Electronically Delivered

October 1, 2025

Licensee
Barross Cottage LLC
401 South Avenue
Two Harbors, MN 55616

RE: Project Number(s) SL20987016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 13, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement;
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;
Level 3: a fine of $1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 4: a fine of $3,000 per incident, in addition to any enforcement mechanism authorized in

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

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

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

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

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

The correction order documentation should include the following:

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

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

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

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

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

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

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

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

If you have any questions, please contact me.

Sincerely,

Jessie Chenze

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20987	A. BUILDING: _____ B. WING _____	08/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BARROSS COTTAGE LLC	401 SOUTH AVENUE TWO HARBORS, MN 55616

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL20987016-0 On August 12, 2025, through August 13, 2025, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were six residents; six receiving services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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

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0 480	Continued From page 2 existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated August, 12, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24	0 480		

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0 480	Continued From page 3 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program that complies with accepted health care, medical and nursing standards for infection control by one of two unlicensed personnel (ULP-E) observed during medication administration. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect	0 510		

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0 510	Continued From page 4 a large portion or all of the residents). The findings include: ULP-E was hired May 1, 2011, to provide direct care services to the residents of the facility. ULP-E's training transcripts indicated ULP-E completed infection control training on July 12, 2025. On August 13, 2025, at 7:45 a.m., the surveyor observed ULP-E put on a pair of disposable gloves, prepare and administer R3's morning medications. Without changing gloves or performing hand hygiene, ULP-E prepared and administered R5's morning medications. Wearing the same pair of gloves, ULP-E prepared and administered R4's morning medications, eye drops and nasal spray. On August 13, 2025, at 1:02 p.m., during a telephone interview, clinical nurse supervisor (CNS)-B stated staff were expected to change gloves and perform hand hygiene in between resident contact. On August 13, 2025, at 1:15 p.m., ULP-E stated ULP-E wore gloves the whole time, used a tweezer to handle resident medications and did not touch any resident directly so ULP-E thought ULP-E did not have to change gloves in between administering resident medications. Owner (O)-C stated gloves should be changed and hand hygiene completed in between administering resident medications. The licensee's Hand Hygiene policy dated August 1, 2021, indicated hand washing shall be	0 510		

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0 510	Continued From page 5 performed between resident cares and whenever direct physical contact with a resident takes place. Use of gloves does not replace hand washing. Hands should be washed or decontaminated: -before and after direct contact with a resident; -if moving from a contaminated body site to a clean site during resident care; -after contact with environmental surfaces or equipment in the immediate vicinity of the resident; -after removing gloves or gowns; and -before eating or after using the restroom. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 650 SS=E	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement	0 650		

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0 650	Continued From page 6 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-)-E, registered nurse (RN)-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 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: During the entrance conference on August 12, 2025, at 10:22 a.m., owner (O)-C was identified as responsible for maintaining employee records and O-C stated they were familiar with the assisted living regulations. ULP-E ULP-E was hired May 1, 2011, to provide direct care services to the residents of the facility.	0 650		

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0 650	Continued From page 7 On August 13, 2025, at 7:45 a.m., the surveyor observed ULP-E administering R3's scheduled medications. ULP-E's record lacked evidence an annual performance review that defined areas of improvement needed and training needs had been completed. RN-G RN-G was hired April 18, 2025, to supervise and provide direct care services to the residents of the facility. RN-G's employee record lacked the following: -a job description; -annual performance review. On August 13, 2025, at 11:19 a.m., O-C stated they were unable to find a job description and an annual performance review for RN-G or an annual performance review for ULP-E. O-C stated in each resident chart was a sign-off sheet with staff initials indicating staff have read each resident's care plan. O-C reviewed resident charts and stated RN-G initials were not included on the sign off sheets in the resident charts indicating RN-G had not reviewed each resident care plan as required. The licensee's Personnel Records policy dated August 1, 2021, indicated a personnel file would be maintained for each paid employee and would include the following: -performance evaluations which identify areas of improvement needed and training needs; and -a current job description, which includes qualifications, responsibilities and identification of supervisors.	0 650		

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0 650	Continued From page 8 The licensee's Performance Review policy dated August 1, 2021, indicated the licensee would conduct a performance review on new staff within the first 30 days of beginning work and thereafter annually based on the anniversary date. The Staff Orientation To Individual Resident policy dated August 1, 2021, indicated staff providing services would be orientated specifically to each individual resident and the services to be provided. The orientation may be provided in person, orally, in writing, or electronically. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 660 SS=E	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision.	0 660		

