Electronically Delivered
March 14, 2022

Administrator
Barrett Assisted Living Inc
800 Spruce Avenue
Barrett, MN 56311

RE: Project Number(s) SL20428015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on February 24, 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 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,

Jessica Gallmeier, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jess.gallmeier@state.mn.us
Phone: 651-247-0268 Fax: 651-215-9697

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20428	A. BUILDING: _____ B. WING _____	02/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BARRETT ASSISTED LIVING INC	800 SPRUCE AVENUE BARRETT, MN 56311

(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#20428015 On February 22, 2022, through February 24, 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 19 residents receiving 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.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	0 470		

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0 470	Continued From page 1 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 interview and record review, the licensee failed to develop and implement a staffing plan to determine staffing levels to meet the needs of all residents. 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	0 470		

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0 470	Continued From page 2	0 470		

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:

The licensee held an assisted living facility license. The facility was licensed for a capacity of 21 residents and had a current census of 19 residents.

During the entrance conference on February 22, 2022, at approximately 10:20 a.m., registered nurse (RN)-A was identified as the clinical nurse supervisor.

On February 23, 2022, at approximately 10:00 a.m., RN-A confirmed they had not developed a written staffing plan to indicate when to increase or decrease staff or indicate what measures were considered with scheduling. RN-A stated staffing levels would fluctuate depending on acuity and other resident needs but there was no formal written plan in place.

The licensee's 4.06 Staffing & Scheduling policy dated August 1, 2021, indicated the clinical nurse supervisor would develop and implement a written staffing plan that provides an adequate number of qualified direct-care staff to meet the residents' needs 24-hours a day, seven days a week. The clinical nurse supervisor must ensure that staffing levels were adequate to address the following:
a. Each resident's needs, as identified in the resident's service plan and assisted living contract;
b. Each resident's acuity level, as determined by

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0 470	Continued From page 3 the most recent assessment or individualized review; c. The ability of staff to timely meet the residents' scheduled and reasonably foreseeable unscheduled needs given the physical layout of the facility premises; d. Whether the facility has a secured dementia care unit; and e. Staff experience, training, and competency. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) 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: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record	0 480		

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0 480	Continued From page 4 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) 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: Please refer to the included document titled, Food and Beverage Establishment Inspection Report, dated February 23, 2022, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but	0 780		

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0 780	Continued From page 5 not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that are interconnected so that actuation of one alarm causes all alarms in the dwelling unit to actuate. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On a facility tour with Registered Nurse (RN)-A and Maintenance (M)-F on February 24, 2022, between approximately 10:55 a.m. and 12:00 p.m., it was observed that a portion the sleeping rooms that were equipped with smoke alarms were not interconnected with the other smoke	0 780		

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0 780	Continued From page 6 alarms in the dwelling unit so that actuation of one alarm would cause all alarms to operate. This deficient condition was visually verified by (RN)-A and (M)-F accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) 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	0 810		

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0 810	Continued From page 7 evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop a fire safety and evacuation plan with required elements. 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). Findings include: A record review and interview were conducted on February 08, 2022, between approximately 10:10 a.m. and 10:55 a.m. with the Registered Nurse (RN)-A and Maintenance (M)-F on the fire safety and evacuation plan for the facility. Record review indicated that the fire safety and evacuation plan did not have fire protection procedures necessary for residents. During interview, (RN)-A stated that they felt licensee had provisions for fire protection procedures for residents but was unable to locate them or in the fire safety and evacuation plan or policy. Record review indicated that the fire safety and	0 810		

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0 810	Continued From page 8 evacuation plan did not include the identification of unique or unusual resident needs for movement or evacuation in the procedures for resident movement, evacuation, or relocation during a fire or similar emergency. During interview, (RN)-A stated that the licensee did not have anything in the fire safety and evacuation plan that prescribed any different measures or that provided identification of unique needs of residents for movement or evacuation. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 920 SS=C	144G.50 Subd. 2 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 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	0 920		

