Electronically Delivered

December 31, 2024

Licensee
Barrett Assisted Living Community Inc
800 Spruce Avenue
Barrett, MN 56311

RE: Project Number(s) SL20428016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on November 20, 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.

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

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

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

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

The correction order documentation should include the following:

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

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

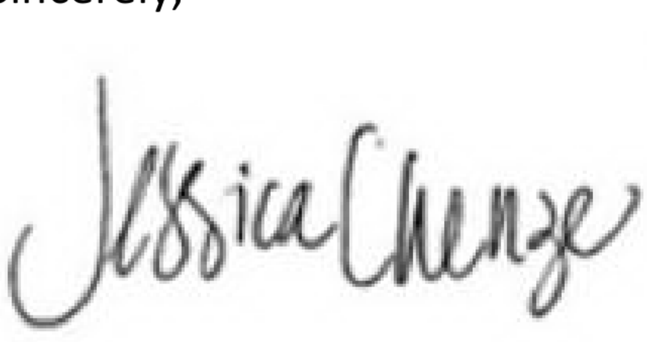
To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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

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

If you have any questions, please contact me.

Sincerely,



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

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20428	A. BUILDING: _____ B. WING _____	11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BARRETT ASSISTED LIVING COMMUNITY 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 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: SL20428016-0 On November 18, 2024, through November 20, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 18 residents; 18 receiving services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 340 SS=F	144G.30 Subd. 5 Correction orders (a) A correction order may be issued whenever	0 340		

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0 340	Continued From page 1 the commissioner finds upon survey or during a complaint investigation that a facility, a managerial official, an agent of the facility, or staff of the facility is not in compliance with this chapter. The correction order shall cite the specific statute and document areas of noncompliance and the time allowed for correction. (b) The commissioner shall mail or email copies of any correction order to the facility within 30 calendar days after the survey exit date. A copy of each correction order and copies of any documentation supplied to the commissioner shall be kept on file by the facility and public documents shall be made available for viewing by any person upon request. Copies may be kept electronically. (c) By the correction order date, the facility must: (1) document in the facility's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have sufficient documentation with actions taken to comply with the correction order tag identification 810, for a routine survey completed on February 24, 2022. 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	0 340		

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0 340	Continued From page 2 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 a routine survey on November 19, 2024, at 1:47 p.m., the engineering surveyor reviewed the licensee's Fire Safety and Evacuation Plan (FSEP). The licensee lacked evidence to indicate the FSEP was updated and corrected to meet the specific layout of the facility and provide actions for employees to take in the event of a fire or similar emergency. The licensee was unable to provide documentation from the previous survey ending February 22, 2024, that the FSEP had been updated to meet requirements. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 340		
0 650 SS=F	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (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	0 650		

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0 650	Continued From page 3 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 annual training content for two of two employees (licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A, unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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: LALD/CNS-A LALD/CNS-A was hired on January 2, 2019, and began providing assisted living services on August 1, 2021, to the licensee's residents. ULP-C ULP-C was hired on October 14, 2013, and began providing assisted living services on	0 650		

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0 650	Continued From page 4 August 1, 2021, to the licensee's residents. On October 19, 2024, at 8:05 a.m., the surveyor observed ULP-C administer R2's scheduled morning medications. LALD/CNS-A and ULP-C's employee records included an annual training document dated October 1, 2024, however the document lacked principles of person-centered planning/service delivery as part of the training. On October 19, 2024, at 3:10 p.m., LALD/CNS-A confirmed principles of person-centered care planning/service delivery was not on the annual in service training document dated October 1, 2024, however, stated person-centered care was part of the training. LALD/CNS-A stated the form was used for all staff that attended the in-service training, and the annual training form had not been updated. The licensee's 5.06 Annual Required Staff Training dated August 1, 2021, indicated the following training elements must be included every 12 months to all staff who performs direct care services: -principles of person-centered planning and service delivery and how they apply direct support services provided by the staff person. The licensee's 4.05 Employee Record policy dated August 1, 2021, indicated employee records for each person will include: -records for all training and in-service education required and/or provided including record of competence testing as required. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0190, Subp. 6, effective October	0 650		

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0 650	Continued From page 5 2022, the licensee must maintain a record of staff training and competency required under this part and Minnesota Statutes, chapter 144G, that documents the following information for each competency evaluation, training, retraining, and orientation topic: (1) facility name, location, and license number; (2) name of the training topic or training program, and the training methodology, such as classroom style, web-based training, video, or one-to-one training; (3) date of the training and competency evaluation, and the total amount of time of the training and competency evaluation; (4) name and title of the instructor and the instructor's signature, and the name and title of the competency evaluator, if different from the instructor, and the evaluator's signature with a statement attesting that the employee successfully completed the training and competency evaluation; and (5) name and title of the staff person completing the training, and the staff person's signature with statement attesting that the staff person successfully completed the training as described in the training documentation. 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 (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses	0 680		