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0 660	Continued From page 9 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) and Minnesota Department of Health (MDH), including a history and symptoms screening for active TB for two of three employees (unlicensed personnel (ULP)-D, registered nurse (RN)-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 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: During the entrance conference on August 12, 2025, at 10:22 a.m., owner (O)-C was identified as responsible for maintaining employee records and O-C stated they were familiar with the assisted living regulations. The facility's TB assessment was completed August 1, 2024, and the facility was determined to be a low risk level. ULP-D ULP-D was hired October 24, 2024, to provide	0 660		

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0 660	Continued From page 10 direct care services to the residents of the facility. On August 12, 2025, at 12:41 p.m., the surveyor observed ULP-D administering R2's scheduled medications. ULP-D's employee record included negative TB results on October 31, 2024, and November 16, 2024; however, lacked evidence ULP-D completed a history and symptom screening for active TB. RN-G RN-G was hired April 18, 2025, to supervise and provide direct care services to the residents of the facility. RN-G's employee record included a QuantiFERON TB gold plus negative lab screening for TB on June 25, 2025; however, lacked evidence RN-G completed a history and screening for active TB. On August 13, 2025, at 9:52 a.m., O-C stated they were unable to find ULP-D or RN-G's TB history and screening questions and was unsure why either were not competed. O-C stated ULP-D and RN-G had their TB tests outside of the licensee and that may be why a history and screening questionnaire was not in their employee records. The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and based on CDC guidelines, indicated an employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a	0 660		

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0 660	Continued From page 11 negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be documented in the employee's record. In addition, the guidelines include, "TB training is required at time of hire for all HCWs." The licensee's Tuberculosis Screening policy dated December 18, 2024, indicated upon hire all staff would be tested for tuberculosis with either a two-step Mantoux or IGRA laboratory blood test. The results of the TB test would be recorded and kept in the employee's medical record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
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 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	01060		

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01060	Continued From page 12 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 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/or 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 (R2).	01060		

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01060	Continued From page 13 This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on August 12, 2025, at 10:22 a.m., owner (O)-C stated the licensee was familiar with the assisted living laws and regulations. R2's diagnoses included peripheral vascular disease (PVD), cataracts, seasonal allergies, hypertension (high blood pressure), and cerebral vascular accident (stroke) with left hemiparesis (one sided muscle weakness). R2's Service Plan dated August 3, 2021, indicated to refer to R2's care plan, medication and treatment plans for services. R2's care plan dated August 7, 2025, indicated R2 required assistance with ambulation, transferring, toileting, medication administration, personal hygiene, dressing and bathing. R2's clinical notes indicated the following: -On August 2, 2025, R2 went to the hospital for complaints of chest pain and shortness of breath; -On August 3, 2025, R2 was admitted to the hospital; and -On August 7, 2025, R2 returned from the hospital after being treated for pneumonia.	01060		

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01060	Continued From page 14 R2's record lacked 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; - 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, R2's record lacked notification to the OOLTC that the resident had been relocated and had not returned to the facility within four days. On August 13, 2025, at 1:10 p.m., during a telephone interview, clinical nurse supervisor (CNS)-B stated O-C completed and provided the emergency relocation information to residents and notified the OOLTC of resident hospitalizations. On August 13, 2025, at 1:15 p.m., O-C stated O-C was aware of the requirement and provided the resident or resident's representative the emergency relocation notice information and notified the ombudsman of hospitalizations four days or longer; however, O-C stated she was off during the time of R2's hospitalization and did not provide the required information.	01060		

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01060	Continued From page 15 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01060		
01530 SS=F	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a	01530		

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01530	Continued From page 16 supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure direct care staff received the required two hours of initial training on mental illness and de-escalation topics for three of three employees (unlicensed personnel (ULP)-D, ULP-E, registered nurse (RN)-G). This had the potential affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on August 12, 2025, at 10:22 a.m., owner (O)-C was identified as responsible for maintaining employee records and O-C stated they were familiar with the assisted living regulations.	01530		

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01530	Continued From page 17 ULP-D was hired October 24, 2024, to provide direct care services to the residents of the facility. On August 12, 2025, at 12:41 p.m., the surveyor observed ULP-D administering R2's scheduled medications. ULP-E was hired May 1, 2011, to provide direct care services to the residents of the facility. On August 13, 2025, at 7:45 a.m., the surveyor observed ULP-E administering R3's scheduled medications. RN-G was hired April 18, 2025, to supervise and provide direct care services to the residents of the facility. ULP-D, ULP-E and RN-G's records lacked documentation ULP-D, ULP-E and RN-G completed the required two hours of initial training on mental illness and de-escalation topics which became effective July 1, 2025. On August 13, 2025, at 11:19 a.m., O-C stated they received notification from Educare (online training program) informing the release of the new mental illness and de-escalating training topics and assigned to staff; however, O-C stated not all employees completed the required training. O-C stated when O-C assigned the mental illness and de-escalating training only the annual one hour training course had been assigned. The licensee's Assisted Living Dementia Training policy dated August 1, 2021, indicated assisted living staff would receive the required training on	01530		

