



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

October 21, 2024

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

RE: Project Number(s) SL30389015

Dear Licensee:

On October 2, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the July 12, 2024, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

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

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

JMD



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

August 7, 2024

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

RE: Project Number(s) SL30389015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 12, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement.

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

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

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

In accordance with Minn. Stat. § 144G.31, Subd. 4(a)(5), MDH may impose fine amounts of either \$1,000 or \$5,000 to licensees who are found to be responsible for maltreatment. MDH may impose 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. MDH 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(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, the following fines are assessed pursuant to this survey:

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

St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - \$3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$3,500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

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

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a

hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. to submit a hearing request, please visit:

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

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

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **<https://forms.office.com/g/Bm5uQEPhVa>**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,

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

Jessie Chenze, Supervisor

State Evaluation Team

Email: Jessie.Chenze@state.mn.us

Telephone: 218-332-5175 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30389	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/12/2024
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: SL30389015 On July 8, 2024, through July 12, 2024, 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 8 residents receiving services under the provider's Assisted Living Facility. An immediate correction order was identified on July 8, 2024, issued for SL30389015, tag identification 1290. Immediacy was not removed during survey, and non-compliance remains at a scope and level of I.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
0 110 SS=C	144G.10 Subdivision 1a Assisted living director license required	0 110			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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0 110	Continued From page 1 Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the licensed assisted living director (LALD) was listed as the Director of Record for the licensee. This had the potential to affect all the licensee's residents, staff, and visitors. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On July 8, 2024, at 7:17 a.m., the surveyor reviewed the Board of Executives for Long-Term Services and Support (BELTSS) website. The BELTSS website indicated LALD-A held a current assisted living director licenses issued July 18, 2021; and would expire October 31, 2024. The BELTSS website did not indicate LALD-A as the Director of Record for the licensee. During entrance conference on July 8, 2024, between 10:15 a.m. and 10:40 a.m., LALD-A identified himself as the current LALD for the facility. The surveyor and LALD-A reviewed the BELTSS website and LALD-A was not indicated	0 110			

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0 110	Continued From page 2 as the Director of Record. LALD/CNS-A stated he was unaware it was required to be listed as the Director of Record for all of three of his facilities. The licensee's Assisted Living Director policy dated August 1, 2021, indicted the licensee was required to have an Assisted Living licensed or permitted by the Board of Executives for Long Term Services and Support (BELTSS). No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110			
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: (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 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	0 480			

Minnesota Department of Health

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0 480	Continued From page 3 the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated July 8, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480			
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure infection control standards were followed during meal assistance by one of one employee (unlicensed personnel (ULP)-H). This practice resulted in a level two violation (a	0 510			

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0 510	Continued From page 4 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: On July 8, 2024, at 12:32 p.m., the surveyor observed ULP-H provide feeding assistance to R2. ULP-H was sitting at the kitchen island and R2 was sitting next to ULP-H in a Geri chair (specialized wheelchair that reclines). At 12:37 p.m., ULP-H was observed wearing gloves, feeding R2 applesauce from a blue plastic bowl. ULP-H got up from the kitchen island and dished up a plate of food and sat back at the kitchen Island with the plate of food. Wearing the same pair of gloves, ULP-E proceed to feed R2 applesauce and egg noodles. In between feeding R2, ULP-H would take bites of her food, not changing gloves or performing hand hygiene. At 12:52 p.m., ULP-H removed R2's her plate and R2's dishes, rinsed the dishes in the sink then placed the dishes in the dishwasher. ULP-H removed gloves and did not perform hand hygiene. On July 8, 2024, at 12:40 p.m., ULP-H stated she never thought about infection control concerns when she was eating and feeding R2 at the same time, wearing the same pair of gloves and not performing hand hygiene in between. ULP-H stated now that it was brought to her attention, ULP-H realized the possibility of spreading germs. On July 9, 2024, at 8:47 p.m., registered nurse	0 510			

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0 510	Continued From page 5 (RN)-B stated staff should not be eating at the same time of feeding residents; and further RN-B stated it would be an infection control concern. The licensee's Hand washing policy dated August 1, 2021, indicated hand washing should be used to protect the spread of infections and shall be completed before, during, and after preparing food, and before eating. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510			
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee	0 550			

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0 550	Continued From page 6 failed to post the required information related to the grievance procedure. This had the potential to affect all current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During a facility tour on July 8, 2024, at 10:02 a.m., the surveyor observed, and firmed confirmed with physical plant manager (PPM)-C, the licensee's grievance procedure was posted at the nurses desk in the kitchen/dining area; however, the grievance procedure posting lacked the required content to include the e-mail contact information for the individuals who are responsible for handling resident grievances and contact information for the Office of Ombudsman for Mental Health and Developmental Disabilities. On July 12, 2024, at 3:45 p.m., during exit conference, licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A and registered nurse (RN)-B stated they thought they had posted an updated grievance procedure with the email address of the individual responsible for handling resident grievances and contact information for the Office of Ombudsman for Mental Health and Developmental Disabilities. RN-B confirmed the licensee's grievance procedure posted had not been updated to include the required information noted above.	0 550			