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0 920	Continued From page 9 (7) disclosure of the facility's ability to provide specialized diets. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to execute a written contract with the required content for two of two residents (R1 and R2) with records reviewed. This had the potential to affect all 19 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 service plan, dated January 3, 2022, indicated the resident received the following services: assistance with dressing, oral hygiene, hair care, grooming, toileting, bathing, transfers and mobility, medication administration and medication storage, daily OK check, weekly housekeeping and laundry, and treatments to her abdominal folds. On February 24, 2022, at 8:07 a.m., the surveyor observed R1 receive her morning medications from unlicensed personnel (ULP)-B. R1's contract, dated December 30, 2021, lacked the following required content: -a disclosure of the category of assisted living facility license held by the facility, and if the facility	0 920		

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0 920	Continued From page 10 is not an assisted living facility with dementia care, a disclosure that it does not hold an assisted living facility with dementia care license. R2 R2's service plan, dated December 30, 2021, indicated the resident received the following services: assistance with dressing, grooming, hair care, toileting, bathing, and applying ace wraps, medication administration and medication storage, daily OK check, weekly housekeeping and laundry, and wound care. On February 24, 2022, at approximately 8:45 a.m., the surveyor observed ULP-B administer R2's morning medications and at approximately 9:00 a.m., assist the resident with toileting and getting dressed. R2's contract dated December 30, 2021, lacked the following required content: -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 care, a disclosure that it does not hold an assisted living facility with dementia care license. On February 23, 2022, at approximately 2:15 p.m., registered nurse (RN)-A confirmed the licensee's contract was missing some of the required content, and the contract was the same for all residents. The licensee's policy related to Assisted Living Contract contents was requested, but not provided. No further information was provided. TIME PERIOD FOR CORRECTION:	0 920		

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0 920	Continued From page 11 Twenty-One (21) days	0 920		
01290 SS=F	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring 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 an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study was submitted and received for one of four employees (certified nursing assistant (CNA)-E) 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:	01290		

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BARRETT ASSISTED LIVING INC	800 SPRUCE AVENUE BARRETT, MN 56311

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01290	Continued From page 12 On February 22, 2022, at approximately 3:00 p.m., registered nurse (RN)-A stated staff from the attached nursing home would come to the assisted living to provide assistance to the unlicensed personnel (ULP). RN-A stated the nursing home staff would bring a hoyer lift and provide assistance to the unlicensed personnel (ULP) if an assisted living resident fell and required assistance to get off of the floor with a Hoyer lift. RN-A was not sure if the nursing home staff had completed background studies that were affiliated with the licensee's assisted living license, however confirmed some nursing home staff were also employed as ULP at the assisted living, while others were not. RN-A stated it was not currently their process to do background studies on nursing home employees who periodically came over to provide assistance as RN-A stated it was similar to emergency medical services who would come in the building to provide assistance getting a resident off the floor. On February 23, 2022 at approximately 2:30 p.m., RN-A confirmed CNA-E had come over from the attached nursing home and provided lift assistance for a resident who fell and required a second person to get up on December 27, 2021. RN-A was not sure what assisted living specific training CNA-E had received and was not sure if the employees background study was affiliated to their license. The licensee's 4.02 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.	01290		

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01290	Continued From page 13 No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01650 SS=F	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 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:	01650		

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01650	Continued From page 14 Based on observation, interview, and record review, the licensee failed to ensure the service plan included the required content for two of two residents (R1, R2) with records reviewed. 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), 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: R1 R1 admitted to the facility on May 1, 2021 and began receiving services under the assisted living license on August 1, 2021. R1's diagnoses included mild cognitive impairment, depression, and congestive heart failure. On February 24, 2022 at approximately 8:07 a.m., the surveyor observed unlicensed personnel (ULP)-B administer R1's morning medications. R1's service plan, dated January 3, 2022, indicated the resident received the following services: assistance with dressing, oral hygiene, hair care, grooming, toileting, and bathing, medication administration, hands on assistance with transfers and mobility, treatments to abdominal folds, weekly housekeeping and laundry, a daily OK check, and med storage and set up.	01650		

