Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

April 11, 2025

Licensee
Barross Cottage II LLC
806 13th Avenue
Two Harbors, MN 55616

RE: Project Number(s) SL29942016

Dear Licensee:

On March 13, 2025, 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 December 18, 2024. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the December 18, 2024 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on December 18, 2024, found not corrected at the time of the March 13, 2025, follow-up survey and/or subject to penalty assessment are as follows:

1760-Documentation Of Administration Of Medication-144g.71 Subd. 8
2370-Right To Come And Go Freely-144g.91 Subd. 9- $500.00
2430-Confidentiality Of Records-144g.91 Subd. 15- $500.00

The details of the violations noted at the time of this follow-up survey completed on March 13, 2025 (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.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $1000.00**. 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 outlined on the state form; however, plans of correction are not required to be submitted for approval.

IMPOSITION OF FINES:

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.

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.

We urge you to review these orders carefully. If you have questions, please contact Jessie Cheze 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,

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

KKM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29942	A. BUILDING: _____ B. WING _____	R 03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BARROSS COTTAGE II LLC	806 13TH 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 FOLLOW UP SURVEY WITH RE-ISSUE OF ORDERS INITIAL COMMENTS SL29942016-1 On March 12, 2025, through March 13, 2025, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on December 18, 2024. At the time of the survey, there were nine residents: nine receiving services under the Assisted Living License. As a result of the follow-up survey, 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 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, existing floor, wall, and ceiling finishes are	{0 480}		

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{0 480}	Continued From page 2 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:	{0 480}	Not reviewed during this survey.	
{0 780} SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment 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	{0 780}		

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{0 780}	Continued From page 3 buildings may be battery operated; This MN Requirement is not met as evidenced by:	{0 780}	Not reviewed during this survey.	
{0 800} SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by:	{0 800}	Not reviewed during this survey.	
{0 810} SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and	{0 810}		

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{0 810}	Continued From page 4 (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by:	{0 810}	Not reviewed during this survey.	
{01640} SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on	{01640}		

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{01640}	Continued From page 5 resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by:	{01640}	Not reviewed during this survey.	
{01760} SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by:	{01760}		

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{01760}	Continued From page 6 Based on observation, interview, and record review, the licensee failed to ensure the steps of the medication administration process was followed by one of two employees (unlicensed personnel (ULP-G). In addition, the licensee failed to ensure medication was given per manufacturer's instructions for one of two residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: STEPS OF THE MEDICATION PROCESS On March 12, 2025, at 1:38 p.m., the surveyor observed ULP-G perform hand hygiene, and review R4's medication administration record (MAR). ULP-G applied gloves and prepared R4's medication crusher. ULP-G removed R4's medication from a pre-set dosage box. ULP-G crushed R4's acetaminophen (mild pain) and opened R4's gabapentin (nerve pain) capsule. ULP-G documented in R4's MAR. ULP-G mixed the medication into applesauce and took the medication mixture to R4's room. ULP-G administered R4's medication, removed gloves, washed hands, and returned the MAR to a cabinet. The surveyor did not observe ULP-G document in R4's MAR that ULP-G had administered R4's medication. Directly after the above observation ULP-G stated	{01760}	Not reviewed during this survey.	

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{01760}	Continued From page 7 she documented R4's medication as administered when she prepared R4's medication. ULP-G stated R4 does not decline medication. ULP-G stated she usually documented medication as administered after administration, however, since R4's medications were crushed she documented prior to R4's medication administration. ULP-G added she would have had to have thrown R4's medication away if R4 would not have taken the medication. On March 12, 2025, at 1:48 p.m., licensed assisted living director/owner (LALD/O)-A stated she thought ULP-G had either dotted R4's MAR or wrote down her first initial. LALD/O-A stated she was not aware ULP-G had documented R4's medication as administered prior to medication administration. LALD/O-A stated ULPs were trained to document after medication administration. On March 13, 2025, at 7:49 a.m., clinical nurse supervisor (CNS)-C stated ULPs know they are to document after medications are administered, not prior to medication administration. CNS-C stated this was a medication error. MANUFACTURER'S INSTRUCTIONS R3's diagnosis included diabetes and congested heart failure (CHF-condition in which the heart's function as a pump is inadequate to meet the body's needs). R3's service plan dated February 26, 2025, indicated R3 received medication administration. R3's MAR dated March 1, 2025, through March 12, 2025, included: - Lantus 100 units/milliliter (ml) (long-acting insulin) 40 units, subcutaneous (SQ/under skin,	{01760}		

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{01760}	Continued From page 8 into fatty tissue) in the a.m. (morning). Rotate sites (LA= left arm, RA= right arm, LL= left leg, RL=right leg, ST=stomach). R3's prescriber order dated February 7, 2025, included the above order. On March 13, 2025, at 7:18 a.m., the surveyor observed ULP-G prepare R3's Lantus insulin pen using correct technique. ULP-G asked R3, "how about right here today?" (motioning to R3's left upper arm site). ULP-G cleaned the area with an alcohol pad and injected 40 units of Lantus into R3's left arm. Directly after the above observation R3's MAR was reviewed with ULP-G. R3's MAR indicated on March 12, 2025, R3's left arm site (LA) had been used for Lantus injection. ULP-G stated she did not review the previous injection site location prior to R3's insulin administration. ULP-G stated she did not rotate insulin injection site as instructed on R3's MAR. R3's MAR dated March 1, 2025, through March 12, 2025, included the following site injection documentation: - March 1, 2025, = ST - March 2, 2025, = ST - March 8, 2025, = ST - March 9, 2025, = ST - March 12, 2025, = LA - March 13, 2025, = LA. R3's MAR indicated that from March 1, 2025, through March 13, 2025, R3's insulin injection site was not rotated three times. On March 13, 2025, at 7:51 a.m., CNS-C stated ULPs should check the MAR prior to insulin	{01760}		

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{01760}	Continued From page 9 administration to know which site was last used, to ensure insulin sites were rotated. The manufacturer's instructions for Lantus Solostar pen dated 2022 noted change rotate injection sites within the area of choice for each dose to reduce your risk of getting lipodystrophy (pits in skin or thickened skin) and localized cutaneous amyloidosis (skin with lumps) at the injection sites. Do not use the same spot for each injection or inject where the skin is pitted, thickened, lumpy, tender, bruised, scaly, hard, scarred or damaged. The licensee's Administration of Medication, Treatment and Therapy By Unlicensed Personnel policy dated May 20, 2022, noted unlicensed personal that provided assistance with medication, treatment and therapy administration would be trained and competency tested by the registered nurse on the following: documentation, after assistance with self-administration of medications or medications, treatment and therapy administration, consistent with our facility's procedures for documenting the MAR. The licensee's Administration of Medication, Treatment and Therapy by Unlicensed Personnel policy dated May 20, 2022, noted unlicensed personnel that would provide assistance with medication, treatment and therapy administration would be trained and competency tested by the RN on the following: a. The complete procedures for checking the resident' mediation administration record and medication profile, treatment and therapy profile and nay additional information b. Infection control precautions that must be followed when administrating medication,	{01760}		

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{01760}	Continued From page 10 treatment and therapy c. Preparation of the medication for the resident when necessary d. Administration of the medication, treatment and therapy to the resident (or assistance with self-administration) e. Documenting, after assistance with self-administration of medications or medications, treatment and therapy administration, consistent with our facility's procedures for documenting the MAR f. The procedure for staff to notify the RN of any mediations or dietary supplement that are being used by the resident and that are not included in the assessment for mediation management services. The RN had developed written, specific instruction for each resident. In addition, the RN had documented that the unlicensed personnel have been trained and have demonstrated competency to follow the procedures. Further, documentation of each unlicensed staff person's training and competency to assist or administer medications, treatment and therapy would be retained in the personnel record of each staff person who had satisfied the above training and competency requirements. No further information was provided.	{01760}		
{02370} SS=F	144G.91 Subd. 9 Right to come and go freely Residents have the right to enter and leave the facility as they choose. This right may be restricted only as allowed by other law and consistent with a resident's service plan. This MN Requirement is not met as evidenced by:	{02370}		

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{02370}	Continued From page 11 Based on observation, interview and record review, the licensee failed to ensure residents have the right to come and go from the facility as they choose. 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: The licensee had an assisted living license issued on April 1, 2024, with an expiration date of March 31, 2025. On December 16, 2024, during the initial entrance conference at 11:10 a.m., the surveyor inquired if there was an access code required to enter the building. Licensed assisted living director/owner (LALD/O)-A stated there was a code and told the surveyor the code. In addition, on December 16, 2024, at approximately 4:30 p.m., the surveyor required a code to exit the facility. On March 12, 2025, at 10:16 a.m., the surveyor observed a keypad code system on the exit door. The surveyor attempted to open the door however the door was locked. The surveyor did not observe any signage posted that noted the exit code. The surveyor could not exit the facility. On March 12, 2025, at 11:46 a.m., the surveyor observed R8 (epigastric pain) assist R9 out of a bathroom. R8 stated he was given the code to	{02370}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29942	A. BUILDING: _____ B. WING _____	R 03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{02370}	Continued From page 12 exit the facility. R8 stated he was married to R9 (cognitive impairment). R8 stated "she (R9) had Alzheimer's" and R8 was not given the exit code. On March 12, 2025, at 11:49 a.m., R3 (diabetes and congested heart failure (CHF-condition in which the heart's function as a pump was inadequate to meet the body's needs) stated "they (licensee) won't tell me the code to exit the building. R3 stated only "those" that work at the facility know the code, and added "few people" (residents) are given the exit code. R3 stated, he told the licensee that if he needed to get out and could not, he (R3) "would carry something to break a window or something". On March 12, 2025, at 12:03 p.m., co-owner (CO)- E stated he had a switch put in that would shut off the doors, (control switch that released the door to the unlocked position from a remote location, such as the nurse's station) as engineering requested. CO-E stated the "door people" (company) did not have time to fix the code issue (to remove the coding system). CO-E stated the licensee was still waiting to get the door work completed. CO-E and LALD/O-A stated the door still required a code to exit the building and the code was not posted anywhere to exit the building at the time of the survey. The Minnesota Bill of Rights dated November 8, 2022, noted residents have the right to enter and leave the facility as they chose. The right may be restricted only as allowed by other law and consistent with a resident's service plan. No further information was provided.	{02370}		

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{02430}	Continued From page 13	{02430}		
{02430} SS=F	144G.91 Subd. 15 Confidentiality of records (a) Residents have the right to have personal, financial, health, and medical information kept private, to approve or refuse release of information to any outside party, and to be advised of the assisted living facility's policies and procedures regarding disclosure of the information. Residents must be notified when personal records are requested by any outside party. (b) Residents have the right to access their own records. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure resident's personal health and medical information was kept private. This had the potential to affect all residents residing at the assisted living facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On March 12, 2025, at 10:22 a.m., the surveyor observed an open communication binder on the counter in a kitchen type of area that was used for medication preparation and a closed medication administration record (MAR), that had tabs (9) that noted the names of the licensee's residents. The surveyor observed two residents	{02430}		