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0 550	Continued From page 7 The licensee's Complaint/Grievance Posting policy dated August 1, 2021, indicated the licensee would post, in a conspicuous place, information about the licensee's complaint/grievance procedure, and the name, telephone number, and email contact information for the individual(s) who were responsible for handling resident complaint/grievances. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 550			
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post the required 911 emergency number in common areas at the assisted living. This had the potential to affect all residents, staff, and visitors.	0 640			

Minnesota Department of Health

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0 640	Continued From page 8 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During a facility tour on July 8, 2024, at 10:02 a.m., the surveyor confirmed with physical plant manager (PPM)-C, the surveyor did not observe 911 emergency number posted in any common areas, or near phones at the assisted living. On July 12, 2024, at 3:45 p.m., during exit conference, licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A and registered nurse (RN)-B stated they thought the 911 emergency number had been posted as required. The licensee's Vulnerable Adult Maltreatment-Prevention and Reporting policy dated August 1, 2021, indicated the licensee would post the 911 emergency number in common areas and near telephones provided by the licensee and post the reporting number for MAARC. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 640			

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0 650	Continued From page 9	0 650			
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records contained the required content for one of two employees (registered nurse (RN)-B). 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	0 650			

Minnesota Department of Health

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0 650	Continued From page 10 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: RN-B was hired June 4, 2014, to provide supervision and direct care services to residents of the facility. On July 8, 2024, through July 9, 2024, the surveyor observed RN-B provide direct care services to the licensee's residents. RN-B's employee record contained a Job Description and Performance Appraisal dated February 1, 2022; however, RN-B's record lacked evidence an annual performance review was completed for 2023. On July 9, 2024, at 2:45 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated he thought he completed RN-B's annual performance review because it had been identified an issue at another assisted living facility owned by the licensee. The licensee's Employee Evaluation policy dated August 1, 2021, indicated all staff of the licensee would be given an employee evaluation at least annually. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650			
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness	0 680			

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0 680	Continued From page 11 (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 interview and record review, the licensee failed to have a written emergency preparedness plan with all the required content. This had the potential to affect all residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	0 680			

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0 680	Continued From page 12 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's Emergency Preparedness Plan [Building #1] dated January 11, 2024, lacked the following content and/or policies and procedures to address: - a missing resident plan that was reviewed quarterly, last reviewed January 11, 2024; - a description of the population served by the licensee; - development of arrangements with other facilities and providers to receive residents if needed; and - emergency prep testing requirements. On July 9, 2024, at 3:03 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated he signed up with the local coalition to assist with developing the licensee's emergency disaster plan. LALD/CNS-A stated the licensee was in the process on obtaining signed arrangement agreements with shelter sites. LALD/CNS-A stated the licensee's emergency plan was missing requirements as noted above. The licensee's Emergency Preparedness Plan-Appendix Z Compliance policy dated August 1, 2021, indicated the licensee would develop and implement an emergency preparedness plan to include all the required elements of Appendix Z. The plan would be in writing, reviewed annually and be based on the licensee's assisted living-based community-based risk assessments, utilizing an all-hazards approach.	0 680			

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0 680	Continued From page 13 Per Assisted Living Facilities: Minnesota Rules Chapter 4659, 4659.0110, Subp. 4. Review missing resident plan. The assisted living director and clinical nurse supervisor must review the missing person plan at least quarterly and document any changes to the plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680			
0 690 SS=E	144G.43 Subdivision 1 Resident record (a) Assisted living facilities must maintain records for each resident for whom it is providing services. Entries in the resident records must be current, legible, permanently recorded, dated, and authenticated with the name and title of the person making the entry. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain resident records with current, legible, permanently recorded, dated, and authenticated with the name and title of the person making the entry for two of two residents (R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the	0 690			

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0 690	Continued From page 14 situation has occurred repeatedly; but is not found to be pervasive). The findings include: R2 R2's diagnoses included chronic obstructive pulmonary disease (COPD), cerebral vascular disease (condition that affects blood to the brain), and stroke (damage to the brain from interrupted blood flow). On July 9, 2024, at 9:14 a.m., the surveyor observed unlicensed personnel (ULP)-E administering R2's scheduled morning medications. R2's Service Plan dated June 11, 2024, assistance with dressing, bathing, grooming, transfers and mobility, toileting, eating, medication administration, laundry and housekeeping. R2's Individual Abuse Prevention Plan (IAPP) assessment and Medication Self-Administration Assessment lacked the dates the assessments were completed by registered nurse (RN)-B; furthermore, R2's Client Information form lacked the date and authentication of the name of the representative who completed the form. R3 R3's diagnoses included dementia, hypertension (high blood pressure), and diabetes. R3's Service Plan dated January 14, 2024, included assistance with dressing, grooming, bathing, toileting, medication administration, assistance with compression stockings, blood glucose monitoring, laundry and housekeeping.	0 690			