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01530	Continued From page 18 dementia care during orientation and annually. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01890 SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to monitor for expired medications being stored by the licensee. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on August 12, 2025, at 10:22 a.m., owner (O)-C, stated the licensee provided medication storage for the residents at the facility and the resident	01890		

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01890	Continued From page 19 medications were stored in locked cabinet in the kitchen. On August 12, 2025, at 2:01 p.m., the surveyor reviewed the medication storage cabinet with unlicensed personnel (ULP)-F and observed the following: -R2's two opened packages of Salonpas patches (topical pain reliever) had expired February 2025; -R2's opened laxative powder had expired April 2025; -the license's unopened stock of adult tussin (cough syrup) had expired November 2024; and -the licensee's opened stock of ClearLax powder (used to treat constipation) had expired June 2025. On August 13, 2025, at 1:02 p.m., on a telephone interview with clinical nurse (CNS)-B, CNS-B stated the review of the medication storage had been recently assigned as a new task to registered nurse (RN)-G a couple of months ago. The licensee's Storage of Medications policy January 28, 2022, indicated the RN would establish a system that addresses the storage and handling medications including how refills and prescriptions would be monitored. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
02310 SS=F	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	02310		

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02310	Continued From page 20 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 ensure the care and services were provided according to acceptable health care and medical, or nursing standards for one of one resident (R2) who utilized a consumer bedrail. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on August 12, 2025, at 10:22 a.m., owner (O)-C stated the licensee was familiar with the current minimum assisted living requirements. On August 12, 2025, at 11:09 a.m., the surveyor observed a bedrail attached to R2's upper right side of the bed. R2's diagnosis included cerebral vascular accident (stroke) with left hemiparesis (one sided muscle weakness). R2's Service Plan dated August 3, 2021,	02310		

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02310	Continued From page 21 indicated to refer to R2's care plan for services. R2's care plan dated August 7, 2025, indicated R2 required assistance with ambulation, transferring, toileting, medication administration, personal hygiene, dressing and bathing. R2's care plan indicated R2 utilized a bedrail to allow independence with bed mobility and R2's bedrail would be monitored monthly and as needed for safety. R2's Treatment and Therapy Plan dated August 7, 2025, indicated R2 had a M-Rail (a type of device with a "M" shape to assist with bed mobility) and staff would monitor the bedrail daily. R2's Restraint/Entrapment Assessment dated May 14, 2025, indicated R2 used a M-Rail to assist with positioning and transferring, risk vs benefits were discussed and the M-Rail was installed per manufacture instructions; however, R2's record lacked evidence the licensee referred to the Consumer Product Safety Commission (CPSC) website for bedrail recall information at the time of installation or with every 90-day comprehensive assessment. On August 12, 2025, at 1:46 p.m., O-C stated they were unaware of the requirement to check the CPSC website for recalls on consumer bedrails. On August 12, 2025, at 1:49 p.m., O-C stated they just viewed the CPSC website and confirmed R2's M-Rail was not on the recall list. On August 13, 2025, at 1:02 p.m., in a telephone interview with clinical nurse supervisor (CNS)-B, CNS-B stated bedrails were a part of resident	02310		

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02310	Continued From page 22 assessments and they were not familiar with the requirement to check the CPSC website for consumer bedrail recalls. The licensee's Devices and Device Assessment policy dated August 16, 2022, indicated if a resident expressed the desire to use a device or a device is in use or recommended, a nurse would compete a device assessment at the time of move in, upon hospital return, change in condition, and or upon discover of a rail. For non-hospital beds, devices would be installed according got the device manufacturer's instruction, document in the resident's record and two times a year the clinical nurse supervisor would check the Food and Drug Administration (FDA) website for recalls on bed assistive devices. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	02310		
02410 SS=D	144G.91 Subd. 13 Personal and treatment privacy (a) Residents have the right to consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being. Staff must respect the privacy of a resident's space by knocking on the door and seeking consent before entering, except in an emergency or unless otherwise documented in the resident's service plan. (b) Residents have the right to have and use a lockable door to the resident's unit. The facility shall provide locks on the resident's unit. Only a staff member with a specific need to enter the	02410		

