



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

March 26, 2024

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

RE: Project Number(s) SL26579015

Dear Licensee:

On March 19, 2024, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on March 19, 2024. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the March 19, 2024 survey.

The Department of Health 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.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on January 5, 2024, found not corrected at the time of the March 19, 2024, follow-up survey and/or subject to penalty assessment are as follows:

- 0650-Employee Records-144g.42 Subd. 8**
- 1060-Emergency Relocation-144g.52 Subd. 9**
- 1650-Service Plan, Implementation And Revisions To-144g.70 Subd. 4 (f)**
- 1880-Storage Of Medications-144g.71 Subd. 19**
- 2310-Appropriate Care And Services-144g.91 Subd. 4 (a)**

The details of the violations noted at the time of this follow-up survey completed on March 19, 2024 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

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.

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.

A state correction order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

To submit a reconsideration request, please visit:

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

We urge you to review these orders carefully. If you have questions, please contact Jessie Chenze at 218-332-5175.

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

Sincerely,

A handwritten signature in cursive script that reads "Jessica 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: 26579	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 03/19/2024
NAME OF PROVIDER OR SUPPLIER BARNES CARE INC		STREET ADDRESS, CITY, STATE, ZIP CODE 56 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 In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been 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: SL26579015-1 On March 18, 2024, through March 19, 2024, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on January 5, 2024. At the time of the survey, there were nine residents; nine residents receiving services under the Assisted Living license. As a result of the revisit, the following orders were reissued.	{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 License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.		
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	{0 480}			

Minnesota Department of Health

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

TITLE

(X6) DATE

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{0 480}	Continued From page 1 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: No further action required	{0 480}			
{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	{0 650}			

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{0 650}	Continued From page 2 review, the licensee failed to ensure employee records contained the required content for one of two employees (unlicensed personnel (ULP)-G). 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-G had a start date of September 15, 2023, to provide direct care services to the licensee's residents. On March 18, 2024, at 1:20 p.m., the surveyor observed ULP-G assisting residents with lunch and ULP-G monitoring R6's blood pressure. ULP-G's employee record included the required training transcripts; however, lacked evidence ULP-G received the following competencies: -appropriate and safe techniques in personal hygiene and grooming, including: -hair care and bathing; -care of teeth and gums, and oral prosthetic devices; -care and use of hearing aids; and -dressing and assisting with toileting. On March 18, 2024, at 3:01 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated he completed activities of daily living (ADLs) competencies with all staff; however, does not document competencies in the	{0 650}			

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{0 650}	Continued From page 3 required areas noted above. LALD/CNS-A stated he currently used competency evaluations provided through Educare (online training program) which did not include competencies for bathing, dressing, grooming, toileting or oral care. The licensee's Employee Record policy dated August 1, 2021, indicated employee records for each person would include records of all training and in-service education required and/or provided including record of competency testing as required. The licensee's Orientation and Training policy date August 1, 2021, indicated prior to delegation of services the registered nurse or licensed health professional must make certain the unlicensed personnel were trained in proper methods to perform the tasks or procedures for each client and are able to demonstrate the ability to competently follow the procedures and perform the tasks. Training and competency evaluations for all ULPs would include: -appropriate and safe techniques in personal hygiene and grooming, including hair care and bathing, care of teeth, gums, and oral prosthetic devices, care and use of hearing aids, dressing and assisting with toileting. The licensee's Training Records policy dated August 1, 2021, indicated the licensee would maintain a record of staff training and competency required. The licensee would document the following information for each competency evaluation, training, retraining, and orientation topics. No further information was provided.	{0 650}			

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{0 780}	Continued From page 4	{0 780}			
{0 780} SS=D	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: No further action required.	{0 780}			
{0 790} SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code;	{0 790}			

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{0 790}	Continued From page 5	{0 790}			
	(3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: No further action required.				
{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: No further action required.	{0 800}			
{0 810} SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms;	{0 810}			

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{0 810}	Continued From page 6 (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: No further action required.	{0 810}			
{01060} SS=D	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	{01060}			

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{01060}	Continued From page 7 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 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	{01060}			

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{01060}	Continued From page 8 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide written notice with required content to the resident, legal representative, and designated representative for one of one resident (R1) reviewed for a hospitalization. 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 March 18, 2024, at 10:04 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A and registered nurse (RN)-B stated R1 was hospitalized and had not returned to the facility. RN-B stated an email was sent to the Office of Ombudsman for Long-Term Care (OOLTC) to inform of R1's hospitalization longer than four days. R1's diagnoses included type 2 diabetes, congestive heart failure, cellulitis, chronic kidney disease. R1's Service Plan dated July 10, 2023, indicated R1 required assistance with dressing, bathing, wound care, medication management, housekeeping, and laundry.	{01060}			

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{01060}	Continued From page 9 R1's Progress Notes dated February 20, 2024, indicated R1 was transported to the emergency room for complaints of left arm and chest pain. R1's Progress Note dated February 23, 2024, indicated RN-B sent notification to the OOLTC via email of R1's hospitalization and R1's return date was unknown. R1's record did not include a written notice that contained, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for the OOLTC and the Office of Ombudsman for Mental Health and Developmental Disabilities; - 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 - 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. On January 2, 2024, at 12:17 a.m., registered nurse (RN)-B stated a written notice of emergency relocation with the above noted content had not been provided to the resident and/or resident's representative. The licensee's Emergency Relocation policy dated August 1, 2021, indicated in the event of an emergency relocation, the licensee would provide a written notice that contains, at a minimum: the reason for the relocation; the name and contact	{01060}			

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{01060}	Continued From page 10 information for the location to which the resident has been relocated and any new service provider; and contact information for the OOLTC. No further information was provided.	{01060}			
{01650} SS=D	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced	{01650}			

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{01650}	Continued From page 11 by: Based on interview and record review, the licensee failed to ensure the service plan included the required content for one of two residents (R7). 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: R7's diagnoses included diabetes type II and dementia. R7's physician orders dated August 5, 2023, included blood glucose monitoring Monday, Wednesday, and Friday. R7's March 2024, Medication Administration Record indicated R1 received blood glucose monitoring Monday, Wednesday, and Fridays. R7's Service Plan dated July 26, 2023, respectively, lacked the following required content: -a description of the services to be provided to include blood glucose monitoring. On March 19, 2024, at 11:55 a.m., registered nurse (RN)-B verified R7's service plan did not list blood glucose monitoring and was recently added after surveyor reviewed resident record. The licensee's Service Plan policy dated August	{01650}			