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0 690	Continued From page 15 R3's Rental Agreement lacked the date the Rental Agreement was signed by the resident's representative and furthermore, lacked authentication of the date and name of the licensee's representative at the time the agreement was initiated. On July 9, 2024, at 8:45 a.m., RN-B verified R2's IAPP and Medication Assessment and Client Information form lacked the dates RN-B completed R2's assessments and authentication of the date and name of the representative who completed R2's Client Information form. On July 9, 2024, at 1:06 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated when the licensee's Rental Agreement had been updated, the new agreement was placed in R3's file awaiting signature. LALD/CNS-A stated he was unable to recall the date the licensee's Rental Agreement was updated; furthermore, stated the Rental Agreement had not been recently updated. The licensee's undated Service Plans policy indicated the service plan and any revisions must include a signature or other authentication by the licensee and by the tenant or the tenant's representative documenting agreement on the services to be provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 690			
0 730 SS=D	144G.43 Subd. 3 Contents of resident record	0 730			

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0 730	Continued From page 16 Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and	0 730			

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0 730	Continued From page 17 any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a resident's record included documentation of maintenance and care of nebulizer equipment for one of one resident (R2) who received nebulizer treatment/therapy services from the licensee. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings included: R2's diagnoses included chronic obstructive pulmonary disease (COPD), cerebral vascular disease (condition that affects blood to the brain), and stroke (damage to the brain from interrupted blood flow). R2's Service Plan dated June 11, 2024, assistance with dressing, bathing, grooming, transfers and mobility, toileting, eating, medication administration, laundry and housekeeping.	0 730			

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0 730	Continued From page 18 R2's unsigned hospice orders dated June 19, 2024, included Budesonide 0.5 milligrams (mg)/2 milliliters (ml) suspension for nebulizer one vial twice a day for shortness of breath. On July 9, 2024, at 9:36 a.m., the surveyor observed unlicensed personnel (ULP)-E set up R2's nebulizer with Budesonide 0.5 mg/2 ml one vial solution and administer via nebulizer mask. ULP-E waited in R2's room during R2's nebulizer treatment. At 9:44 a.m., ULP-E removed R2's nebulizer mask and placed the equipment on a stand. ULP-E did not rinse R2's nebulizer equipment or leave open to dry after use. Immediately following R2's nebulizer administration, ULP-E stated she did not rinse R2's nebulizer equipment after use; furthermore, R2's record did not direct staff to clean equipment after use. ULP-E stated R2's record did not indicate how often and who was responsible for changing R2's nebulizer supplies and equipment. On July 9, 2024, at 1:41 p.m., registered nurse (RN)-B stated the nurses were responsible to changing R2's nebulizer equipment and tubing and RN-B verified R2's record lacked identifying the responsible person and frequency for changing R2's nebulizer equipment. The licensee's Nebulizer Treatment policy dated August 1, 2021, indicted to clean nebulizer after treatment to prevent bacteria growth and to replace the nebulizer kit and tubing every two weeks. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 730			

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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 not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that functioned and are interconnected so that the actuation of one alarm causes all alarms in the dwelling unit to actuate. 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	0 780			

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0 780	Continued From page 20 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 on July 9, 2024, at approximately 2:25 p.m. with the physical plant manager (PPM)-A-C. The PPM-A-C tested the smoke alarms throughout the home. It was observed that when the smoke alarms were push button tested, some of the alarms did not operate. All the smoke alarms in the residence where not interconnected. The deficient condition was visually verified by the PPM-A-C accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780			
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by:	0 800			

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0 800	Continued From page 21 Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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 facility tour on July 9, 2024, with the physical plant manager (PPM)-A-C, between 12:30 p.m. and 3:30 p.m. the following facility hazards and disrepair were observed: Fire Doors: Surveyor observed several emergency and exit lights did not operate when push button tested. Surveyor explained to the PPM-A-C, that exit and emergency shall be push button tested monthly and the 30 minute test performed annually (and documented) according to the 2020 Minnesota State Fire Code. Extension Cord: Surveyor observed a black extension cord being used permanently in the office area. Surveyor explained to the PPM-A-C, that extension cords cannot be used as a permanent	0 800			

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0 800	Continued From page 22 means of wiring. Lint: Surveyor observed an excessive amount of lint behind the clothes dryer. Surveyor explained to the PPM-A-C, that the area behind the dryer shall be cleaned periodically to keep from lint and other debris build up. The deficient condition was visually verified by the PPM-A-C accompanying on the tour. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 800			
0 820 SS=F	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility's physical	0 820			

