



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

September 15, 2026

Licensee
Barnes Care Inc
58 West Highway 61
Esko, MN 55733

RE: Project Number(s) SL30389016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 19, 2026, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement;

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;

Level 3: a fine of \$1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;

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

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

St - 0 - 0810 - 144g.45 Subd. 2 (b-F) - Fire Protection And Physical Environment - \$500.00

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

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

REQUESTING A HEARING

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

matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

To submit a hearing request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

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

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **<https://forms.office.com/g/Bm5uQEPhVa>**. Your input is important to us and will enable MDH to improve its processes and communication with providers.

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

If you have any questions, please contact me.

Sincerely,

A handwritten signature in black ink that reads "Jessie Chenze". The signature is written in a cursive, flowing style.

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

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30389	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/19/2026
NAME OF PROVIDER OR SUPPLIER BARNES CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 58 WEST 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 *****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: SL30389016-0 On August 17, 2026, through August 19, 2026, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were eight resident(s); eight receiving services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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

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0 480	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated August 18, 2026, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.	0 480			

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0 480	Continued From page 3	0 480			
0 680 SS=F	TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates. 144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop a written emergency preparedness plan (EPP) with all the required content defined in Appendix Z. This had the potential to affect residents receiving services	0 680			

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0 680	Continued From page 4 under the assisted living license, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on August 17, 2026, at 10:41 a.m., through 11:08 a.m., licensed assisted living director/registered nurse (LALD/RN)-A stated the licensee was familiar with the assisted living minimum requirements. The licensee's white three ring binder labeled Emergency Preparedness Plan dated January 3, 2026, lacked the following required content: -exercises to test the licensee's EPP at least twice per year, including unannounced staff drills using the EPP. On August 19, 2026, at 11:25 a.m., LALD/RN-A stated the licensee did not have written documentation of testing and analyzing the licensee's emergency preparedness plan and was aware of the requirements. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0100, sections A and B, effective October 2022, assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under	0 680			

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0 680	Continued From page 5 Code of Federal Regulations, title 42, section 483.73, or successor requirements. This part references documents, specifications, methods, and standards in "State Operations Manual Appendix Z - Emergency Preparedness for All Providers and Certified Supplier Types: Interpretive Guidance," which is incorporated by reference. The licensee's Emergency Preparedness Plan-Appendix Z Compliance policy dated August 1, 2021, noted the licensee's emergency preparedness plan would include all required elements of Appendix Z including conduct, at a minimum, two emergency preparedness drills every 12 months. One annual exercise would be a full-scale community wide exercise. The second annual exercise would either be a second full-scale community-wide exercise or a tabletop exercise focused on the licensee's living setting. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days T	0 680			
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to:	0 810			

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0 810	Continued From page 6 (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a	0 810			

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0 810	Continued From page 7 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 the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated August 17, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	0 810			
01290 SS=D	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits.	01290			

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01290	Continued From page 8 This MN Requirement is not met as evidenced by: Based on observations, interview, and record review, the licensee failed to ensure a background study (BGS) was submitted and a clearance was received in affiliation with the assisted living licensee's current health facility identification (HFID 30389) for one of nine employees (unlicensed personnel (ULP)-D). This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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 August 17, 2026, at 9:00 a.m., the surveyor sent the licensee an email informing on August 17, 2026, the surveyor would be arriving at 10:30 a.m., to complete the licensing survey. In the email a list of specific forms and documents were requested to have available upon the surveyors arrival including a current list of employees and the background NETStudy results, for all of the employees listed on the employee roster. On August 17, 2026, 2:43 p.m., the surveyor reviewed the licensee's facility NETStudy results for HFID 30385 and noted ULP-D's background study was affiliated with the licensee's HFID on August 17, 2026, the day the licensing survey start date.	01290			