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{01650}	Continued From page 12 1, 2021, indicated the service plan would include: -a description of the services to be provided, the fees for services, and the frequency of each service to be provided based on the most recent assessment and resident preferences. No further information was provided.	{01650}			
{01880} SS=E	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to date time-sensitive medications with opened or expiration dates for R3, R6. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On March 19, 2024, at 9:31 a.m., the surveyor observed the medication storage room with registered nurse (RN)-B. RN-B confirmed the	{01880}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 26579	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 03/19/2024
NAME OF PROVIDER OR SUPPLIER BARNES CARE INC		STREET ADDRESS, CITY, STATE, ZIP CODE 56 WEST HIGHWAY 61 ESKO, MN 55733			
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{01880}	Continued From page 13 following: -R3's Nasonex nasal spray (used to treat allergy symptoms) lacked the date the nasal spray had been opened and when the nasal spray and inhaler would expire. -R6's Azelastine 0.05% eye drop (used to treat itching of the eye) lacked the date the eye drop had been opened and when the eye drop would expire. During the medication storage room observation, RN-B stated staff were to date when medications were opened to include eye drops, inhalers, nasal sprays, and insulin. The manufacturer's instructions for Nasonex dated November 2022, indicated Nasonex should be used within two months after opened. The manufacturer's instructions for Azelastine mg eye drop dated September 2018, indicated once Azelastine was opened, do not use if the bottle had been open longer than 28 days. The licensee's Medications Storage policy dated August 1, 2021, indicated medication would be stored consistent with the manufacturer's recommendations. No further information was provided.	{01880}			
{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.	{02310}			

Minnesota Department of Health

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{02310}	Continued From page 14 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 (R5) who utilized a consumer transfer pole. 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 March 18, 2024, at 10:04 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A and registered nurse (RN)-A, LALD/CNS-A stated there no residents using consumer bed rails. LALD/CNS-A stated R5 had a transfer pole installed which was attached to the floor and ceiling. LALD/CNS-A stated a comprehensive assessment had not been completed for R5's transfer pole because it was not a consumer bed rail and the transfer pole was not attached to R5's bed. On March 19, 2024, at 11:40 a.m., the surveyor observed in R5's room a white pole with a pivoting handle in the middle, securely attached to the ceiling and floor. R5 stated he used the transfer pole to assist getting in and out of bed.	{02310}			

Minnesota Department of Health

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{02310}	Continued From page 15 R5's diagnoses included Parkinson's disease and blindness in the left eye. R5's Resident Care Plan dated August 31, 2023, indicated R5 required assistance with transfers. R5's resident record included a signed risk verses benefits dated January 5, 2024, by R5 on the use of the transfer pole and possible risk of entrapment. R5's Progress Note dated January 15, 2024, indicated R5's transfer pole was installed per manufacturer directions, was in good working order, and was not on listed on the Consumer Product Safety Commission (CSPC) website for recalls. R5's resident record respectfully lacked a comprehensive assessment on the use of an assisted device as required in the uniform assessment tool. On March 19, 2024, at 11:55 a.m., LALD/CNS-A confirmed R5's record lacked a comprehensive assessment for the use of an assisted devices. The licensee's Assessments, Reviews and Monitoring policy dated August 1, 2021, indicated the initial assessment or reassessment must include all the elements of the uniform assessment tool as required as specified in Rule. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0140, Subp. 2. Nursing Assessment. A. A nursing assessment or reassessment under Minnesota Statutes, section 144G.70, subdivision 2, paragraphs (b) must be conducted on a	{02310}			

Minnesota Department of Health

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{02310}	Continued From page 16 prospective resident or resident receiving any of the assisted living services identified in Minnesota Statutes, section 144G.08, subdivision 9, clauses (6) to (12). B. The nursing assessment or reassessment under item A must: (1) address part 4659.0150, subpart 2, items A to N: (B) activities of daily living including: mobility, including ambulation, transfers, and assistive devices. No further information provided.	{02310}			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

January 26, 2024

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

RE: Project Number(s) SL26579015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on January 5, 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 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services = \$3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$3,000.00**. 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

Barnes Care, Inc.

January 26, 2024

Page 3

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.

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

If you have any questions, please contact me.

Sincerely,

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

Jessie Chenze, Supervisor

State Evaluation Team

Email: jessie.chenze@state.mn.us

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

PMB

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 26579	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/05/2024
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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: SL26579015 On January 2, 2024, through January 5, 2024, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 9 residents receiving services under the Assisted Care license. An immediate correction order was identified on January 3, 2024, issued for SL26579015, tag identification 2310. On January 3, 2024, the immediacy of correction order 2310 was removed, however noncompliance remained 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 License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.		
0 110 SS=C	144G.10 Subdivision 1a Assisted living director license required Each assisted living facility must employ an	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 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 December 2023, at 9:36 a.m., the evaluator 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. During entrance conference on January 2, 2024, at 10:03 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 as the Director of Record.	0 110			

Minnesota Department of Health

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0 110	Continued From page 2 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 the residents). The findings include:	0 480			

Minnesota Department of Health

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0 480	Continued From page 3 Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated January 3, 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			
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to engage in and maintain documentation of quality management activities appropriate to the size of the facility and relevant to the type of services provided.. This had the potential to affect all residents receiving assisted living services. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 580			

Minnesota Department of Health

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0 580	Continued From page 4 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On January 4, 2024, at 2:41 p.m., physical plant manager (PPM)-C stated they meet at least quarterly but did not document quality management activities and was unaware of the requirement. The licensee's Quality Management Project policy dated August 1, 2021, indicated the licensee would have at least one documented quality management project in place at all times and retain records of such projects for at least two years. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 580			
0 650 SS=E	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;	0 650			

Minnesota Department of Health

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0 650	Continued From page 5 (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 two of three employees (unlicensed personnel (ULP)-D, licensed assisted living director (LALD)-A). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: ULP-D ULP-D had a start date of February 3, 2023, to provide direct care services to the licensee's	0 650			

Minnesota Department of Health

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0 650	Continued From page 6 residents. On January 2, 2024, at 12:06 p.m., the surveyor observed ULP-D administering R5's scheduled afternoon medications. ULP-D's employee record lacked evidence ULP-D had received the following competencies: -appropriate and safe techniques in personal hygiene and grooming, including: -hair care and bathing; -care of teeth and gums, and oral prosthetic devices; -care and use of hearing aids; and -dressing and assisting with toileting. On January 4, 2024, at 1:58 p.m., LALD-A stated activities of daily living skills noted above were a part of the new employee training and competency evaluations for ULPs. LALD-A stated he completed ULP-D's competency evaluations noted above and was unsure why documentation was not in ULP-D's record. On January 4, 2024, at 2:33 p.m., ULP-D stated LALD-A completed all ULP-D's competency evaluations including personal hygiene, grooming, oral care, dressing, grooming and hearing aids. LALD-A LALD-A had a start date of August 11, 2011, to provide direct supervision to the licensee's residents. LALD-A's employee record contained a Job Description and Performance Appraisal dated August 1, 2022. LALD-A's record lacked evidence an annual performance review was completed for 2023.	0 650			