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{02430}	Continued From page 14 in the attached commons/TV area and one resident ambulating down a hallway leading to the common's/TV area. The surveyor did not observe any staff in the area, within view. Communication binder information visible included: - page one: a column labeled from 4:00 p.m., until 8:00 p.m., that included names of resident's and times of medication administration, and medication administration information such as inhaler, remove TEDS (compression stockings), check blood sugar, alarm use, can crush medication. -page two: daily internal charting documentation, with five resident's names and notes written by staff, dated March 11, 2025. On March 12, 2025, at 10:23 a.m., unlicensed personnel (ULP)-G stated the MAR was normally out on the counter but closed. On March 12, 2025, at 10:25 a.m., the surveyor observed ULP-G assist R5 to the bathroom. On March 12, 2025, at approximately 12:00 p.m., licensed assisted living director/owner (LALD/O)-A stated only the MAR was left on the counter and the MAR was closed. LALD/O-A stated she thought that was ok, to leave the MAR on the counter closed. The surveyor reviewed photos of the communication binder opened on the counter with LALD/O-A. LALD/O-A stated the communication binder should not have been left on the counter open. LALD/O-A and co-owner (CO)-E confirmed by leaving the MAR, even if closed, on the counter, resident medical information was not secure. LALD/O-A stated resident's medical information could have been accessed by resident's, families, and visitors.	{02430}		

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{02430}	Continued From page 15 The Minnesota Bill of Rights dated November 8, 2022, noted residents have the right to have personal, financial, health, and medial information private. The licensee's Security of Resident Records policy dated August 1, 2021, noted all information in the resident record must be kept confidential and accessible only to authorized agency personnel. No further information provided.	{02430}		

Electronically Delivered

February 10, 2025

Licensee
Barross Cottage II LLC
806 13th Avenue
Two Harbors, MN 55616

RE: Project Number(s) SL29942016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on December 18, 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.

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

St - 0 - 0495 - 144g.41 Subdivision. 1 (13) - Minimum Requirements - $3,000.00
St - 0 - 1750 - 144g.71 Subd. 7 - Delegation Of Medication Administration - $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $6,000.00**. 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 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, Supervisor
State Evaluation Team
Email: Jessie.Chenze@state.mn.us
Telephone: 218-332-5175 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 000	Initial Comments ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL29942016 On December 16, 2024, through December 18, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were nine resident receiving services under the Assisted Living Facility license. An immediate correction order was identified on December 16, 2024, issued for SL29942016, tag identification 0495, and was issued at a level three widespread scope (I). An immediate correction order was identified on December 17, 2024, issued for SL29942016, tag identification 1750, and was issued at a level three widespread scope (I).	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 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, existing floor, wall, and ceiling finishes are	0 480		

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0 480	Continued From page 2 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 December 17, 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	0 480		

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0 480	Continued From page 3 to the FBEIR for any compliance dates.	0 480		
0 495 SS=I	144G.41 Subdivision. 1 (13) Minimum Requirements (13) provide staff access to an on-call registered nurse 24 hours per day, seven days per week. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure staff had access to a registered nurse (RN) 24 hours per day, seven days per week. This had the potential to affect all residents receiving assisted living services. This resulted in an immediate correction order on December 16, 2024. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee held an assisted living facility license and was licensed for a capacity of 10 residents. The current census at the facility was nine (9) as of December 16, 2024. On December 16, 2024, at 11:05 a.m., during the entrance conference, licensed assisted living	0 495		

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0 495	Continued From page 4 director/owner (LALD/O)-A stated clinical nurse supervisor (CNS)-C could not answer a phone call "right now" but CNS-C could answer a text message. LALD/O-A said CNS-C worked day shift at (name of a day surgery center). LALD/O-A stated she felt 20 minutes was a reasonable time for CNS-C to reply. LALD/O-A added if more was needed, 911 would be called. LALD/O-A added the facility had no additional nurse but was waiting for one staff to get her licensed practical nurse (LPN) degree so there would be a second nurse available. On December 16, 2024, at 12:53 p.m., LALD/O-A stated CNS-C worked Monday through Friday, at a walk-in clinic, for the most part. LALD/O-A said she had the previous RN on backup and still on the NetStudy roster, and the previous RN had told LALD/O-A to call if ever needed, however, the previous RN was not scheduled on the on-call list, a phone number was not listed, nor did the the previous RN have a schedule with the licensee. On December 16, 2024, at 1:17 p.m., unlicensed personnel (ULP)-D stated CNS-C does not always answer the phone when called. ULP-D said CNS-C would text staff back when CNS-C could. The surveyor asked to see the on-call list, there was only one RN phone number listed, CNS-C. ULP-D stated if CNS-C could not be reached LALD/O-A would be called for direction. LALD/O-A did not hold a license as a RN. On December 16, 2024, at 1:42 p.m., ULP-B stated 10 to 15 minutes was how long it took for CNS-C to get back to her sometimes. On December 16, 2024, at 1:46 p.m., ULP-D stated she only had to contact CNS-C once and	0 495		

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0 495	Continued From page 5 that time CNS-C got right back to her. On December 16, 2024, at 1:47 p.m., CNS-C stated staff (ULPs) were to call LALD/O-A if CNS-C was not available. CNS-C stated LALD/O-A was back up for on-call. CNS-C said she worked at a day surgery center, Monday through Friday and it depended on the day how often she was available, or not available. CNS-C added she had her phone on her person and if she could not answer, she may be able to text back. CNS-C stated there was protocol in place, if it was an emergency to call 911 or hospice. CNS-C added she could only give staff recommendations as she would not be seeing residents in person. CNS-C stated families were very involved, and family may or may not want a resident sent to the emergency department. In addition, CNS-C stated if she was not available, staff were to call LALD/O-A, 911, or family, as family was very involved. CNS-C said if a resident had fallen on the floor, the licensee's protocol was to call 911 or hospice or family. CNS-C stated ULPs normally would text a resident's room number, and concern, such as a low blood sugar reading. CNS-C said she felt a half an hour would be a reasonable time for her to respond to ULP questions/concerns. CNS-C stated if there was a hospital return, LALD/O-A would let her know and CNS-C would stop in the evening to complete an assessment. CNS-C stated, "No one in their life is available every minute of the day. I come in the evening. I'd have to look at my schedule. I come and go when it works with for me." R2's Uniform Disclosure of Assisted Living Services and Amenities, dated May 26, 2021, included: -unlicensed staff are in the building and available to respond to resident requests 24/7 (twenty-four	0 495		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 495	Continued From page 6 hours per day, seven days per week) -availability of licensed (RN/LPN) staff (in addition to an RN who is required to be accessible to the staff 24/7): check one if applicable. No boxes were checked. The form indicated licensed staff were on site 24/7 or licensed staff were either in the building, an attached building, or within the campus and available to respond to resident requests 24/7. The licensee's undated Clinical Nurse Supervisor Job Description template located in the policy binder noted: -hours: 10-20 hours/week and on-call 24/7 -was available for on-call medical questions and/or emergencies via phone 24/7. The licensee's Staffing, Direct-Care Staffing Plan & Daily Schedule policy dated August 1, 2021, noted: -registered nurse (RN) would be available to staff working at all times, availability may be in person, via phone, or via other electronic communication method. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	0 495		
0 510 SS=D	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	0 510		

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	29942	A. BUILDING: _____ B. WING _____	12/18/2024

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0 510	Continued From page 7 control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure infection control standards were followed by one of two unlicensed personnel (ULP)-D 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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On December 17, 2024, from 6:59 a.m., through 7:31 a.m., the surveyor continuously observed ULP-D administer medication to the licensee's residents. On December 17, 2024, at 6:59 a.m., the surveyor observed ULP-D prepare and administer R6's morning medication. The surveyor did not observe ULP-D perform hand hygiene prior to or after medication administration. On December 17, 2024, at 7:05 a.m., the surveyor observed ULP-D prepare R4's morning medication which consisted of an eye drop, oral	0 510		

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0 510	Continued From page 8 medications which ULP-D had crushed and mixed with applesauce, and a transdermal (on the skin) pain patch. ULP-D set the items on a tray along with a pair of gloves. ULP-D cut open the pain patch and took the tray to R4's room. ULP-D applied gloves and told R4 she would administer the eye drop first, as R4 was laying down. ULP-D handed R4 a tissue, and instilled eye drops into R4's eyes. R4 sat up and ULP-D administered R4's morning oral medications via spoon. ULP-D got onto R4's bed and applied a pain patch to R4's lower back. ULP-D returned to the medication preparation area, put the spoon into the sink and removed gloves. ULP-D returned the eye drop to the locked medication cabinet and documented R4's medication as administered. The surveyor did not observe ULP-D perform hand hygiene prior to or after glove use. On December 17, 2024, at 7:16 a.m., the surveyor observed ULP-D unlocked the medication cabinet and prepare R2's oral morning medication. ULP-D assisted R2 with positioning for medication administration and administered R2's medication. The surveyor did not observe ULP-D perform hand hygiene before or after medication administration. On December 17, 2024, at 7:20 a.m., the surveyor observed ULP-D open the locked medication cabinet, remove a dosage box for R7. ULP-D placed R7's thyroid medication into ULP-D's bare hand to examine the medication. ULP-D said "it" (medication) was "tiny" and she was having a hard time identifying the medication. ULP-D administered R7's morning medication. The surveyor did not observe ULP-D perform hand hygiene prior to or after medication administration.	0 510		

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0 510	Continued From page 9 On December 17, 2024, at 7:31 a.m., the surveyor observed ULP-D secured her hair with a hair tie. ULP-D washed her hands. On December 17, 2024, at 7:31 a.m., ULP-D stated she did not wash her hands as required, as she should have. ULP-D added just "knowing" she was being observed must have been the reason she did not perform hand hygiene. On December 17, 2024, at 3:31 p.m., clinical nurse supervisor (CNS)-C stated hands should be washed in-between residents or sanitizer used if there was no obvious reason. CNS-C confirmed hand hygiene should be done between glove changes. The licensee's Hand Hygiene policy dated August 1, 2021, noted: When hands should be washed. Hand washing shall be performed between residents' cares and whenever direct physical contact with a resident took place. Use of gloves did not replace hand washing. Hands should be washed or decontaminated: a. before and after direct contact with a resident b. if moving from a contaminated-body site to a clean-body site during resident care c. after contact with environmental surfaces or equipment in the immediate vicinity of the resident d. after removing gloves or gowns e. fore eating and after using a restroom. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		

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0 660	Continued From page 10	0 660		
0 660 SS=F	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. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC). The licensee failed to complete a TB risk assessment annually. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	0 660		