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01290	Continued From page 9 ULP-D was hired April 8, 2026, to provide direct care services to residents of the facility. On August 17, 2026, at 12:05 p.m., the surveyor observed ULP-D administering R4's medications. ULP-D's employee record lacked a cleared background study for HFID 30385 and included a Department of Human Service (DHS) Background Clearance Letter dated April 8, 2026, with HFID 29535, another assisted living owned by the licensee. On August 17, 2026, at 4:00 p.m., clinical nurse supervisor (CNS)-B reviewed the NETStudy roster and confirmed ULP-D's affiliation date was August 17, 2026, the day the surveyor requested the documents. CNS-B stated manager (M)-C was responsible for all employees' background studies. On August 19, 2026, at 11:33 a.m., M-C stated M-C noticed ULP-D's background study was not affiliated with the licensee when M-C reviewed the licensee's DHS NETStudy on August 17, 2026, after the surveyor requested the document in the survey entrance email. M-C stated M-C thought all employees had been affiliated with each of their assisted livings and did not know why ULP-D was missed. The licensee's Background Studies policy dated August 1, 2021, noted no employee may provide direct services and have independent direct contact with any residents until acceptable result of the background study have been received. The licensee would not employ individuals whose results of the background study indicated disqualification for the position.	01290			

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01290	Continued From page 10 No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290			
01420 SS=D	144G.62 Subd. 2 Delegation of assisted living services (b) When the registered nurse or licensed health professional delegates tasks to unlicensed personnel, that person must ensure that prior to the delegation the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each resident and is able to demonstrate the ability to competently follow the procedures and perform the tasks. If the unlicensed personnel has not regularly performed the delegated assisted living task for a period of 24 consecutive months, the unlicensed personnel must demonstrate competency in the task to the registered nurse or appropriate licensed health professional. The registered nurse or licensed health professional must document instructions for the delegated tasks in the resident's record. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) provided written instructions in the resident's record for delegated tasks provided by unlicensed personnel (ULP) for one of one resident (R2). 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	01420			

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01420	Continued From page 11 cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on August 17, 2026, at 10:41 a.m., through 11:08 a.m., licensed assisted living director/registered nurse (LALD/RN)-A stated the licensee provided treatment and therapy services to the licensee's residents. R2's diagnoses included hypertension (high blood pressure), chronic kidney disease and coronary artery disease. On August 18, 2026, at 7:20 a.m., the surveyor observed ULP-E assist R2 transfer out of bed and ambulate into the bathroom. During the observation, the surveyor observed a motion sensor alarm on R2's floor directed toward R2's bed. R2's Service Plan dated March 18, 2026, indicated R2 received assistance with dressing, toileting, bathing, grooming, safety checks, medication administration, transferring and mobility when needed, housekeeping and laundry. R2's Post Fall Review dated March 13 and March 19, 2026, indicated R2 fell in R2's room trying to get out of bed. R2's floor alarm was placed in R2's room in the beginning of March and motion alarm was activated and alerted staff with each fall.	01420			

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01420	Continued From page 12 R2's Individualized Treatment and Therapy Plan dated June 20, 2025, did not include motion sensor alarms. R2's July and August 2026 Treatment records did not include R2's motion sensor alarm. On August 18, 2026, at 11:41 a.m., clinical nurse supervisor (CNS)-B stated R2's motion sensor alarm was recently put in place and CNS-B had not updated R2's care plan, treatment plan or services delivered to include instructions on the use of the alarm. CNS-B reviewed R2's record and stated CNS-B could not find written specific instructions for R2's motion sensor alarm. On August 18, 2026, at 12:22 p.m., ULP-E stated R2's motion sensor alarm was placed in R2's room due to falls a few months ago. ULP-E stated ULP-E could not recall how ULP-E was trained or informed of R2's alarm. ULP-E reviewed R2's care plan and service delivery record and stated there were no written instructions for the use of R2's motion sensor alarm. The licensee's Delegation of Assisted Living Services policy dated August 1, 2025, indicated an RN may delegate nursing services to a person who has successfully completed staff orientation, who has been trained in the service to be provided, and who has demonstrated to the RN the ability to competently follow the procedures for the resident. These services include, but are not limited to: - performing routine delegated medical or nursing procedures, such as use of alarms; and -the registered nurse or licensed health professional would document instructions for the delegated tasks in the resident's record.	01420			

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01420	Continued From page 13 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01420			
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and	01500			

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01500	Continued From page 14 (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an employee received all the required content for annual training for each 12 months of employment for one of two employees (licensed assisted living director/registered nurse (LALD/RN)-A). 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	01500			