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NAME OF PROVIDER OR SUPPLIER BARNES CARE INC		STREET ADDRESS, CITY, STATE, ZIP CODE 56 WEST HIGHWAY 61 ESKO, MN 55733			
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0 650	Continued From page 7 On January 4, 2024, at 3:41 p.m., LALD-A stated he did not have job performance review completed for 2023 and was unaware his position as LALD required an annual performance review. The licensee's Employee Record policy dated August 1, 2021, indicated employee records for each person would include records of all training and in-service education required and/or provided including record of competency testing as required. The licensee's Training Records policy dated August 1, 2021, indicated the licensee would maintain a record of staff training and competency required. The licensee would document the following information for each competency evaluation, training, retraining, and orientation topics. 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 (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	0 680			

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0 680	Continued From page 8 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 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:	0 680			

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0 680	Continued From page 9 The licensee's Emergency Preparedness Plan dated August 1, 2021, lacked the following content and/or policies and procedures to address: - a completed risk assessment; - process for EP cooperation with state and local EP officials/organizations; - a missing resident plan that was reviewed quarterly; - a description of the population served by the licensee; - development of policies/procedures to address: - procedure for tracking staff and residents; - subsistence needs for staff and residents during an emergency to include (food, water, medical supplies, pharmacy supplies, sewer and waste disposal, emergency lighting, fire detection, extinguishing and alarm systems); - emergency staffing strategies to include volunteers; - development of arrangements with other facilities and providers to receive residents if needed; and - the facilities role in providing care and treatment at alternative sites under a 1135 waiver; - a communication plan that included: - arrangement with other facilities; - contact information for federal, state, tribal, local EP staff, ombudsman, state licensing and certification agencies; - primary and alternative means for communicating with facility staff, federal, state, regional and local emergency management agencies; - a means to provide information regarding the facility's needs, and its ability to provide assistance to include information about their occupancy; and -emergency prep testing requirements.	0 680			

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0 680	Continued From page 10 On January 5, 2024, at 10:45 a.m., licensed assisted living director (LALD)-A stated he signed up with the local coalition to assist with developing the licensee's emergency disaster plan and confirmed the emergency plan had not been fully developed to meet all the 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. 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			
0 780 SS=D	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	0 780			

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0 780	Continued From page 11 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 a smoke alarm in a resident's sleeping room. 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 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:	0 780			

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0 780	Continued From page 12 On January 4, 2024, at 10:00 a.m., survey staff toured the facility with physical plant manager (PPM)-C. During the tour, survey staff observed a smoke alarm was not installed in the bedroom for resident room 4. The smoke alarm bracket on the ceiling was empty. On January 4, 2024, at 10:00 a.m., PPM-C verified the smoke alarm was missing and stated during the tour interview they did not know this smoke alarm had been removed. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780			
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to install and maintain the portable fire extinguishers as required by statute. This deficient condition had the potential to affect all residents, staff, and visitors.	0 790			

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0 790	Continued From page 13 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: On January 4, 2024, at 10:00 a.m., survey staff toured the facility with physical plant manager (PPM)-C. During the tour, survey staff observed the following: 1. Monthly fire extinguisher inspection records on the back of the tags were blank. Fire extinguisher inspections must be conducted every month to ensure each extinguisher is in its designated place, it has not been tampered with, and there is no obvious physical damage or condition that would interfere with its use or operation. 2. Three portable fire extinguishers installed in the facility were located in rooms that required access through a door and these locations were not identified. Fire extinguishers should be placed in areas where they are readily accessible in the event of a fire, which typically includes normal paths of travel. Signs must be installed indicating the fire extinguisher's location if it is not visible. During the tour interview on January 4, 2024, at 10:00 a.m., PPM-C verified monthly fire extinguisher inspections had not been completed and the locations of fire extinguishers not identified. PPM-C stated the fire extinguisher in the pantry would be relocated to the kitchen and	0 790			

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0 790	Continued From page 14 signs would be posted for the other two fire extinguishers. PPM-C stated the facility would start completing monthly fire extinguisher inspections. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790			
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: Based on observation and interview, the licensee failed to provide the physical environment in a continuous state of good repair and operation with regard to 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	0 800			

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0 800	Continued From page 15 On January 4, 2024, at 10:00 a.m., survey staff toured the facility with physical plant manager (PPM)-C. During the tour, survey staff observed the following: 1. Keypad locks requiring a code to exit and thumb turn deadbolt locks were installed on three doors designated as emergency exits. Exit doors must open with one action. During the tour interview, PPM-C verified the locking arrangements on these exit doors. 2. In the bathroom of occupied resident room 8, a refrigerator was plugged into an extension cord. Extension cords must not be used as a substitute for permanent wiring. During the tour interview, PPM-C verified the refrigerator needed to be relocated and plugged directly into an electrical outlet. 3. In occupied resident room 2, a door sweep had been installed on the door leading into the corridor. This door sweep was constructed of newspaper and synthetic board attached by tape to the bottom of the door. In areas where door sweeps are used, they must be properly installed and constructed to ensure they do not create a trip hazard or obstruction. During the facility tour interview, PPM-C stated the door sweep had been installed by the resident to try and block noise from entering the room. During an interview, on January 4, 2024, at 12:20 p.m., PPM-C verified the door sweep was improperly installed and stated it would be removed. 4. In the bathroom of occupied resident room 2, the base trim near the shower was	0 800			

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0 800	Continued From page 16 water-damaged. During the facility tour interview, PPM-C verified the base trim was damaged and stated it would be replaced. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800			
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of	0 810			

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0 810	Continued From page 17 the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to develop fire safety and evacuation plans with the required content, and provide 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 January 4, 2024, physical plant manager (PPM)-C provided documents on the fire safety and evacuation plans (FSEP), fire safety and evacuation training, and employee evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLANS On January 4, 2024, at 10:00 a.m., survey staff toured the facility with PPM-C. During the facility tour, survey staff observed resident room numbers were not identified on the emergency floor plans. During the facility tour interview, PPM-C verified the resident room numbers were missing from the plans and stated these plans required revision. TRAINING Record review indicated the licensee failed to provide training to employees on the FSEP upon hire and/or at least twice per year as evident by	0 810			

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0 810	Continued From page 18 the lack of training documentation. No training records were provided. During an interview on January 4, 2024, at 12:20 p.m., PPM-C verified employee training records were not available to support FSEP training was completed. Record review indicated the licensee failed to provided fire safety and evacuation training to residents at least once per year as evident by the lack of training documentation. No training records were provided. During an interview on January 4, 2024, at 12:20 p.m., PPM-C verified resident training records were not available to support this training was completed. DRILLS Record review indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month as evident by fire drill reports lacking the required frequency. Five fire drills were recorded in 2023, completed in February, May, July, August, and November. During an interview on January 4, 2024, at 12:20 p.m., PPM-C verified employee fire drills had not been completed six times a year and at a frequency of every other month. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810			
0 950 SS=A	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract:	0 950			

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0 950	Continued From page 19 "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to offer one of one resident (R1) the opportunity to identify a or decline a designated representative. 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 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).	0 950			