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0 680	Continued From page 6 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 ensure the Emergency Preparedness Plan (EPP) was reviewed annually and the missing resident policy was reviewed quarterly. This had the potential to affect all residents, staff, and any visitors of 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) 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).	0 680		

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0 680	Continued From page 7 The findings include: The licensee's EPP was dated August 1, 2021, and lacked documentation the EPP was reviewed annually. The licensee's Missing Resident policy dated August 1, 2021, lacked documentation the policy was reviewed quarterly. On October 20, 2024, at 11:39 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated she has updated some information in the EPP but has not signed it off as reviewed. Additionally, LALD/CNS-A stated the missing resident policy had been reviewed twice a year, not quarterly. The licensee's 9.01 Emergency Preparedness Plan - Appendix Z Compliance policy dated August 1, 2021, indicated [facility] emergency preparedness plan will include all required elements of appendix Z. The plan will be in writing and reviewed annually. The licensee's 2.28 Missing Resident Policy dated August 1, 2021, indicated the [facility] will review this policy and any individual resident plans that pertain to elopement at least quarterly, and all changes will be documented. 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.	0 680		

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0 680	Continued From page 8 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill.	0 810		

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0 810	Continued From page 9 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training and drills. 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) 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 November 19, 2024, at 1:47 p.m., maintenance (M)-D and licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: The FSEP (fire safety and evacuation plan) included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate) was very basic. The provided FSEP was from a third-party provider and had not been updated to meet the specific layout of this facility	0 810		

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0 810	Continued From page 10 and provide complete actions for employees to take in the event of a fire or similar emergency. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and	01060		

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01060	Continued From page 11 designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to notify the Office of Ombudsman for Long-Term Care (OOLTC) of a resident emergency relocation within four days for one of one resident (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) 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: R3's diagnoses included hypertension (high blood pressure), hyperlipidemia (high cholesterol) and paroxysmal atrial fibrillation (irregular heartbeat). R3's service plan dated September 7, 2021, indicated R3 received assistance with medication administration, assistance with bathing and compression socks, monthly blood draw, safety	01060		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01060	Continued From page 12 checks, housekeeping, and laundry. R3's record lacked an emergency location with the required content to the OOLTC that the resident had been relocated and had not returned to the facility within four days. R3's progress notes indicated the following: -October 3, 2024, at 9:38 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A noted R3 has left hip fracture, displaced of femoral head. Surgery planned today at [hospital]. Will need short stay for physical therapy (PT)/occupational therapy (OT). [Skilled nursing home] has a room on reserve. On November 18, 2023, at 3:12 p.m., LALD/CNS-A stated she did not notify OOLTC of R3's emergency relocation, and never does with hospitalizations. LALD/CNS-A stated she thought an emergency relocation was not needed as it was an injury or illness. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01950 SS=F	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment	01950		

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	20428	A. BUILDING: _____ B. WING _____	11/20/2024

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01950	Continued From page 13 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 the registered nurse (RN) specified in writing, specific resident instructions in the resident record for unlicensed personnel (ULP) performing a treatment for two of two residents (R1, R2) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on October 18, 2024, at 9:00 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A confirmed the licensee provided treatment and therapy services.	01950		

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01950	Continued From page 14 R1 R1's diagnoses included diabetes, hyperlipidemia (high cholesterol) and hypertensive heart disease (long term uncontrolled high blood pressure). R1's signed service plan dated November 22, 2021, indicated R1 required assistance with medication administration, including blood glucose checks four times a day with sliding scale. R1's November 2024 electronic medication administration record (EMAR) indicated resident received sliding scale and blood glucose checks as follows: -Humalog Kwik pen subcutaneous solution pen-injector 100 units/milliliter (ml). Inject as per sliding scale: If 160-300 give 8 units, hold if below 160; give if 160; 301-400 call RN for instructions, subcutaneously three times a day for type 2 diabetes. R1's prescriber orders, dated October 31, 2024, indicated the following: -Humalog Kwik pen subcutaneous solution pen-injector 100 units/ml. Inject as per sliding scale: If 160-300 give 8 units, hold if below 160; give if 160; 301-400 call RN for instructions, subcutaneously three times a day for type 2 diabetes. Hold if blood glucose is less than 160. On November 19, 2024, at 11:04 a.m., the surveyor observed ULP-C assist with obtaining blood glucose and sliding scale insulin. ULP-C stated if it were low, around 70 she would call the nurse. R1's record lacked specific written instructions to include parameters for blood glucose and when to notify the RN.	01950		

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01950	Continued From page 15 R2 R2's diagnoses included hyperlipidemia, hypertension (high blood pressure), and Parkinson's disease (brain disorder). R2's signed service plan dated April 22, 2024, indicated resident received assistance with compression stockings application daily. R2's November 2024 treatment administration record (TAR) indicated resident received the following treatment: -compression socks bilateral lower extremities for edema and remove at night (HS). R2's prescriber orders dated November 9, 2024, indicated the following: -to continue wearing compression stockings during the day. On November 19, 2024, at 8:04 a.m., the surveyor observed ULP-C administer R2's morning medications. On October 19, 2024, at 8:09 a.m., ULP-C stated night shift applied R2's compression stockings. The surveyor observed R2 wearing compression stockings. R2's record lacked written specific instructions for the use of R2's compression stockings. On October 20, 2024, at 10:25 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated she does not put specific instructions on the TAR unless it is prescriber ordered. Additionally, LALD/CNS-A indicated staff were trained on competencies when to call the nurse in regard to blood sugars and	01950		