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01500	Continued From page 15 limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on August 17, 2026, at 10:41 a.m., through 11:08 a.m., LALD/RN-A stated LALD/RN-A was responsible for maintaining employee records and was aware of the required contents in an employee record. LALD/RN-A had a start date of March 1, 2004, and effective August 1, 2021, began to supervise and provide direct care services to residents at the assisted living. LALD/RN-A's employee record lacked documentation the following required annual training topics were completed in 2025: -principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; and -review of provider's policies and procedures. On August 19, 2026, at 11:25 a.m., LALD/RN-A stated LALD/RN-A was unsure if LALD/RN-A completed the annual training noted above in 2025, and would send any additional trainings to the surveyor. The licensee's Annual Required Staff Training policy dated August 1, 2021, indicated training records, kept in employee records would be retained for each employee to track compliance with annual training requirements. The following training elements must be included every 12 months to all staff who perform direct care services:	01500			

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01500	Continued From page 16 -review of the facility's policies and procedures relating to the provisions of assisted living services and how to implement those policies and procedures; and -principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500			
01530 SS=D	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member	01530			

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01530	Continued From page 17 must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of two employees (unlicensed personnel (ULP)-D) received the required amount of mental illness and de-escalation training within the required time frame. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on August 17,	01530			

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01530	Continued From page 18 2026, at 10:41 a.m., through 11:08 a.m., licensed assisted living director/registered nurse (LALD/RN)-A stated the licensee was aware of required contents in an employee record. ULP-D was hired on April 8, 2026, to provide direct care services to residents at the assisted living facility. ULP-D's Transcript Report dated August 17, 2026, included EduCare courses (online training) ULP-D completed for the licensee, however, the training transcript indicated ULP-D completed a total of 1.25 hours out of the required two hours of initial mental illness and de-escalation training. On August 19, 2026, at 11:25 a.m., LALD/RN-A stated LALD/RN-A was aware of the mental illness and de-escalation training requirements and did not know why ULP-D only completed 1.25 hours of the required training on EduCare. The licensee's Training Records policy dated August 1, 2021, indicated the licensee would maintain a record of staff training and competency required, The licensee's did not have a policy and procedure on the required mental illness and de-escalation employee training. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530			
01550 SS=D	144G.64 (a) (4) Training in Dementia, Mental Illness, and De-	01550			

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01550	Continued From page 19 (4) staff who do not provide direct care, including maintenance, housekeeping, and food service staff, must have at least four hours of initial training on topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date, and must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of one non-direct care employee (activities (A)-F) received the required amount of dementia, mental illness, and de-escalation training in the required time frame. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on August 17, 2026, at 10:41 a.m., licensed assisted living director/registered nurse (LALD/RN)-A stated the licensee was aware of required contents in an	01550			

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01550	Continued From page 20 employee record. A-F was hired on May 1, 2026, to provide direct activities for residents at the assisted living facility. A-F's employee record included dementia training transcripts courses completed; however, A-F's record lacked documentation A-F completed the initial two hours of mental health and de-escalation training as required topics within 160 hours of employment start date. On August 19, 2026, at 11:25 a.m., LALD/RN-A stated A-F worked part-time and may not have worked 160 hours since hired. LALD/RN-A stated the licensee would provide documentation of A-F's hours worked and email to the surveyor by the end of the next business day (August 20, 2026). As of the close of business on August 20, 2026, the licensee had not provided the surveyor with documentation verifying the hours worked by A-F since date of hire. The licensee's Employee Records policy dated August 1, 2021, indicated the licensee would keep an employee record for all paid employees. Employee records would be kept up to date and confidential. Employee records for each person would include records for of all training and in-service education required and/or provided including record of competency testing as required. The licensee's Dementia Training policy dated August 1, 2021, indicated all staff of the licensee were required to complete dementia training at the time of hire and annually thereafter. The	01550			

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01550	Continued From page 21 policy did not address mental illness or de-escalation employee training. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01550			
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse	01620			

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01620	Continued From page 22 Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the registered nurse (RN) completed an alarm assessment for one of one resident (R2). In addition, the licensee failed to ensure a registered nurse (RN) conducted assessments with the uniform assessment tool that included all required content for one of two residents (R2). 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	01620			