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0 950	Continued From page 20 The findings include: R1's diagnoses included type 2 diabetes, congestive heart failure, cellulitis and chronic kidney disease. R1's Rental Agreement was signed July 10, 2023. R1's Service Plan dated July 10, 2023, indicated R1 received assistance with bathing, medication administration, wound care, housekeeping and laundry. R1's record did not include evidence R1 was offered or declined the opportunity to identify a designated representative. On January 4, 2024, at 10:11 a.m., registered nurse (RN)-B stated residents were provided a representative form to complete at the time of admission. After review of R1's record, RN-B stated R1's record did not include a designated representative form. The licensee's Designated Representative policy date August 1, 2021, indicated before or at the time of execution of an assisted living contract, the licensee would offer residents the opportunity to identify a designated representative in writing. A signed Designated Representative form must be filled out documenting the residents' choice in designated representative, the form would be kept in the resident record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 950			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 26579	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/05/2024
NAME OF PROVIDER OR SUPPLIER BARNES CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 56 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
01060	Continued From page 21	01060			
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 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	01060			

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01060	Continued From page 22 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 provide written notice with required content to the resident, legal representative, and designated representative, and failed to provide the notification to the Office of Ombudsman for Long-Term Care (OOLTC) when the resident did not return from the emergency relocation within four days for one of one resident (R1) reviewed for a hospitalization. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1's diagnoses included type 2 diabetes, congestive heart failure, cellulitis, chronic kidney disease. R1's Service Plan dated July 10, 2023, indicated R1 required assistance with bathing, wound care, medication management, housekeeping, and laundry. R1's Interagency Referral Form dated November 20, 2023, indicted R1 was admitted to the	01060			

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01060	Continued From page 23 hospital for left lower leg cellulitis on November 10, 2023, and was discharged back to the licensee on November 20, 2023. R1's record did not include a written notice that contained, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for the OOLTC and the Office of Ombudsman for Mental Health and Developmental Disabilities; - 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 - 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. In addition, R1's record did not include notification to the OOLTC that the resident had been relocated and had not returned to the facility within four days. On January 2, 2024, at 12:17 a.m., registered nurse (RN)-B stated she was not aware of the requirements that a written notice of emergency relocation with the above noted content needed to be provided to the resident and/or resident's representative and notification to the ombudsman was required for a hospital stay of four days or greater. The licensee's Emergency Relocation policy dated August 1, 2021, indicated in the event of an	01060			

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01060	Continued From page 24 emergency relocation, the licensee would provide a written notice that contains, at a minimum: the reason for the relocation; the name and contact information for the location to which the resident has been relocated and any new service provider; and contact information for the OOLTC. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01060			
01290 SS=D	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of 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 a background study was submitted and clearance was received in affiliation with the assisted living license for one of two employees (unlicensed personnel (ULP)-D).	01290			

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01290	Continued From page 25 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-D had a start date of February 3, 2023, to provide direct care services to the licensee's residents. On January 2, 2024, at 12:06 p.m., the surveyor observed ULP-D administering R5's scheduled afternoon medications. ULP-D's employee record contained a background study clearance, affiliated with another assisted living license owned by the licensee, dated January 27, 2023. On January 4, 2024, licensed assisted living director (LALD)-A stated physical plant manager (PPM)-C conducted employees background studies and confirmed ULP-D's background study clearance was affiliated with the licensee's other assisted living owned by the licensee. The licensee's Background Studies policy, dated August 1, 2021, indicated using Minnesota Department of Human Services (MN DHS) NetStudy online program, the licensee would initiate a background study on all employees being considered for hire.	01290			

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01290	Continued From page 26 No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) day	01290			
01370 SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries	01370			

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01370	Continued From page 27 between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency evaluations included all the required training for one of two (unlicensed personnel (ULP)-D). 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-D had a start date of February 3, 2023, to provide direct care services to the licensee's residents. On January 2, 2024, at 12:06 p.m., the surveyor observed ULP-D administering R5's scheduled afternoon medications. ULP-D's employee record lacked evidence ULP-D had received the following required training and/or competencies: -communication skills that include preserving the dignity of the client and showing respect for the	01370			

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01370	Continued From page 28 client and the client's preferences, cultural background, and family; and -awareness of commonly used health technology equipment and assistive devices. On January 4, 2024, at 1:03 p.m., licensed assisted living director (LALD)-A verified ULP-D's employee training transcripts did not include evidence ULP-D completed all of the required training noted above. The licensee's Competency Training Evaluations policy dated August 1, 2021, indicated prior to delegation of services the licensee must make certain the ULPs are trained in the proper methods to perform the tasks or procedures for each client and are able to demonstrate the ability to competently follow the procedures and perform the tasks. Training and competency evaluation for the ULPs would include: -communication skills that include preserving the dignity of the client and showing respect for the client and the client's preferences, cultural background, and family; and -awareness of commonly used health technology equipment and assistive devices. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370			
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the	01500			

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01500	Continued From page 29 provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and	01500			

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01500	Continued From page 30 challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an employee received all of the required annual training content for each 12 months of employment for one of one employee licensed assisted living director (LALD)-A. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a 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 January 2, 2024, at 10:03 a.m., licensed assisted living director (LALD)-A identified himself as the LALD and the clinical nurse supervisor (CNS). LALD-A had a start date of January 1, 2006, and began providing assisted living services and staff	01500			

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01500	Continued From page 31 supervision on August 1, 2021. LALD's employee record did not include the following required annual training: - training on reporting of maltreatment of vulnerable adults under Mandated Reporting of Maltreatment of Vulnerable Adults Chapter 626, sections section 557 & 5572 - review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights - a review of infection control techniques and implementation of infection control standards including a review of hand washing techniques; the need for an use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases - review of the facility's policies and procedures related to the provision of assisted living services and how to implement those policies and procedures; and - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. On January 4, 2024, at 3:41 p.m., LALD-A provided the surveyor with LALD-A's training transcripts and verified he had not completed annual training in 2023. The licensee's Annual Required Staff Training policy dated August 1, 2021, indicated all staff that perform direct care services at the licensee would complete at least eight hours of annual training for each 12 months of employment. The training elements would include: - training on reporting of maltreatment of	01500			

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01500	Continued From page 32 vulnerable adults under section 626.557 - review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights - a review of infection control techniques and implementation of infection control standards including a review of hand washing techniques; the need for an use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases - review of the facility's policies and procedures related to the provision of assisted living services and how to implement those policies and procedures; and - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500			
01530 SS=D	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed	01530			

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01530	Continued From page 33 at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of three employees (licensed assisted living director (LALD)-A), received the required two hours of dementia care annual training. 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: LALD-A had a hire date of January 1, 2006, and began providing assisted living services on August 1, 2021.	01530			

