oral medications, gather blood glucose supplies, insulin, eye drop and enter R2's room. ULP-C donned gloves and administered one drop of Refresh eye drops into each eye. Using proper technique, ULP-C conducted a blood glucose check on R2 which resulted in a reading of 204 milligrams (mg)/deciliter (dl). ULP-C dialed R2's Lantus Solostar insulin pen (a multiple dose pen shaped injector device used for insulin administration) to 10 units although did not prime the insulin pen of two units prior to administering R2's insulin into R2's lower right abdomen.

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	29535	A. BUILDING: _____ B. WING _____	07/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BARNES CARE	154 EAST HIGHWAY 61 ESKO, MN 55733

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01760	Continued From page 55 On July 19, 2022, at approximately 7:39 a.m., ULP-C confirmed she did not prime R2's Lantus insulin pen of two units prior to administration and stated insulin pens only needed to be primed when the insulin pens were opened for the first time. ULP-C confirmed she administered one drop of Refresh Tears into R2's eyes. ULP-C confirmed R2's orders for Refresh Tears was to instill two drops in each eye. On July 20, 2022, at approximately 1:06 p.m., RN-B confirmed staff were trained to prime insulin pens two units before drawing up prescribed insulin dose to ensure the correct dose of insulin was administered. RN-B further stated staff should be comparing the MAR with the label on the medication to ensure accuracy. The licensee's Medication and Treatment Orders-Implementing policy dated August 1, 2021, indicated the following: - if a licensed nurse is not on duty when an order is received, the ULP would notify the licensed nurse within one hour of receipt of order. If licensed nurse in not available, staff would leave a voice message describing order and resident involved; and -orders can only be implemented when indirect contact with the licensed nurse. ULP will not implement orders or changes to orders unless in direct contact with the licensed nurse. The licensee's Medication and Treatment-Administration and Delegation policy dated August 1, 2021, indicated when administration of medications or treatment/therapy is delegated or assigned to unlicensed personnel, the licensee would ensure the registered nurse had instructed the ULP in the	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01760	Continued From page 56 proper methods with respect to each resident and the ULP has demonstrated the ability to competently follow the procedures. Specified, in writing, specific instructions for each resident and documented those instructions in the resident's records. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
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 legible information including the expiration date for time sensitive medications for four of four residents (R2, R5, R6, R7) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more	01890		

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01890	Continued From page 57 than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). Findings include: On July 18, 2022, at approximately 12:02 p.m., the surveyor observed the medication cart with registered nurse (RN)-B. RN-B observed and confirmed the following: R2 R2's Spiriva inhaler (used to treat tightened muscles of the lung), lacked an original prescription label. R2's Lantus Insulin pen (a multi dose pen shaped injector device for insulin administration) lacked an original prescription label. R6 R6's Symbicort inhaler (used to treat wheezing and shortness of breath) lacked an original prescription label and the date the inhaler had been opened and would expire. R7 R7's Refresh Tears eye drop lacked an original prescription label. R8 R8's Levemir insulin pen lacked the date the insulin was opened and would expire. On July 18, 2022, at approximately 12:10 p.m., RN-B confirmed insulin pens, eye drops, and inhalers should have an open and end date on time-sensitive medication and all prescribed medications should have an original prescription label.	01890		

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01890	Continued From page 58 The manufacturer's instructions for Levemir pre-filled insulin pen revised September 2020, directed to discard after six weeks. The manufacturer's instructions for Symbicort inhalers dated July 26, 2021, directed to discard the inhaler three months after removal from the foil pouch. The licensee's Medication Storage policy dated August 1, 2021, indicated medications would be stored consistent with manufacturer's recommendations. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01950 SS=D	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01950	Continued From page 59 each resident and documented those instructions in the resident's record; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure specific written instructions for each resident were documented in one of one resident's record (R2) who received blood glucose monitoring. 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: On July 18, 2022, at approximately 10:35 a.m., during entrance conference, licensed assisted living director (LALD)-A and registered nurse (RN)-A confirmed the licensee provided blood glucose (sugar) monitoring. R2's diagnoses included diabetes, atrial fibrillation (irregular heartbeat), cardiomyopathy (a disease of the heart muscle that makes it harder for the heart to pump blood to the rest of the body), and hyperlipidemia (high cholesterol). R2's record lacked specific written instructions to include parameters for monitoring R2's blood sugar results.	01950		