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01650	Continued From page 15 R1's service plan lacked the following required content: -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. R1's service plan had an area to identify circumstances where emergency medical services were not to be summoned could be listed, but was left blank. R2 R2 admitted to the facility on July 29, 2020, and began receiving services under the assisted living license on August 1, 2021. R2's diagnoses included congestive heart failure, post-polio syndrome, and mild cognitive impairment. On February 24, 2022, at approximately 8:45 a.m., the surveyor observed ULP-B administer R2's morning medications and at approximately 9:00 a.m., assist the resident with toileting and getting dressed. R2's service plan, dated December 30, 2021, indicated the resident received the following services: assistance with dressing, grooming, hair care, toileting, bathing, and applying ace wraps, medication administration and medication storage, daily OK check, weekly housekeeping and laundry, and wound care. R2's service plan lacked the following required content: -the circumstances in which emergency medical services are not to be summoned consistent with	01650		

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01650	Continued From page 16 chapters 145B and 145C, and declarations made by the resident under those chapters. R2's service plan had an area to identify circumstances where emergency medical services were not to be summoned could be listed, but was left blank. On February 23, 2022, at approximately 10:15 a.m., registered nurse (RN)-A confirmed the section on both service plans was not filled out. RN-A indicated the above section of the service plan was not completed for any resident as it was the licensee's procedure to always call 911. RN-A stated if there was a resident who did not want 911 called, it would be indicated on the service plan and by leaving it blank, it was intended to mean they'd always call emergency medical services. The licensee's policy, Service Plan, dated August 1, 2021, indicated the service plan would include how the facility will support documented resident health care directive decisions, if any-including circumstances when emergency medical services are not to be summoned. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650		
01940 SS=E	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written	01940		

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01940	Continued From page 17 statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to prepare and include in the service plan a written statement of the treatment or therapy services to be provided to the resident for two of two residents (R1, R2) receiving treatments. 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	01940		

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01940	Continued From page 18	01940		

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 mild cognitive impairment, depression, and congestive heart failure.

R1's service plan, dated January 3, 2022, indicated the resident received the following services: assistance with dressing, oral hygiene, hair care, grooming, toileting, bathing, transfers and mobility, medication administration and medication storage, daily OK check, weekly housekeeping and laundry, and treatments to her abdominal folds. R1's service plan did not include the resident's compression socks or CPAP (continuous positive airway pressure, a machine that uses positive pressure to prevent upper airway collapse).

R1's treatment administration record (TAR) indicated staff put on and removed compression socks daily. The TAR did not contain any documentation for a CPAP.

R1's prescriber orders, dated August 24, 2021, contained an order for CPAP on at hs (bed time). R1 did not have a current order for compression socks.

On February 22, 2022, at approximately 3:50 p.m., the surveyor observed R1 wearing compression socks. The surveyor observed a

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01940	Continued From page 19 CPAP machine near R1's bed. On February 24, 2022, at approximately 8:07 a.m., the surveyor observed unlicensed personnel (ULP)-B administer R1's morning medications. R1 was observed to be wearing compression socks. R2 R2's diagnoses included congestive heart failure, post-polio syndrome, and mild cognitive impairment. R2's service plan, dated December 30, 2021, indicated the resident received the following services: assistance with dressing, grooming, hair care, toileting, bathing, and applying ace wraps, medication administration and medication storage, daily OK check, weekly housekeeping and laundry, and wound care. R2's service plan did not include the resident's daily weight. Instructions on R2's medication administration record (MAR) indicated the RN was to be notified of a 3 pound weight gain in one day or 5 pound weight gain in one week. R2's prescriber orders, dated October 22, 2021, indicated staff were to monitor daily weights and report a 3 pound weight gain in one day or a 5 pound weight gain in one week. On February 24, 2022, at approximately 8:45 a.m., ULP-B was observed to administer R2's morning medications and at approximately 9:00 a.m., assist the resident with toileting and getting dressed. On February 22, 2022, at approximately 2:00 p.m., registered nurse (RN)-A confirmed R1 and	01940		