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01620	Continued From page 23 situation has occurred only occasionally). The findings include: ALARMS R2's diagnoses included hypertension (high blood pressure), chronic kidney disease and coronary artery disease. R2's Service Plan dated March 18, 2026, indicated R2 received assistance with dressing, toileting, bathing, grooming, safety checks, medication administration, transferring and mobility when needed and housekeeping and laundry. On August 18, 2026, at 7:20 a.m., the surveyor observed unlicensed personnel (ULP)-E assist R2 transfer out of bed and ambulate into the bathroom. During the observation, the surveyor observed a sensor alarm on R2's floor directed toward R2's bed. R2's initial assessment dated July 7, 2025, and reviewed by the RN on September 16, 2025, December 18, 2025, and March 18, 2026, indicated there were no updates or changes needed to R2's care plan. R2 assessment included: - ambulation: R2 required assist of one with wheelchair; - transfers-R2 required assist of one; - bed mobility-R2 was independent with the use of side rails; - musculoskeletal-R2 had osteoarthritis and had a history of falls; and - fall risk assessment was blank and had not been completed. R2's Individual Abuse Prevention Plan dated June	01620			

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01620	Continued From page 24 20, 2025, in the vulnerabilities column was blank and indicated R2 was not assessed for the ability to summons for assistance, call for help by using a call light or telephone. Furthermore, R2's assessment did not address interventions to include alarm mechanisms currently being used. R2's comprehensive and quarterly assessments lacked evidence of the need/use of an alarm for fall prevention. R2's Resident Care Plan dated May 1, 2026, indicated R2 was at risk for falls and to monitor for safe transfers; however, R2's care plan lacked fall interventions to include the use of a motion sensor alarm. On August 18, 2026, at 12:22 p.m., ULP-E stated R2's sensor alarm was put in R2's room due to falls a few months ago and ULP-E could not recall who educated ULP-E on R2's alarm. ULP-E reviewed R2's care plan and stated R2's sensor alarm was not identified in R2's care plan or services delivered. UNIFORM ASSESSMENT TOOL R2's Comprehensive Uniform Assessment tool dated June 19, 2025, included questions to assess residents in the following required areas; however, were not completed and left blank: -communication and sensory capabilities including hearing and the ability to understand and be understood; and -risk indicators, including risk for falls including history of falls. R2's RN Quarterly Reviews dated July 7, 2025, September 16, 2026, December 18, 2025, March 18, 2026, and June 16, 2026, indicated no change in hearing; however, R2's hearing had not	01620			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01620	Continued From page 25 been addressed on initial admission assessment and R2's quarterly assessments did not include an area to address history of falls or risk for falls. On August 18, 2026, at 2:45 p.m., clinical nurse supervisor (CNS)-B stated R2's alarm was put into place a few months ago after R2 had repeated falls. CNS-B stated CNS-B did not think alarms needed to be included in assessments or the resident care plan. CNS-B stated CNS-B was unsure if staff were trained in sensor alarms during original training because licensed assisted living director/registered nurse LALD/RN-A completed all staff training. CNS-B stated R2's initial comprehensive assessment was not completed in the areas for hearing, ability to understand and be understood and fall risk or history of falls. The licensee's Assessments, Reviews and Monitoring policy dated August 1, 2021, indicated the licensee would conduct a nursing assessment by a registered nurse of there physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in. The initial nursing assessment or reassessment must include all the elements of the uniform assessment tool as required. For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5) as listed here: - assisting with dressing, self-feeding, oral hygiene, hair care, grooming, toileting, and bathing; - providing standby assistance; - providing verbal or visual reminders to the resident to take regularly scheduled medication,	01620			