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0 660	Continued From page 11 The findings include: On December 16, 2024, at 12:07 p.m., the surveyor reviewed the facility's TB risk assessment: -date last TB risk assessment was conducted: June 29, 2022. On December 16, 2024, at 12:09 p.m., licensed assisted living director/owner (LALD/O)-A stated the facility TB risk assessment was to be completed annually. LALD/O-A said she was waiting for the new TB form to come out as LALD/O-A pointed the facility's TB risk assessment form which noted, updated June 2023. LALD/O-A said she "probably" should have updated the facility TB risk assessment. On December 17, 2024, at 3:33 p.m., clinical nurse supervisor (CNS)-C stated she had not done anything with the facility's TB risk assessment. CNS-C added she had never known about it (TB risk assessment). The licensee's TB Prevention and Control policy dated May 20, 2022, noted registered nurse (RN) was responsible for ensuring an organizational TB program was developed, implemented and maintained. Annually a community TB risk assessment would be completed. The Minnesota Department of Health (MDH) guidelines "Regulations for Tuberculosis Control in Minnesota Health Care Settings" dated February 3, 2022, and based on CDC guidelines, indicated a TB risk assessment should be completed on an annual basis. No further information was provided.	0 660		

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0 660	Continued From page 12 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 660		
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 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 (EPP) updated annually as required. This had the potential to affect all residents, staff and visitors.	0 680		

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0 680	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, 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 December 16, 2024, at approximately 11:30 a.m., the surveyor toured the assisted living facility with licensed assisted living director/owner (LALD/O)-A and observed the licensee's EPP binder located in the common area near the front entry of the facility. On December 16, 2024, at 12:21 p.m., the surveyor reviewed the facility's EPP with LALD/O-A. LALD/O-A stated the facility's EPP risk assessment was dated July 12, 2021. LALD/O-A stated the EPP had not been reviewed recently and added she (LALD/O-A) would need to do that (update EPP). On December 16, 2024, at 12:22 p.m., LALD/O-A stated the licensee had joined the health care coalition, right after the last survey. Contracts with other facilities were reviewed with LALD/O-A, and the contracts (two) were both dated August 30, 2022. LALD/O-A added one of the contracts/sites was for another facility owned by the licensee. Further, the facility's EPP action plans annual review was dated September 12, 2023. On December 16, 2024, at 12:31 p.m., LALD/O-A stated the facility risk assessment was completed	0 680		

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0 680	Continued From page 14 on July 12, 2021, and it had not been redone. LALD/O-A said, honestly, she had looked for the risk assessment for the most part, adding she had been short staffed a lot and needed to fill in. LALD/O-A confirmed the facility's EPP had not been reviewed or updated as required. On December 16, 2024, at 12:48 p.m., the missing person plan was reviewed with LALD/O-A dated April 3, 2023. LALD/O-A stated she was not aware the mission person plan needed to be reviewed quarterly. The emergency operations plan, communications plan, and policies and procedures listed above (this facility would be prepared to manage emergency and disaster situations, including missing residents through our hazard assessment and emergency planning) would be reviewed and updated at least annually, dated August 1, 2021. The licensee's Emergency and Disaster Preparedness policy dated August 1, 2021, noted the EPP addressed the following requirements: (a) it is based on and included a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents (b) included strategies for addressing emergency events identified the risk assessment (c) addressed our resident population, including, but not limited to, person at risk, the type of service the facility had the ability to provide in an emergency; and continuity of operation, including delegations of authority and succession plans (d) included a process for cooperation and collaboration with local, tribal, regional, State, or Federal emergency preparedness officials' efforts to maintain an integrated response during	0 680		

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0 680	Continued From page 15 disaster or emergency situation (e) the emergency disaster plan contends a plan for evacuation, addressed elements of sheltering in place, identified temporary relocation sites, and details staff assignments in the event of a disaster or an emergency. The emergency operations plan, communications plan, and the policies and procures listed above would be reviewed and updated at least annually. The licensee's Missing Resident policy dated August 1, 2021, noted the assisted living director and clinical nurse supervisor would review the missing resident plan at least quarterly and document any changes to the plan. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0110, Subp. 4, effective October 2022, the assisted living director and clinical nurse supervisor must review the missing person plan at least quarterly and document any changes to the plan. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0100, sections A and B, effective October 2022, assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations, title 42, section 483.73, or successor requirements. This part references documents, specifications, methods, and standards in "State Operations Manual Appendix Z - Emergency Preparedness for All Providers and Certified Supplier Types: Interpretive Guidance," which is incorporated by reference. No further information was provided.	0 680		

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0 680	Continued From page 16 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to keep the facility in compliance with the Minnesota Fire Code. The deficient conditions have the ability to affect all staff and residents. This practice resulted in a level two violation (a	0 780		

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0 780	Continued From page 17 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On facility tour with the licensed assisted living director (A/LALD)-O on December 17, 2024, between 8:45 a.m. and 10:45 a.m. the following deficient conditions were observed: CARBON MONOXIDE: The surveyor observed no carbon monoxide protection in the building. The surveyor explained to the A/LALD-O that carbon monoxide protection is required to meet the Minnesota State Fire Code. MAGNETIC LOCKED EXIT DOORS: The surveyor observed that all the exit doors were being locked with magnetic locks from the inside and outside. The facility did not have the following: 1. They did not verify that the doors released under power loss or fire sprinkler or fire alarm activation. 2. The facility did not have a control locking system capable of being unlocked by a signal or switch from the fire command center, a nursing station, or other approved location. 3. The facility did not provide procedures for the	0 780		

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0 780	Continued From page 18 operations of the unlocking system in their emergency planning and preparedness plan. 4. Emergency lighting was not provided on both sides of the doors equipped with a controlled egress locking device. 5. The floor levels within the building or portion of the building with controlled egress were not divided into at least two compartments by smoke barriers meeting the requirements of the Minnesota Building Code. The surveyor explained to the A/LALD-O that to have these locks remain, they shall meet the special locking requirements of the Minnesota State Fire Code. EMERGENCY GENERATOR: During record review of the standby generator, no documentation was provided showing the required testing of the generator. This generator powers the lights in the facility. No battery-operated emergency lights were present. The surveyor explained to the A/LALD-O that the required testing shall be completed and documented. The deficient conditions were visually verified by the A/LALD-O accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds,	0 800		

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0 800	Continued From page 19 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 maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On facility tour with the licensed assisted living director (A/LALD)-O on December 17, 2024, between 8:45 a.m. and 10:45 a.m. the following deficient conditions were observed: FLOORING: The surveyor observed cracked ceramic tile and rusty heat vents in the bathrooms and duct tape on the floor at transitions with the carpet in a couple of areas in the facility. These items were	0 800		

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0 800	Continued From page 20 noted during the January 26, 2022, survey and did not get fixed. The surveyor explained to the A/LALD-O that the facility shall be kept in good repair and that all the items noted above shall be fixed. The deficient conditions were visually verified by the A/LALD-O accompanying on the tour. TIME PERIOD FOR CORRECTION: Twenty-one (21) 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) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The	0 810		

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	29942	A. BUILDING: _____ B. WING _____	12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BARROSS COTTAGE II LLC	806 13TH AVENUE TWO HARBORS, MN 55616

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0 810	Continued From page 21 training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and the annual training on the fire safety and evacuation plan was not being completed for residents and documented at new hire and semi-annually for employees. 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: A record review and interview were conducted on December 17, 2024, at approximately 10:00 a.m. with the licensed assisted living director (A/LALD)-O on the fire safety and evacuation plan for the facility. FIRE/EVACUATION PLAN:	0 810		

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0 810	Continued From page 22 During record review the surveyor noticed no indication in the plan on how to unlock the doors in an emergency. DRILLS: During record review the surveyor noticed fire drills were not being completed on the overnight shift. TRAINING: During record review the surveyor A/LALD-O stated there was no documentation of training on the fire safety and evacuation plan for the employees or residents. The surveyor explained to the A/LALD-O that the procedures for unlocking the doors shall be spelled out in the fire safety and evacuation plan, that the fire/evacuation drills shall be conducted twice per year per shift with at least one drill every other month and documented and that training on the fire safety and evacuation plan shall be conducted at new hire and twice per year thereafter for employees and be offered to the residents once per year. The training shall be documented. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01420 SS=F	144G.62 Subd. 2 Delegation of assisted living services (b) When the registered nurse or licensed health professional delegates tasks to unlicensed personnel, that person must ensure that prior to	01420		

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01420	Continued From page 23 the delegation the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each resident and is able to demonstrate the ability to competently follow the procedures and perform the tasks. If the unlicensed personnel has not regularly performed the delegated assisted living task for a period of 24 consecutive months, the unlicensed personnel must demonstrate competency in the task to the registered nurse or appropriate licensed health professional. The registered nurse or licensed health professional must document instructions for the delegated tasks in the resident's record. 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) ensured training and competency demonstration was completed for one of one unlicensed personnel (ULP-D). Additionally, the licensee failed to provide written instructions in the resident records for delegated tasks for two of two residents (R2, R5). 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: ULP-D ULP-D began employment on August 12, 2024, to provide assisted living services to the licensee's	01420		

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01420	Continued From page 24 residents. FALL ALARM On December 17, 2024, at 7:38 a.m., the surveyor observed ULP-D and ULP-B assisting R2. The surveyor observed a fall alarm (Fall Watch II) on R5's bed. ULP-D stated the fall alarm was used on R5's bed when R5 laid down at night. ULP-D added R5 got up to go to the bathroom and the alarm notified ULPs so R5 did not go back to her chair instead of returning to R5's bed. ULP-D said the ULPs trade off every other day, medications, and personal cares. SIT TO STAND LIFT ULP-D's employee file included: Skill Competency: Lifting and Safe Transfer, Procedure: transfer using a sit to stand lift dated August 14, 2024, "pass" authenticated by licensed assisted living director/owner (LALD/O)-A. On December 17, 2024, at 9:52 a.m., the surveyor observed ULP-D and ULP-B use a sit-to stand (Sabina II, mechanical lift: designed for users with some mobility and strength, needing some assistance) to transfer R2 from her hospital bed to commode. ULP-B and ULP-D applied a support vest around R2's waist and belted it loosely around R2's middle. R2 reached up and held onto the sit-to-stand lift with her right hand and her left arm hung loose at R2's side. ULP-D's employee record lacked training and competency completed by clinical nurse supervisor (CNS-C/RN) for sit-to-stand lift and for fall alarm. On December 17, 2024, at 1:01 p.m., LALD/O-A stated she thought ULP-D's training for	01420		