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01940	Continued From page 20 R2 did not have all the treatments listed as required on the service plan. The licensee's policy, Medication & Treatment Administration & Delegation, dated August 1, 2021, indicated the licensee would prepare and include in the service plan a written statement of the medication management or treatment management services that will be provided to the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure treatment or therapies were administered as directed, or to document the reason they were not administered, and any follow up procedures that were provided to meet the resident's needs, for one of one resident (R2)	01960		

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01960	Continued From page 21 receiving daily weights 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 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 ensure the registered nurse (RN) was notified of R2's weights being out of range, as ordered. R2's diagnoses included congestive heart failure, post-polio syndrome, and mild cognitive impairment. R2's service plan, dated December 30, 2021, indicated the resident received the following services: assistance with dressing, grooming, hair care, toileting, bathing, and applying ace wraps, medication administration and medication storage, daily OK check, weekly housekeeping and laundry, and wound care. R2's prescriber orders, dated October 22, 2021, indicated staff were to monitor daily weights and report a 3 pound weight gain in one day or a 5 pound weight gain in one week. Instructions on R2's medication administration record (MAR) indicated the RN was to be notified of a 3 pound weight gain in one day or 5 pound weight gain in one week. R2's weight was recorded at 155.8 pounds on	01960		

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01960	Continued From page 22 February 20, 2022, and 160.8 pounds on February 21, 2022, a gain of 5 pounds in one day. R2's record lacked evidence that the RN was notified of the weight gain. On February 22, 2022, at approximately 3:30 p.m., RN-A confirmed she was not updated on the resident's weight gain. A policy on updating the RN with changes in treatment or therapies being administered was requested, but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to obtain a prescriber's order for a treatment provided for one of two residents receiving treatments (R1) with records reviewed.	01970		

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01970	Continued From page 23 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's diagnoses included mild cognitive impairment, depression, and congestive heart failure. R1's service plan, dated January 3, 2022, indicated the resident received the following services: assistance with dressing, oral hygiene, hair care, grooming, toileting, bathing, transfers and mobility, medication administration and medication storage, daily OK check, weekly housekeeping and laundry, and treatments to her abdominal folds. R1's treatment administration record (TAR), dated February 2022, indicated staff put on and removed compression socks daily. R1's prescriber orders, dated December 23, 2021, did not contain an order for compression socks. On February 22, 2022, at approximately 2:00 p.m., registered nurse (RN)-A confirmed R1's current prescriber orders did contain an order for compression socks. On February 22, 2022, at approximately 3:50 p.m., the surveyor observed R1 wearing	01970		

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01970	Continued From page 24 compression socks. On February 24, 2022, at approximately 8:07 a.m., the surveyor observed unlicensed personnel (ULP)-B administer R1's morning medications. R1 was observed to be wearing compression socks. The licensee's policy, Medication & Treatment Administration & Delegation, dated August 1, 2021, indicated a current prescription would be on file for all medications and treatments. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		
02310 SS=D	144G.91 Subd. 4 Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to assess the necessity of bed rail usage for one of one resident with bedrails (R1). 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	02310		