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01530	Continued From page 34 LALD-A's employee record lacked evidence two hours of annual dementia training was completed in 2023. On January 4, 2024, at 3:41 p.m., LALD-A provided the surveyor with LALD-A's training transcripts and verified he had not completed two hours of annual dementia care training in 2023. The licensee's Dementia Training policy dated August 1, 2021, indicated all staff of the licensee are required to complete dementia training at the time of hire and annually thereafter. All staff would complete two hours of additional training for each 12 months of work thereafter. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01530			
01560 SS=D	144G.64 (a, b, c) TRAINING IN DEMENTIA CARE REQUIRED (5) new employees may satisfy the initial training requirements by producing written proof of previously completed required training within the past 18 months. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and other dementias; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; (4) communication skills; and (5) person-centered planning and service delivery. (c) The facility shall provide to consumers in written or electronic form a description of the	01560			

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01560	Continued From page 35 training program, the categories of employees trained, the frequency of training, and the basic topics covered. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure dementia training included all the required content for one of two employees (unlicensed personnel (ULP)-D.) 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-D had a start date of February 3, 2023, to provide direct care services to the licensee's residents. On January 2, 2024, at 12:06 p.m., the surveyor observed ULP-D administering R5's scheduled afternoon medications. ULP-D's employee record lacked evidence ULP-D received the following dementia training: -the explanation of Alzheimer's disease and other dementia; -problem solving with challenging behaviors; -communication skills; and -person-centered planning and service delivery.	01560			

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01560	Continued From page 36 On January 4, 2024, at 1:03 p.m., licensed assisted living director (LALD)-A confirmed ULP-D's employee record and training transcripts lacked the required dementia training content upon orientation. The licensee's Dementia Training policy date August 1, 2021, indicated direct care employees would complete eight hours of initial training within 160 hours of the employment start date. The required dementia care topics would include: -An explanation of Alzheimer's disease and other dementias; -Assistance with activities of daily living; -Problem solving with challenging behaviors; -Communication skills; and -Person-centered planning and service delivery. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01560			
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of	01620			

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01620	Continued From page 37 services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a registered nurse (RN) conducted assessments with a uniform assessment tool that included all required assessment area content for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1's diagnoses included type 2 diabetes, congestive heart failure, cellulitis and chronic kidney disease. R1's RN Evaluation/Baseline Assessment was completed July 11, 2023. On January 3, 2024, at 10:04 a.m., the surveyor	01620			

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01620	Continued From page 38 observed unlicensed personnel (ULP)-E administer R1's morning medications. R1's RN Evaluation/Baseline Assessment form, dated July 11, 2023, lacked the following required assessment content: -the resident's personal lifestyle preferences, including: sleep patterns, spiritual and cultural preferences; -advance health care directives and end-of-life preference, including whether a person has or wants to see a "do not resuscitate" order and "do not attempt resuscitation order" or "physician/provider orders for life sustaining treatment" order; -dental status; -instrumental activities of daily living, including: housework and laundry; and transportation; -physical health status including a review of relevant health history and current health conditions including medical and nursing diagnoses, allergies and sensitivities related to medication, seasonality, environment, and food, infectious conditions; -a review of medical, dental, and emergency room visits in the past 12 months, including visits to a primary health care provider, hospitalization, surgeries, and care from a post-acute facility; -review of any reports from a physical therapist, occupational therapist, speech therapist, or cognitive evaluations within the last 12 months; -pain; -list of treatments, including type, frequency, and level of assistance needed; -nursing needs, including potential to receive nursing delegated services; and -risk indicators, including emergency evacuation ability, complex medication regimen, risk for dehydration, including history of urinary tract infections and current fluid intake pattern, and	01620			

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01620	Continued From page 39 unsuccessful prior placements. R1's 14 day RN Quarterly Review completed July 26, 2023, did not include the following required assessment content: -the resident's personal lifestyle preferences, including: spiritual and cultural preferences. On January 2, 2024, at 2:05 p.m., RN-B confirmed the RN Evaluation/Baseline Assessment was the assessment tool being used for all residents. RN-B confirmed the above information was missing from the assessment tool being used and R1's assessment had several areas on the assessment form that were incomplete. The licensee's Assessments, Reviews and Monitoring policy dated August 1, 2021, indicated the initial assessment or reassessment must include all the elements of the uniform assessment tool as required as specified in Rule. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0140, Subp. 2. Nursing Assessment. A. A nursing assessment or reassessment under Minnesota Statutes, section 144G.70, subdivision 2, paragraphs (b) and (c), must be conducted on a prospective resident or resident receiving any of the assisted living services identified in Minnesota Statutes, section 144G.08, subdivision 9, clauses (6) to (12). B. The nursing assessment or reassessment under item A must: (1) address part 4659.0150, subpart 2, items A to N; (2) be conducted in person unless an exception under Minnesota Statutes, section 144G.70, subdivision 2, paragraph (b), applies;	01620			

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01620	Continued From page 40 (3) be conducted using a uniform assessment tool that complies with part 4659.0150; and (4) be in writing, dated, and signed by the registered nurse who conducted the assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620			
01650 SS=D	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and	01650			

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01650	Continued From page 41 declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the service plan included the required content for one of two residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's diagnoses included type 2 diabetes, congestive heart failure, cellulitis and chronic kidney disease. R1's undated Treatment and Therapy plan indicated R1 received blood glucose monitoring and daily assistance with Thrombo-Embollic Deterrent (TED) stockings (used to prevent blood clots and prevent swelling). On January 3, 2024, at 10:04 a.m., the surveyor observed unlicensed personnel (ULP)-E administer R1's morning medications. R1's Service Plan dated July 17, 2023, respectively, lacked the following required content: -a description of the services to be provided to	01650			

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01650	Continued From page 42 include blood glucose monitoring and assistance with TED stockings; and -frequency of each service, according to the resident's current assessment and resident preferences. On January 2, 2024, at 2:05 p.m., registered nurse (RN)-B reviewed R1's service plan and confirmed R1's service plan did not include the frequency of services. The licensee's Service Plan policy dated August 1, 2021, indicated the service plan would include: -a description of the services to be provided, the fees for services, and the frequency of each service to be provided based on the most recent assessment and resident preferences. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650			
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 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	01790			

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01790	Continued From page 43 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 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	01790			

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01790	Continued From page 44 (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 the registered nurse (RN) developed written procedures with all the required content for unlicensed personnel (ULP) providing medications for residents having unplanned time away when the licensed nurse was not available. In addition, the licensee failed to ensure one of one unlicensed personnel (ULP)-D was trained 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 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: ULP-D had a start date of February 3, 2023, to provide direct care services to the licensee's residents which include medication administration. On January 2, 2024, at 12:06 p.m., the surveyor observed ULP-D administering R5's scheduled	01790			

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01790	Continued From page 45 afternoon medications. ULP-D's employee record lacked evidence to indicate ULP-D had been trained and had demonstrated competency to provide medications to residents for unplanned times away from home. On January 5, 2024, at 10:45 a.m., registered nurse (RN)-B provided the surveyor with the licensee's Medication Management-Planned and Unplanned Time Away policy. RN-B stated she was unable to find a written procedure for unplanned time away. Licensed assisted living director (LALD)-A stated he covers the procedure during orientation training; however, does not document training or competency. The licensee's Medication Management - Planned and Unplanned Time Away policy dated August 1, 2021, indicated the licensee providing medication management services to the resident and controls the resident's access to the medication the following procedures for giving accurate and current medications to clients for unplanned times away from home would be followed, according to the resident's individual medication management plan. For unplanned time away when a licensed nurse is not available, a pharmacist or licensed nurse was not available, the registered nurse may delegate this task to unlicensed personnel. The registered nurse would train the unlicensed staff and determine the unlicensed staff was competent to follow the procedures for giving medications to residents. The registered nurse would develop written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that were prescribed for the client.	01790			