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0 820	Continued From page 23 environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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 July 9, 2024, at approximately 12:30 p.m., surveyor toured the facility with the physical plant manger (PPM)-A-C and the following was observed. Front exit door: The front door had an exit sign posted on it and this door was designated as an emergency exit on the posted evacuation map. There was a magnetic lock on the interior side of this door that required entry of a code into a keypad beside the door to exit. The code was labeled on the key pad. Back exit door: The back door was designated as an emergency exit on the posted evacuation map. There was a magnetic lock on the interior side of this door that required entry of a code into a keypad beside the door to exit. The code was labeled on the key pad.	0 820			

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0 820	Continued From page 24 (2) side exit doors: The (2) side exit doors were designated as emergency exits on the posted evacuation map. There was a magnetic lock on the interior side of this door that required entry of a code into a keypad beside the door to exit. The code was labeled on the key pad. The deficient conditions were visually verified by the PPM-A-C accompanying on the tour. TIME PERIOD FOR CORRECTION: Two (2) days	0 820			
01290 SS=I	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 observation, interview and record review, the licensee failed to ensure all	01290			

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01290	Continued From page 25 employees with access to residents and resident records had a cleared background study completed via NetStudy 2.0 for 6 of 6 employees (registered nurse (RN)-B), (unlicensed personnel (ULP)-D, ULP-E, ULP-H, ULP-I, ULP-J). This had the potential to affect all residents, employees, and visitors. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to 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). This resulted in an immediate correction order on July 8, 2024. The findings include: On July 8, 2024, at 1:54 p.m., the surveyor observed ULP-E and ULP-H assist R2 with a transfer using a Hoyer (a mechanical lift). RN-B RN-B was hired June 4, 2014, to provide supervision and direct care services to residents of the facility. RN-B's employee record lacked documentation of a cleared background study. Review of NetStudy 2.0 on July 8, 2024, at 1:36 p.m., indicated a background study had not been submitted for RN-B · ULP-D ULP-D was hired on April 13, 2021, to provide direct care services to residents of the facility. ULP-D's employee record lacked documentation	01290			

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01290	Continued From page 26 of a cleared background study. Review of NetStudy 2.0 on July 8, 2024, at 1:36 p.m., indicated a background study had not been submitted for ULP-D. ULP-E ULP-E was hired on November 23, 2012, to provide direct care services to residents of the facility. ULP-E's employee record lacked documentation of a cleared background study. Review of NetStudy 2.0 on July 8, 2024, at 1:36 p.m., indicated a background study had not been submitted for ULP-E. ULP-H ULP-H was hired on June 6, 2024, to provide direct care services to residents of the facility. ULP-H's employee record lacked documentation of a cleared background study. Review of NetStudy 2.0 on July 8, 2024, at 1:36 p.m., indicated a background study had not been submitted for ULP-H. ULP-I ULP-I was hired on May 1, 2024, to provide dining and food service to residents of the facility. ULP-I's employee record lacked documentation of a cleared background study. Review of NetStudy 2.0 on July 8, 2024, at 1:36 p.m., indicated a background study had not been submitted for ULP-I. ULP-J ULP-J was hired on September 19, 2017, to provide direct care services to residents of the facility. ULP-J's employee record lacked documentation of a cleared background study. Review of NetStudy 2.0 on July 8, 2024, at 1:36 p.m., indicated a background study had not been submitted for ULP-J.	01290			

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01290	Continued From page 27 On July 2, 2024, at 2:32 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated he was unable to located any background study clearance letters in RN-B, ULP-D, ULP-E, ULP-H, ULP-I or ULP-J's employee records. On July 8, 2024, at 3:58. p.m., physical plant manager/agent (PPM/A)-C stated the ULPs noted above provided independent direct resident contact during their shift and were not under direction supervision by another employee. The licensee's Background Checks policy, dated August 1, 2021, noted licensee would conduct a Minnesota Department of Human Services Background Study on all employees, volunteers and contractors of the licensee. No employee may provide direct services and have an independent direct contact with any residents until acceptable result of the background study have been received. The licensee will not employ individuals whose results of the background study indicate disqualification for the position. If hired prior to receiving the results of the background study, or the tentative background study results indicate more time is needed requiring supervision, new hires shall not be permitted to interact or provide services to residents of licensee except under the direct supervision (eyesight) of another qualified person. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE Immediacy is not removed as of survey exit on July 12, 2024, and non-compliance remains at a scope and level of widespread, level three (I).	01290			

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01700 SS=D	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted a face-to-face medication management assessment to include a review of medications in all required areas for one of two residents (R2).	01700			

