



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 4, 2026

Administrator

BARRETT CARE CENTER INC

800 SPRUCE AVENUE

BARRETT, MN 56311

RE: CCN:245575

Cycle Start Date: July 22, 2026

Dear Administrator:

On July 22, 2026, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F" and/or an "E" tag), i.e., the plan of correction should be directed to:

Nicole Dahl, RN, Regional Operations Supervisor

Marshall District Office

Health Regulation Division

Minnesota Department of Health

1400 East Lyon Street, Suite 102 Marshall, Minnesota 56258-2504

Email: Nicole.Dahl@state.mn.us

Office: 507-476-4230

Mobile: (507) 251-6264 Mobile: (605) 881-6192

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by October 22, 2026 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by

the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by January 22, 2027 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

**Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101**

Email: travis.ahrens@state.mn.us

Web: www.sfm.dps.mn.gov

Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'M. Poepping', with a stylized, cursive script.

Melissa Poepping, Compliance Analyst

Federal Enforcement | Health Regulation Division

Minnesota Department of Health

P.O. Box 64900

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4117

Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245575		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/22/2026	
NAME OF PROVIDER OR SUPPLIER BARRETT CARE CENTER INC				STREET ADDRESS, CITY, STATE, ZIP CODE 800 SPRUCE AVENUE , BARRETT, Minnesota, 56311			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
E0000	Initial Comments On (7/20/26 through 7/22/26), a survey for compliance with CFR §483.73, Appendix Z, Emergency Preparedness Requirements was conducted during a federal Risk Based survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.			E0000			
F0000	INITIAL COMMENTS On 7/20/26 through 7/22/26, a federal recertification survey (S5575039-0) was conducted using the Risk-Based Survey (RBS) process at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H55753298 (2792956) and H55753299 (2655886). NO deficiencies were cited. The following complaint was reviewed: H55753297 (2961528). Incidental findings were cited at F607, F609, and F610. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations			F0000			

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F0000	Continued from page 1 has been attained.			F0000			
F0607 SS = D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to follow the policy following a report of an allegation of a suspicion of a crime and/or neglect of duty of residents, when an allegation of illicit substance use while on duty by 1 of 1 staff (licensed practical nurse (LPN-A) occurred and immediately suspend LPN-A pending the investigation. Findings include:			F0607			

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F0607 SS = D	Continued from page 2 Review of the 3/23/26, complainant report to the SA identified on 3/22/26, nursing assistant (NA)-A witnessed licensed practical nurse (LPN)-A smoking what appeared to be methamphetamine and contacted the charge nurse on duty (RN-B) and the director of nursing (DON). NA-A was told by the DON that there “was no proof”. NA-A then sent a video and picture (unknown route) of LPN-A allegedly smoking methamphetamine, however, the DON did not reply to that communication. The administrator was notified around 2:30 p.m., on 3/22/26 and only responded to NA-A, “thank you”. NA-A also contacted the sheriff’s office to report the incident while LPN-A was still working his shift. NA-A was concerned for vulnerable adults that LPN-A was caring for and was advised to contact the SA. There was no mention NA-A had advised the sheriff’s office she had photo and video evidence supporting her claim. Review of the 1/1/26, facility Employee Handbook identified all employees were responsible for helping to prevent and eliminate conditions which may cause accidents to residents, employees, or visitors. Staff were to report concerns to their department manager. Failure by a licensed personnel member (registered nurse, licensed practical nurse, certified nursing assistant) to meet professional obligations may result in mandatory reporting to the appropriate licensing board under state law and facility policy. The facility prohibited retaliation against any employee who, in good faith, reported misconduct, safety concerns, or violations of the Vulnerable Adult Act, or who participated in any investigation. There was no mention in the handbook about use of illicit substances being prohibited in the handbook. Interview on 7/21/26 at 4:00 p.m., with the administrator identified that she had seen the video that NA-A had sent to the DON. She stated, “you could not even tell who it was... it was unclear”. The facility had completed an investigation. She did not have the video when asked to view it, but the DON had it on her phone. Per the facility policy, staff could not video another employee without their permission and the employee who made the complaint, was no longer employed at the facility. The administrator felt the employee left when she did not get the maintenance position she had applied for. She confirmed LPN-A was the nurse that NA-A made the complaint about. She reported an investigation had been completed, and she had called and spoke to LPN-A that day, and the DON had spoke to the other nurse on duty (RN-B). RN-B			F0607			

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F0607 SS = D	Continued from page 3 had reported to the DON “nothing was going on” or different about LPN-A. A copy of the investigation the facility completed was requested. Interview on 7/21/26 at 4:15 p.m., with DON identified she no longer had the video as that was back in March 2026. The DON reported there were no incidents that day while LPN-A was working, “no medication errors or anything”. The facility did not drug test their employees, so they did not have LPN-A complete a drug test following the allegation. She revealed that NA-A was very upset that she did not get a position she had applied for, and things had “just become different”, and she was more “disgruntled” after not getting the maintenance position she had wanted. Review of 3/22/26, facility investigation identified the administrator had received a call from the DON at 1:55 p.m., informing her that she had been notified via phone from RN-B that NA-A allegedly had seen LPN-A out in the parking lot, on his break, in his car smoking something that was potentially drugs. NA-A reported LPN-A had taken excessive breaks that day. NA-A had sent the DON a video of LPN-A in the car smoking. The DON spoke to RN-B regarding the reported allegation, and RN-B had reported that she did not think LPN-A was intoxicated or impaired at all. The administrator spoke to NA-A at 2:49 p.m. and received a video of the incident stating the DON had not responded to her report, and she wanted to be sure it had been reported to the administrator. At that time, the administrator responded to NA-A she would follow up on the incident and thanked her for bringing it to her attention. The administrator identified she had spoken to LPN-A and he did not “appear intoxicated” to her. She had asked him about how he was feeling, and about his breaks being excessive. LPN-A responded he did not feel his breaks had been excessive and assured her that he would keep a “better eye on” the timing of his breaks. He also reported feeling “fine” and he was “doing his job”. The investigation identified the video was shown to the pharmacist, and he stated that the video was “very difficult to see”, and it could “potentially be a medical device” in the video. The pharmacist agreed with the administrator and DON that the video was “unclear” who was in the vehicle and what was being smoked. The administrator noted in the investigation per the facility policy, that videotaping of a fellow employee without their knowledge while on break was prohibited. The allegation was unsubstantiated based			F0607			