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01950	Continued From page 60 R2's Service Plan dated August 31, 2022, indicated R2 received services which included medication administration, blood glucose monitoring, housekeeping, laundry, and monitoring and assist with dressing, grooming toileting, and bathing. R2's prescriber orders dated May 25, 2022, directed R2's blood sugar monitoring to be completed every morning at breakfast time. R2's undated Treatment and Therapy plan indicated R2's blood sugar would be taken every morning. R2's July 2022, Medication Admiration Record (MAR) directed to check R2's fasting blood sugar (taken before eating or drinking) every morning. On July 19, 2022, at approximately 7:18 a.m., unlicensed personnel (ULP)-C was observed monitoring R2's blood glucose and administering R2's morning scheduled insulin. On July 19, 2022, at approximately 7:39 a.m., ULP-C confirmed R2's record lacked written blood sugar parameters. On July 20, 2022, at approximately 12:40 p.m., RN-B confirmed R2's record lacked specific written instructions to include parameters for blood glucose results. The licensee's Medication and Treatment-Administration and Delegation policy dated August 1, 2021, indicated when administration of medications or treat/therapy is delegated or assigned to unlicensed personnel, the licensee would ensure the RN has specified	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01950	Continued From page 61 in writing specific instructions for each resident and documented those instructions in the resident's record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		
03030 SS=D	626.557 Subd. (4,a) Internal reporting of maltreatment (a) Each facility shall establish and enforce an ongoing written procedure in compliance with applicable licensing rules to ensure that all cases of suspected maltreatment are reported. If a facility has an internal reporting procedure, a mandated reporter may meet the reporting requirements of this section by reporting internally. However, the facility remains responsible for complying with the immediate reporting requirements of this section. (b) A facility with an internal reporting procedure that receives an internal report by a mandated reporter shall give the mandated reporter a written notice stating whether the facility has reported the incident to the common entry point. The written notice must be provided within two working days and in a manner that protects the confidentiality of the reporter. (c) The written response to the mandated reporter shall note that if the mandated reporter is not satisfied with the action taken by the facility on whether to report the incident to the common entry point, then the mandated reporter may report externally. (d) A facility may not prohibit a mandated reporter from reporting externally, and a facility is prohibited from retaliating against a mandated reporter who reports an incident to the common	03030		

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03030	Continued From page 62	03030		

entry point in good faith. The written notice by the facility must inform the mandated reporter of this protection from retaliatory measures by the facility against the mandated reporter for reporting externally.

This MN Requirement is not met as evidenced by:
Based on interview, and record review, the licensee failed to report timely to the Minnesota Adult Abuse Reporting Center (MAARC) for a resident-to-resident altercation and complete a thorough investigation for two of two residents (R4, R5) with records reviewed. In addition, the licensee failed to implement their written procedures pertaining to reporting vulnerable adult maltreatment for two of two residents (R4, R5) with records reviewed.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).

The findings include:

R4
R4's diagnoses included Alzheimer's.

R4's Service Plan dated August 30, 2021, indicated R4 received assistance with bathing, medications, meals, laundry, and housekeeping.

R4's Resident Care Plan dated July 8, 2020, indicated R4 had behaviors which required

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	29535	A. BUILDING: _____ B. WING _____	07/21/2022

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03030	Continued From page 63 regular interventions. R4's Daily Behavior Observation form dated July 1, through July 20, 2022, indicated R4's targeted behavior included refusing medications, eating, showering, and throwing stuff and R4's had 12 observed documented behaviors. R5 R5's diagnoses included epilepsy (seizures), anxiety and depression. R5's Service Plan dated April 21, 2022, indicated R5 received assistance with dressing, grooming, bathing, medications, meals, laundry, and housekeeping. R5's Resident Care Plan dated April 25, 2022, indicated R5 had no behaviors that needed interventions. R5's July 2022, Daily Behavior Observation form indicated R5 had no identified targeted behaviors listed and had no behaviors observed. The licence's Resident/Visitor Unusual Occurrence Report dated July 16, 2022, indicated R5 was trying to redirect R4 into a new area, R4 became agitated and slapped R5 across the face. The report indicated there was no visible injury. Staff notified RN-B and R4's family and did not notify R5's family per R5's request. The licensee's staff communication book dated July 16, 2022, had an entry indicating R4 slapped R5 across the face and to be aware of R4's behaviors becoming aggressive. On July 19, 2022, at approximately 8:47 a.m., licensed assisted living director (LALD)-A	03030		