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01700	Continued From page 29 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During entrance conference on July 8, 2024, between 10:15 a.m., and 10:40 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee provided medication management services. R2's diagnoses included chronic obstructive pulmonary disease (COPD), cerebral vascular disease (condition that affects blood to the brain), and stroke (damage to the brain from interrupted blood flow). R2's Service Plan dated June 11, 2024, included assistance with medication administration. R2's unsigned hospice orders dated June 19, 2024, included the following medications: -Budesonide 0.5 milligrams (mg)/2 milliliters (ml) suspension for nebulizer one vial twice a day for shortness of breath; -Incurse Ellipta 62.5 micrograms (mcg) inhaler one puff into the lungs daily for shortness of breath; and -prednisone 1 mg tablet, take four tablets daily (used to treat inflammation). On July 8, 2024, at 11:37 a.m., RN-B confirmed R2's record did not include a review of all	01700			

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01700	Continued From page 30 prescribed medications for side effects, contraindications, and allergic or adverse reactions. RN-B stated R2 was a new resident, and the pharmacy normally provided a review of medications to review with the residents. On July 9, 2024, at 9:14 a.m., the surveyor observed unlicensed personnel (ULP)-E administering R2 scheduled morning medications. The licensee's Medication Management - Assessment, Monitoring and Reassessment policy dated August 1, 2024, indicated the licensee would, prior to providing medication management services, have a RN, licensed health professional, or authorized prescriber conduct an assessment to determine what medication management services would be provided and how the services would be provided. The assessment would be conducted face-to-face and would include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. In addition, the assessment must identify interventions needed in management of medications to prevent diversion. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700			
01750 SS=D	144G.71 Subd. 7 Delegation of medication administration	01750			

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01750	Continued From page 31 When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) prepared in writing specific instructions for one of one resident (R2) who received medication management 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: During entrance conference on July 8, 2024, at 10:15 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee provided medication management services. R2's diagnoses included chronic obstructive	01750			

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01750	Continued From page 32 pulmonary disease (COPD), cerebral vascular disease (condition that affects blood to the brain), and stroke (damage to the brain from interrupted blood flow). R2's Service Plan dated June 11, 2024, included assistance with medication administration. R2's Uniform Assessment Tool assessment dated June 26, 2024, indicated R2 medications were crushed and dissolved in water for administration. R2's unsigned hospice orders dated June 19, 2024, included the following medications: -Budesonide 0.5 milligrams (mg)/2 milliliters (ml) suspension for nebulizer one vial twice a day for shortness of breath; -Incurse Ellipta 62.5 micrograms (mcg) inhaler one puff into the lungs daily for shortness of breath; and -prednisone 1 mg tablet, take four tablets daily (used to treat inflammation). On July 9, 2024, at 9:14 a.m., the surveyor observed unlicensed personnel (ULP)-E crush four prednisone 1 mg tablets into a powder substance, mix into yogurt and administer to R2. R2's June and July 2024, medication administration records (MAR) indicated R2 received prednisone 1 mg four tablets daily; however, R2's MARs did not include written instructions to crush R2's medications and mix with applesauce or other substances. On July 9, 2024, at 9:44 a.m., ULP-E stated R2's MAR did not indicate to crush R2's medications and staff were directed by the nurses when R2 was admitted, to crush R2's medications.	01750			

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01750	Continued From page 33 On July 9, 2024, at 9:47 a.m., RN-B stated R2 was on hospice and had orders to crush medications. RN-B stated R2's June and July MARs did not include written instructions to crush R2's medications. The licensee's Medication Management Individualized Plan policy date August 1, 2021, indicated the licensee would develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: -documentation of specific resident instructions relating to the administration of medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750			
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan.	01760			

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01760	Continued From page 34 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure physician orders were transcribed accurately and administered as ordered for one of two residents (R3) who received medication management services by the licensee. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: R3's diagnoses included dementia, hypertension (high blood pressure), and diabetes. R3's Service Plan dated January 14, 2024, indicated R3 required assistance with medication administration. On July 9, 2024, at 10:52 a.m., the surveyor observed unlicensed personnel (ULP)-E administering R3's medications. R3's physician orders dated June 5, 2024, included athlete's foot to right fourth and fifth toes and to apply terbinafine cream (used to treat fungus) between toes twice a day. R3's June 2024, medication administration record (MAR) included Lamisil cream (used to treat fungus) twice a day until gone. R3's July 2024, MAR included terbinafine 1% cream (Lamisil);	01760			