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01790	Continued From page 46 The written procedure must address: - the type of container or containers to be used for the medications appropriate to the provider's medication system; - how the container or containers must be labeled; - written information about the medications to given to the client or client's representative; - how the unlicensed staff must document in the resident's record that medications have been given to the client or client's representative, 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 medications that were provided to the resident, and other required information; - how the RN shall be notified that medications have been given to the client or client's representative and whether the RN needs to be contacted before the medications are given to the client or the client's representative; -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 -how the ULP 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. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790			
01880 SS=E	144G.71 Subd. 19 Storage of medications	01880			

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01880	Continued From page 47 An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were maintained bearing the original prescription labels for resident (R1). In addition, the licensee failed to date time-sensitive medications with opened or expiration dates for R6. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On January 2, 2024, at 2:29 p.m., the surveyor observed the medication cart with registered nurse (RN)-B. RN-B confirmed the following: PRESCRIPTION LABELS -R1's two opened Tresiba Flex Touch (long acting) insulin pens lacked original prescription labels to include the resident name, pharmacy, instructions for use, date dispensed and prescription number. TIME SENSITIVE MEDICATIONS	01880			

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01880	Continued From page 48 R6's opened ketorolac eye drop (used to treat inflammation) lacked the date the eye drop had been opened and when the eye drop would expire. On January 2, 2024, at 2:30 p.m., RN-B stated she relied on the pharmacy to put a sticker on time-sensitive medications and staff should be writing the date the medication was opened and would expire. RN-B stated the pharmacy only put the prescription label on the insulin box and not on the individual insulin pens. The manufacturer's instructions for ketorolac (Acular) eye drop dated February 2022, indicated to throw the bottle away 28 days after opening, even if there is solution remaining. The licensee's Medications Storage policy dated August 1, 2021, indicated medication would be stored consistent with the manufacturer's recommendations. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880			
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications	01910			

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01910	Continued From page 49 remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document in the resident's record the required content on disposition of the medications for one of one resident (R4) upon discharge. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R4's Discharge Summary dated August 4, 2023, indicated R4 was admitted on July 14, 2023, and discharged August 3, 2023. R4 received assistance with bathing, grooming, toileting, and medication management. R4's Medication Administration Record (MAR)	01910			

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NAME OF PROVIDER OR SUPPLIER BARNES CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 56 WEST HIGHWAY 61 ESKO, MN 55733		
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01910	Continued From page 50 dated August 1 and August 2, 2023, indicated R4 received the following medications: -aspirin 81 milligrams (mg) one table daily; -atorvastatin 20 mg one tablet daily; -finasteride 5 mg one table daily; -isosorbide 60 mg one table daily; -omega-3 fish 1000 mg one capsule daily; -omeprazole 20 mg one capsule daily; -potassium chloride 10 millequivalent (mEq) one capsule daily; -vitamin D3 50 micrograms (mcg) one capsule daily; -furosemide 40 mg one tablet twice a day; -metformin 100 mg one table twice a day; -metoprolol succinate 25 mg one tablet twice a day; -lorazepam 0.5 mg one tablet every four hours as needed for anxiety; and -morphine 0.25 milliliters (ml) every two as needed for shortness of breath or pain. R4's Medication Destruction Record dated December 19, 2023, did not include a disposition of medications to include the strength of the medications and did not include the following prescribed medications: -finasteride 5 mg; -potassium chloride 10 mEq; and -furosemide 40 mg. On January 3, 2024, at 3:25 p.m., registered nurse (RN)-B verified the above listed medications were not included on R4's Medication Destruction Record and was unaware documentation of the medication strength was required. The licensee's Medication Disposal policy dated August 1, 2021, indicated upon disposition, the license must document in the resident's record	01910			

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01910	Continued From page 51 the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910			
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and	01940			

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01940	Continued From page 52 therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for one of one resident (R1) 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: R1's diagnoses included type 2 diabetes, congestive heart failure, cellulitis, and chronic kidney disease. On January 2, 2024, at 1:00 p.m., the surveyor observed a machine with cables connected to inflating lower leg sleeve like boots in R1's room. R1 stated staff put the compression boots on him for an hour twice a day to help with the circulation in his lower legs. R1's record did not include evidence of an	01940			

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01940	Continued From page 53 individualized treatment management plan for R1's compression boot therapy which included: - a written statement on the service plan of the treatment or therapy services that will be provided to the resident; - documentation of specific resident instructions relating to the treatments or therapy administration; and - identification of treatment or therapy tasks that would be delegated to unlicensed personnel for compression boot therapy. On January 2, 2024, at 2:05 p.m., registered nurse (RN)-B stated R1's compression boots were not included on R1's treatment and therapy plan because she was unaware R1 had compression boots in his room. Unlicensed personnel (ULP)-D stated a nurse from the wound care provider ordered the compression boots and gave verbal orders to ULP-D to apply the compression boots an hour twice a day. The licensee's Treatment and Therapy Management Plan policy dated August 1, 2021, indicated the licensee would develop and maintain a current individualized treatment and therapy management record fore each resident which must contain at least the following: -a statement of the type of services that will be provided; -documentation of specific resident instructions relating to the treatments or therapy administration; -identification of treatment or therapy tasks that will be delegated to unlicensed personnel -procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; -any resident-specific requirements relating to	01940			

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01940	Continued From page 54 documentation of treatment and therapy received; and verification that all treatment and therapy was administered as prescribed Monitoring of treatment or therapy to prevent possible complications or adverse reactions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940			
01950 SS=D	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for 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,	01950			

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01950	Continued From page 55 specified in writing for each resident, and documented those instructions in the resident's record for one of one resident (R1) 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: R1's diagnoses included diabetes type II and dementia and cellulitis. On January 2, 2024, at 12:51 p.m., the surveyor observed ULP-F observe R1 scan his FreeStyle Libre device (a device that measures glucose levels through a small sensor applied to the back of the arm) and reported his blood glucose result of 190 milligrams per deciliter (mg/dl). ULP-F handed R1's Novolog (fast acting) insulin pen and instructed R1 to prime the insulin pen with two units then dial his insulin pen to 19 units (16 units of scheduled insulin plus three units of sliding scale insulin). R1 followed ULP-F's instructions and administered 19 units of Novolog insulin into his abdomen. ULP-F stated there were no set blood glucose parameters in R1's record of when to notify the registered nurse (RN) and only for R1's sliding scale insulin. On January 2, 2024, at 1:00 p.m., the surveyor observed a machine with cables connected to inflating lower leg sleeve like boots in R1's room.	01950			