Minnesota Department of Health

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01620	Continued From page 26 which includes bringing the resident previously set up medication, medication in original containers, or liquid or food to accompany the medication; - providing verbal or visual reminders to the resident to perform regularly scheduled treatments and exercises; - preparing modified diets ordered by a licensed health professional; - the individualized review or subsequent reviews must include all the required elements as specified in Rule, conducted in person (unless see #2), be in writing dated and signed by the registered nurse who conducted the individualized review; Communication and sensory capabilities, including: hearing and the ability to understand. The licensee's Uniform Assessment Tool policy dated August 1, 2021, indicated the licensee would use a uniform assessment tool that addressed all of the required elements. The license's uniform assessment tool would address -mobility, including ambulation, transfers and assisted devices; -risk for falls including history of falls; -communication and sensory capabilities, including hearing and the ability to understand and be understood; and -risk for falls, including history of falls. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0140, Subp. 2, effective October 2022, a nursing assessment or reassessment under Minnesota Statutes, section 144G.70, subdivision 2, paragraphs (b) and (c), must be conducted on a prospective resident or resident receiving any of the assisted living services identified in Minnesota Statutes, section 144G.08, subdivision 9, clauses (6) to (12).	01620			

Minnesota Department of Health

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01620	Continued From page 27 B. The nursing assessment or reassessment under item A must: (1) address part 4659.0150, subpart 2, items A to N; (2) be conducted in person unless an exception under Minnesota Statutes, section 144G.70, subdivision 2, paragraph (b), applies; (3) be conducted using a uniform assessment tool that complies with part 4659.0150; and (4) be in writing, dated, and signed by the registered nurse who conducted the assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620			
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure treatment or therapies were administered as directed and failed to document the reason they were not administered for one of one resident (R2) with	01960			

Minnesota Department of Health

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01960	Continued From page 28 treatment and/or therapies. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2's diagnoses included hypertension (high blood pressure), chronic kidney disease and coronary artery disease. R2's prescribed orders dated May 29, 2026, included an order for amlodipine 5 milligrams (mg) (used to treat high blood pressure) once daily if R2's systolic blood pressure (bottom number) was above 150. R2's July and August 2026 Blood Pressure readings record log directed to take R2's blood pressure two hours after morning medications and if R2's systolic blood pressure was greater than 150 to administer amlodipine daily. R2's blood pressure log indicated R2's blood pressure was not monitored or recorded and was documented as "sleeping", on July 4, 23, 24, 30 and August 5, 6, 9, 12, and 14. R2's record lacked documentation R2's blood pressure was monitored as directed on the dates note above. On August 19, 2026, at 9:54 a.m., clinical nurse supervisor (CNS)-B stated R2's record did not	01960			

Minnesota Department of Health

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01960	Continued From page 29 indicate a specific time to check R2's blood pressure and only directed two hours after morning medications were administered. CNS-B stated CNS-B followed up with staff and staff reported R2's family requested R2 not to be woken up to monitor blood pressures. CNS-B stated documenting "sleeping" in replace of a blood pressure recording was not acceptable and staff should make further attempts to monitor R2's blood pressure at a later time when R2 was awake. The licensee's Medication and Treatment Record Documentation and Refusal policy dated August 1, 2021, indicated If medication and or treatment/therapy assistance and/or administration were not completed as prescribed, documentation must include the reason why it was not completed and any follow up procedures that were provided. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960			
02410 SS=D	144G.91 Subd. 13 Personal and treatment privacy (a) Residents have the right to consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being. Staff must respect the privacy of a resident's space by knocking on the door and seeking consent before entering, except in an emergency or unless otherwise documented in the resident's service plan. (b) Residents have the right to have and use a lockable door to the resident's unit. The facility	02410			

Minnesota Department of Health

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02410	Continued From page 30 shall provide locks on the resident's unit. Only a staff member with a specific need to enter the unit shall have keys. This right may be restricted in certain circumstances if necessary for a resident's health and safety and documented in the resident's service plan. (c) Residents have the right to respect and privacy regarding the resident's service plan. Case discussion, consultation, examination, and treatment are confidential and must be conducted discreetly. Privacy must be respected during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure privacy was maintained for one of one resident (R3) while receiving services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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 August 18, 2026, at 9:16 a.m., the surveyor observed unlicensed personnel (ULP)-E complete a blood glucose test for R3 at the dining room table during breakfast with three other residents seated at the table. ULP-E had attempted 2 times after the first attempt was	02410			