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F0607 SS = D	Continued from page 4 on the information provided. There was no mention the administrator had performed a thorough investigation consisting of asking residents if their cares were delayed or not completed, if the facility had reviewed any medical records to identify potential neglect, medication errors, etc while LPN-A was working that day. There was also no mention in the investigation that the administrator had interviewed other staff or families about the concerns or had interviewed NA-A in depth about her concerns. There was also no indication if a suspicion of alleged drug use occurred, that the facility had reviewed their controlled medications to identify if potential diversion had taken place nor was there evidence they had called law enforcement (LE) for them to conduct an investigation or view the evidence supplied by NA-A, or had immediately suspended LPN-A while the investigation occurred. Interview on 7/22/26 at 9:01 a.m., with NA-A identified on 3/22/26, RN-B and LPN-A were the nurses on duty for the shift. LPN-A had spent a lot of time in his car, and NA-A, along with another unidentified staff, had been “keeping track” of LPN-A taking breaks. LPN-A had only been in the building for approximately 2 of NA-A’s 8-hour shift. LPN-A was seen smoking in his car from “some kind of a pipe”. NA-A reported she had a picture and a video, and you “could see” that it was a long glass pipe he was lighting from the bottom. She stated from what she found on google search, she believed it was a methamphetamine pipe. She reported there was another NA that had witnessed LPN-A, who also thought the same thing. NA-A reported she had followed the chain-of-command and reported her concern to the RN-B. RN-B called and reported the concern to the DON but “nothing was done”. LPN-A remained at work. NA-A stated she shared the video with the facility and then was told “there was no way to prove what he was doing, and it was probably a vape that he was smoking”. The next day that she had worked, the DON told her to come to her office and when NA-A asked what it was about, the DON had replied she would be told once in the office. NA-A had asked for a witness to be present, and the DON had RN-B join. NA-A also asked if she could record the conversation and was told she was not allowed to record. The DON was reported to have yelled at her saying she was “just spreading rumors and ruining the reputation of other employees”. Once she started to scream at her, she walked out of the office. She then asked RN-B to write what happened in that meeting and RN-B refused. NA-A said LPN-A worked his entire shift that day. NA-A stated she had reported LPN-A			F0607			

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F0607 SS = D	Continued from page 5 because LPN-A was responsible for taking care of vulnerable adults and passing their medication, and she was worried if he was under the influence, that he could “mess up”. She further revealed that she had told LPN-A earlier that day on 3/22/26, about a resident who reported abdominal pain, and LPN-A replied to NA-A “it was probably just gas pain” and never checked on that resident. Throughout the shift, LPN-A would pass some medications, and then go out and sit in his car. This was not unusual for LPN-A though, and that was why NA-A said they were keeping track of how much he was out in his car, so that they could report back to the DON as it was a common occurrence. NA then stated she had the picture and video of LPN-A and would share it with the SA surveyors. Review of the video NA-A provided showed a male, (LPN-A) sitting in a car, slumped over to his right side. LPN-A then sat upright and was observed to be wearing a gray or blue jacket/sweatshirt type clothing with white writing on it, holding an object to his mouth in his left hand that had a long cylinder-shaped stem pipe-like object, that had a round sphere-like ball at the end and was shiny in appearance. The still picture NA-A provided showed LPN-A holding this pipe-like object grasped in his left hand, wearing the same clothing. LPN-A had on glasses and had short hair in both the video and the still picture. Review of LPN-A’s personnel file identified LPN-A had satisfactory reviews in 2021 and 2023. In 2024, LPN-A has satisfactory in all but one column labeled, “reports to work on time/attendance” which was noted to need improvement. LPN-A’s 2026 review, performed on 3/23/26, one day after the incident, identified he was satisfactory with work performance, however there was a note “Reminder to watch breaks, be ready to work by 2 (often coming in a few minutes after).” No disciplinary action was noted in his file. No 2025 employee review was submitted. Interview on 7/22/26 at 9:49 a.m., with RN-B identified she had worked on 3/22/26. RN-B reported during morning break LPN-A was out in his car and gone for “quite some time... over an hour”. RN-B had looked outside and seen LPN-A sitting in his car “smoking some type of pipe”. RN-B stated she then called her supervisor (the DON) and reported this and told her there was another employee (NA-A) who thought he was smoking			F0607			

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F0607 SS = D	Continued from page 6 something “like a drug”. The supervisor said, “we could not assume [it was illegal substances]”. She reported she did not notice any impairment in LPN-A herself upon his return. LPN-A does go out to his car “a lot” and that was not unusual for him. LPN-A tended to take more breaks than anyone else. It was frustrating when he takes “excessive breaks” because she ended up covering any (resident) behaviors, alarms, or anything else that happens on his assigned hall when he was not there to “do his part”. LPN-A would often go out to his car to smoke or sleep. RN-B had not witnessed any concerns with LPN-A that day and she reported she had kept an eye on him the entire shift to make sure he was doing everything he was supposed to be doing. RN-B said she never “felt” like LPN-A was impaired and did not observe signs of impairment. RN-B had not noted how she assessed LPN-A for signs of potential impairment. RN-B made no mention if she had been advised to perform any tasks to ensure resident safety had occurred while LPN-A was outside the facility in the parking lot, or if she should have performed any other procedures, or that the DON was going to come to the facility on 3/22/26 (Sunday) to immediately perform investigative tasks or follow facility policy by immediately suspending LPN-A, pending an investigation. Interview on 7/22/26 at 12:52 p.m., with the consulting pharmacist (RPh) identified he had been shown the video and reported it was very “grainy”. The video was of a “male” in his car, and he looked like he was leaning down using “some kind of inhalation [device]”. The question posed (to him) was, could this person be smoking a crack pipe? In his opinion, usually with that type of pipe you would see visual smoke. He was unable to determine if the male was or wasn’t using a pipe. He reported his first impression was that this person may be using an “albuterol inhaler or Symbicort for something like asthma”. The pharmacist was unable to recall if he was at the facility when he reviewed the video or if it had been sent the video to review. He reported he was asked to give his opinion, and his first reaction was that this was “not proof of anything”, this was just “someone inhaling something”. When asked specifically by the facility if it looked like methamphetamine, the answer was “unlikely because you would have seen a flame and a cloud of smoke”. It was not clear what experience and/or training RPh had in identifying illicit substance use/abuse or specific paraphernalia used.			F0607			

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F0607 SS = D	Continued from page 7 Interview on 7/22/26 at 11:09 a.m., with local police department dispatch identified that they had received a call at 4:44 p.m. on 3/22/26, for a report of an employee who was suspected of smoking a pipe. The deputy assigned reported that he recalled the individual was not at the facility by the time he got the report (unknown time). He was unaware of any video or picture of the event but would have liked to have had that information at the time of the incident. The hard part about the situation was a person can have all the drugs in their system that they want, but he would have had to have physical evidence and probable cause to search the individual. As he recalled, he heard about the incident after the fact, so there was not really anything he could do about it. The courts would consider the video now as “stale evidence” at this point. Interview on 7/22/26 at 1:52 p.m., with DON and assistant director of nursing (ADON) identified the DON stated when asked if the facility was to report an allegation of a suspicion of a crime to law enforcement, that she would need to review the regulation and the policy. The ADON stated in review of the video that was sent to the facility, management was not able to confirm the video had taken place on the property. The DON reported the RN on duty at the time (RN-B) assessed LPN-A. He did not appear to be impaired, so she felt there was no suspicion of a crime. She revealed LPN-A was a smoker and had a history of taking “excessive breaks”. The ADON then stated, “was it even legal that she recorded him?” The DON reported the facility did not report to law enforcement or make a SA report, as they felt they did not have suspicion of LPN-A committing a crime. She reported she did not suspend LPN-A, but they did start an investigation at the time. The video was not provided when the concern was first brought to the DON’s attention... the video came later that day (3/22/26). NA-A did not believe RN-B did anything after she reported it to her, so that was when NA-A sent the video to the DON. The DON reported in their interpretation of the report and video, they did not feel the report warranted a call to the police or notification to the SA, but the matter was investigated. The DON again stated that RN-B assessed LPN-A and determined he was not impaired so there was not suspicion of a crime that needed to be reported. The DON did confirm an allegation could be considered suspicion however, LPN-A was assessed and had no impairment so there was no need to call the police. The DON and ADON made no mention of any specific training RN-B had to identify illicit drug use and/or impairment from use for appropriate			F0607			