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01420	Continued From page 25 sit-to-stand lift was in ULP-D's employee file. On December 17, 2024, at 1:07 p.m., LALD/O-A stated there was no evidence of fall alarm training or competency in ULP-D's employee record. On December 17, 2024, at 4:03 p.m., CNS-C stated sit-to-stand training and fall alarm training was before her time (hired at facility). CNS-C said she had observed ULPs use the sit-to stand lift. CNS-C added LALD/O-A had been deemed competent to instruct ULPs to operate the sit-to-stand lift and fall alarms. On December 18, at approximately 12:45 p.m., LALD/O-A stated she was a licensed staff and thought per the statues she could train and deem ULPs competent. LALD/O-A confirmed ULPs were not trained or deemed competent by a RN (CNS-C). WRITTEN INSTRUCTION R2 R2's diagnoses included cardiovascular accident/CVA (stroke, when blood flow to the brain was interrupted, leading to brain damage) left side affected, diabetes, congested heart failure (CHF-condition in which the heart's function as a pump is inadequate to meet the body's needs), total right and total left knee replacement. R2's Service Plan dated July 31, 2024, noted, see plan of care. R2's Plan of Care, attachment to R2's service plan last reviewed on October 31, 2024, with no changes, included: - transferring: staff will use the Sit to Stand until I (R2) regain strength, staff will use the Sit To	01420		

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01420	Continued From page 26 Stand when I (R2) am feeling weak - safety: please monitor for use if bed & chair alarm is needed. MECHANICAL LIFT The manufacturer's undated instructions for Sabina II noted the patient grabs the sling bar. Remember that Sabina II sit-to-stand lift has two different speeds. For maximum comfort, the lift mast should be affixed to the based in the best possible of the three fastening holes. R2's record did not include specific use for the sit-to-stand lift as R2 was not able to grab onto sling bar with left hand. FALL PREVENTION ALARMS R5 R5's diagnoses included dementia, joint/muscle pain, and irregular heartbeat. R5's Service Plan dated August 3, 2023, noted, see plan of care. R5's Plan of Care, attachment to R5's service plan last reviewed October 20, 2024, included: -please use a bed & chair alarm under me in my room. On December 17, 2024, at 3:35 p.m., CNS-C stated every resident's use of alarms were different. CNS-C said staff (ULPs) were aware and if there was a chair alarm it could be inter-changeable (bed/chair.) CNS-C stated if it is not specified the alarm should be used at nighttime. CNS-C said alarms were implemented before her arrival. CNS-C was not at the facility and unable to review resident records. On December 18, 2024, at 8:40 a.m., LALD/O-A	01420		

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01420	Continued From page 27 stated she was not able to locate specific instructions in R2 or R5's records for delegated tasks. The licensee's Delegation of Nursing Tasks dated August 1, 2021, noted a registered nurse may delegate nursing services, or an authorized Licensed Health Professional my delegate treatment or assign therapy tasks, to unlicensed personnel that: -have successfully completed the training required for unlicensed personnel -have been trained in the services to be provided -have demonstrated to the RN or the Licensed Health Professional the ability to competently follow the procedures for the resident and possess the knowledge and skills consistent with the complexity of the tasks. In addition, prior to delegating a nurse task, the RN would include written instructions for performing the procedure for the resident in the resident's record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01420		
01440 SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability	01440		

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01440	Continued From page 28 to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure direct supervision of staff performing delegated tasks was provided within 30 calendar days after the date on which the individual begins working for the licensee for two of two unlicensed personnel (ULP-D, ULP-F). 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: ULP-D ULP-D was hired on August 12, 2024, to provide direct care services to residents at the assisted	01440		

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01440	Continued From page 29 living facility. On December 17, 2024, from 6:59 a.m. until 10:27 a.m., the surveyor observed ULP-D administer scheduled morning medication which included oral medication, transdermal (on the skin) medication, eye drops, and insulin administration. ULP-D was not under direct supervision. ULP-D's employee record lacked to include evidence a 30-day supervision of delegated tasks was completed. ULP-F ULP-F was hired on June 12, 2024, to provide direct care services to residents at the assisted living facility. On December 17, 2024, at 6:55 a.m., the surveyor observed ULP-F give ULP-D report from the night shift. ULP-F's employee record lacked to include evidence a 30-day supervision of delegated tasks was completed. On December 17, 2024, at 4:04 p.m., clinical nurse supervisor (CNS)-C stated she had never heard of 30-day ULP supervision and was not aware of the requirement. CNS-C confirmed 30-day supervision of delegated tasks were not completed as required. The licensee's Supervision of Unlicensed Personnel policy dated August 1, 2021, noted, direct supervisor of staff providing delegated nursing tasks, delegated treatments or assigned therapy tasks must be performed within 30 days after the person began work for the facility and	01440		

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01440	Continued From page 30 had been trained and determined competent to perform all the tasks assigned. The registered nurse (RN) would directly staff performing delegated nursing tasks and the appropriate licensed health professional would supervise unlicensed staff performing any delegated treatments or assigned therapies. After the pintail period of direct supervision, the RN and/or licensed health professional would determine the frequency of ongoing, additional direct supervision based on the individual staff person' performance and on the needs and condition of individual residents, the types of service being provided and the experience of the staff. No further information as provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440		
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 services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90	01620		

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01620	Continued From page 31 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 device assessments were completed for two of two residents, (R2, R5). 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: R2 R2's diagnoses included cardiovascular accident/CVA (stroke, when blood flow to the brain was interrupted, leading to brain damage) left side affected, diabetes, congested heart failure (CHF-condition in which the heart's function as a pump is inadequate to meet the body's needs), total right and total left knee replacement. R2's Service Plan dated July 31, 2024, noted, see plan of care.	01620		

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01620	Continued From page 32 R2's Plan of Care, attachment to R2's service plan last reviewed on October 31, 2024, with no changes, included: - transferring: Staff will use the Sit to Stand until R2 regains strength, staff will use the Sit To Stand when I (R2) am feeling weak. On December 17, 2024, at 9:52 a.m., the surveyor observed ULP-D and ULP-B use a sit-to stand (Sabina II, mechanical lift: designed for users with some mobility and strength, needing some assistance) to transfer R2 from her hospital bed to commode. ULP-B and ULP-D applied a support vest around R2's waist and belted it loosely around R2's middle. R2 reached up and held onto the sit-to-stand lift with her right hand and her left arm hung loose at R2's side. The manufacturer's undated instructions for Sabina II noted the Sabina sit-to stand lift was especially designed for people who have difficulty in standing up on their own from seated position. Sabina sit-to stand lift is intended for use with patients who are able to actively participate in the raising motion. There are two different sling bar options for Sabina sit-to-stand lift, as well as many different sit-to-stand vests. The patient's overall mobility determines the choice of sling bar and sit-to-stand vest. There are combinations suitable for people who are especially sensitive to pressure under the arms, such as people who are paralyzed on one side. The ComfortVest is designed to lift behind the back and on the outside of the arms. Sometimes due to the patient's state of health or mobility: weakened musculature, lack of strength and/or diminished mobility in hip or knee e joints. In order to get the best possible use out of Sabina sit-to-stand lift, there are some things to keep in min: -connect the vest inner strap loop (B) to the sling	01620		

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01620	Continued From page 33 bar hooks -raise the lift mast to achieve higher lifting height -try a smaller vest size. A smaller vest means a shorter distance to the hooks and a more upright standing position. R2's record did not include an assessment for the sit-to-stand lift as R2 was not able to grab onto sling bar with left hand. R5 R5's diagnoses included dementia, joint/muscle pain, and irregular heartbeat. R5's Service Plan dated August 3, 2023, noted, see plan of care. R5's Plan of Care, attachment to R5's service plan last reviewed October 20, 2024, included: -please use a bed & chair alarm under me in my room. On December 17, 2024, at 7:38 a.m., the surveyor observed ULP-B was make R5's bed and the surveyor observed a fall alarm (Fall Watch II) on R5's bed. ULP-B stated the fall alarm was used on R5's bed when R5 laid down at night. ULP-B added R5 got up to go to the bathroom and the alarm notified ULP so R5 did not go back to her chair instead of returned to R5's bed. On December 18, 2024, at 10:07 a.m., the surveyor heard the sound of a Fall Watch II alarm. On December 18, 2024, at 9:24 a.m., licensed assisted living director/owner (LALD/O)-A stated she was not able to find an assessment for the use the Sabina II lift for R2 or an assessment for	01620		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01620	Continued From page 34 R5's Fall Watch II alarm. LALD/O stated she could call clinical nurse supervisor (CNS)-C however LALD/O-C confirmed R2 and R5 records lack the required assessments. LALD/O-A was not able to locate manufacturer's instructions for the alarms used. The surveyor reviewed the manufacturer's instructions for the Sabina sit-to stand lift with LALD/O-A. LALD/O-A said she now understood the importance of assessments for devices. The licensee's Devices, and Device Assessment policy dated August 16, 2022, noted due to the risk of injury related to the use of physical devices, such devices would only be used after an assessment had been completed to determine the risks and benefits of this sue. The resident/responsible party would be educated regarding the risks and benefits of physical devices. Physical devices would be reviewed for safety and used according to manufacturer's recommendations. Continued use of physical devices would be assessed at least every 90 days or with significant change to determine if the device was still needed to enhance the resident's safety and/or bed mobility. If the physical device restricted a resident's freedom of movement, if constitutes a restraint, and our facilities are restraint free. Physical devices that do not restrict the resident's freedom of movement are used to assist the resident in bed mobility are not restraints. The licenses Resident Alarm Use policy dated March 1, 2026, noted: - RN would be consulted before starting an alarm on any resident. - The RN would assess the resident for other potential safety prevention interventions before an alarm would be started	01620		

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01620	Continued From page 35 -Alarms would be checked every day and as needed to ensure alarms were in working order. The licensee's Delegation of Nursing Tasks dated August 1, 2021, noted a registered nurse may delegate nursing services after: -completing a nursing assessment of the residents' functional status and need for nursing services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of	01640		

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01640	Continued From page 36 the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure one of two residents (R2) service plan was revised to include provided services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2's diagnoses included cardiovascular accident/CVA (stroke, when blood flow to the brain was interrupted, leading to brain damage) left side affected, diabetes, congested heart failure (CHF-condition in which the heart's function as a pump is inadequate to meet the body's needs), total right and total left knee replacement. R2's Service Plan dated July 31, 2024, noted, see plan of care. R2's Plan of Care, attachment to R2's service plan last reviewed on October 31, 2024, with no changes, included medication administration, transferring assist, and assist with TED stockings (compression). R2's prescriber order dated October 14, 2024,	01640		

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01640	Continued From page 37 included: -order compression sleeve to left arm -PT/OT (physical and occupational therapy ordered. R2's prescriber order dated December 13, 2024, included: -compression sleeve to left arm. On December 17, 2024, at 9:52 a.m., the surveyor observed ULP-D and ULP-B use a sit-to stand (Sabina II, mechanical lift: designed for users with some mobility and strength, needing some assistance) to transfer R2 from her hospital bed to commode. The surveyor observed R2 wearing an arm sleeve on her left hand (fingered and up to elbow) which had been applied by ULP-B. On December 16, 2024, at 4:14 p.m., R2's care plan was reviewed with licensed assisted living director/owner (LALD/O)-A. LALD stated R2's care plan had not been updated to include exercise. On December 17, 2024, at 3:50 p.m., clinical nurse supervisor (CNS)-C stated she did not see R2's exercise or arm sleeve on R2's service plan. CNS-C stated R2 was not being charged for those services. On December 17, 2024, at 11:26 a.m., LALD/O-A stated R2's service plan had not been updated to include R2's left arm sleeve. LALD/O-A added that was something therapy had left for R2. LALD/O-A said sometimes "they" (therapy) will do something, and I am not notified." On December 17, 2024, at 3:41 CNS-C stated R2's service plan was not updated to include	01640		