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01760	Continued From page 35 however, was crossed out and was only administered on July 1, 2024. On July 9, 2024, at 1:41 p.m., registered nurse (RN)-B confirmed R3's antifungal cream was not transcribed on R3's July's MAR and RN-B could not find physician orders indicating R3's antifungal cream had been discontinued. RN-B stated she did not know who or why R3's antifungal cream had been crossed out on July's MAR. RN-B stated ULPs should not be making any changes to the resident's orders on the MAR. RN-B stated R3 had not been receiving antifungal cream as ordered. The licensee's Medication and Treatment Orders-Implementing policy dated August 1, 2021, indicated orders can only be implemented when in direct contact with the licensed nurse. ULP will not implement orders or changes to orders unless direct contact and instruction with the licensed nurse. The licensee's Medication and Treatment Orders policy dated August 1, 2024, indicted the residents MAR and TAR (treatment administration record) would be audited by the licensed nurse or designee for documentation compliance. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760			
01790 SS=D	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed	01790			

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01790	Continued From page 36 nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of	01790			

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01790	Continued From page 37 medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of one unlicensed personnel (ULP-E) was trained by registered nurse (RN) and had demonstrated competency to prepare and give medications for residents having unplanned time away. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-E was hired on November 23, 2012, to provide direct care services to residents of the	01790			

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01790	Continued From page 38 facility. On July 9, 2024, at 9:14 a.m., the surveyor observed ULP-E administer R2's medications. ULP-E's employee record lacked evidence to indicate she had demonstrated competency to provide medications to residents for unplanned times away from home. On July 9, 2024, at 12:48 p.m., ULP-E stated she prepared medications to be sent with residents when they went out for the day. ULP-E stated she thought she received training on how to prepare through Educare (online training program) and did not recall if she was trained by the nurse. ULP-E stated the licensee had a box with all the supplies and a written procedure to follow when preparing medications to send with the resident. On July 9, 2024, at 2:48 p.m., licensed assisted living director/clinical nurse supervisor (CNS)-A stated staff were trained on preparing medications to send with residents during medication training upon hire. LALD/RN-A reviewed ULP-E's employee record and stated he developed new training forms with unplanned time away training identified on the form and verified ULP-E's training records did not include unplanned time away. The licensee's Medication Management-Planned and Unplanned Time Away policy dated August 1, 2021, indicated the registered nurse had trained the unlicensed staff and determined the unlicensed staff was competent to follow the procedures for giving medications to residents. No further information was provided.	01790			

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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 07/12/2024
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
01790	Continued From page 39	01790			
	TIME PERIOD FOR CORRECTION: Seven (7) days				
01820 SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure current written or electronically recorded prescriptions were obtained for one of two residents (R3) who received medication management 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: R3's diagnoses included dementia, hypertension (high blood pressure), and diabetes. R3's Service Plan dated January 14, 2024, indicated R3 received assistance with medication administration.	01820			

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 07/12/2024
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
01820	Continued From page 40 On July 9, 2024, at 10:52 a.m., the surveyor observed unlicensed personnel (ULP)-E administering R3's scheduled medications. R3's June and July 2024, medication administration records (MAR) indicated R3 received exemestane 25 milligrams (mg) one table daily (used to treat breast cancer); however, R3's physician orders dated June 5, and June 6, 2024, did not include and an order for exemestane 25 mg one table daily. On July 9, 2024, at 1:43 p.m., registered nurse (RN)-B confirmed R3's physician orders dated June 5, and June 6, 2024, did not include an order for exemestane 25 mg daily. RN-B stated R3 would have had to have a physician order at some time for exemestane medication for the pharmacy to supply the medication. RN-B stated she would call the pharmacy to obtain a copy of the order. The licensee's Medication and Treatment Orders policy dated August 1, 2024, indicated the RN was responsible for assuring current, authorized prescriber orders for medications or treatments administered by the staff were kept on file in the residents' records. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820			
01950 SS=D	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or	01950			

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 07/12/2024
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
01950	Continued From page 41 other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure instructions, specified in writing for each resident, and documented those instructions in the resident's record for one of one resident (R3) who had treatments managed by the facility. 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: R3's diagnoses included dementia, hypertension	01950			

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 07/12/2024
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
01950	Continued From page 42 (high blood pressure), and diabetes. R3's Service Plan dated January 14, 2024, included weekly blood glucose monitoring. R3's June and July medication administration records (MAR) indicated R3 received blood glucose monitoring every Sunday. R3's record did not include blood glucose parameters of when to notify the nurse. On July 9, 2024, at 1:06 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated written instructions for R3's blood glucose parameters should be in R3's binder. LALD/CNS-A reviewed R3's record and stated there were no written blood glucose parameters on R3's MAR or record of when to notify the nurse. The licensee's Medication and Treatment-Administration and Delegation policy dated August 1, 2024, indicated prior to a ULP providing delegated medication administration and/or treatments/therapy, the RN must specify, in writing, specific instructions for each resident and document those instructions in the resident's record. The licensee's Treatment and Therapy Management Plan policy dated August 1, 2021, indicated the licensee would develop and maintain a current individualized and therapy management record for each resident which must contain at least the following: -procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatment or therapy services.	01950			