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F0607 SS = D	Continued from page 8 assessment. LPN-A's timecard was requested for 3/22/26, but not provided by the end of survey. Follow-up email was sent 7/23/26 requesting that information again. Review of the 1/1/26, Employee Handbook identified absence from duty was related to call-in's, however excessive breaks were not mentioned. Use of camera phones for the purpose of photographing residents without their consent was strictly prohibited. There was no such prohibition on taking pictures of staff in outdoor spaces. The facility was to make timely and thorough investigations of all reports and allegations of abuse (and neglect). All members of staff were responsible for helping prevent and eliminate conditions which may cause accidents to residents. Supervisors were to use a progressive process on dealing with work habits that required corrective action. They were to have an employee conference, notice of concern, then a final notice of performance improvement, followed by termination of employment. All staff were mandatory reporters. There was no mention of potential drug use by staff in the employee hand book. Review of the current, undated Abuse Prevention Policy and Plan identified it was the policy of the facility to protect residents who, because of physical or mental disability were dependent on institutional services and were particularly vulnerable to abuse and neglect, to provide safe living environments for vulnerable adults, and assist persons charged with care to provide safe environments. All reports were to be investigated. The facility policy was to orientate, maintain, and follow the abuse prevention plan at all times. A report was required when a mandated reported has reason to believe that a vulnerable adult is being, or has been maltreated (abuse, neglect, financial exploitation, et. Al). Residents of the facility had the right to be free from all types of abuse including verbal, sexual, physical, and mental abuse, corporal punishment, mistreatment, neglect/deprivation, injuries of unknown source (unexplained injuries), misappropriation of resident property, and involuntary seclusion. Definitions included in the policy were: Neglect was defined as a failure of the facility, its employees or service providers, to provide goods and services necessary to a resident to avoid physical harm, pain, mental anguish, or emotional			F0607			

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F0607 SS = D	Continued from page 9 distress. Willful was defined as an individual must have acted deliberately not that the individual must have intended to inflict injury or harm. Depravation of goods and services was defined as depriving residents of services that are necessary to provide care but choosing not to do it. The policy further noted signs of actual physical neglect included inadequate provision of care and a caregiver that was indifferent to residents' personal care and needs. Staff were to report incidents, findings, and corrective measures to appropriate agencies as outlined in the facility's abuse reporting policy. Investigating abuse would be done by the charge nurse, DON, SSD and/or the administrator. The interview was to consist of: Interview person(s) reporting the abuse. Interview any witnesses that may have knowledge of the abuse (or neglect). Interview resident (as appropriate). Interview employees of any accused abuse (or neglect). Interview staff persons having contact with resident during the shift of alleged abuse Interview with resident roommates (if applicable), family and visitors. In the case of abuse, an appropriate report form was to be completed, and the information recorded in the resident's medical chart. Alleged or suspected cases of abuse (or neglect) that are reported, the Administrator, Social Services Designee or Director of Nursing was to notify the following agencies of the incident: Minnesota Department of Health. Resident Representative. Law Enforcement. During the investigation, accused employees were to be reassigned to non-resident contact duties or suspended with or without pay until the investigation has been completed. Reporting abuse (or neglect) was to be done immediately upon discovery. Initial			F0607			

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F0607 SS = D	Continued from page 10 reports of abuse (or neglect) were to be reported to MDH, via a secure web site, immediately (not later than 2 hours) of discovery of the incident after forming the suspicion of abuse (or neglect).			F0607			
F0609 SS = D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to report an allegation of a suspicion of a crime and/or neglect of duty of residents to the State Agency (SA) and Law Enforcement when an allegation of illicit substance use while on duty by 1 of 1 staff (licensed practical nurse (LPN-A) was reported to management. Findings include: Review of the 3/23/26, complainant report to the SA identified on 3/22/26, nursing assistant (NA)-A witnessed licensed practical nurse (LPN)-A smoking			F0609			

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F0609 SS = D	Continued from page 11 what appeared to be methamphetamine and contacted the charge nurse on duty (RN-B) and the director of nursing (DON). NA-A was told by the DON that there “was no proof”. NA-A then sent a video and picture (unknown route) of LPN-A allegedly smoking methamphetamine, however, the DON did not reply to that communication. The administrator was notified around 2:30 p.m., on 3/22/26 and only responded to NA-A, “thank you”. NA-A also contacted the sheriff’s office to report the incident while LPN-A was still working his shift. NA-A was concerned for vulnerable adults that LPN-A was caring for and was advised to contact the SA. There was no mention NA-A had advised the sheriff’s office she had photo and video evidence supporting her claim. Review of the 1/1/26, facility Employee Handbook identified all employees were responsible for helping to prevent and eliminate conditions which may cause accidents to residents, employees, or visitors. Staff were to report concerns to their department manager. Failure by a licensed personnel member (registered nurse, licensed practical nurse, certified nursing assistant) to meet professional obligations may result in mandatory reporting to the appropriate licensing board under state law and facility policy. The facility prohibited retaliation against any employee who, in good faith, reported misconduct, safety concerns, or violations of the Vulnerable Adult Act, or who participated in any investigation. There was no mention in the handbook about use of illicit substances being prohibited in the handbook. Interview on 7/21/26 at 4:00 p.m., with the administrator identified that she had seen the video that NA-A had sent to the DON. She stated, “you could not even tell who it was... it was unclear”. The facility had completed an investigation. She did not have the video when asked to view it, but the DON had it on her phone. Per the facility policy, staff could not video another employee without their permission and the employee who made the complaint, was no longer employed at the facility. The administrator felt the employee left when she did not get the maintenance position she had applied for. She confirmed LPN-A was the nurse that NA-A made the complaint about. She reported an investigation had been completed, and she had called and spoke to LPN-A that day, and the DON had spoke to the other nurse on duty (RN-B). RN-B had reported to the DON “nothing was going on” or different about LPN-A. A copy of the investigation the facility completed was requested.			F0609			

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F0609 SS = D	Continued from page 12 Interview on 7/21/26 at 4:15 p.m., with DON identified she no longer had the video as that was back in March 2026. The DON reported there were no incidents that day while LPN-A was working, “no medication errors or anything”. The facility did not drug test their employees, so they did not have LPN-A complete a drug test following the allegation. She revealed that NA-A was very upset that she did not get a position she had applied for, and things had “just become different”, and she was more “disgruntled” after not getting the maintenance position she had wanted. Review of 3/22/26, facility investigation identified the administrator had received a call from the DON at 1:55 p.m., informing her that she had been notified via phone from RN-B that NA-A allegedly had seen LPN-A out in the parking lot, on his break, in his car smoking something that was potentially drugs. NA-A reported LPN-A had taken excessive breaks that day. NA-A had sent the DON a video of LPN-A in the car smoking. The DON spoke to RN-B regarding the reported allegation, and RN-B had reported that she did not think LPN-A was intoxicated or impaired at all. The administrator spoke to NA-A at 2:49 p.m. and received a video of the incident stating the DON had not responded to her report, and she wanted to be sure it had been reported to the administrator. At that time, the administrator responded to NA-A she would follow up on the incident and thanked her for bringing it to her attention. The administrator identified she had spoken to LPN-A and he did not “appear intoxicated” to her. She had asked him about how he was feeling, and about his breaks being excessive. LPN-A responded he did not feel his breaks had been excessive and assured her that he would keep a “better eye on” the timing of his breaks. He also reported feeling “fine” and he was “doing his job”. The investigation identified the video was shown to the pharmacist, and he stated that the video was “very difficult to see”, and it could “potentially be a medical device” in the video. The pharmacist agreed with the administrator and DON that the video was “unclear” who was in the vehicle and what was being smoked. The administrator noted in the investigation per the facility policy, that videotaping of a fellow employee without their knowledge while on break was prohibited. The allegation was unsubstantiated based on the information provided. There was no mention the administrator had performed a thorough investigation consisting of asking residents if their			F0609			