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01640	Continued From page 38 exercises. CNS-C noted that exercises had been added to R2's MAR to see if R2 would be willing to do exercise. CNS-C added by having exercises on the MAR, as a sign off they would then know "so we could bring outcome to MD (medical doctor)." CNS-C stated she had just learned of R2's left arm sleeve the day prior (December 16, 2024). CNS-C confirmed R2's service plan had not been revised as required. The licensee's Contents of Service Plans policy dated August 1, 2021, noted all assisted living resident have an up-to-date service plan identifying services to be provided based on the assessment by the RN and/or other licensed health professional. Service plans and any revisions to services plans would have a signature or other authentication by the facility and by the resident. Service plans were reviewed and resided as needed based upon on-going resident assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01640		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident;	01650		

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01650	Continued From page 39 (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the service plan included the required content for one of one resident (R2). 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: R2's diagnoses included cardiovascular accident/CVA (stroke, when blood flow to the	01650		

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01650	Continued From page 40 brain was interrupted, leading to brain damage) left side affected, diabetes, congested heart failure (CHF-condition in which the heart's function as a pump is inadequate to meet the body's needs), total right and total left knee replacement. R2's Service Plan dated July 31, 2024, noted, see plan of care. R2's Plan of Care, attachment to R2's service plan last reviewed on October 31, 2024, with no changes, included medication administration, transferring assist, and assist with TED stockings (compression). On December 17, 2024, at 9:52 a.m., the surveyor observed ULP-D and ULP-B use a sit-to stand (Sabina II, mechanical lift: designed for users with some mobility and strength, needing some assistance) to transfer R2 from her hospital bed to commode. R2's service plan lacked: - the methods of monitoring assessments of residents - the methods of monitoring staff providing the services. On December 16, 2024, at 4:19 p.m., the surveyor reviewed R2's service plan with licensed assisted living director/owner (LALD/O)-A. LALD/O-A pointed out to the surveyor where the service plan template noted: -a nursing assessment would be conducted by a registered nurse (RN) prior to admission or on the day of admission. Residents would have reassessment done no more than 14 days after initiation of services and every 90 day. Ongoing reassessments and monitoring would be done as	01650		

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01650	Continued From page 41 needed and cannot exceed 90 days from last assessment, and -caregivers: supervision schedule, within 30 days after the caregiver began work and thereafter an needed by RN. LALD/O-A confirmed R2's service plan lacked to include the methods of monitoring residents and staff. On December 17, 2024, 3:40 p.m., clinical nurse supervisor (CNS)-C stated she was not familiar with the content of the service plans used at the facility. The licensee's Contents of Service Plans policy dated August 1, 2021, noted service plans were include: -schedule and methods of monitoring assessments -schedule and methods of monitoring staff providing services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650		
01750 SS=I	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions	01750		

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01750	Continued From page 42 in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure prior to delegation of medication administration, unlicensed personnel demonstrated competency to the registered nurse (RN), for two of two unlicensed personnel (ULP-D, ULP-F). Further, the licensee failed to ensure the RN prepared in writing, specific instructions for each resident, and documented those instructions for two of three residents (R4, R5). This resulted in an immediate correction order on December 17, 2024. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: MEDICATION COMPETENCY ULP-D ULP-D began employment on August 12, 2024, to provide assisted living services to the licensee's residents. On December 17, 2024, from 6:59 a.m. until 10:27 a.m., the surveyor observed ULP-D	01750		

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01750	Continued From page 43 administer scheduled morning medication which included oral medication, transdermal (on the skin) medication, eye drops, and insulin administration. ULP-E was not under direct supervision. On December 17, 2024, at 7:35 a.m., ULP-D stated licensed assisted living director/owner (LALD/O)-A trained her on medications. The surveyor asked if the RN had ever watched ULP-D administer medications? ULP-D said, LALD/O "showed" her (ULP-D) medication administration. ULP-D's employee record included an Educare (on-line training program) transcript which included: -medication administration routes, dated August 22, 2024 -insulin administration, dated August 23, 2024 -insulin pens, dated August 23, 2024 -nebulizers (small machine that creates a mist out of liquid medication, allowing for quicker and easier absorption of medication into the lungs) and inhalers, dated August 23, 2024. ULP-D's employee record lacked evidence ULP-D demonstrated competency to the RN for medication administration. ULP-F ULP-F began employment on June 12, 2024, to provide assisted living services to the licensee's residents. On December 17, 2024, at 6:24 a.m., ULP-F stated co-owner (CO)-E did ULP-F's training which included medication administration. ULP-F said, "to be honest" she had only seen the RN two or three times, during new resident meetings.	01750		

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01750	Continued From page 44 ULP-F stated she did not see clinical nurse supervisor (CNS)-C during her training. ULP-F added CNS-C showed up maybe one day of the week, during the daytime when "I" (ULP-F) was not at the facility. On December 17, 2024, at 6:55 a.m., the surveyor observed ULP-F give ULP-D report from the night shift. ULP-F's employee record included an Educare transcript which included: -medication administration routes, dated June 11, 2024 -insulin administration, dated June 20, 2024 -insulin pens, dated June 23, 2024 -nebulizers and inhalers, dated June 23, 2024. ULP-F's employee record lacked evidence ULP-F demonstrated competency by the RN in medication administration. On December 17, 2024, at 1:46 p.m., CO-E stated he trained the overnight staff (ULP-F). CO-E stated there were no medications scheduled to be given on the night shift but CO-E confirmed medication administration may be required on the night shift. On December 17, 2024, at 3:40 p.m., CNS-C stated she trained LALD/O-A "off" on medications so LALD/O-A could train staff (ULP) on medication administration. CNS-C added she was not "always available." CNS-C said she watched LALD/O-A train ULPs on medications several times. CNS-C added in "my practice," one could train as long as they (staff) were deemed competent. The surveyor asked if CO-E had been deemed competent to train on medications by herself and CNS-C replied, yes.	01750		

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01750	Continued From page 45 On December 18, 2024, at 8:39 a.m., LALD/O-A stated she was not able to locate any evidence medication competency had been completed in employee files. The Minnesota Board of Nursing, Nurse Practice Act, dated 2024, indicated in 148.171, Subd. 15. The "practice of professional nursing" means the performance, with or without compensation, of those services that incorporates caring for all patients in all setting through nursing standards recognized by the board and includes, but is not limited to: (17) accountability for the quality of care delivered, recognizing the limits of knowledge and experience; addressing situations beyond the nurse's competency; and performing to the level of education, knowledge, and skill ordinarily expected of an individual who has completed an approved professional nursing education program as described in section 148.211, Subd. 1. The licensee's Training Unlicensed Personnel For Medication, Treatment, and Therapy Administration policy dated August 1, 2021, noted before the RN delegated the task of assistance with self-administration of medications or the task of medication administration, treatment and therapy the RN would instruct the unlicensed personnel on performing these tasks and determine the unlicensed personnel as competent to perform the tasks. SPECIFIC INSTRUCTIONS R4 R4's diagnosis included low back pain. R4's care plan, part of service plan reviewed December 11, 2024, included medication	01750		

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01750	Continued From page 46 administration. R4's medication administration record (MAR) dated December 1, 2024, through December 17, 2024, included: -lidocaine 4% patch, apply one patch daily and remove at bedtime. NO more than 12 hours on. R4's prescriber order dated October 22, 2024, included the above medication. On December 17, 2024, at 7:05 a.m., the surveyor observed ULP-D prepare R4's morning medication, which included a lidocaine patch. ULP-D and the surveyor reviewed R4's December MAR. ULP-D stated R4's MAR did not include where the lidocaine patch was to be placed. ULP-D added she knew the patch was to be placed on R4's lower back. R5 R's diagnosis included dementia. R5's care plan, part of service plan reviewed October 20, 2024, included medication administration. R5's December 1, 2024, through December 16, 2024, MAR included: -Advair HFA 115-21 micrograms (mcg), inhalation aerosol. Inhale two puffs into the lungs, two times daily (asthma control). R5's prescriber order dated August 29, 2024, included the above medication. On December 16, 2024, at approxamatly 12:15 p.m., the surveyor observed ULP-B service R5 lunch.	01750		

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01750	Continued From page 47 On December 16, 2024, at 11:47 a.m., the surveyor reviewed R5's MAR with LALD/O-A and the manufacturer's insert located in R5's Advair inhaler. LALD/O-A stated R5's record did not include specific instructions for R5's inhaler. On December 17, 2024, at 3:45 p.m., CNS-C stated "we" (LALD/O-A) talked about directions on MARs. CNS-C said MARs should include instructions for ULPs for medication administration, such as following manufacturer's directions and placement of medication. CNS-C confirmed R4 and R5's records lacked specific instructions for medication administration. The manufacturer's instructions for Advair dated December 2021, noted rinse your mouth with water without swallowing after each dose of Advair. This will help lessen the chance of getting a yeast infection (thrush) in your mouth and throat. The licensee's Administration of Medication, Treatment and Therapy By Unlicensed Personnel policy dated May 20, 2022, noted unlicensed personal that provided assistance with medication, treatment and therapy administration would be trained and competency tested by the registered nurse. The licensee's Administration of Medication, Treatment and Therapy By Unlicensed Personnel policy dated May 20, 2022, noted unlicensed personnel that would provide assistance with medication, treatment and therapy administration would be trained and competency tested by the RN on the following: a. The complete procedures for checking the resident' mediation administration record and medication profile, treatment and therapy profile	01750		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01750	Continued From page 48 and nay additional information b. Infection control precautions that must be followed when administrating medication, treatment and therapy c. Preparation of the medication for the resident when necessary d. Administration of the medication, treatment and therapy to the resident (or assistance with self-administration) e. Documenting, after assistance with self-administration of medications or medications, treatment and therapy administration, consistent with our facility's procedures for documenting the MAR f. The procedure for staff to notify the RN of any mediations or dietary supplement that are being used by the resident and that are not included in the assessment for mediation management services. The RN had developed written, specific instruction for each resident. In addition, the RN had documented that the unlicensed personnel have been trained and have demonstrated competency to follow the procedures. Further, documentation of each unlicensed staff person's training and competency to assist or administer medications, treatment and therapy would be retained in the personnel record of each staff person who had satisfied the above training and competency requirements. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01750		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted	01760		

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	29942	A. BUILDING: _____ B. WING _____	12/18/2024