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 07/12/2024
NAME OF PROVIDER OR SUPPLIER BARNES CARE INC		STREET ADDRESS, CITY, STATE, ZIP CODE 58 WEST HIGHWAY 61 ESKO, MN 55733			
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01950	Continued From page 43 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01950			



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

Type: Full
Date: 07/08/24
Time: 10:30:00
Report: 1027241076

Food and Beverage Establishment Inspection Report

Page 1

Location:

Barnes Care Inc
58 West Highway 61
Esko, MN55733
Carlton County, 09

Establishment Info:

ID #: 0037894
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 2188792635
ID #:

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

The following orders were issued during this inspection.

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

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

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

RAW EGGS WERE STORED OVER READY TO EAT FOODS IN UPRIGHT COOLER. STAFF MOVED EGGS TO A LOWER SHELF. COS

Corrected on Site

3-500B Microbial Control: hot and cold holding

3-501.16A2 ** Priority 1 **

MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.

BUTTER WAS BEING STORED OUTSIDE OF REFRIGERATION. STAFF MOVED BUTTER TO REFRIGERATION. COS.

Corrected on Site

4-300 Equipment Numbers and Capacities

4-302.13B ** Priority 2 **

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

PROVIDE THERMOLABELS OR A MIN/MAX THERMOMETER FOR MEASURING HOT WATER TEMPERATURE IN DISH MACHINE.

Comply By: 07/22/24

Type: Full
Date: 07/08/24
Time: 10:30:00
Report: 1027241076
Barnes Care Inc

Food and Beverage Establishment Inspection Report

Page 2

2-100 Supervision

2-102.12AMN

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

AT TIME OF INSPECTION OWNER HAD TAKEN A SERVE-SAFE COURSE, BUT HAD NOT APPLIED FOR A FOOD PROTECTION MANAGER CERTIFICATION.

Comply By: 09/09/24

Surface and Equipment Sanitizers

Hot Water: = at >160F Degrees Fahrenheit

Location:

Violation Issued: No

Food and Equipment Temperatures

Process/Item: Upright Cooler

Temperature: 40 Degrees Fahrenheit - Location: HOT DOG

Violation Issued: No

Process/Item: Upright Cooler

Temperature: 39 Degrees Fahrenheit - Location: SLICED CHEESE

Violation Issued: No

Process/Item: Upright Freezer

Temperature: Degrees Fahrenheit - Location: ALL FOODS FROZEN

Violation Issued: No

Process/Item: Upright Freezer

Temperature: Degrees Fahrenheit - Location: ALL FOODS FROZEN

Violation Issued: No

Process/Item: Upright Freezer

Temperature: Degrees Fahrenheit - Location: ALL FOODS FROZEN

Violation Issued: No

Process/Item: Hot Holding

Temperature: 187 Degrees Fahrenheit - Location: BEEF TIPS

Violation Issued: No

Process/Item: Upright Cooler

Temperature: 41 Degrees Fahrenheit - Location: TACO SALAD

Violation Issued: No

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

DISCUSSED EMPLOYEE ILLNESS AND EXCLUSIONS, REQUIRED SANITIZER STRENGTHS, AND FOOD REQUIREMENTS FOR SERVING TO A HIGHLY SUSCEPTIBLE POPULATION. DISCUSSED AVOIDING BARE HAND CONTACT WITH READY TO EAT FOODS.

RECENT SHIPMENT OF FOOD RECEIVED INCLUDED UNPASTEURIZED EGGS. DISCUSSED WITH OWNER THAT UNPASTEURIZED EGGS CANNOT BE POOLED AND USED IN FOODS

Type: Full
Date: 07/08/24
Time: 10:30:00
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Barnes Care Inc

Food and Beverage Establishment Inspection Report

Page 3

SUCH AS EGG BAKE. OWNER STATED UNPASTEURIZED EGGS WOULD NOT BE POOLED IN MEALS AND ONLY COOKED INDIVIDUALLY FOR OMELETTES OR SCRAMBLED EGGS.

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 1027241076 of 07/08/24.

Certified Food Protection Manager: SEE ORDERS

Certification Number: _____ Expires: ____ / ____ / ____

Inspection report reviewed with person in charge and emailed.