Minnesota Department of Health

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02410	Continued From page 31 unsuccessful. On the second attempt, ULP-E completed R3's blood glucose check and stated to R3 the reading was 91 mg/dL. R3 was sitting at the dining table and asked why R3 had to have her finger poked and ULP-E explained it was because R3 had diabetes and needed to have blood glucose checks to monitor blood sugar levels. The surveyor did not observe ULP-E ask R3 if R3 wanted to move to a private area to complete the blood glucose test or ask the other three residents seated at the table if they were okay with a blood glucose test being performed in front of them. On August 18, 2026, at 9:25 a.m., ULP-E stated ULP-E waited until R3 was ready to get up and come out for breakfast to check R3's blood glucose right before ULP-E ate breakfast. ULP-E stated it was common practice. On August 19, 2026, at 11:35 a.m., licensed assisted living director/registered nurse (LALD/RN)-A stated staff have been educated and talked to on several occasions on not completing blood glucose monitoring in public settings especially at the dining table with other residents present. The licensee's Minnesota Bill of Rights for Assisted Living dated January 1, 2026, residents have the right to respect and privacy regarding the resident's service plan. Case discussion, consultation, examination, and treatment are confidential and must be conducted discreetly. Privacy must be respected during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance. No further information was provided.	02410			

Minnesota Department of Health

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02410	Continued From page 32 TIME PERIOD FOR CORRECTION: Seven (7) days	02410			



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

Food & Beverage Inspection Report

Page: 1

Establishment Info

BARNES CARE INC
58 West Highway 61
Esko, MN 55733
Carlton County
Parcel:

Phone:

License Info

License: HFID 30389

Risk:
License:
Expires on:
CFPM: MADISON PALLIN
CFPM #: FM122430; Exp: 3/6/2027

Inspection Info

Report Number: F1027261083
Inspection Type: Full - Single
Date: 8/18/2026 Time: 10:30 AM
Duration: minutes
Announced Inspection: Yes
Total Priority 1 Orders: 0
Total Priority 2 Orders: 1
Total Priority 3 Orders: 0
Delivery: Emailed

New Order: 4-200 Equipment Design and Construction

4-203.12 *Priority Level: Priority 2 CFP#: 36*

MN Rule 4626.0560 Replace ambient air and water temperature measuring devices that are not accurate to plus or minus 3 degrees F.

COMMENT: THERMOMETER IN UPRIGHT COOLER READ 28F. REPLACE THERMOMETER

Comply By: 9/1/2026 Originally Issued On: 8/18/2026

Food & Beverage General Comment

DISCUSSED EMPLOYEE ILLNESS AND EXCLUSIONS, REQUIRED SANITIZER STRENGTHS, AND AVOIDING BARE HAND CONTACT WITH READY TO EAT FOODS. ALL FOODS ARE COOKED TO 165F AND EGGS ARE NOT POOLED UNLESS THEY ARE PASTEURIZED EGGS.

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

I acknowledge receipt of the Duluth District Office inspection report number F1027261083 from 8/18/2026

Ian Harrison

JUSTIN BARNES
OWNER

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



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

Temperature Observations/Recordings

Page: 1

Establishment Info

BARNES CARE INC
Esko
County/Group: Carlton County

Inspection Info

Report Number: F1027261083
Inspection Type: Full
Date: 8/18/2026
Time: 10:30 AM

Food Temperature: Product/Item/Unit: ALL FOODS FROZEN; **Temperature Process:**

Location: Upright Freezer at Degrees F.

Comment: 3 UPRIGHT FREEZERS

Violation Issued?: No

Equipment Temperature: Product/Item/Unit: THERMOMETER; **Temperature Process:**

Location: Upright Cooler at 32 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: Product/Item/Unit: MILK; **Temperature Process:**

Location: Upright Cooler at 41 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: Product/Item/Unit: SPAM SALAD; **Temperature Process:**

Location: Upright Cooler at 40 Degrees F.

Comment:

Violation Issued?: No



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

Sanitizer Observations/Recordings

Page: 1

Establishment Info

BARNES CARE INC
Esko
County/Group: Carlton County

Inspection Info

Report Number: F1027261083
Inspection Type: Full
Date: 8/18/2026
Time: 10:30 AM

Sanitizing Chemical: Product: Quaternary Ammonia; **Sanitizing Process:** Spray Bottle

Location: Equal To 400 PPM

Comment:

Violation Issued?: No

Sanitizing Equipment: Product: Hot Water; **Sanitizing Process:** Dish Machine

Location: Equal To 167 Degrees F.