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01950	Continued From page 16 compression stockings. The licensee's 7.15 Medications & Treatment - Administration and Delegation policy dated August 1, 2021, indicated when administration of medications or treatment/therapy is delegated or assigned to unlicensed personnel, [facility] will ensure that the registered nurse has specified, in writing, specific instructions for each resident and documented those instructions in the resident's record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		
02310 SS=D	144G.91 Subd. 4 (a) 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 provide care and services according to acceptable health care, medical or nursing standards for one of one resident (R2) who utilized consumer bed rails. 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	02310		

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02310	Continued From page 17 was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On November 19, 2024, at 8:09 a.m., the surveyor observed unsecured bilateral consumer bed rails on R2's bed. The surveyor and unlicensed personnel (ULP)-C observed the unsecured consumer bed rails which could be easily moved out six inches from between the mattress and box spring on both sides. R2 stated the bed rails help her get in and out of bed and help her reposition in bed, she brought the bed rails with her when she moved in. R2 R2's diagnoses included dated hyperlipidemia (high cholesterol), hypertension (high blood pressure), and Parkinson's disease (brain disorder). R2's bed rail assessment dated April 22, 2024, indicated R2 used the consumer bed rail on recommendation from physical therapy to assist with repositioning in bed and to get in and out of bed. R2's Consent for Assisted Devices to Bed signed and dated April 22, 2024, indicated benefits versus risks of half side rails or grab bars have been explained to resident and a Guide to Bed Safety pamphlet was received. In addition, the resident gave permission and agrees to the use of half-length side rails or grab bars. R2's Individual Abuse Prevention Plan (IAPP) dated April 22, 2024, indicated resident has grab	02310		

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02310	Continued From page 18 bars. In addition, the IAPP indicated the side rail/bed positioning device assessment is in place, and the resident will experience improved ability with bed mobility and positioning. R2's consumer bed rail was not securely attached to the bed causing risk of entrapment. On October 19, 2024, at 2:30 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated she understands the concerns of not having the consumer bed rail secure and how it moves out from the bed and resident could potentially fall into it and get stuck between the mattress and the bed rail. On October 20, 2024, at 12:12 p.m., LALD/CNS-A stated she spoke with R2 and R2 wanted to keep the consumer bed rails but would be willing to replace if needed. 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 Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently Asked Questions (FAQs), last updated December 26, 2023, indicated, "Unlike hospital beds, there is no current published guidance related to	02310		

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02310	Continued From page 19 portable bed rails used on non-hospital style beds ("consumer beds"), so licensees should refer to individual manufacturer's guidelines for appropriate installation, maintenance, and use. In addition, licensees should refer to the Consumer Product Safety Commission (CSPC) for the most up-to-date information related to portable bed side rail recall information. To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint. Additionally, the licensee must ensure the bed rail is securely attached to the bed frame per manufacturer guidelines. This includes consideration of any identified contradictions of use such as height/weight restrictions, age, mattress, bed frame set up, etc." Also included, "Documentation about a resident's bed rails includes, but is not limited to: - purpose and intention of the bed rail; - condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; - the resident's bed rail use/need assessment; - risk vs. benefits discussion (individualized to each resident's risks); - the resident's preferences; - installation and use according to manufacturer's guidelines; - physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and	02310		

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02310	Continued From page 20 - any necessary information related to interventions to mitigate safety risk or negotiated risk agreements." The licensee's 6.28 Side Rail policy dated August 1, 2021, indicated verify the side rails are safe. Staff from [facility] will determine if the side rails is considered to be safe. "Safe" shall be defined as meeting all the requirements. The side rail is used consistent with the manufacturer directions. Be aware of side rails that slide between the mattress and box spring designed for toddler use. The side rails are installed securely and maintained in good operating condition. Be aware of "wobbly" side rails. 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: *11/18/24*
Time: 16:02:46
Report: 7935241096

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.

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Quaternary Ammonia: = 200 ppm at Degrees Fahrenheit
Location: Spray Bottle
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 40 Degrees Fahrenheit - Location: Cooler
Violation Issued: No

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

Type: Full
Date: *11/18/24*
Time: 16:02:46
Report: 7935241096
Barrett Assisted Living Inc

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the MN Department of Health inspection report number 7935241096 of 11/18/24.

Certified Food Protection Manager: NA

Certification Number: NA Expires: / /

Signed: _____
Establishment Representative

Signed: _____
Rebecca Tonneson
Public Health San Supervisor
Fergus Falls District Office
218-332-5142
rebecca.tonneson@state.mn.us