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01950	Continued From page 56 R1 stated staff put the compression boots on him for an hour twice a day to help with the circulation in his lower legs. R1's Care Plan dated July 12, 2023, indicated R1 received the following delegated nursing services to include blood glucose monitoring; however, R1's Care Plan lacked R1's compression boots. R1's undated Treatment and Therapy Plan indicated R1 required blood glucose monitoring services; however, R1's Treatment and Therapy Plan did not include R1's compression boots. R1's December 2023, medication administration record (MAR) indicated record blood glucose (sugar levels in the blood) levels three times a day. R1's January 2024, Blood Glucose Log Sheets indicated staff were recording R1's blood glucose levels three times a day. R1's record did not include written blood glucose parameters of when to notify the registered nurse and did not include written instructions for the use of R1's compression boots. On January 2, 2024, at 1:55 p.m., RN-B stated R1 checked his own blood glucose using the FreeStyle Libre device and staff recorded the results to determine the amount of sliding scale insulin R1 would receive. RN-B stated R1's blood glucose parameters should be listed on the resident's MAR for when to notify the RN. RN-B reviewed R1's December 2023, and January 2024, MAR and stated there were no set blood glucose parameters listed for R1 in R1's record. RN-B stated there were no written instructions for R1's compression boots because she was	01950			

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01950	Continued From page 57 unaware R1 had compression boots in his room and staff were applying them twice a day. The licensee's Medication and Treatment-Administration and Delegation policy dated August 1, 2021, prior to providing delegated medication administration and or treatment/therapy, the following must occur: -an RN must specify, in writing, specific instructions for each resident and document those instructions in the residents' record. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950			
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure written or electronically recorded orders were obtained for one of one resident (R1) who had treatments managed by the provider. This practice resulted in a level two violation (a violation that did not harm a resident's health or	01970			

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01970	Continued From page 58 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's diagnoses included type 2 diabetes and cellulitis of left lower leg. On January 2, 2024, at 1:00 p.m., the surveyor observed a machine with cables connected to inflating lower leg sleeve like boots in R1's room. R1 stated staff put the compression boots on him for an hour twice a day to help with the circulation in his lower legs. R1's record did not include prescriber orders or instructions for R1's compression boots. On January 2, 2024, at 2:05 p.m., registered nurse (RN)-B stated she was unaware R1 had compression boots in his room. Unlicensed personnel (ULP)-D stated a nurse from the wound care provider ordered the compression boots and gave verbal orders to ULP-D to apply the compression boots an hour twice a day. RN-B stated she never received verbal, written, or electronic orders for R1's compression boots and would contact the wound care provider for more information. RN-B stated ULPs were not allowed to receive orders from any provider and staff should have notified the nurse right away. On January 4, 2024, at 10:31 a.m., licensed assisted living director (LALD)-A stated ULPs were not allowed to receive orders from providers	01970			

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01970	Continued From page 59 and should have informed the nurse the compression boots were in R1's room. LALD-A further stated ULPs should not have applied R1's compression boots without orders or written instructions. The licensee's Medication and Treatment Orders-Receiving policy dated August 1, 2021, indicated an RN, licensed practical nurse (LPN), therapist, or person at the licensee who is qualified to receive orders would obtain all medications and treatment orders either in writing, verbally, or electronically by an authorized provider. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970			
02310 SS=I	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 three of three residents (R1, R2, R3) who utilized bed rails. This practice resulted in a level three violation (a violation that harmed a resident's health or safety,	02310			

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02310	Continued From page 60 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). The findings include: R1 R1's diagnoses included type 2 diabetes, congestive heart failure, cellulitis, and chronic kidney disease. On January 2, 2023, at 12:57 p.m., the surveyor observed R1 had a standard bed with a consumer rectangular shaped metal bed rail positioned on the right upper side of the bed. The base of the bed rail was not secured to the bed frame and was tucked between the bed frame and the mattress. R1's Service Plan dated July 10, 2023, indicated R1 required assistance with bathing, wound care, medication management, housekeeping, and laundry. R1's Bedrail Risk Assessment dated July 8, 2023, indicated R1 had a bed rail that was secured, compatible with the bed frame and was in good working order. R1's RN Quarterly Review dated December 15, 2023, did not indicate R1 required the use of a bed rail. R1's Resident Care Plan dated July 12, 2023, did not indicate R1 required the use of a bed rail.	02310			

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02310	Continued From page 61 R1's record lacked the following: -type of consumer bed rail being used; -installation and use of the device according to manufacturer's guidelines; -evidence the licensee referred to the Consumer Product Safety Commission (CSPC) for bed rail recall information; and -on going assessment for the use of an assisted device as required in the uniform assessment tool. R2 R2's diagnoses included high blood pressure, macular degeneration, osteoarthritis, osteoporosis, diastolic heart failure, and hearing loss. On January 3, 2023, at 8:08 a.m., the surveyor observed R2 had bilateral bed rails in the upright position, attached to R2's hospital bed. R2 was not in the room. R2's Service Plan dated February 16, 2023, indicated R2 required assistance with dressing, grooming, bathing, medication management, ambulation, transfers, housekeeping and laundry. R2's Bedrail Risk Assessment dated February 16, 2022, indicated R2 had bed rails that were secured, compatible with the bed, in good working condition, and the gap between the bed rail and the headboard measured less than 60 millimeters (mm) or greater than 250 mm. R2's RN Quarterly Review dated June 14, 2023, did not indicate R2 required the use of bed rails. R2's Resident Care Plan dated April 7, 2022, did not indicate R2 required the use of bed rails.	02310			

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02310	Continued From page 62 R2's record lacked a comprehensive assessment on the use of an assistive device to include actual measurements of the entrapment zones and further lacked on going assessment for the use of an assisted device as required in the uniform assessment tool. R3 R3's diagnoses included arthritis. On January 3, 2023, at 8:12 a.m., the surveyor observed R3 had bilateral bed rails in the down position, attached to R3's hospital bed. R3 stated she used the bed rails to help with repositioning in bed. R3's Service Plan dated October 14, 2022, indicated R3 required assistance with dressing, grooming, bathing, toileting, transfers, medication management, housekeeping and laundry. R3's Bedrail Risk Assessment dated December 12, 2023, indicated R3 had bed rails that were secured, compatible with the bed, in good working condition, and the gap between the bed rail and the headboard measured less than 60 millimeters (mm) or greater than 250 mm. R3's RN Quarterly Review dated December 15, 2023, did not indicate R3 required the use of bed rails. R3's Resident Plan of Care dated August 31, 2021, did not indicate R3 required the use of bed rails. R3's record lacked a comprehensive assessment on the use of an assistive device to include actual measurements of the entrapment zones and further lacked on going assessment for the use of	02310			