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F0609 SS = D	Continued from page 13 cares were delayed or not completed, if the facility had reviewed any medical records to identify potential neglect, medication errors, etc while LPN-A was working that day. There was also no mention in the investigation that the administrator had interviewed other staff or families about the concerns or had interviewed NA-A in depth about her concerns. There was also no indication if a suspicion of alleged drug use occurred, that the facility had reviewed their controlled medications to identify if potential diversion had taken place nor was there evidence they had called law enforcement (LE) for them to conduct an investigation or view the evidence supplied by NA-A, or had immediately suspended LPN-A while the investigation occurred. Interview on 7/22/26 at 9:01 a.m., with NA-A identified on 3/22/26, RN-B and LPN-A were the nurses on duty for the shift. LPN-A had spent a lot of time in his car, and NA-A, along with another unidentified staff, had been “keeping track” of LPN-A taking breaks. LPN-A had only been in the building for approximately 2 of NA-A’s 8-hour shift. LPN-A was seen smoking in his car from “some kind of a pipe”. NA-A reported she had a picture and a video, and you “could see” that it was a long glass pipe he was lighting from the bottom. She stated from what she found on google search, she believed it was a methamphetamine pipe. She reported there was another NA that had witnessed LPN-A, who also thought the same thing. NA-A reported she had followed the chain-of-command and reported her concern to the RN-B. RN-B called and reported the concern to the DON but “nothing was done”. LPN-A remained at work. NA-A stated she shared the video with the facility and then was told “there was no way to prove what he was doing, and it was probably a vape that he was smoking”. The next day that she had worked, the DON told her to come to her office and when NA-A asked what it was about, the DON had replied she would be told once in the office. NA-A had asked for a witness to be present, and the DON had RN-B join. NA-A also asked if she could record the conversation and was told she was not allowed to record. The DON was reported to have yelled at her saying she was “just spreading rumors and ruining the reputation of other employees”. Once she started to scream at her, she walked out of the office. She then asked RN-B to write what happened in that meeting and RN-B refused. NA-A said LPN-A worked his entire shift that day. NA-A stated she had reported LPN-A because LPN-A was responsible for taking care of vulnerable adults and passing their medication, and she was worried if he was under the influence, that			F0609			

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F0609 SS = D	Continued from page 14 he could “mess up”. She further revealed that she had told LPN-A earlier that day on 3/22/26, about a resident who reported abdominal pain, and LPN-A replied to NA-A “it was probably just gas pain” and never checked on that resident. Throughout the shift, LPN-A would pass some medications, and then go out and sit in his car. This was not unusual for LPN-A though, and that was why NA-A said they were keeping track of how much he was out in his car, so that they could report back to the DON as it was a common occurrence. NA-A then stated she had the picture and video of LPN-A and would share it with the SA surveyors. Review of the video NA-A provided showed a male, (LPN-A) sitting in a car, slumped over to his right side. LPN-A then sat upright and was observed to be wearing a gray or blue jacket/sweatshirt type clothing with white writing on it, holding an object to his mouth in his left hand that had a long cylinder-shaped stem pipe-like object, that had a round sphere-like ball at the end and was shiny in appearance. The still picture NA-A provided showed LPN-A holding this pipe-like object grasped in his left hand, wearing the same clothing. LPN-A had on glasses and had short hair in both the video and the still picture. Review of LPN-A’s personnel file identified LPN-A had satisfactory reviews in 2021 and 2023. In 2024, LPN-A has satisfactory in all but one column labeled, “reports to work on time/attendance” which was noted to need improvement. LPN-A’s 2026 review, performed on 3/23/26, one day after the incident, identified he was satisfactory with work performance, however there was a note “Reminder to watch breaks, be ready to work by 2 (often coming in a few minutes after).” No disciplinary action was noted in his file. No 2025 employee review was submitted. Interview on 7/22/26 at 9:49 a.m., with RN-B identified she had worked on 3/22/26. RN-B reported during morning break LPN-A was out in his car and gone for “quite some time... over an hour”. RN-B had looked outside and seen LPN-A sitting in his car “smoking some type of pipe”. RN-B stated she then called her supervisor (the DON) and reported this and told her there was another employee (NA-A) who thought he was smoking something “like a drug”. The supervisor said, “we could not assume [it was illegal substances]”. She reported she did not notice any impairment in			F0609			

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F0609 SS = D	Continued from page 15 LPN-A herself upon his return. LPN-A does go out to his car “a lot” and that was not unusual for him. LPN-A tended to take more breaks than anyone else. It was frustrating when he takes “excessive breaks” because she ended up covering any (resident) behaviors, alarms, or anything else that happens on his assigned hall when he was not there to “do his part”. LPN-A would often go out to his car to smoke or sleep. RN-B had not witnessed any concerns with LPN-A that day and she reported she had kept an eye on him the entire shift to make sure he was doing everything he was supposed to be doing. RN-B said she never “felt” like LPN-A was impaired and did not observe signs of impairment. RN-B had not noted how she assessed LPN-A for signs of potential impairment. RN-B made no mention if she had been advised to perform any tasks to ensure resident safety had occurred while LPN-A was outside the facility in the parking lot, or if she should have performed any other procedures, or that the DON was going to come to the facility on 3/22/26 (Sunday) to immediately perform investigative tasks or follow facility policy by immediately suspending LPN-A, pending an investigation. Interview on 7/22/26 at 12:52 p.m., with the consulting pharmacist (RPh) identified he had been shown the video and reported it was very “grainy”. The video was of a “male” in his car, and he looked like he was leaning down using “some kind of inhalation [device]”. The question posed (to him) was, could this person be smoking a crack pipe? In his opinion, usually with that type of pipe you would see visual smoke. He was unable to determine if the male was or wasn’t using a pipe. He reported his first impression was that this person may be using an “albuterol inhaler or Symbicort for something like asthma”. The pharmacist was unable to recall if he was at the facility when he reviewed the video or if it had been sent the video to review. He reported he was asked to give his opinion, and his first reaction was that this was “not proof of anything”, this was just “someone inhaling something”. When asked specifically by the facility if it looked like methamphetamine, the answer was “unlikely because you would have seen a flame and a cloud of smoke”. It was not clear what experience and/or training RPh had in identifying illicit substance use/abuse or specific paraphernalia used. Interview on 7/22/26 at 11:09 a.m., with local police department dispatch identified that they had received a call at 4:44 p.m. on 3/22/26, for a report of an			F0609			