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01760	Continued From page 49 living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the steps of the medication administration process was followed for one of two employees, unlicensed personnel (ULP)-B 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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On December 16, 2024, from 11:55 a.m. through approximately 12:05 p.m., the surveyor continuously observed ULP-D administer medication to the licensee's residents.	01760		

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01760	Continued From page 50 On December 16, 2024, at 11:55 a.m., the surveyor observed ULP-B take a medication cup of prepared medications to R4 who was in a bathroom and administer R4's medication. The surveyor did not observe ULP-B document R4's medication as administered. On December 16, 2024, at 11:57 a.m., the surveyor observed ULP-B knock on R3's room to inform him it was lunch time and told R3 she (ULP-B) would be back. ULP-B reviewed R3's MAR. ULP-B returned to R3's room with a blood glucose (BG) meter, testing strip, alcohol wipe, and lancet. ULP-B took R3's BG with correct technique to receive a reading of 189. ULP-B returned R3's BG supplies and documented on R3's medication administration record (MAR) that the service had been completed and the BG result for R3. On December 16, 2024, at 12:02 p.m., ULP-B stated she was going to "grab" R2's BG "real" quick. ULP-B reviewed R2's MAR. ULP-B removed R2 from the kitchen table and brought R2 to the medication preparation area. ULP-B used correct technique to obtain R2's BG reading of 167. ULP-B documented in R2's MAR that the service had been completed and the BG result. On December 16, 2024, at 12:06 p.m., the surveyor asked ULP-B if R4's MAR could be reviewed. ULP-B opened R4's MAR and stated she had marked (dotted) R4's MAR when R4's medication was prepared but she (ULP-B) had not documented R4's medication as administered. ULP-B stated she should have documented R4's medication as administered right after R4's medication was given. On December 17, 2024, at 3:47 p.m., clinical	01760		

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01760	Continued From page 51 nurse supervisor (CNS)-C asked if anything occurred to prevent ULP-D from documenting R4's medication after medication administration. CNS-C said ULPs should document directly after medication administration. The licensee's Administration of Medication, Treatment and Therapy By Unlicensed Personnel policy dated May 20, 2022, noted unlicensed personal that provided assistance with medication, treatment and therapy administration would be trained and competency tested by the registered nurse on the following: documentation, after assistance with self-administration of medications or medications, treatment and therapy administration, consistent with our facility's procedures for documenting the MAR. The licensee's Administration of Medication, Treatment and Therapy by Unlicensed Personnel policy dated May 20, 2022, noted unlicensed personnel that would provide assistance with medication, treatment and therapy administration would be trained and competency tested by the RN on the following: a. The complete procedures for checking the resident' mediation administration record and medication profile, treatment and therapy profile and nay additional information b. Infection control precautions that must be followed when administrating medication, treatment and therapy c. Preparation of the medication for the resident when necessary d. Administration of the medication, treatment and therapy to the resident (or assistance with self-administration) e. Documenting, after assistance with self-administration of medications or medications,	01760		

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01760	Continued From page 52 treatment and therapy administration, consistent with our facility's procedures for documenting the MAR f. The procedure for staff to notify the RN of any mediations or dietary supplement that are being used by the resident and that are not included in the assessment for mediation management services. The RN had developed written, specific instruction for each resident. In addition, the RN had documented that the unlicensed personnel have been trained and have demonstrated competency to follow the procedures. Further, documentation of each unlicensed staff person's training and competency to assist or administer medications, treatment and therapy would be retained in the personnel record of each staff person who had satisfied the above training and competency requirements. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01790 SS=F	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	01790		

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01790	Continued From page 53 medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of 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	01790		

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01790	Continued From page 54 completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of one unlicensed personnel (ULP-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: During the entrance conference on December 16, 2024, at 11:13 a.m., licensed assisted living director/owner (LALD/O)-A stated all of the nine residents at the establishment received medication management services. ULP-D began employment on August 12, 2024, to provide assisted living services to the licensee's residents. On December 17, 2024, at 7:05 a.m., the	01790		

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01790	Continued From page 55 surveyor observed ULP-D prepare R4's morning medication. ULP-D's record lacked evidence to indicate the registered nurse (RN) provided training and determined competency to prepare and administer medications to residents for unplanned times away. On December 17, 2024, at 4:01 p.m., clinical nurse supervisor (CNS)-C stated she had been asked to review the licensee's Unplanned Time Away Medication policy, from the past registered nurse (RN). CNS-C said she looked at the policy, but she did not complete any ULP training or competency training for unplanned time away medication. CNS-C added she was not aware of the requirement. CNS-C added, there were written instructions for ULPs to follow. The licensee's Delegation of Medications to be Given to Residents by Unlicensed Staff For Residents Time Away From Home policy dated August 1, 2021, noted only staff that had been trained and have satisfactorily demonstrated competency would be assigned to place medications prepared by a pharmacist or a licensed nurse in the appropriate container for an unplanned leave of absence not to exceed seven days of medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all	01880		

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01880	Continued From page 56 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 securely stored during the medication administration process by one of two unlicensed personnel (ULP)-D. This had the potential to affect all nine residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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: On December 17, 2024, at 7:52 a.m., the surveyor observed the medication cabinet unsecured and no staff within view in the open medication preparation area/ kitchen type of area (off the common's area in one of the two pass throughs at the facility).. On December 17, 2024, at 7:54 a.m., licensed assisted living director/owner (LALD/O)-A stated the medication cabinet should be locked. LALD/O-A told ULP-D the medication door needed to be secured. ULP-D replied she must not have closed the cabinet door hard enough to the engage the lock.	01880		

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01880	Continued From page 57 On December 17, 2024, at 3:48 p.m., clinical nurse supervisor (CNS)-C stated the medication cabinet was supposed to be secured at all times, unless ULP was within reach of the medication cabinet. CNS-C added residents walk through that area. The licensee's Store of Medications policy dated January 28, 2022, noted the RN (registered nurse) must conduct a face-to-face nursing assessment of a resident's need for medication management services, including the appropriate method to store the resident's medication and whether secured storage was appropriate given the resident's functional and cognitive status, concerns about the potential for drug diversion or other considerations. The RN would establish a system that addressed the storage and handling of medications, including: -where medications would be stored -who was authorized to access the medications -controls and procedures to identity or prevent diversion of medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=E	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.	01890		

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01890	Continued From page 58 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 label with legible information including the expiration date for time sensitive medications for two of four residents (R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On December 16, 2024, at 11:38 a.m., the surveyor reviewed the contents of the locked medication cabinet with licensed assisted living director/owner (LALD/O)-A. LALD/O-A observed and confirmed the following: -one opened Lantus (long acting) insulin pen 100 units/milliliter (ml) for R2 dated December 15, 2024, but did not have a label which indicated the date the insulin pen would expire -one opened Humalog (short acting) insulin pen 100 units/ml for R2, dated December 4, 2024, but did not have a label which indicated the date the insulin pen would expire. The Humalog pen had an "on hold" label wrapped around the pen -one opened Lantus insulin pen 100 units/ml for R3, dated December 11, 2024, which did not have a label which indicated the date the insulin	01890		

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01890	Continued From page 59 pen would expire. Directly after the above observation the surveyor inquired about R2's "on hold" with no expiration date Humalog pen. LALD/O-A said it made sense that R2's Humalog pen have an expiration date written on it, if the medication was reordered in the future. LALD/O-A added she was not sure if the nurse (clinical nurse supervisor, CNS-C) wrote the expiration date on the insulin pens but LALD/O-A confirmed none of the insulin pens included expiration dates. The manufacturer's instructions for Lantus dated August 2022, noted after 28 days, throw out opened Lantus pen away-even if it still had insulin in it. The manufacturer's instructions for Humalog dated 2020, noted throw away the Humalog pen you are using after 28 days, even if it still had insulin left in it. The licensee's Store of Medications policy dated January 28, 2022, noted the RN (registered nurse) would provide education to the resident/resident's representative on proper storage of medications in the home including the need to be refrigerated, or stored in a cool, dry area, and according to manufacturer's recommendations. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen	01940		

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01940	Continued From page 60 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 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 two residents (R2) who had treatments managed by the facility.	01940		

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01940	Continued From page 61 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: R2's diagnoses included cardiovascular accident/CVA (stroke, when blood flow to the brain was interrupted, leading to brain damage) left side affected, diabetes, congested heart failure (CHF-condition in which the heart's function as a pump is inadequate to meet the body's needs), total right and total left knee replacement. R2's Service Plan dated July 31, 2024, noted, see plan of care. R2's record included Client Treatment or Therapy Management Plan dated July 31, 2024, which included: -TEDs stockings, PRN (as desired or as needed). R2's Plan of Care, attachment to R2's service plan last reviewed on October 31, 2024, with no changes, included blood sugar monitoring, and staff to assist with TED stockings (compression) as needed for swelling. R2's prescriber order dated October 14, 2024, included: -obtain compression sleeve for left arm -PT/OT (physical and occupational therapy)	01940		

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01940	Continued From page 62 ordered. R2's prescriber order dated December 13, 2024, included: -compression sleeve to left arm R2's December 1, 2024, through December 16, 2024, medication administration record (MAR) included: -do therapy exercises two times/day with resident On December 17, 2024, at 10:27 a.m., the surveyor observed unlicensed personnel (ULP)-D monitor R2's blood glucose with correct technique. R2 wore a left arm sleeve (compression) applied by ULP-B. ULP-B stated the ULPs take turns and stated "I" (ULP-B) administered yesterday and ULP-D did "cares" that day. ULP-B added R2 does not wear arm sleeve every day. The surveyor observed exercise handouts/instructions in R2's room. R2's record did not include a statement of the type of service being provided: - compression sleeve - exercise. On December 16, 2024, at 4:14 p.m., the surveyor reviewed R2's MAR with licensed assisted living direction/owner (LALD)/O-A. LALD/O-A stated R2's record did not include a written statement that the service of compression sleeve application was provided. On December 17, 2024, at 3:43 p.m., clinical nurse supervisor (CNS)-C stated exercises were added to R2's MAR to "see" if R2 would be willing to participate in an exercise program, adding then she could then "bring" that information to R2's doctor (prescriber). CNS-C confirmed R2's record	01940		

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	29942	A. BUILDING: _____ B. WING _____	12/18/2024

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01940	Continued From page 63 did not have a written statement that the service that an exercise program was provided. The licensee's Individualized Medication, Treatment & Therapy Management Plans policy dated August 1, 2021, noted registered nurse (RN) would develop a treatment and therapy management plan for each resident receiving treatment and/or therapy management services. The treatment and therapy management plan would include: a. Statement of the type of service(s) provided b. Documentation of specific resident instructions relating to the treatment and/or therapy administration c. documentation of treatment or therapy tasks that may be delegated an an unlicensed staff member d. procures for notifying a RN or appropriate licensed health professional when a problem arose with treatments and/or therapy services e. Resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment and/or therapy to prevent possible complications or adverse reactions. Medication, treatment, and therapy management plans would be current and updated when there were changes. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01950 SS=F	144G.72 Subd. 4 Administration of treatments and therapy	01950		