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02410	Continued From page 23 unit shall have keys. This right may be restricted in certain circumstances if necessary for a resident's health and safety and documented in the resident's service plan. (c) Residents have the right to respect and privacy regarding the resident's service plan. Case discussion, consultation, examination, and treatment are confidential and must be conducted discreetly. Privacy must be respected during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure privacy was maintained for one of three residents (R4) during medication management services in a nonprivate area. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on August 12, 2025, at 10:33 a.m., owner (O)-C stated the licensee provided medication management services to residents at the facility. On August 13, 2024, at 7:54 a.m., the surveyor	02410		

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02410	Continued From page 24 observed R4 sitting at the dining table with other residents eating breakfast. The surveyor observed unlicensed personnel (ULP)-E prepare and administer R4's scheduled morning medications. ULP-E proceeded to administer R4's artificial tears into both eyes and Fluticasone nasal spray at the dining table. The surveyor did not observe ULP-E offer to move R4 into a private area to administer eye drops and nasal spray. In addition, the surveyor did not observe ULP-E ask other residents at the dining table if they were comfortable with having R4's eye drops and nasal spray administered at the dining room table. On August 13, 2025, at 1:02 p.m., during a telephone interview, clinical nurse supervisor (CNS)-B stated staff were allowed to administer eye drops, nasal sprays and treatments at the dining table unless otherwise directed by the resident. On August 13, 2025, at 1:15 p.m., O-C stated they did not consider other resident preferences when administering medications and treatments at the dining table or in a public setting. The licensee's Administering Eye Drop policy dated March 14, 2015, indicated to provide privacy. The licensee's Training Unlicensed Personnel for Medication, Treatment and Therapy Administration dated August 1, 2021, indicated before the registered nurse (RN) delegated the task of assistance with medications or the task of medication administration, treatment and therapy the RN would instruct the unlicensed personnel on performing these tasks and determine the	02410		

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02410	Continued From page 25 unlicensed personnel as competent to perform the tasks. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02410		

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

Food & Beverage Inspection Report

Establishment Info

BARROSS COTTAGE LLC
401 SOUTH AVENUE
Two Harbors, MN 55616
Lake County
Parcel:

Phone:

License Info

License: HFID 20987

Risk:
License:
Expires on:
CFPM: Todd P Fabbri
CFPM #: 26000; Exp: 5/3/2028

Inspection Info

Report Number: F7980251063
Inspection Type: Full - Joint
Date: 8/12/2025 Time: 11:00:52 AM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 1
Delivery: Emailed

New Order: 2-100 Supervision
2-102.12FMN *Priority Level: Priority 3 CFP#: 2*
MN Rule 4626.0033F The certified food protection manager must identify the hazards in the operation of the food establishment; develop or implement policies, procedures, or standards to prevent foodborne illness in the food establishment; coordinate training, supervision or direction of food preparation activities; take corrective action in the food establishment as needed to protect the health of the consumer; and, complete in-house self-inspections of the daily operations in the food establishment at a frequency that ensures food safety policies and procedures are followed.
COMMENT: USE THE DISH MACHINE THERMO LABELS DAILY TO VERIFY THE MACHINE IS REACHING 160F OR ABOVE. LABELS ARE AVAILABLE BUT MUST BE USED DAILY BY STAFF.
Comply By: 8/12/2025 Originally Issued On: 8/12/2025

Food & Beverage General Comment

Joint inspection with Sativa Bushey HRD nursing evaluator

Discussed employee illness with cook. Proper illness procedures are followed anyone ill with vomiting and/or diarrhea is excluded for 24 hours after all symptoms stop and illness recorded in the illness log.

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

I acknowledge receipt of the Duluth District Office inspection report number F7980251063 from 8/12/2025

Sara Bents

Cindy Story Fabbri
Owner

Sara Bents,
Public Health Sanitarian 3
218-302-6184
sara.bents@state.mn.us

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

Temperature Observations/Recordings

Establishment Info

BARROSS COTTAGE LLC
Two Harbors
County/Group: Lake County

Inspection Info

Report Number: F7980251063
Inspection Type: Full
Date: 8/12/2025
Time: 11:00:52 AM

Food Temperature: Product/Item/Unit: Yogurt**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 34 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Apple sauce**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 30 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: All items frozen hard**; Temperature Process:** Cold-Holding
Location: Upright Freezer at Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: All items frozen hard**; Temperature Process:** Cold-Holding
Location: Chest Freezer at Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Chicken**; Temperature Process:** Cooking
Location: Oven at 184 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Corn**; Temperature Process:** Cooking
Location: Stove at 183 Degrees F.
Comment:
Violation Issued?: No