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F0609 SS = D	Continued from page 16 employee who was suspected of smoking a pipe. The deputy assigned reported that he recalled the individual was not at the facility by the time he got the report (unknown time). He was unaware of any video or picture of the event but would have liked to have had that information at the time of the incident. The hard part about the situation was a person can have all the drugs in their system that they want, but he would have had to have physical evidence and probable cause to search the individual. As he recalled, he heard about the incident after the fact, so there was not really anything he could do about it. The courts would consider the video now as “stale evidence” at this point. Interview on 7/22/26 at 1:52 p.m., with DON and assistant director of nursing (ADON) identified the DON stated when asked if the facility was to report an allegation of a suspicion of a crime to law enforcement, that she would need to review the regulation and the policy. The ADON stated in review of the video that was sent to the facility, management was not able to confirm the video had taken place on the property. The DON reported the RN on duty at the time (RN-B) assessed LPN-A. He did not appear to be impaired, so she felt there was no suspicion of a crime. She revealed LPN-A was a smoker and had a history of taking “excessive breaks”. The ADON then stated, “was it even legal that she recorded him?” The DON reported the facility did not report to law enforcement or make a SA report, as they felt they did not have suspicion of LPN-A committing a crime. She reported she did not suspend LPN-A, but they did start an investigation at the time. The video was not provided when the concern was first brought to the DON's attention... the video came later that day (3/22/26). NA-A did not believe RN-B did anything after she reported it to her, so that was when NA-A sent the video to the DON. The DON reported in their interpretation of the report and video, they did not feel the report warranted a call to the police or notification to the SA, but the matter was investigated. The DON again stated that RN-B assessed LPN-A and determined he was not impaired so there was not suspicion of a crime that needed to be reported. The DON did confirm an allegation could be considered suspicion however, LPN-A was assessed and had no impairment so there was no need to call the police. The DON and ADON made no mention of any specific training RN-B had to identify illicit drug use and/or impairment from use for appropriate assessment.			F0609			

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F0609 SS = D	Continued from page 17 LPN-A's timecard was requested for 3/22/26, but not provided by the end of survey. Follow-up email was sent 7/23/26 requesting that information again. Review of the 1/1/26, Employee Handbook identified absence from duty was related to call-in's, however excessive breaks were not mentioned. Use of camera phones for the purpose of photographing residents without their consent was strictly prohibited. There was no such prohibition on taking pictures of staff in outdoor spaces. The facility was to make timely and thorough investigations of all reports and allegations of abuse (and neglect). All members of staff were responsible for helping prevent and eliminate conditions which may cause accidents to residents. Supervisors were to use a progressive process on dealing with work habits that required corrective action. They were to have an employee conference, notice of concern, then a final notice of performance improvement, followed by termination of employment. All staff were mandatory reporters. There was no mention of potential drug use by staff in the employee hand book. Review of the current, undated Abuse Prevention Policy and Plan identified it was the policy of the facility to protect residents who, because of physical or mental disability were dependent on institutional services and were particularly vulnerable to abuse and neglect, to provide safe living environments for vulnerable adults, and assist persons charged with care to provide safe environments. All reports were to be investigated. The facility policy was to orientate, maintain, and follow the abuse prevention plan at all times. A report was required when a mandated reported has reason to believe that a vulnerable adult is being, or has been maltreated (abuse, neglect, financial exploitation, et. Al). Residents of the facility had the right to be free from all types of abuse including verbal, sexual, physical, and mental abuse, corporal punishment, mistreatment, neglect/deprivation, injuries of unknown source (unexplained injuries), misappropriation of resident property, and involuntary seclusion. Definitions included in the policy were: Neglect was defined as a failure of the facility, its employees or service providers, to provide goods and services necessary to a resident to avoid physical harm, pain, mental anguish, or emotional distress. Willful was defined as an individual must have acted			F0609			

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F0609 SS = D	Continued from page 18 deliberately not that the individual must have intended to inflict injury or harm. Deprivation of goods and services was defined as depriving residents of services that are necessary to provide care but choosing not to do it. The policy further noted signs of actual physical neglect included inadequate provision of care and a caregiver that was indifferent to residents' personal care and needs. Staff were to report incidents, findings, and corrective measures to appropriate agencies as outlined in the facility's abuse reporting policy. Investigating abuse would be done by the charge nurse, DON, SSD and/or the administrator. The interview was to consist of: Interview person(s) reporting the abuse. Interview any witnesses that may have knowledge of the abuse (or neglect). Interview resident (as appropriate). Interview employees of any accused abuse (or neglect). Interview staff persons having contact with resident during the shift of alleged abuse Interview with resident roommates (if applicable), family and visitors. In the case of abuse, an appropriate report form was to be completed, and the information recorded in the resident's medical chart. Alleged or suspected cases of abuse (or neglect) that are reported, the Administrator, Social Services Designee or Director of Nursing was to notify the following agencies of the incident: Minnesota Department of Health. Resident Representative. Law Enforcement. During the investigation, accused employees were to be reassigned to non-resident contact duties or suspended with or without pay until the investigation has been completed. Reporting abuse (or neglect) was to be done immediately upon discovery. Initial reports of abuse (or neglect) were to be reported to MDH, via a secure web site, immediately (not later than 2 hours) of discovery of the incident after			F0609			

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F0609 SS = D	Continued from page 19 forming the suspicion of abuse (or neglect).			F0609			
F0610 SS = D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to thoroughly investigate an allegation of a suspicion of a crime and/or neglect of duty of residents by 1 of 1 staff (licensed practical nurse (LPN-A) who was reported to have used illicit substances while on duty. Findings include: Review of the 3/23/26, complainant report to the SA identified on 3/22/26, nursing assistant (NA)-A witnessed licensed practical nurse (LPN)-A smoking what appeared to be methamphetamine and contacted the charge nurse on duty (RN-B) and the director of nursing (DON). NA-A was told by the DON that there “was no proof”. NA-A then sent a video and picture (unknown route) of LPN-A allegedly smoking methamphetamine, however, the DON did not reply to that communication. The administrator was notified around 2:30 p.m., on 3/22/26 and only responded to NA-A, “thank you”. NA-A also contacted the sheriff’s office to report the incident while LPN-A was still working his shift. NA-A was concerned for vulnerable adults that LPN-A was caring for and was advised to contact			F0610			

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F0610 SS = D	Continued from page 20 the SA. There was no mention NA-A had advised the sheriff’s office she had photo and video evidence supporting her claim. Review of the 1/1/26, facility Employee Handbook identified all employees were responsible for helping to prevent and eliminate conditions which may cause accidents to residents, employees, or visitors. Staff were to report concerns to their department manager. Failure by a licensed personnel member (registered nurse, licensed practical nurse, certified nursing assistant) to meet professional obligations may result in mandatory reporting to the appropriate licensing board under state law and facility policy. The facility prohibited retaliation against any employee who, in good faith, reported misconduct, safety concerns, or violations of the Vulnerable Adult Act, or who participated in any investigation. There was no mention in the handbook about use of illicit substances being prohibited in the handbook. Interview on 7/21/26 at 4:00 p.m., with the administrator identified that she had seen the video that NA-A had sent to the DON. She stated, “you could not even tell who it was... it was unclear”. The facility had completed an investigation. She did not have the video when asked to view it, but the DON had it on her phone. Per the facility policy, staff could not video another employee without their permission and the employee who made the complaint, was no longer employed at the facility. The administrator felt the employee left when she did not get the maintenance position she had applied for. She confirmed LPN-A was the nurse that NA-A made the complaint about. She reported an investigation had been completed, and she had called and spoke to LPN-A that day, and the DON had spoke to the other nurse on duty (RN-B). RN-B had reported to the DON “nothing was going on” or different about LPN-A. A copy of the investigation the facility completed was requested. Interview on 7/21/26 at 4:15 p.m., with DON identified she no longer had the video as that was back in March 2026. The DON reported there were no incidents that day while LPN-A was working, “no medication errors or anything”. The facility did not drug test their employees, so they did not have LPN-A complete a drug test following the allegation. She revealed that NA-A was very upset that she did not get a position she had applied for, and things had “just become different”, and she was more “disgruntled” after not getting the maintenance			F0610			

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F0610 SS = D	Continued from page 21 position she had wanted. Review of 3/22/26, facility investigation identified the administrator had received a call from the DON at 1:55 p.m., informing her that she had been notified via phone from RN-B that NA-A allegedly had seen LPN-A out in the parking lot, on his break, in his car smoking something that was potentially drugs. NA-A reported LPN-A had taken excessive breaks that day. NA-A had sent the DON a video of LPN-A in the car smoking. The DON spoke to RN-B regarding the reported allegation, and RN-B had reported that she did not think LPN-A was intoxicated or impaired at all. The administrator spoke to NA-A at 2:49 p.m. and received a video of the incident stating the DON had not responded to her report, and she wanted to be sure it had been reported to the administrator. At that time, the administrator responded to NA-A she would follow up on the incident and thanked her for bringing it to her attention. The administrator identified she had spoken to LPN-A and he did not “appear intoxicated” to her. She had asked him about how he was feeling, and about his breaks being excessive. LPN-A responded he did not feel his breaks had been excessive and assured her that he would keep a “better eye on” the timing of his breaks. He also reported feeling “fine” and he was “doing his job”. The investigation identified the video was shown to the pharmacist, and he stated that the video was “very difficult to see”, and it could “potentially be a medical device” in the video. The pharmacist agreed with the administrator and DON that the video was “unclear” who was in the vehicle and what was being smoked. The administrator noted in the investigation per the facility policy, that videotaping of a fellow employee without their knowledge while on break was prohibited. The allegation was unsubstantiated based on the information provided. There was no mention the administrator had performed a thorough investigation consisting of asking residents if their cares were delayed or not completed, if the facility had reviewed any medical records to identify potential neglect, medication errors, etc while LPN-A was working that day. There was also no mention in the investigation that the administrator had interviewed other staff or families about the concerns or had interviewed NA-A in depth about her concerns. There was also no indication if a suspicion of alleged drug use occurred, that the facility had reviewed their controlled medications to identify if potential diversion had taken place nor was there evidence they had called law enforcement (LE) for them to conduct an investigation or view the			F0610			

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F0610 SS = D	Continued from page 22 evidence supplied by NA-A, or had immediately suspended LPN-A while the investigation occurred. Interview on 7/22/26 at 9:01 a.m., with NA-A identified on 3/22/26, RN-B and LPN-A were the nurses on duty for the shift. LPN-A had spent a lot of time in his car, and NA-A, along with another unidentified staff, had been “keeping track” of LPN-A taking breaks. LPN-A had only been in the building for approximately 2 of NA-A’s 8-hour shift. LPN-A was seen smoking in his car from “some kind of a pipe”. NA-A reported she had a picture and a video, and you “could see” that it was a long glass pipe he was lighting from the bottom. She stated from what she found on google search, she believed it was a methamphetamine pipe. She reported there was another NA that had witnessed LPN-A, who also thought the same thing. NA-A reported she had followed the chain-of-command and reported her concern to the RN-B. RN-B called and reported the concern to the DON but “nothing was done”. LPN-A remained at work. NA-A stated she shared the video with the facility and then was told “there was no way to prove what he was doing, and it was probably a vape that he was smoking”. The next day that she had worked, the DON told her to come to her office and when NA-A asked what it was about, the DON had replied she would be told once in the office. NA-A had asked for a witness to be present, and the DON had RN-B join. NA-A also asked if she could record the conversation and was told she was not allowed to record. The DON was reported to have yelled at her saying she was “just spreading rumors and ruining the reputation of other employees”. Once she started to scream at her, she walked out of the office. She then asked RN-B to write what happened in that meeting and RN-B refused. NA-A said LPN-A worked his entire shift that day. NA-A stated she had reported LPN-A because LPN-A was responsible for taking care of vulnerable adults and passing their medication, and she was worried if he was under the influence, that he could “mess up”. She further revealed that she had told LPN-A earlier that day on 3/22/26, about a resident who reported abdominal pain, and LPN-A replied to NA-A “it was probably just gas pain” and never checked on that resident. Throughout the shift, LPN-A would pass some medications, and then go out and sit in his car. This was not unusual for LPN-A though, and that was why NA-A said they were keeping track of how much he was out in his car, so that they could report back to the DON as it was a common occurrence. NA then stated she had the picture and video of LPN-A and would share it with the SA surveyors.			F0610			

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F0610 SS = D	Continued from page 23 Review of the video NA-A provided showed a male, (LPN-A) sitting in a car, slumped over to his right side. LPN-A then sat upright and was observed to be wearing a gray or blue jacket/sweatshirt type clothing with white writing on it, holding an object to his mouth in his left hand that had a long cylinder-shaped stem pipe-like object, that had a round sphere-like ball at the end and was shiny in appearance. The still picture NA-A provided showed LPN-A holding this pipe-like object grasped in his left hand, wearing the same clothing. LPN-A had on glasses and had short hair in both the video and the still picture. Review of LPN-A’s personnel file identified LPN-A had satisfactory reviews in 2021 and 2023. In 2024, LPN-A has satisfactory in all but one column labeled, “reports to work on time/attendance” which was noted to need improvement. LPN-A’s 2026 review, performed on 3/23/26, one day after the incident, identified he was satisfactory with work performance, however there was a note “Reminder to watch breaks, be ready to work by 2 (often coming in a few minutes after).” No disciplinary action was noted in his file. No 2025 employee review was submitted. Interview on 7/22/26 at 9:49 a.m., with RN-B identified she had worked on 3/22/26. RN-B reported during morning break LPN-A was out in his car and gone for “quite some time... over an hour”. RN-B had looked outside and seen LPN-A sitting in his car “smoking some type of pipe”. RN-B stated she then called her supervisor (the DON) and reported this and told her there was another employee (NA-A) who thought he was smoking something “like a drug”. The supervisor said, “we could not assume [it was illegal substances]”. She reported she did not notice any impairment in LPN-A herself upon his return. LPN-A does go out to his car “a lot” and that was not unusual for him. LPN-A tended to take more breaks than anyone else. It was frustrating when he takes “excessive breaks” because she ended up covering any (resident) behaviors, alarms, or anything else that happens on his assigned hall when he was not there to “do his part”. LPN-A would often go out to his car to smoke or sleep. RN-B had not witnessed any concerns with LPN-A that day and she reported she had kept an eye on him the entire shift to make sure he was doing everything he was supposed to be doing. RN-B said she never “felt” like LPN-A was impaired			F0610			

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F0610 SS = D	Continued from page 24 and did not observe signs of impairment. RN-B had not noted how she assessed LPN-A for signs of potential impairment. RN-B made no mention if she had been advised to perform any tasks to ensure resident safety had occurred while LPN-A was outside the facility in the parking lot, or if she should have performed any other procedures, or that the DON was going to come to the facility on 3/22/26 (Sunday) to immediately perform investigative tasks or follow facility policy by immediately suspending LPN-A, pending an investigation. Interview on 7/22/26 at 12:52 p.m., with the consulting pharmacist (RPh) identified he had been shown the video and reported it was very “grainy”. The video was of a “male” in his car, and he looked like he was leaning down using “some kind of inhalation [device]”. The question posed (to him) was, could this person be smoking a crack pipe? In his opinion, usually with that type of pipe you would see visual smoke. He was unable to determine if the male was or wasn’t using a pipe. He reported his first impression was that this person may be using an “albuterol inhaler or Symbicort for something like asthma”. The pharmacist was unable to recall if he was at the facility when he reviewed the video or if it had been sent the video to review. He reported he was asked to give his opinion, and his first reaction was that this was “not proof of anything”, this was just “someone inhaling something”. When asked specifically by the facility if it looked like methamphetamine, the answer was “unlikely because you would have seen a flame and a cloud of smoke”. It was not clear what experience and/or training RPh had in identifying illicit substance use/abuse or specific paraphernalia used. Interview on 7/22/26 at 11:09 a.m., with local police department dispatch identified that they had received a call at 4:44 p.m. on 3/22/26, for a report of an employee who was suspected of smoking a pipe. The deputy assigned reported that he recalled the individual was not at the facility by the time he got the report (unknown time). He was unaware of any video or picture of the event but would have liked to have had that information at the time of the incident. The hard part about the situation was a person can have all the drugs in their system that they want, but he would have had to have physical evidence and probable cause to search the individual. As he recalled, he heard about the incident after the fact, so there was not really anything he could do about it. The courts would consider the video now as			F0610			

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F0610 SS = D	Continued from page 25 “stale evidence” at this point. Interview on 7/22/26 at 1:52 p.m., with DON and assistant director of nursing (ADON) identified the DON stated when asked if the facility was to report an allegation of a suspicion of a crime to law enforcement, that she would need to review the regulation and the policy. The ADON stated in review of the video that was sent to the facility, management was not able to confirm the video had taken place on the property. The DON reported the RN on duty at the time (RN-B) assessed LPN-A. He did not appear to be impaired, so she felt there was no suspicion of a crime. She revealed LPN-A was a smoker and had a history of taking “excessive breaks”. The ADON then stated, “was it even legal that she recorded him?” The DON reported the facility did not report to law enforcement or make a SA report, as they felt they did not have suspicion of LPN-A committing a crime. She reported she did not suspend LPN-A, but they did start an investigation at the time. The video was not provided when the concern was first brought to the DON’s attention... the video came later that day (3/22/26). NA-A did not believe RN-B did anything after she reported it to her, so that was when NA-A sent the video to the DON. The DON reported in their interpretation of the report and video, they did not feel the report warranted a call to the police or notification to the SA, but the matter was investigated. The DON again stated that RN-B assessed LPN-A and determined he was not impaired so there was not suspicion of a crime that needed to be reported. The DON did confirm an allegation could be considered suspicion however, LPN-A was assessed and had no impairment so there was no need to call the police. The DON and ADON made no mention of any specific training RN-B had to identify illicit drug use and/or impairment from use for appropriate assessment. LPN-A’s timecard was requested for 3/22/26, but not provided by the end of survey. Follow-up email was sent 7/23/26 requesting that information again. Review of the 1/1/26, Employee Handbook identified absence from duty was related to call-in’s, however excessive breaks were not mentioned. Use of camera phones for the purpose of photographing residents without their consent was strictly prohibited. There was no such prohibition on taking pictures of staff in outdoor spaces. The facility was to make timely and thorough investigations of all reports and			F0610			

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F0610 SS = D	Continued from page 26 allegations of abuse (and neglect). All members of staff were responsible for helping prevent and eliminate conditions which may cause accidents to residents. Supervisors were to use a progressive process on dealing with work habits that required corrective action. They were to have an employee conference, notice of concern, then a final notice of performance improvement, followed by termination of employment. All staff were mandatory reporters. There was no mention of potential drug use by staff in the employee hand book. Review of the current, undated Abuse Prevention Policy and Plan identified it was the policy of the facility to protect residents who, because of physical or mental disability were dependent on institutional services and were particularly vulnerable to abuse and neglect, to provide safe living environments for vulnerable adults, and assist persons charged with care to provide safe environments. All reports were to be investigated. The facility policy was to orientate, maintain, and follow the abuse prevention plan at all times. A report was required when a mandated reported has reason to believe that a vulnerable adult is being, or has been maltreated (abuse, neglect, financial exploitation, et. Al). Residents of the facility had the right to be free from all types of abuse including verbal, sexual, physical, and mental abuse, corporal punishment, mistreatment, neglect/deprivation, injuries of unknown source (unexplained injuries), misappropriation of resident property, and involuntary seclusion. Definitions included in the policy were: Neglect was defined as a failure of the facility, its employees or service providers, to provide goods and services necessary to a resident to avoid physical harm, pain, mental anguish, or emotional distress. Willful was defined as an individual must have acted deliberately not that the individual must have intended to inflict injury or harm. Depravation of goods and services was defined as depriving residents of services that are necessary to provide care but choosing not to do it. The policy further noted signs of actual physical neglect included inadequate provision of care and a caregiver that was indifferent to residents' personal care and needs. Staff were to report incidents, findings, and corrective measures to appropriate agencies as outlined in the facility's abuse reporting			F0610			

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F0610 SS = D	Continued from page 27 policy. Investigating abuse would be done by the charge nurse, DON, SSD and/or the administrator. The interview was to consist of: Interview person(s) reporting the abuse. Interview any witnesses that may have knowledge of the abuse (or neglect). Interview resident (as appropriate). Interview employees of any accused abuse (or neglect). Interview staff persons having contact with resident during the shift of alleged abuse Interview with resident roommates (if applicable), family and visitors. In the case of abuse, an appropriate report form was to be completed, and the information recorded in the resident's medical chart. Alleged or suspected cases of abuse (or neglect) that are reported, the Administrator, Social Services Designee or Director of Nursing was to notify the following agencies of the incident: Minnesota Department of Health. Resident Representative. Law Enforcement. During the investigation, accused employees were to be reassigned to non-resident contact duties or suspended with or without pay until the investigation has been completed. Reporting abuse (or neglect) was to be done immediately upon discovery. Initial reports of abuse (or neglect) were to be reported to MDH, via a secure web site, immediately (not later than 2 hours) of discovery of the incident after forming the suspicion of abuse (or neglect).			F0610			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245575		(X2) MULTIPLE CONSTRUCTION A. BUILDING 1 and 2 B. WING		(X3) DATE SURVEY COMPLETED 06/25/2025	
NAME OF PROVIDER OR SUPPLIER BARRETT CARE CENTER INC				STREET ADDRESS, CITY, STATE, ZIP CODE 800 SPRUCE AVENUE , BARRETT, Minnesota, 56311			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K0000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code recertification survey was conducted on 06/25/2025 by the Minnesota Department of Public Safety, Fire Marshal Division. At the time of this survey, Barrett Care Center Bldg 01 & 02 was found NOT in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or			K0000			