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01950	Continued From page 64 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 prior to delegating therapy and treatment tasks, unlicensed personnel (ULP-D) demonstrated training and competency to a registered nurse (RN) for one of one resident (R2). In addition, the licensee failed to ensure the RN prepared in writing specific instructions for each resident and documented those instructions for one of one resident (R2) receiving treatments. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic	01950		

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01950	Continued From page 65 failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R2's diagnoses included cardiovascular accident/CVA (stroke, when blood flow to the brain was interrupted, leading to brain damage) left side affected, diabetes, congested heart failure (CHF-condition in which the heart's function as a pump is inadequate to meet the body's needs), total right and total left knee replacement. R2's Service Plan dated July 31, 2024, noted, see plan of care. R2's Plan of Care, attachment to R2's service plan last reviewed on October 31, 2024, with no changes, included blood sugar monitoring, and staff to assist with TED stockings (compression) as needed for swelling. R2's prescriber order dated October 14, 2024, included: -obtain compression sleeve for left arm -PT/OT (physical and occupational therapy) ordered. R2's prescriber order dated December 13, 2024, included: -compression sleeve to left arm -Accu Checks (blood sugar monitoring) three times daily -TEDs (compression stockings) PRN (as needed or desired) for swelling R2's December 1, 2024, through December 16, 2024, medication administration record (MAR) included:	01950		

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01950	Continued From page 66 -do therapy exercises two times/day with resident -Accu-checks, monitor blood sugars three times daily before, breakfast, lunch, bedtime. Notify RN (registered nurse) if less 80 or greater than 400. On December 17, 2024, at 10:27 a.m., the surveyor observed ULP-D monitor R2's blood glucose with correct technique. ULP-D was not under direct supervision. R2 wore a left arm sleeve (compression) applied by ULP-B. ULP-B stated the ULPs take turns, and stated "I" (ULP-B) administered yesterday and ULP-D did cares that day. ULP-B added R2 does not wear arm sleeve every day. TREATMENT AND THERAPY TRAINING AND COMPETENCY ULP-D began employment on August 12, 2024, to provide assisted living services to the licensee's residents. ULP-D's employee record included an Educare (on-line training program) transcript which included: -blood glucose testing, dated August 22, 2024 -ACE wraps (compression), dated August 22, 2024 -compression stockings (TEDs), dated August 23, 2024. ULP-D's employee record lacked evidence ULP-D demonstrated competency to the RN for blood glucose testing or compression wear. ULP-D's record lacked evidence of exercise training or competency. On December 17, 2024, at 10:27 a.m., ULP-D said therapy talked to "them (ULPs working)" about what was noted for R2's exercise program.	01950		

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01950	Continued From page 67 On December 17, 2024, at 7:35 a.m., ULP-D stated licensed assisted living director/owner (LALD/O)-A trained her on several tasks. On December 17, 2024, at 3:40 p.m., clinical nurse supervisor (CNS)-C stated she trained LALD/O-A "off" on several tasks so LALD-/O-A could train staff (ULP) on the tasks. CNS-C added she was not "always available." CNS-C said she watched LALD/O-A train ULPs on blood sugar monitoring, TEDs and "things like that." CNS-C added in "my practice," one could train as long as they (staff) were deemed competent. On December 17, 2024, at 3:49 p.m., CNS-C stated she assumed OT trained the staff (ULPs) who were working when OT was at the facility. CNS-C said she would have needed to have been notified on the arm sleeve, and added she learned of R2's arm sleeve yesterday (December 16, 2024.) CNS-C stated therapy left handouts for R2's exercise program for ULPs to follow, and therapy talked to staff about R2's exercises. CNS-C stated she did not do training and competencies for any ULP for R2's arm sleeve or exercise program. On December 18, 2024, at 8:39 a.m., LALD/O stated ULP-D's record lacked evidence of blood glucose competency completion. On December 18, 2024, at 8:40 a.m., LALD/O-A stated she did not find any documentation of training or competency for R2's arm sleeve, or exercise. On December 18, at approximately 12:45 p.m., LALD/O-A stated she was a licensed staff and thought, per the statues, she could train and	01950		

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01950	Continued From page 68 deem ULPs competent, for R2's blood glucose and TEDs. SPECIFIC INSTRUCTIONS ARM SLEEVE R2's record lacked an entry for arm sleeve. EXERCISE On December 17, 2024, at 9:52 a.m., the surveyor observed a handwritten note labeled "In the Recliner" in R2's room that noted: -shoulder abduction: lift the blue stick, put on deodorant, push pillow off arm rest -external rotation/elbow flexion: bend forward shoulder -pronation of supination: turn palm up and down -wrist flexion extension: interlock fingers-push wrist back -wrist deviation: interlock fingers bend wrist up and down -wrist extension: fingers straight and together like praying -flexion: make a fist with left hand, curl right hand over to bed fingers -finger extension: tell left hand to go straight and spread fingers. In addition, there was printed out pages with pictures, that included: -finger flexion/extension: starting position: lying on back, lying on less affected (right/left side, sitting options, all blank and repeat blank times) -wrist radial/ulnar deviation: starting position: lying on back, lying on less affected (right/left side, sitting options, all blank and repeat blank times) -composite wrist/finger extension: starting position: lying on back, lying on less affected (right/left side, sitting options, all blank and repeat blank times) -wrist flexion/extension: starting position: lying on back, lying on less affected (right/left side, sitting	01950		

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01950	Continued From page 69 options, all blank and repeat blank times) -forearm supination/pronation: starting position: lying on back, lying on less affected (right/left side, sitting options, all blank and repeat blank times) elbow flexion/extensions: starting position: lying on back, lying on less affected (right/left side, sitting options, all blank and repeat blank times) -shoulder external rotation: starting position: lying on back, lying on less affected (right/left side, sitting options, all blank and repeat blank times) -shoulder abduction: starting position: lying on back, sitting, (options) blank and repeat blank times) shoulder flexion: starting position: lying on back, lying on less affected (right/left side, sitting options, all blank and repeat blank times) On December 16, 2024, at 4:14 p.m., the surveyor reviewed R2's MAR with LALD/O-A. LALD/O-A stated R2's MAR did not include specific direction for staff regarding R2's exercise program: such was where to find the exercise program and what issues ULPs should report to nursing. On December 17, 2024, at 10:27 a.m., ULP-D stated there was a handout in R2's room for exercise. ULP-D stated R2's record did not include any instructions for R2's exercise. On December 17, 2024, at 3:43 p.m., CNS-C stated exercise were added to R2's MAR to "see" if R2 would be willing to participate in an exercise program, adding then she could then "bring" that information to R2's doctor (prescriber). CNS-C did not state whether or not R2's record included instructions for ULP for exercise program. TEDs	01950		

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01950	Continued From page 70 R2's care plan lacked any specific instructions for R2's TEDS, such as when and what to report to nursing. On December 17, 2024, at 3:52 p.m., CNS-C stated specific directions for TEDs or arm sleeves would be to alert CNS-C if complications occurred: if too tight, if there was pain, if the TEDs were the type with holes in the toes, swelling or if the toes were pale or cold. On December 17, 2024, at 3:54 p.m., CNS-C stated she thought the specific directions were in resident records and if specific necessary directions were not in the resident records, she was not aware of it. On December 18, 2024, at 8:40 a.m., LALD/O-A stated she was not able to locate any directions for R2's exercise or left arm sleeve in R2's record. The licensee's Administration of Medication, Treatment and Therapy By Unlicensed Personnel policy dated May 20, 2022, noted unlicensed personnel that would provide assistance with medication, treatment and therapy administration would be trained and competency tested by the RN on the following: a. The complete procedures for checking the resident' mediation administration record and medication profile, treatment and therapy profile and nay additional information b. infection control precautions that must be followed when administrating medication, treatment and therapy c. Preparation of the medication for the resident when necessary d. Administration of the medication, treatment and therapy to the resident (or assistance with	01950		

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01950	Continued From page 71 self-administration) e. Documenting, after assistance with self-administration of medications or medication, treatment and therapy administration, consistent with our facility's procedures for documenting the MAR f. The procedure for staff to notify the RN of any mediations or dietary supplement that are being used by the resident and that are not included in the assessment for mediation management services. The RN had developed written, specific instruction for each resident. In addition, the RN had documented that the unlicensed personnel have been trained and have demonstrated competency to follow the procedures. Further, documentation of each unlicensed staff person's training and competency to assist or administer medications, treatment and therapy would be retained in the personnel record of each staff person who had satisfied the above training and competency requirements. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		
02370 SS=F	144G.91 Subd. 9 Right to come and go freely Residents have the right to enter and leave the facility as they choose. This right may be restricted only as allowed by other law and consistent with a resident's service plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure residents	02370		

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02370	Continued From page 72 have the right to come and go from the facility as they choose. 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: The licensee had an assisted living license issued on April 1, 2024, with an expiration date of March 31, 2025. On December 16, 2024, during the entrance conference at 11:10 a.m., the surveyor inquired if there was an access code required to enter the building. Licensed assisted living director/owner (LALD/O)-A stated there was and told the surveyor the code. On December 16, 2024, at approximately 4:30 p.m., the surveyor required a code to exit the facility. On December 17, 2024, at 6:27 a.m., unlicensed personnel (ULP)-F stated the entry door was secured because some of the residents had dementia and attempted to exit the facility. ULP-F said she did not know if the residents who did not have dementia knew the code to exit the facility. On December 17, 2024, at 6:32 a.m., LALD/O-A stated the entry door was for security of the residents, so intruders did not enter. LALD/O-A said the entry door had not changed and was the	02370		

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02370	Continued From page 73 same door which was there when she took ownership of the facility. LALD/O-A added she did not know how to disarm the coding system. On December 17, 2024, at 7:04 a.m., R6 (diagnoses: b-cell lymphoma /cancer) stated he would like to have the code to get outside. R6 added his daughter knew the code and it was just "beep, beep, beep." R6 stated he did not know the code to exit the facility. On December 17, 2024, at 7:30 a.m., ULP-B stated "we" (staff) use the code to let residents exit the facility. ULP-B added no one (residents) now try to get out, but in the past they (residents) did. ULP-B added one resident was given the code, but that resident has forgotten the code. ULP-B said the entry door required a code for as long as she had worked at the facility. On December 17, 2024, at 7:35 a.m., ULP-D stated none of the residents attempt to exit the building, they (residents) are all "pretty content", they don't know the code, they don't leave unless with family. On December 17, 2024, at 9:50 a.m., R3 (diagnosis congested heart failure/CHF) stated "they (licensee) won't tell me the code to exit the building. R3 stated he had asked for the code for two years. R3 said, "I have told them, you guys lock the door and if I don't have the code and I can't get out and need to I'll tell you. I will grab something and break a window." On December 17, 2024, at 3:54 p.m., clinical nurse supervisor (CNS)-C stated the front entry door was locked for security reasons, just so that people are not coming up, ringing not just coming in. The surveyor asked about the door requiring a	02370		