New Food TemperatureRecord: Product/Item/Unit: Potatoes**; Temperature Process:** Cooking
Location: Oven at 200 Degrees F.
Comment:
Violation Issued?: No

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

Sanitizer Observations/Recordings

Establishment Info

BARROSS COTTAGE LLC
Two Harbors
County/Group: Lake County

Inspection Info

Report Number: F7980251063
Inspection Type: Full
Date: 8/12/2025
Time: 11:00:52 AM

Sanitizing Chemical: **Product:** Quaternary Ammonia**; Sanitizing Process:** Wiping Cloth Bucket
Location: Kitchen **Equal To** 200 PPM
Comment:
Violation Issued?: No

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Kitchen **Greater Than** 160 Degrees F.
Comment: Dish machine thermo label black from previous facility test
Violation Issued?: No

Minnesota (MDH) Version
EH Manager; RPT: F7980251063

Food Establishment Inspection Report

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

No. of Risk Factor/Intervention/Violations	1	Date: 8/12/2025
No. of Repeat Risk Factor/Intervention/Violations		Time: 11:00:52 AM
Score (optional)		Dur: min

Establishment:	Address:	City/State:	Zip:	Phone:
BARROSS COTTAGE LLC	401 SOUTH AVENUE	Two Harbors, MN	55616	
License/Permit #:	**Permit Holder:**	**Purpose of Inspection:**	**Est. Type:**	**Risk Category:**
HFID 20987		Full		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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

IN=in compliance **OUT**=not in compliance **N/O**=not observed **N/A**=not applicable

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

COS=corrected on-site during inspection **R**=repeat violation

	Compliance Status		COS	R
	Supervision			
1	IN	Person in charge present, demonstrate knowledge and performs duties		
2	OUT	Certified Food Protection Manager		
	Employee Health			
3	IN	knowledge, responsibiities, and reporting		
4	IN	Proper use of restriction and exclusion		
5	IN	Response to vomiting, diarrheal events		
	Good Hygienic Practices			
6	IN	Proper eating, tasting, drinking, tobacco use		
7	IN	No discharge from eyes, nose, and mouth		
	Preventing Contamination by Hands			
8	IN	Hands clean and properly washed		
9	IN	No bare hand contact with RTE foods, alternatives		
10	IN	Adequate handwashing sinks supplied and access		
	Approved Source			
11	IN	Food obtained from approved source		
12	IN	Food Received at proper temperature		
13	IN	Food in good condition, safe & unadulterated		
14	N/A	Records available: shellstock tags, parasite dest.		
	Protection From Contamination			
15	IN	Food separated and protected		
16	IN	Food-contact surfaces; cleaned & sanitized		
17	IN	Proper Disposition of returned, previously served, reconditioned,& unsafe food		

	Compliance Status		COS	R
	Time/Temperature Control for Safety			
18	IN	Proper cooking time & temperatures		
19	IN	Proper reheating procedures for hot holding		
20	N/O	Proper cooling time and temperature		
21	N/A	Proper hot holding temperatures		
22	IN	Proper cold holding temperatures		
23	IN	Proper date marking & disposition		
24	N/A	Time as public health control;procedures & record		
	Consumer Advisory			
25	IN	Consumer advisory provided for raw or undercooked foods		
	Highly Susceptible Populations			
26	IN	Pasteurized foods used; prohibited foods not offered		
	Food/Color Additives and Toxic Substances			
27	IN	Food additives; approved & properly used		
28	IN	Toxic substances properly identified;stored;used		
	Conformance with Approved Procedures			
29	IN	Compliance with variance, specialized processes & HACCP plan		

Risk factors are improper practices or procedures identified as the most prevalent contributing factors of foodborne illness or injury. Public Health Interventions 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" or OUT in box if numbered item is **not** in compliance Mark "X" in appropriate box for COS and/or R **COS**=corrected on-site during inspection **R**=repeat violation

			COS	R
		Safe Food and Water		
30	IN	Pasteurized eggs used where required		
31		Water & ice from approved source		
32	IN	Variance obtained for specialized processing methods		
		Food Temperature Control		
33		Proper cooling methods used; adequate equipment for temperature control		
34	N/A	Plant food properly cooked for hot holding		
35	N/O	Approved thawing methods used		
36		Thermometers provided & accurate		
		Food Identification		
37		Food properly labeled; original container		
		Prevention of Food Contamination		
38		Insects, rodents, & animals not present; no unauthorized person		
39		Contamination prevented during food prep, storage, & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

			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 and used		
46		Gloves used properly		
		Utensils, 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 and plan review		

Person in Charge (signature)

Inspector (signature) Sara Bents

Follow-up: Follow-up Date: