Electronically Delivered

February 15, 2022

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

RE: Project Number(s) SL29942015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on January 27, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health 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.

The enclosed State Form documents the state licensing orders. The Department of Health 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 imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

In accordance with Minn. Stat. § 144G.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation

that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5)(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

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

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

The total amount you are assessed is $500.00. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up surveys. The licensee is not required to submit a plan of correction 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 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 the Department of Health within 15 calendar days of the correction order receipt date.

A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557. Please email general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general reconsideration requests to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

Free from Maltreatment reconsideration requests should addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

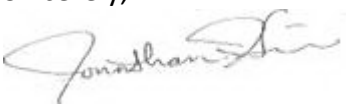
REQUESTING A HEARING

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. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

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.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,



Jonathan Hill, Supervisor
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State Evaluation Team
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Telephone: 651-201-3993 Fax: 651-215-9697

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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 _____	01/27/2022

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 Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL29942015 On, January 26, 2022, through January 27, 2022 the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were seven (7) residents receiving services under the provider's Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared according to the Minnesota Food Code. This had the potential to affect all seven (7) 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 the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated December 14, 2021, for the specific	0 480		

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0 480	Continued From page 2 Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 485 SS=C	144G.41 Subd 1. (13) (i) (A) and (C) Minimum Requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (A) menus must be prepared at least one week in advance, and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; (C) the facility cannot require a resident to include and pay for meals in their contract; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a menu was prepared at least a week in advance and provided to the residents. This had the potential to affect all seven (7) residents. This practice resulted in a level one violation (a	0 485		

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0 485	Continued From page 3 violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On January 26, 2022, at approximately 12:00 p.m. licensed assisted living director (LALD)-A provided the surveyor with a copy of a weekly menu plan for the week of January 24, 2022. The weekly menu plan only included menus for the lunch and dinner meals. There was no planned menus for the breakfast meals. LALD-A stated menus were not prepared for the breakfast meal, and the weekly menu is not provided to the residents. The licensee lacked policies pertaining to menus. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as	0 510		

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0 510	Continued From page 4	0 510		

applicable, for infection prevention and control in assisted living facilities.
(c) The facility must maintain written evidence of compliance with this subdivision.

This MN Requirement is not met as evidenced by:
Based on observation, interview and record review, the licensee failed to establish and maintain an infection control program that complied with accepted health care, medical and nursing standards for infection control. This had the potential to affect all seven (7) residents, staff, and visitors.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).

The findings include:

DISINFECTING EQUIPMENT

On January 27, 2022, at approximately 7:54 a.m. unlicensed personnel (ULP)-D was observed to perform Covid-19 screening (taking of resident's temperature and oxygen saturation level) on R1 in the living room where other residents were sitting watching television. ULP-D proceeded to perform Covid-19 screening on resident R2 and R3 also sitting in the living room watching television. At 8:05 a.m. ULP-D was observed performing Covid-19 screening on R4 while R4 was sitting at the dining room table eating breakfast with other residents. ULP-D did not

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0 510	Continued From page 5	0 510		

clean the thermometer and the oxygen saturation machine in between residents performing Covid-19 screening on R1, R2, R3, and R4. At the time of the observation, ULP-D confirmed they did not clean the thermometer and the oxygen saturation machine in between residents.

On January 27, 2022, at approximately 8:15 a.m. licensed assisted living director (LALD)-A confirmed ULP-D should have cleaned the thermometer and oxygen saturation machine between performing Covid-19 screening on R1, R2, R3, and R4.

The licence's Infection Control Cleaning policy dated March 27, 2020, indicated staff were to clean reusable equipment after each use.

PERSONNEL PROTECTIVE EQUIPMENT (PPE)

The MDH guidance titled, COVID-19 Personal Protective Equipment (PPE) and Source Control Grids, dated December 7, 2021, indicated health care workers working with residents without suspected or confirmed SARS-CoV-2 wear eye protection and face masks in communities with moderate and high community transmission levels.

The Centers for Disease Control and Prevention (CDC) guidance titled, Strategies for Optimizing the Supply of Eye Protection updated September 13, 2021, indicated healthcare personnel (HCP) working in areas of high substantial transmission should use eye protection during all resident encounters.

On January 26, 2022, at approximately 10:00 a.m., LALD-A was observed answering the door to let the surveyor in the facility only wearing a

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0 510	Continued From page 6 mask and no eye protection. ULP-C was observed in the kitchen area only wearing a mask and no eye protection. Registered nurse (RN)-B at approximately 1:45 p.m. only wearing a mask and no eye protection. On January 26, 2022, at approximately 10:30 a.m. LALD-A stated she thought they no longer needed to wear eye protection. LALD-A instructed employees on the need to wear eye protection. The license's Covid-19 Infection Control policy dated May 19, 2020, indicated the facility would make available to employees PPE per CDC and MDH (Minnesota Department of Health) guidelines. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
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;	0 680		

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0 680	Continued From page 7 and (5) have a written policy and procedure regarding missing tenant 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 observation, interview and record review, the licensee failed to have a written emergency disaster plan with all required content and failed to post an emergency plan prominently. This had the potential to affect all seven (7) residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on January 26, 2022, at approximately 10:00 a.m. the Minnesota Department of Health (MDH) surveyor requested to view the licensee's emergency preparedness plan. Licensed assisted living director (LALD)-A	0 680		

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0 680	Continued From page 8 provided a copy of the licensee's emergency preparedness plan. On January 26, 2022, at approximately 11:00 a.m. a MDH surveyor toured the facility with LALD-A. There was no observed signage or information posted regarding the licensee's emergency plan in the assisted living building. On January 26, 2022 at approximately 1:40 p.m. LALD-A confirmed the licensee lacked an emergency preparedness plan that included the following required content: - a comprehensive program to include infectious diseases and pandemics; - a description of the population served by the licensee; - process for emergency preparedness (EP) cooperation with state and local EP officials/organizations; - procedure for tracking staff and residents; - subsistence needs for staff and residents during emergency situation; - development of policies/procedures to address: - evacuation plan (not customized for the facility); - fire (not customized for the facility) - shelter in place; - a tracking system used to document locations or residents and staff - the medical record documentation system to preserve resident information - emergency staff strategies - the facility's role in providing care and treatment at alternative sites - a communication plan that included: - arrangement with other facilities - names and contact information for staff, resident physicians, other facilities - contact information for federal, state, tribal,	0 680		

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0 680	Continued From page 9 local EP staff, ombudsman - primary and alternative means for communicating with facility staff, federal, state, regional and local emergency management agencies - a method of sharing information and medical documentation for residents - a means to provide information regarding the facility's needs, and its ability to provide assistance to include information about their occupancy -a method of sharing information from the emergency plan with residents and their families - EP training and testing program - EP training program for staff (including documentation of training provided) - EP testing/annual testing requirements. The licensee's Emergency and Disaster Preparedness policy dated August 1, 2021, indicated: 1. A hazard vulnerability assessment (HVA) had been completed to identify the most probable emergency situations that may be experienced by this facility or community. 2. An assisted living facility with dementia care that had a secured dementia care unit must include in their hazard vulnerability assessment a safety risk must be performed on and around the properly. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; 3. Based on the HVA, an Emergency Preparedness Plan has been developed. 4. The Emergency Preparedness Plan addresses the following requirements: (a) It is based on and includes a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents.	0 680		

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0 680	Continued From page 10 (b) Includes strategies for addressing emergency events identified by the risk assessment. (c) Addresses our resident population, including, but not limited to, persons at-risk; the type of services the facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans. (d) Includes a process for cooperation and collaboration with local, tribal, regional. State, or Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation. (e) The emergency disaster plan 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. 5. A written Communication Plan is complete that addresses the elements listed in 42 C.F.R. §483.73(c). 6. Our facility has developed and implements emergency preparedness policies and procedures in compliance with 42 C.F.R. §483.73(c). 7. A written policy and procedure regarding missing residents is complete in compliance with MN Rule 4659.0110. 8. The facility will post the emergency disaster plan prominently. 9. The facility provides building emergency exit diagrams to all residents. 10. Emergency exit diagrams are posted on each floor. 11. Training and Exercises. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		

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0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of 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 document review and interview, the licensee failed to provide the required evacuation	0 810		

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 _____	01/27/2022

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
0 810	Continued From page 12 drill frequency. This had the potential to affect all seven (7) residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On January 26, 2022, at approximately 12:15 p.m. the LALD-A provided documents for review. Documents were reviewed by survey staff on January 26, 2022, between 12:15 p.m. and 12:45 p.m. No policies or procedures were provided for evacuation drills. No evacuation drill logs or schedules were included. On January 26, 2022, at approximately 12:50 p.m. during the exit interview with LALD-A, they confirmed the evacuation drill frequency was not met. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01620 SS=F	144G.70 Subd. 2 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	01620		

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	29942	A. BUILDING: _____ B. WING _____	01/27/2022

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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01620	Continued From page 13 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 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 the uniform assessment tool was used to complete assessments for one of one resident (R1) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), 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:	01620		

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 _____	01/27/2022

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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01620	Continued From page 14 On January 26, 2022 at approximately 8:15 a.m. unlicensed personnel (ULP)-C was observed administering R1 morning medications. R1's initial assessment dated October 6, 2021, 14 day reassessment dated October 20, 2021, and 90 reassessment dated January 4, 2022, lacked evidence the uniform assessment tool had been used to complete the assessments. On January 26, 2022, at approximately 1:35 p.m. licensed assisted living director (LALD)-A and RN-B both stated they were not aware of the uniform assessment tool requirement. RN-B confirmed the uniform assessment tool was not used to complete R1's assessments and all other resident's assessment. The licensee's Initial and On-Going Nursing Assessment of Residents policy dated August 1, 2021, indicated a comprehensive assessment included but may not be limited to the requirements outlined by Minnesota Rule. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01620		
02310 SS=D	144G.91 Subd. 4 Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced	02310		

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	29942	A. BUILDING: _____ B. WING _____	01/27/2022

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

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02310	Continued From page 15 by: Based on observation, interview and record review, the licensee failed to ensure the care and services were provided according to a suitable and up-to-date plan, and subject to accepted health care and medical, or nursing standards for one of one resident (R3) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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: The licensee failed to ensure an oxygen cylinder was secured in a rack to prevent tipping or damage. R3's diagnoses included post fracture and heart failure. R3's medication administration record for January 2022, indicated R3 had an order for oxygen PRN (as necessary). On January 26, 2022, at approximately 11:20 a.m. the engineer noted during her tour of the facility, an unsecured portable oxygen tank leaning up against the wall between an oxygen concentrator and another portable oxygen tank that was secured in a rolling holder in R3's room. On January 27, 2022, at approximately 11:00 a.m. licensed assisted living director (LALD)-A stated R3 had PRN oxygen orders from Hospice and R3 had never used the oxygen. LALD-A	02310		

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 _____	01/27/2022

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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02310	Continued From page 16 confirmed one of the portable oxygen tanks in R3's room was not secure. LALD-A stated they did not have a policy pertaining to oxygen storage. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		
02410 SS=E	144G.91 Subd. 13 Personal and treatment privacy (a) Residents have the right to consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being. Staff must respect the privacy of a resident's space by knocking on the door and seeking consent before entering, except in an emergency or where clearly inadvisable or unless otherwise documented in the resident's service plan. (b) Residents have the right to have and use a lockable door to the resident's unit. The facility shall provide locks on the resident's unit. Only a staff member with a specific need to enter the unit shall have keys. This right may be restricted in certain circumstances if necessary for a resident's health and safety and documented in the resident's service plan. (c) Residents have the right to respect and privacy regarding the resident's service plan. Case discussion, consultation, examination, and treatment are confidential and must be conducted discreetly. Privacy must be respected during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance.	02410		

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 _____	01/27/2022

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02410	Continued From page 17 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure privacy was maintained during resident Covid-19 screening for four of four residents (R1, R2, R3, R4) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On January 27, 2022, at approximately 7:54 a.m. unlicensed personnel (ULP)-D was observed to perform Covid-19 screening (taking of resident's temperature and oxygen saturation level) on R1 in the living room were other residents were sitting watching television. ULP-D proceeded to perform Covid-19 screening on resident R2 and R3 also sitting in the living room watching television. At 8:05 a.m. ULP-D was observed performing Covid-19 screening on R4 while R4 was sitting at the dining room table eating breakfast with other residents. On January 27, 2022, at approximately 8:15 a.m. licensed assisted living director (LALD)-A confirmed ULP-D should have performed R1, R2, R3, and R4's Covid-19 screening in a private area. LALD-A stated the licensee did not have a policy. No further information was provided.	02410		

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02410	Continued From page 18 TIME PERIOD FOR CORRECTION: Seven (7) days	02410		

MDH

11 E Superior Street
Duluth
218-302-6166

Type: Full
Date: *01/26/22*
Time: 11:00:07
Report: 7980221009

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.

4-700 Sanitizing Equipment and Utensils

4-703.11C ** Priority 1 **

MN Rule 4626.0905C Sanitize food contact surfaces of equipment and utensils after cleaning by using an approved chemical sanitizer in manual or mechanical operations for at least 7 or 10 seconds for chlorine depending on temperature, concentration, and pH; and 30 seconds for all other chemical sanitizers or a contact time used in relation with a combination of temperature, concentration, and pH.

LARGE ITEMS POTS AND PANS ARE HAND WASHED. AFTER WASHING AND RINSING THE ITEMS MUST BE SANITIZED THEN AIR DRIED. A BIN WAS SET UP WITH BLEACH TO SANITIZE ITEMS AFTER WASHING

Corrected on Site

2-500 Responding to contamination events

2-501.11 ** Priority 2 **

MN Rule 4626.0123 Provide employees with procedures to follow for cleanup of vomit or fecal matter in the establishment. The procedures must minimize the spread of contamination to food and surfaces within the facility, and minimize the exposure of employees and consumers to contamination.

INFORMATION WILL BE SENT WITH THE REPORT ON HOW TO MAKE YOUR OWN KIT OR ONE CAN BE PURCHASED

Comply By: 02/09/22

6-300 Physical Facility Numbers and Capacities

6-301.14A

MN Rule 4626.1457 Provide a sign or poster at all handwashing sinks used by food employees that notifies them to wash their hands

SIGNS WILL BE EMAILED WITH REPORT FOR HAND SINK

Food and Beverage Establishment Inspection Report

Comply By: 02/02/22

Surface and Equipment Sanitizers

Hot Water: = at Degrees Fahrenheit
Location: Bosch dish machine label was black
Violation Issued: No

Chlorine: = 50 ppm at Degrees Fahrenheit
Location: Sanitizer bin for hand washing dishes
Violation Issued: No

Food and Equipment Temperatures

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

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

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

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

Process/Item: Upright Cooler
Temperature: 35 Degrees Fahrenheit - Location: Nurse station-ranch
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 35 Degrees Fahrenheit - Location: Milk
Violation Issued: No

Process/Item: Upright Freezer
Temperature: Degrees Fahrenheit - Location: All freezers frozen hard
Violation Issued: No

Process/Item: Cooking
Temperature: 194 Degrees Fahrenheit - Location: Mashed potatoes
Violation Issued: No

Process/Item: Cooking
Temperature: 164 Degrees Fahrenheit - Location: Hamburger gravy
Violation Issued: No

Type: Full
Date: *01/26/22*
Time: 11:00:07
Report: 7980221009
Barross Cottage Ii Llc

Food and Beverage Establishment Inspection Report

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

Notes
1. Inspections was conducted with Sharon Szamatula and Michelle Leitinger from HRD.
2. All food is made and served the same day, domestic equipment is allowed. If food is cooled and reheated commercial equipment would be required.
3. Owner would like to remodel the kitchen and replace upper and lower cabinetry along with counters. Contact HRD for information on plan review requirements.
4. Thermo labels on site for Bosch hot water dish machine this meets the food code requirement for hot water sanitizing verification.
5. Thin probe thermometer provided in kitchen.
6. Discussed employee illness and excluding employees ill with vomiting and diarrhea. All illness is recorded in the illness log. Illness information will be emailed with the report.

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 7980221009 of 01/26/22.

Certified Food Protection Manager: Cynthia L Story

Certification Number: FM 74966 Expires: 05/24/24

Inspection report reviewed with person in charge and emailed.

Signed: _____
Cynthia Story
Owner

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

Report #: 7980221009

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

MDH

11 E Superior Street
Duluth

No. of RF/PHI Categories Out	3	Date	01/26/22
No. of Repeat RF/PHI Categories Out	0	Time In	11:00:07
Legal Authority MN Rules Chapter 4626		Time Out	

	Address	City/State	Zip Code	Telephone
Barross Cottage Ii Llc	806 13th Avenue	Two Harbors, MN	55616	2188348098

License/Permit #	Permit Holder	Purpose of Inspection	Est Type	Risk Category
0037957		Full		

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
Surpervision			
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	X	
17 IN OUT	Proper disposition of returned, previously served, reconditioned, & unsafe food		

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

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

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

Food Recalls:

Person in Charge (Signature) **Date:** 01/28/22

Inspector (Signature) Sara Bents