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02370	Continued From page 74 code to exit the facility. CNS-C stated, "I believe we (licensee) give the code to everyone." On December 18, 2024, at 8:43 a.m., LALD/O-A shook her head, "no", when the surveyor asked if most of the residents at the facility had some kind of memory issue. On December 18, 2024, at approximately 12:45 p.m., LALD/O-A stated the entry door had not changed and she had been told at the prior survey they did not even need to post the code number at the door to exit the building, as the licensee had offered. LALD/O-A stated the coding system would be removed from the entry door. The Minnesota Bill of Rights dated November 8, 2022, noted residents have the right to enter and leave the facility as they chose. The right may be restricted only as allowed by other law and consistent with a resident's service plan. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	02370		
02430 SS=F	144G.91 Subd. 15 Confidentiality of records (a) Residents have the right to have personal, financial, health, and medical information kept private, to approve or refuse release of information to any outside party, and to be advised of the assisted living facility's policies and procedures regarding disclosure of the information. Residents must be notified when personal records are requested by any outside party. (b) Residents have the right to access their own	02430		

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BARROSS COTTAGE II LLC	806 13TH AVENUE TWO HARBORS, MN 55616

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02430	Continued From page 75 records. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure resident's personal health and medical information was kept private. This had the potential to affect all residents residing at the assisted living facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: MEDICATION ADMINISTRATION RECORD (MAR) On December 17, 2024, at 7:09 a.m., the surveyor observed unlicensed personnel (ULP)-D prepare R4's morning medication. The surveyor observed R4's MAR open on the counter in a kitchen type of area that was used for medication administration when ULP-D went to R4's room to administer R4's morning medication. ULP-D returned to R4's MAR and documented R4's medication as administered. On December 17, 2024, at 7:16 a.m., the surveyor observed ULP-D prepare R2's morning medication. The surveyor observed R2's MAR open on the counter in a kitchen type of area that was used for medication administration when ULP-D went to R2's room to administer R2's morning medication. ULP-D returned to R2's	02430		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29942	A. BUILDING: _____ B. WING _____	12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BARROSS COTTAGE II LLC	806 13TH 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
02430	Continued From page 76 MAR and documented R2's medication as administered. On December 17, 2024, at 7:20 a.m., the surveyor observed ULP-D prepare R7's morning medication. The surveyor observed R7's MAR open on the counter in a kitchen type of area that was used for medication administration when ULP-D went to R7's room to administer R7's morning medication. ULP-D returned to R7's MAR and documented R7's medication as administered. and documented R7's medications as administered. On December 17, 2024, at 7:29 a.m., the surveyor observed R7's MAR closed. On December 17, 2024, at 3:56 p.m., clinical nurse supervisor (CNS)-C stated the MAR should be closed when not in use because residents walk through that area. SECURE PHONE COMMUNICATION On December 16, 2024, at 11:00 a.m., during the entrance conference licensed assisted living director/owner (LALD/O)-A stated CNS-C was available by phone and if CNS-C could not answer, CNS-C could answer text messages. LALD/O-A said ULP's use their personal phones to call/ text CNS-C if and as needed. On December 16, 2024, at 4:24 p.m., LALD/O-A stated ULPs use room numbers and not names of residents when texting CNS-C. LALD/O-A said ULP's use their personal phones and the licensee does not use an app (secured system). LALD/O-A stated she did not know if staff phones were all secure. On December 17, 2024, at 3:57 p.m., CNS-C	02430		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29942	A. BUILDING: _____ B. WING _____	12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BARROSS COTTAGE II LLC	806 13TH 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
02430	Continued From page 77 said she used her personal cell phone to communicate with the ULPs at the facility. CNS-C stated she did not use an app but added she keeps her cell phone secured. CNS-C stated ULPs used their personal cell phones to text/call her. CNS-C confirmed she was not sure if all ULPs had a lock on their personal cell phones. CNS-C stated, we use, room numbers or resident initials not resident names. On December 18, 2024, at approximately 3:15 p.m., LALD/O-A stated she was now aware of the need to secure staff's personal phones and had been looked into an app to be used. The Minnesota Bill of Rights dated November 8, 2022, noted residents have the right to have personal, financial, health, and medial information private. The licensee's Security of Resident Records policy dated August 1, 2021, noted all information in the resident record must be kept confidential and accessible only to authorized agency personnel. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02430		

MDH

11 E Superior Street
Duluth
218-302-6166

Type: Full
Date: *12/17/24*
Time: 10:30:43
Report: 7980241162

Food and Beverage Establishment Inspection Report

Location:

Barross Cottage Ii Llc
806 13th Avenue
Two Harbors, MN55616
Lake County, 38

Establishment Info:

ID #: 0037957
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 2188348098
ID #:

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

The following orders were issued during this inspection.

3-500B Microbial Control: hot and cold holding

3-501.16A2 ***** Priority 1 *****

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

KITCHEN REFRIGERATOR WAS 44F APPLE SAUCE, 46F SOUR CREAM AND 48F PICKLES ON DOOR. UNIT WAS TURNED COLDER DURING INSPECTION THE COILS MAY NEED CLEANING. TCS FOODS MOVED TO OTHER UNIT.

Corrected on Site

4-200 Equipment Design and Construction

4-203.11 ***** Priority 2 *****

MN Rule 4626.0555 Replace food temperature measuring devices that are not accurate to plus or minus 2 degrees F.

BOTH REFRIGERATORS NEED NEW THERMOMETERS. KITCHEN READ 42F AIR TEMP WAS 46F. NURSE STATION READ 46F AIR TEMP WAS 39F.

Comply By: 12/20/24

4-300 Equipment Numbers and Capacities

4-302.14 ***** Priority 2 *****

MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.

QUAT AMMONIA TEST KIT MUST BE USED EACH TIME SANITIZER IS MADE FOR HAND WASHING ITEMS. PURCHASE KIT ONLINE OR HAVE VENDOR PROVIDE A KIT

Comply By: 12/17/24

2-100 Supervision

2-102.12FMN

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.

DAILY SELF INSPECTIONS WOULD HAVE CAUGHT THE HIGH FRIDGE TEMPERATURE, INACCURATE FRIDGE THERMOMETERS AND LACK OF TEST STRIPS FOR QUAT SANITIZER.

Comply By: 12/17/24

Surface and Equipment Sanitizers

Hot Water: = at 170 Degrees Fahrenheit
Location: Dish machine reached 170f+ thermo label black
Violation Issued: No

Quaternary Ammonia: = 400 ppm at Degrees Fahrenheit
Location: Santizing bin for hand washing
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Upright Cooler
Temperature: 46 Degrees Fahrenheit - Location: Kitchen-sour cream
Violation Issued: Yes

Process/Item: Upright Cooler
Temperature: 44 Degrees Fahrenheit - Location: Apple sauce
Violation Issued: Yes

Process/Item: Upright Cooler
Temperature: 48 Degrees Fahrenheit - Location: Pickles on door
Violation Issued: Yes

Process/Item: Upright Cooler
Temperature: 41 Degrees Fahrenheit - Location: Nurse station-Cotto salami
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 41 Degrees Fahrenheit - Location: Strawberry Yogurt
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 41 Degrees Fahrenheit - Location: Eggs
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 41 Degrees Fahrenheit - Location: Milk
Violation Issued: No

Type: Full
Date: *12/17/24*
Time: 10:30:43
Report: 7980241162
Barross Cottage Ii Llc

Food and Beverage Establishment Inspection Report

Process/Item: Cooking
Temperature: 209 Degrees Fahrenheit - Location: Chicken chow mein
Violation Issued: No

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

Notes
1. Proper hand washing, glove use and food handling were observed during the inspection.
2. Make sure sanitizers are tested daily including the hot water on the dish machine run a thermo label. Example daily self inspection form will be emailed.
3. Temperature logs should be kept for the refrigerators examples will be emailed with the report.
4. Vomit clean up kit provided, order cleared from last inspection.
5. Hand washing signs posted at hand sinks, order cleared from last inspection.
6. Discussed employee illness, any staff with vomiting and/or diarrhea is excluded for 24 hours after symptoms stop. Illness is recorded in illness log.
7. Inspection conducted with HRD staff Cyndi Casey and Kevin Sedivy

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

I acknowledge receipt of the MDH inspection report number 7980241162 of 12/17/24.

Certified Food Protection Manager Cynthia Story

Certification Number: FM 2511 Expires: 05/26/27

Inspection report reviewed with person in charge and emailed.

Signed:_____
Cindy Story
Owner

Signed: Sara Bents
Sara Bents
Environmental Health Specialist
Duluth
218-302-6184
sara.bents@state.mn.us

Report #: 7980241162

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

MDH

11 E Superior Street
Duluth

No. of RF/PHI Categories Out	2
No. of Repeat RF/PHI Categories Out	0
Legal Authority MN Rules Chapter 4626	

Date 12/17/24
Time In 10:30:43
Time Out

Barross Cottage Ii Llc	Address: 806 13th Avenue	City/State: Two Harbors, MN	Zip Code: 55616	Telephone: 2188348098
License/Permit #: 0037957	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 compliance **OUT=** not in compliance **N/O=** not observed **N/A=** not applicable **COS=** corrected on-site during inspection **R=** 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 Hygenic 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	X	
23	IN OUT N/A N/O	Proper date marking & disposition		
24	IN OUT N/A N/O	Time as a public health control: procedures & records		
	Consumer Advisory			
25	IN OUT N/A	Consumer advisory provided for raw/undercooked food		
	Highly Susceptible Populations			
26	IN OUT N/A	Pasteurized foods used; prohibited foods not offered		
	Food and Color Additives and Toxic Substances			
27	IN OUT N/A	Food additives: approved & properly used		
28	IN OUT	Toxic substances properly identified, stored, & used		
	Conformance with Approved Procedures			
29	IN OUT N/A	Compliance with variance/specialized process/HACCP		

Risk factors (RF) are improper practices or proceedures 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	X	Thermometers provided & accurate		
		Food Identification		
37		Food properly labled; original container		
		Prevention of Food Contamination		
38		Insects, rodents, & animals not present		
39		Contamination prevented during food prep, storage & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

			COS	R
		Proper Use of Utensils		
43		In-use utensils: properly stored		
44		Utensils, equipment & linens: properly stored, dried, & handled		
45		Single-use/single service articles: properly stored & used		
46		Gloves used properly		
		Utensil Equipment and Vending		
47		Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48	X	Warewashing facilities: installed, maintained, & used; test strips		
49		Non-food contact surfaces clean		
		Physical Facilities		
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		Physical facilities installed, maintained, & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature) **Date:** 12/17/24

Inspector (Signature) Sara Bents