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02310	Continued From page 25 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 February 22, 2022, at approximately 2:20 p.m., the surveyor observed bilateral bedrails near the head of R1's bed. R1's diagnoses included mild cognitive impairment, depression, and congestive heart failure. R1's most recent bed rail assessment, dated February 8, 2022, indicated R1 used the bedrail as a positioning device. The assessment indicated the bedrail was to assist with turning and transferring out of bed. The assessment lacked documentation of the measurements of the bed rail and an assessment of the zones of entrapment. R1's record indicated benefits and risks of using half side rails or grab bars was discussed with the resident's family member on May 1, 2021. On February 22, 2022, at approximately 2:30 p.m., registered nurse (RN)-A measured the bed rail with the surveyor present. The bed rail measured 32 inches wide by 18 inches tall. The bedrail had openings between 2.5 inches and 3.5 inches, which is within the FDA recommended dimensional measurement. RN-A confirmed the resident's assessment did not contain measurements of the bedrail or an assessment of the zones of entrapment. On February 22, 2022, at approximately 4:35 p.m., R1 stated she used the bedrail to get in and out of bed.	02310		

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BARRETT ASSISTED LIVING INC	800 SPRUCE AVENUE BARRETT, MN 56311

(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
02310	Continued From page 26 The March 10, 2006, FDA Side Rail Entrapment Zones and Dimensional Recommendations indicated to reduce the risk of entrapment, zone 1 (space between the rails), should be less than 4 and 3/4 inches. The FDA "A Guide to Bed Safety" revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe". The licensee's policy, 6.28 Side Rails, dated August 1, 2021, indicated the RN would conduct an assessment and determine if the side rail was safe. The policy identified a safe side rail as one that is used consistent with the manufacturer's directions, is secured, and maintained in good operating condition, and are consistent with the FDA's 2006 recommended dimensional measurements to reduce entrapment. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	02310		

MN Department of Health
Food, Pools, and Lodging Services
PO Box 64975
St. Paul, MN 55164-0975
218-332-5150

Type: Full
Date: *02/23/22*
Time: 11:00:00
Report: 7935221035

Food and Beverage Establishment Inspection Report

Location:
Barrett Assisted Living Inc
800 Spruce Avenue
Barrett, MN56311
Grant County, 26

Establishment Info:
ID #: 0037571
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 3205282371
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.

6-300 Physical Facility Numbers and Capacities

6-301.14A

MN Rule 4626.1457 Provide a sign or poster at all handwashing sinks used by food employees that notifies them to wash their hands

DESIGNATE LEFT SIDE OF TWO COMPARTMENT SINK FOR HAND WASHING AND POST A SIGN REMINDING EMPLOYEES TO WASH HANDS.

Comply By: 02/23/22

Surface and Equipment Sanitizers

Quaternary Ammonia: = 400 ppm at Degrees Fahrenheit
Location: Spray Bottle
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 36 Degrees Fahrenheit - Location: Fridge
Violation Issued: No

Process/Item: Cold Holding
Temperature: 37 Degrees Fahrenheit - Location: Juice Machine
Violation Issued: No

Type: Full
Date: *02/23/22*
Time: 11:00:00
Report: 7935221035
Barrett Assisted Living Inc

Food and Beverage Establishment Inspection Report

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

Things to Remember:

1. The Certified Food Manager should be routinely conducting self inspections to ensure that employees are following proper food handling practices.

2. Educate employees on the importance of reporting to management any illness they have or have had recently. Management should exclude any workers ill with vomiting or diarrhea from handling food, and they should keep an up-to-date employee illness log.

3. There should be a Person in Charge at the establishment during all hours of operation. This person should ensure that employees are practicing good hand washing procedures, including being knowledgeable about when hand washing should be done and how to properly wash hands.

4. Employees should use spatula, tongs, deli tissue, gloves, or some other approved means to prevent any direct bare hand contact with ready to eat foods.

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

I acknowledge receipt of the MN Department of Health inspection report number 7935221035 of 02/23/22.

Certified Food Protection Manager: Kelsey Harbig

Certification Number: 99331 Expires: 06/18/22

Signed: _____ Signed: 7935

Establishment Representative

7935

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