Signed: _____

JUSTIN BARNES
OWNER

Signed: Ian Harrison

Ian H

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

Report #: 1027241076

m

DEPARTMENT OF HEALTH

MN Department of Health

Food, Pools, & Lodging Services

P.O. Box 64975

Saint Paul, MN 55164-0975

No. of RF/PHI Categories Out

3

No. of Repeat RF/PHI Categories Out

0

Legal Authority MN Rules Chapter 4626

Date

07/08/24

Time In

10:30:00

Time Out

Barnes Care Inc

Address

58 West Highway 61

City/State

Esko, MN

Zip Code

55733

Telephone

2188792635

License/Permit #

0037894

Permit Holder

Purpose of Inspection

Full

Est Type

Risk Category

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item

Mark "X" in appropriate box for COS and/or R

IN=in complianceOUT= not in complianceN/O= not observedN/A= not applicableCOS=corrected on-site during inspectionR= repeat violation

Compliance Status

COS

R

Supervision

1

IN

OUT

PIC knowledgeable; duties & oversight

2

IN

OUT

N/A

Certified food protection manager, duties

Employee Health

3

IN

OUT

Mgmt/Staff;knowledge,responsibilities&reporting

4

IN

OUT

Proper use of reporting, restriction & exclusion

5

IN

OUT

Procedures for responding to vomiting & diarrheal events

Good Hygienic Practices

6

IN

OUT

N/O

Proper eating, tasting, drinking, or tobacco use

7

IN

OUT

N/O

No discharge from eyes, nose, & mouth

Preventing Contamination by Hands

8

IN

OUT

N/O

Hands clean & properly washed

9

IN

OUT

N/A

N/O

No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed

10

IN

OUT

Adequate handwashing sinks supplied/accessible

Approved Source

11

IN

OUT

Food obtained from approved source

12

IN

OUT

N/A

N/O

Food received at proper temperature

13

IN

OUT

Food in good condition, safe, & unadulterated

14

IN

OUT

N/A

N/O

Required records available; shellstock tags, parasite destruction

Protection from Contamination

15

IN

OUT

N/A

N/O

Food separated and protected

X

16

IN

OUT

N/A

Food contact surfaces: cleaned & sanitized

17

IN

OUT

Proper disposition of returned, previously served, reconditioned, & unsafe food

Compliance Status

COS

R

Time/Temperature Control for Safety

18

IN

OUT

N/A

N/O

Proper cooking time & temperature

19

IN

OUT

N/A

N/O

Proper reheating procedures for hot holding

20

IN

OUT

N/A

N/O

Proper cooling time & temperature

21

IN

OUT

N/A

N/O

Proper hot holding temperatures

22

IN

OUT

N/A

Proper cold holding temperatures

X

23

IN

OUT

N/A

N/O

Proper date marking & disposition

24

IN

OUT

N/A

N/O

Time as a public health control: procedures & records

Consumer Advisory

25

IN

OUT

N/A

Consumer advisory provided for raw/undercooked food

Highly Susceptible Populations

26

IN

OUT

N/A

Pasteurized foods used; prohibited foods not offered

Food and Color Additives and Toxic Substances

27

IN

OUT

N/A

Food additives: approved & properly used

28

IN

OUT

Toxic substances properly identified, stored, & used

Conformance with Approved Procedures

29

IN

OUT

N/A

Compliance with variance/specialized process/HACCP

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

GOOD RETAIL PRACTICES

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

Mark "X" in box if numbered item is not in complianceMark "X" in appropriate box for COS and/or RCOS=corrected on-site during inspectionR= repeat violation

COS

R

Safe Food and Water

30

IN

OUT

N/A

Pasteurized eggs used where required

31

Water & ice obtained from an approved source

32

IN

OUT

N/A

Variance obtained for specialized processing methods

Food Temperature Control

33

Proper cooling methods used; adequate equipment for temperature control

34

IN

OUT

N/A

N/O

Plant food properly cooked for hot holding

35

IN

OUT

N/A

N/O

Approved thawing methods used

36

Thermometers provided & accurate

Food Identification

37

Food properly labled; original container

Prevention of Food Contamination

38

Insects, rodents, & animals not present

39

Contamination prevented during food prep, storage & display

40

Personal cleanliness

41

Wiping cloths: properly used & stored

42

Washing fruits & vegetables

COS

R

Proper Use of Utensils

43

In-use utensils: properly stored

44

Utensils, equipment & linens: properly stored, dried, & handled

45

Single-use/single service articles: properly stored & used

46

Gloves used properly

Utensil Equipment and Vending

47

Food & non-food contact surfaces cleanable, properly designed, constructed, & used

48

X

Warewashing facilities: installed, maintained, & used; test strips

49

Non-food contact surfaces clean

Physical Facilities

50

Hot & cold water available; adequate pressure

51

Plumbing installed; proper backflow devices

52

Sewage & waste water properly disposed

53

Toilet facilities: properly constructed, supplied, & cleaned

54

Garbage & refuse properly disposed; facilities maintained

55

Physical facilities installed, maintained, & clean

56

Adequate ventilation & lighting; designated areas used

57

Compliance with MCIAA

58

Compliance with licensing & plan review

Food Recalls:

Person in Charge (Signature)

Date: 07/11/24

Inspector (Signature)

clan Harrison