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NAME OF PROVIDER OR SUPPLIER BARNES CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 56 WEST HIGHWAY 61 ESKO, MN 55733		
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02310	Continued From page 63 an assisted device as required in the uniform assessment tool. On January 3, 2024, at 9:13 a.m., licensed assisted living director (LALD)-A stated residents were provided a Resident Risk form to include the risks of the use of bed rails and residents signed an informed consent prior to use of the bed rails. LALD-A stated he obtains physician orders, measures the entrapment zones, and completes a bed rail assessment for all residents who choose to have a bed rail. LALD-A stated he does not document the measurements of the zones in the resident record or provides residents and/or families a brochure on bed rail use and safety. LALD-A stated he was aware R2 and R3 had hospital beds with attached bed rails which were provided by hospice and R1 had a consumer bed rail which was installed by family. LALD-A stated he checked R1's bed rail to ensure it was secured and was not loose and confirmed the bed rail was not secured to the bed frame and was tucked between the mattress and the bed frame. LALD-A stated he did not check the CSPC website to see if R1's consumer rail was recalled and was unaware of the website and the requirement. Registered nurse (RN)-B stated she does complete the initial bed rail assessments and it was not a part of the resident quarterly assessment. The surveyor viewed the CSPC website for recalled bed rails and LALD-A confirmed R1's consumer bed rail resembled the Essential Medical Supply bed rail listed on the recall list. The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently Asked Questions (FAQs), last updated December 26, 2023, indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 26579	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/05/2024
NAME OF PROVIDER OR SUPPLIER BARNES CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 56 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
02310	Continued From page 64 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." 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 - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements". Additionally, the MDH website indicated for "consumer beds", the 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. The Assisted Living Resources & Frequently Asked Questions (FAQs), last updated December 26, 2023, current recommendations for recall	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 26579	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/05/2024
NAME OF PROVIDER OR SUPPLIER BARNES CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 56 WEST HIGHWAY 61 ESKO, MN 55733		
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02310	Continued From page 65 include the following "The United States Consumer Product Safety Commission (CSPC) works to save lives and ensure safety by reducing the unreasonable risk of injuries and deaths associated with consumer products, such as portable bed rails. The CSPC posts information on its website related to portable bed rail recalls. Licensees should review the CSPC website regularly for updates on recalled portable bed rails. The opportune time to do this would be with the 90-day assessment due to the requirement included in the uniform assessment tool for assessing assistive devices. The licensee's Side Rail policy dated August 1, 2021, when the licensee was made aware a resident utilized side rails on a bed, the licensee would educate the resident, and when appropriate, the responsible person, regarding the risks and benefits of side rails, and verify that the side rail in use is of a safe design and utilized consistent with the manufacturer's directions. The policy would be followed regardless of who owns or is supplying the side rail. The RN would conduct an assessment to identify intended purpose of the side rail and risks. The side design would be consistent with the FDA's 2006 recommended dimensional measurement to reduce entrapment. Education provided would be documented in the resident record. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate Immediac is removed as confirmed by evaluation supervisor review on January 3, 2024, however noncompliance remains at a scope and level of three, widespread (I).	02310			

Type: Full
Date: 01/03/24
Time: 10:30:00
Report: 1027241001

Food and Beverage Establishment Inspection Report

Page 1

Location:

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

Establishment Info:

ID #: 0039282
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 2188784722
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.

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.
AT TIME OF INSPECTION THERE WAS NOT ANY STAFF THAT HAD A CURRENT CFPM.
Comply By: 03/04/24

2-100 Supervision

2-102.12DMN

MN Rule 4626.0033D Post the certified food protection manager certificate.
POST A CURRENT CFPM CERTIFICATE WHEN OBTAINED.
Comply By: 03/04/24

Surface and Equipment Sanitizers

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

Hot Water: = at >160 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Food and Equipment Temperatures

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

Type: Full
Date: 01/03/24
Time: 10:30:00
Report: 1027241001
Barnes Care Inc

Food and Beverage Establishment
Inspection Report

Process/Item: Upright Cooler
Temperature: 34 Degrees Fahrenheit - Location: THERMOMETER
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 39 Degrees Fahrenheit - Location: MILK
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 38 Degrees Fahrenheit - Location: CHEESE
Violation Issued: No

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

Process/Item: Upright Cooler
Temperature: 39 Degrees Fahrenheit - Location: THERMOMETER
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

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

DISCUSSED EMPLOYEE ILLNESS AND EXCLUSIONS, REQUIRED SANITIZER STRENGTHS, AND AVOIDING BARE HAND CONTACT WITH READY TO EAT FOODS. OWNER STATED THAT GLOVES AND UTENSILS ARE USED WHEN HANDLING READY TO EAT FOODS.

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

I acknowledge receipt of the MN Department of Health inspection report number 1027241001 of 01/03/24.

Certified Food Protection ManagerSEE ORDERS

Certification Number: Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed:
JUSTIN BARNES
OWNER

Signed: Ian H
651-201-4500
health.foodlodging@state.mn.us

Report #: 1027241001

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

1

No. of Repeat RF/PHI Categories Out

0

Legal Authority MN Rules Chapter 4626

Date

01/03/24

Time In

10:30:00

Time Out

Barnes Care Inc

Address

56 West Highway 61

City/State

Esko, MN

Zip Code

55733

Telephone

2188784722

License/Permit #

0039282

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

16

IN

OUT

N/A

Food contact surfaces: cleaned & sanitized

17

IN

OUT

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

Compliance Status

COS

R

Time/Temperature Control for Safety

18

IN

OUT

N/A

N/O

Proper cooking time & temperature

19

IN

OUT

N/A

N/O

Proper reheating procedures for hot holding

20

IN

OUT

N/A

N/O

Proper cooling time & temperature

21

IN

OUT

N/A

N/O

Proper hot holding temperatures

22

IN

OUT

N/A

Proper cold holding temperatures

23

IN

OUT

N/A

N/O

Proper date marking & disposition

24

IN

OUT

N/A

N/O

Time as a public health control: procedures & records

Consumer Advisory

25

IN

OUT

N/A

Consumer advisory provided for raw/undercooked food

Highly Susceptible Populations

26

IN

OUT

N/A

Pasteurized foods used; prohibited foods not offered

Food and Color Additives and Toxic Substances

27

IN

OUT

N/A

Food additives: approved & properly used

28

IN

OUT

Toxic substances properly identified, stored, & used

Conformance with Approved Procedures

29

IN

OUT

N/A

Compliance with variance/specialized process/HACCP

Risk factors(RF) are improper practices or 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 compliance

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

COS=corrected on-site during inspection

R= repeat violation

COS

R

Safe Food and Water

30

IN

OUT

N/A

Pasteurized eggs used where required

31

Water & ice obtained from an approved source

32

IN

OUT

N/A

Variance obtained for specialized processing methods

Food Temperature Control

33

Proper cooling methods used; adequate equipment for temperature control

34

IN

OUT

N/A

N/O

Plant food properly cooked for hot holding

35

IN

OUT

N/A

N/O

Approved thawing methods used

36

Thermometers provided & accurate

Food Identification

37

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

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: 01/04/24

Inspector (Signature)