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03030	Continued From page 64 confirmed the incident between R4 and R5 had not been reported to MAARC and should have been reported within 24 hours after known incident. LALD-A stated he was not the RN on-call at the time of the incident and was just made aware of the altercation. RN-B stated she had been on call and received the call from staff reporting R4 slapped R5 across the face. RN-B stated staff called notified both families of the incident. RN-B confirmed she did not file a report with MAARC and had not followed up on the reported incident. The licensee's Vulnerable Adult Maltreatment-Prevention & Reporting policy, dated August 1, 2021, defined maltreatment as neglect, abuse and exploitation. The policy noted the director of nursing and ED were responsible for investigating and reporting incidents (no later than 24 hours after the maltreatment was first suspected) any incident of suspected maltreatment. The investigation will begin as soon as a report is received. As part of the internal investigation, the director of nursing and ED will: - interview witnesses or persons who may have information concerning the incident - document the witness statements concerning the incidents - review the resident's care plan and relevant chart records and agency policies - review the witness statements, resident records, resident's individual abuse protection plan, and agency policies to determine whether abuse, neglect has occurred, including standards of care, that may have been violated No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	03030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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03030	Continued From page 65 days	03030		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors Subd. 8.Notice to visitors. (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure signage was posted at the main entryway of the establishment to display statutory language to disclose electronic monitoring activity, potentially affecting all residents, staff, and visitors of the licensee. 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: On July 19, 2022, at approximately 10:00 a.m., the surveyor entered the facility. There was no signage observed posted at entryway of the facility regarding electronic monitoring devices.	03090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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03090	Continued From page 66 On July 19, 2022, at approximately 10:35 a.m., licensed assisted living director (LALD)-A stated the licensee had video cameras in the building but were not currently active or working. LALD-A confirmed the licensee did not have signage posted in the entryway regarding electronic monitoring as required. The licensee's Electronic Monitoring policy dated August 1, 2022, indicated signs were installed at each facility entrance assessable to visitors that stated: "Electronic monitoring devices, including security cameras and audio devices may be present to record persons and activities." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	03090		

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

Type: Full
Date: *07/18/22*
Time: 10:15:00
Report: 1027221074

Food and Beverage Establishment Inspection Report

Location:
Barnes Care
154 East Highway 61
Esko, MN55733
Carlton County, 09

Establishment Info:
ID #: 0039399
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 2188792703
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.

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.

RAW EGGS WERE STORED OVER READY TO EAT FOODS. STAFF MOVED EGGS TO BOTTOM SHELF. COS

Corrected on Site

4-300 Equipment Numbers and Capacities

4-302.14 ** Priority 2 **

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

PROVIDE QUATERNARY AMMONIA TEST STRIPS FOR MEASURING SANITIZER STRENGTH.

Comply By: 08/01/22

2-100 Supervision

2-102.12AMN

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

STAFF HAD TAKEN A SERVE-SAFE COURSE, BUT HAD NOT YET APPLIED FOR CFPM. EMPLOY AT LEAST ONE STAFF WITH A CFPM.

Comply By: 08/18/22

Food and Beverage Establishment Inspection Report

2-100 Supervision

2-102.12DMN

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

POST CFPM CERTIFICATE WHEN RECEIVED.

Comply By: 08/18/22

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

3-302.12

MN Rule 4626.0240 Properly label all working containers holding food or food ingredients that are removed from orginal packages with the common name of the food. Label the food in English and any other languages used by employees who handle food.

CONTAINER HOLDING FLOUR WAS NOT LABELED. STAFF PUT LABEL ON CONTAINER DURING INSPECTION. COS

Corrected on Site

Surface and Equipment Sanitizers

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

Hot Water: = at 176 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Upright Cooler
Temperature: 41 Degrees Fahrenheit - Location: HALF & HALF
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 40 Degrees Fahrenheit - Location: SLICED CHEESE
Violation Issued: No

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

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

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

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

Food and Beverage Establishment Inspection Report

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 1027221074 of 07/18/22.

Certified Food Protection Manager: SEE ORDERS

Certification Number: _____ Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed: _____ Signed: Ian Harrison

JUSTIN BARNES

Ian H

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

Report #: 1027221074

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	Date	07/18/22
No. of Repeat RF/PHI Categories Out	0	Time In	10:15:00
Legal Authority MN Rules Chapter 4626		Time Out	

	Address	City/State	Zip Code	Telephone
Barnes Care	154 East Highway 61	Esko, MN	55733	2188792703

License/Permit #	Permit Holder	Purpose of Inspection	Est Type	Risk Category
0039399		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		
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	X	Food properly labled; original container	X	
Prevention of Food Contamination				
38		Insects, rodents, & animals not present		
39		Contamination prevented during food prep, storage & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

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

Food Recalls:

Person in Charge (Signature) **Date:** 07/18/22

Inspector (Signature) Dan Harrison