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X6) DATE
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K0000	Continued from page 1 By e-mail to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Barrett Care Center Bldg 2 In 2015 an addition (bldg 2) was constructed off the northeast corner and is a one-story building with no basement. This wing consists of 6 resident rooms and office spaces. The building construction was determined to be of Type V (III) construction and is separated by a two-hour fire barrier. This building is sprinkled throughout and has smoke detectors in the corridors spaces open to the corridors and sleeping rooms. The facility has a capacity of 40 beds and had a census of 36 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a) are NOT MET as evidenced by:			K0000			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245575		(X2) MULTIPLE CONSTRUCTION A. BUILDING 1 & 2 B. WING		(X3) DATE SURVEY COMPLETED 06/25/2025	
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K0000 K0000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code recertification survey was conducted on 06/25/2025 by the Minnesota Department of Public Safety, Fire Marshal Division. At the time of this survey, Barrett Care Center Bldg 02 was found NOT in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or By e-mail to: FM.HC.Inspections@state.mn.us			K0000 K0000			

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K0000	Continued from page 3 THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Barrett Care Center Bldg 2 In 2015 an addition (bldg 2) was constructed off the northeast corner and is a one-story building with no basement. This wing consists of 6 resident rooms and office spaces. The building construction was determined to be of Type V (III) construction and is separated by a two-hour fire barrier. This building is sprinkled throughout and has smoke detectors in the corridors spaces open to the corridors and sleeping rooms. The facility has a capacity of 40 beds and had a census of 36 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a) are NOT MET as evidenced by:		K0000				
K0291 SS = E	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting		K0291	The allegation of compliance K291 is met as evidence by the following corrective action: The annual emergency lighting test will be performed monthly for 30 seconds and annually for 90 minutes. The annual testing was complete on July 3 for the duration		07/03/2025	

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K0291 SS = E	Continued from page 4 Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test emergency lighting per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.9.1 and 7.9.3.1.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 06/25/2025 at 9:57 AM, it was revealed by a review of available documentation that the emergency lighting in the facility had not had the monthly testing documented as being completed for December 2024. An interview with the Administrator and the Maintenance Director verified this deficient finding at the time of discovery.			K0291	Continued from page 4 of 90 minutes. To assure compliance the monthly testing will be audited for completion 1 x monthly for 3 months and will be reviewed at our Quality Assurance meeting for review and recommendations. Maintenance Director is responsible for completion.		
K0291 SS = E	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test emergency lighting per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.9.1 and 7.9.3.1.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 06/25/2025 at 9:57 AM, it was revealed by a review of available documentation that the emergency lighting			K0291	corrected		07/03/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245575		(X2) MULTIPLE CONSTRUCTION A. BUILDING 1 & 2 B. WING		(X3) DATE SURVEY COMPLETED 06/25/2025	
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K0291 SS = E	Continued from page 5 in the facility had not had the monthly testing documented as being completed for December 2024. An interview with the Administrator and the Maintenance Director verified this deficient finding at the time of discovery.		K0291				
K0353 SS = D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to inspect and maintain the fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.5, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 5.2.1.1.2(5). This deficient finding could have an isolated impact on residents within the facility. Findings include: On 06/25/2025 at 11:35 AM, it was revealed by observation that a sprinkler head in the Basement Furnace Room had plaster on it from a ceiling repair		K0353	The allegation of compliance for K353 is met as evidence by the following corrective action: Due to recent ceiling repair of replastering the ceiling in the basement Nova Fire protection was scheduled to do their annual inspection and came on 6/26/2025 and completed the inspection. Nova was able to remove the plaster from the one sprinkler head and it was cleaned on 6/26/25 by Nova. Responsible person: Maintenance Director		07/03/2025	

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K0353 SS = D	Continued from page 6 that occurred above it.		K0353				
K0355 SS = D	An interview with the Maintenance Director verified this deficient finding at the time of discovery. Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation, the facility failed to maintain portable fire extinguishers per NFPA 101 (2012 edition), Life Safety Code, section 9.7.4.1, and NFPA 10 (2010 edition), Standard for Portable Fire Extinguishers, section 7.2.4.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 06/25/2025 at 9:58 AM, it was revealed by review of available documentation that the facility did not have documentation showing that the monthly fire extinguisher inspections took place in the facility in December 2024. An interview with the Administrator and Maintenance Director verified this deficient finding at the time of discovery.		K0355	corrected		07/03/2025	
K0355 SS = D	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10		K0355	The allegation of compliance for K355 was met as evidence by the following corrective action: Monthly fire extinguisher checks will be completed monthly. An audit will be conducted to assure compliance for 3 months on the monthly checks. This will be reviewed at our next quarterly Quality Assurance meeting for ongoing audits and recommendations.		07/03/2025	

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K0355 SS = D	Continued from page 7 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation, the facility failed to maintain portable fire extinguishers per NFPA 101 (2012 edition), Life Safety Code, section 9.7.4.1, and NFPA 10 (2010 edition), Standard for Portable Fire Extinguishers, section 7.2.4.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 06/25/2025 at 9:58 AM, it was revealed by review of available documentation that the facility did not have documentation showing that the monthly fire extinguisher inspections took place in the facility in December 2024. An interview with the Administrator and Maintenance Director verified this deficient finding at the time of discovery.			K0355	Continued from page 7 Person Responsible: Maintenance Director		
K0372 SS = D	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke barriers per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.3, and 8.5.6.2. This deficient finding could have an isolated			K0372	The allegation of compliance was met for K372 as evidence by the following corrective action: Fire caulking was applied on 6/27/2025 to the conduit penetrating the smoke barrier above the doors leading from building 2 to building 1. Person Responsible: Maintenance Director		07/03/2025

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K0372 SS = D	Continued from page 8 impact on the residents within the facility. Findings include: On 06/25/2025 at 10:56 AM, it was revealed by observation that there was flexible conduit penetrating the smoke barrier that was not properly fire caulked above the smoke barrier doors leading from Building 2 to Building 1. An interview with the Maintenance Director verified this deficient finding at the time of discovery.		K0372				
K0920 SS = D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain the usage of electrical adaptive devices per NFPA 99 (2012 edition), Health Care Facilities Code, section 10.2.3.6. This deficient finding could have an isolated impact on the residents within the facility. Findings include:		K0920	The allegation of compliance for K920 was met by the following corrective action as evidence by: A new medical grade PCREE meeting the conditions of 10.2.3.6 was purchased for patient care related equipment of the proper UL 1363A and implemented to use. Responsible Person: Maintenance Director		07/03/2025	

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K0920 SS = D	Continued from page 9 On 06/25/2025 at 11:18 AM, it was revealed by observation that there was a relocatable power tap being used to supply power to two different pieces of patient care related electrical equipment in Room 414 that did not have the proper UL listing of UL 1363A or UL 60601-1. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K0920			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
September 1, 2026

Administrator
BARRETT CARE CENTER INC
800 SPRUCE AVENUE
BARRETT, MN 56311

RE: CCN: 245575
Cycle Start Date: July 22, 2026

Dear Administrator:

On September 1, 2026, the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink that reads 'Kamala Fiske-Downing'.

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