Comment:

Violation Issued?: No

Minnesota (MDH) Version EH Manager; RPT: F1027261083		Food Establishment Inspection Report		Page 1 of 1		
 Duluth District Office Minnesota Department of Health 11 East Superior Street, Suite 290 Duluth, MN 55802		No. of Risk Factor/Intervention/Violations		0	Date: 8/18/2026	
		No. of Repeat Risk Factor/Intervention/Violations			Time: 10:30 AM	
		Score (optional)			Dur: min	
Establishment: BARNES CARE INC		Address: 58 West Highway 61		City/State: Esko, MN	Zip: 55733	Phone:
License/Permit #: HFID 30389		Permit Holder:		Purpose of Inspection: Full	Est. Type:	Risk Category:
FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS						
Designated compliance status (IN, OUT, N/O, N/A) for each numbered item IN=in compliance OUT=not in compliance N/O=not observed N/A=not applicable				Mark "X" in appropriate box for COS and/or R COS=corrected on-site during inspection R=repeat violation		
Compliance Status				COS	R	
Supervision						
1	IN	Person in charge present, demonstrate knowledge and performs duties				
2	IN	Certified Food Protection Manager				
Employee Health						
3	IN	knowledge, responsibilities, and reporting				
4	IN	Proper use of restriction and exclusion				
5	IN	Response to vomiting, diarrheal events				
Good Hygienic Practices						
6	IN	Proper eating, tasting, drinking, tobacco use				
7	IN	No discharge from eyes, nose, and mouth				
Preventing Contamination by Hands						
8	IN	Hands clean and properly washed				
9	N/O	No bare hand contact with RTE foods, alternatives				
10	IN	Adequate handwashing sinks supplied and access				
Approved Source						
11	IN	Food obtained from approved source				
12	N/O	Food Received at proper temperature				
13	IN	Food in good condition, safe & unadulterated				
14	N/A	Records available: shellstock tags, parasite dest.				
Protection From Contamination						
15	IN	Food separated and protected				
16	IN	Food-contact surfaces; cleaned & sanitized				
17	IN	Proper Disposition of returned, previously served, reconditioned, & unsafe food				
GOOD RETAIL PRACTICES						
Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.						
Mark "X" or OUT in box if numbered item is not in compliance				Mark "X" in appropriate box for COS and/or R COS=corrected on-site during inspection R=repeat violation		
COS				R		
Safe Food and Water						
30	IN	Pasteurized eggs used where required				
31		Water & ice from approved source				
32	N/A	Variance obtained for specialized processing methods				
Food Temperature Control						
33		Proper cooling methods used; adequate equipment for temperature control				
34	N/O	Plant food properly cooked for hot holding				
35	N/O	Approved thawing methods used				
36	X	Thermometers provided & accurate				
Food Identification						
37		Food properly labeled; original container				
Prevention of Food Contamination						
38		Insects, rodents, & animals not present; no unauthorized person				
39		Contamination prevented during food prep, storage, & display				
40		Personal cleanliness				
41		Wiping cloths: properly used & stored				
42		Washing fruits & vegetables				
Person in Charge (signature)						
Inspector (signature)						
Follow-up: Follow-up Date:						

Physical Environment Inspection Report

ASSISTED LIVING | ASSISTED LIVING WITH DEMENTIA CARE

Project No: SL30389016-0	Date: August 17, 2026
Facility Name: BARNES CARE INC	
Facility Address: 58 West Highway 61 Esko MN 55733	

☒ TAG IDENTIFICATION: 0810

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Twenty One (21) days

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

Comments: The FSEP failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The provided FSEP was from a third-party provider and had not been updated to the specific facility. Policy noted use of pull station witch facility was not equipped with.
2. Each assisted living facility shall develop and maintain fire safety and evacuation plans (FSEP) that include fire protection procedures necessary for residents. [Minn. Stat. 144G.45 subd.2]

Comments: The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency.