Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 9, 2025

Administrator
Barrett Care Center Inc
800 Spruce Avenue
Barrett, MN 56311

RE: CCN: 245575
Cycle Start Date: June 25, 2025

Dear Administrator:

On June 25, 2025, 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, MN 56258-2504
Email: nicole.osterloh@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 September 25, 2025 (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 December 25, 2025 (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,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@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 06/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BARRETT CARE CENTER INC	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
F0000	INITIAL COMMENTS On 6/23/25 through 6/25/25, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H55757469 (MN112484). NO deficiencies were cited. 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 has been attained.	F0000		
F0761 SS = D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	F0761		

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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F0761 SS = D	Continued from page 1 §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to follow manufacturer's instructions and label liquid gabapentin (used to treat seizures) solution with an open and discard date for 1 of 1 resident (R24) reviewed for medication storage for 1 of 1 medication rooms. Findings include: Observation on 6/23/25 at 7:15 p.m., identified 1 of 1 medication room fridge had a opened bottle of liquid gabapentin with R24's name on the label had no open or discard date on the bottle. R24's current, undated diagnoses sheet identified R24 had dementia, anxiety, and idiopathic peripheral autonomic neuropathy (nerve damage that affects body functions, such as the heart rate, blood pressure, digestion and temperature). R24's June 2025, medication administration report (MAR) identified R24 was to receive gabapentin 250 milligram (mg)/ 5 milliliter (ml), give 2 mls by mouth daily, 2 mls equals 100mg and gabapentin 250 mg/5 ml, give 6 mls by mouth daily, 6 mls equals 300mg can be given in water for anxiety. Interview on 6/23/25 at 7:22 p.m., with licensed practical nurse (LPN)-A identified R24's solution bottle had no open date or discard date on the label. LPN-A identified R24 medication bottle last up to 90 days, once the seal had been broken. Interview on 6/23/25 at 7:39 p.m., with registered nurse (RN)-B had initially opened the bottle to	F0761		

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F0761 SS = D	Continued from page 2 administer the medication to R24 during his shift, however, RN-B forgot to label the bottle before returning it to the medication fridge. RN-B identified R24's medication was delivered to the facility on 6/14/25, however, RN-B could not provide documentation to support when the medication was delivered. Observation and interview on 6/24/25 at 3:08 p.m., with director of nursing (DON) confirmed R24's solution bottle had no open or discard date on the label. The local pharmacy was called for instructions to identify when R24's solution bottle was to be expired. The pharmacy directed the facility to use the manufacture's label on the bottle, as directed. When asked if there was supporting documentation of when the pharmacy was notified, the DON could not provide documentation of when the call was placed. Interview on 6/24/25 at 3:55 p.m., with licensed pharmacist would expect medications to be labeled with an open or discard date to identify medication use before it expired. Interview on 6/24/25 at 4:02 p.m., with local pharmacy identified R24's gabapentin solution bottle had a highlighted bold date of 6/15/25. The date listed on the bottle was when the medication was prepared and was to be used within one year before it expired. Interview on 6/25/25 at 11:02 a.m., with registered nurse (RN)-A identified the local pharmacy was contacted during the survey to find out when R24's medication was to be expired. RN-A would expect nursing staff to label medications with an open or discard date, when used. Review of September 2003, Labeling of Medications policy identified the facility was to have procedures in place to ensure medications was properly labeled in accordance with state and federal regulations.	F0761		
F0880 SS = F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a	F0880		

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F0880 SS = F	Continued from page 3 safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff	F0880		

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F0880 SS = F	Continued from page 4 involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to analyze the data from the employee illnesses tracking to determine a potential outbreak of Norovirus when 3 of 4 employees (nursing assistant (NA)-B, licensed practical nurse (LPN)-A, assistant director of nursing (ADON)) were out ill with diarrhea and emesis who returned to work within 24 hours. Additionally, the facility failed to have a system in place to monitor resident room refrigerators for cleanliness, expired food, and appropriate temperatures for safe storage of food for 10 of 10 residents (R1, R5, R6, R9, R10, R11, R12, R19, R26, and R135) with in-room refrigerators. The deficient practices has the ability to affect all 35 residents. Findings include: EMPLOYEE SURVEILLANCE Review of the 2024-2025 Norovirus Information for Long-term Care Facilities, located at, https://www.health.state.mn.us/diseases/foodborne/outbreak/facility/ltcfnorotoolkit.pdf, identified Norovirus common symptoms as diarrhea, vomiting, nausea, abdominal pain, low-grade fever, headache, body aches. Monitor for staff illness and restrict ill staff/volunteers from patient care and food handling duties until 72 hours after their vomiting/diarrhea has ended.	F0880		

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F0880 SS = F	Continued from page 5 Review of Staff Illness surveillance for the month of March 2025, identified: 1) 3/18/25, LPN-A called in with signs/symptoms (s/s) of diarrhea and vomiting. NA-A returned to work on 3/19/25, the next day. 2) 3/24/25, NA-B called in with s/s of diarrhea, vomiting, and body aches. NA-B returned to work on 3/25/25, the next day. 3) 3/25/25, NA-A called in with s/s of diarrhea, vomiting, and sore throat. NA-A returned to work on 4/4/25, 9 days later. 4) 3/27/25, the assistant director of nursing (ADON) called in with s/s diarrhea and vomiting. The ADON returned to work on 3/28/25, the next day. Review of Resident illness surveillance for the month of March 2025, identified no residents with gastrointestinal (GI) symptoms. Interview on 6/24/25 at 2:38 p.m., with the director of nursing (DON) identified that the charge nurse determined if a staff could return to work. The charge nurse assessed the staff and made that determination prior to the staff working. When asked about the body aches, diarrhea, and vomiting symptom, if those could potentially be the symptoms of norovirus, the DON said she would need to review the policy. When asked about following the facility return to work policy the DON responded stated she would need to review the policy. Interview on 6/24/25 at 2:43 p.m., with ADON when asked if staff with s/s of diarrhea and vomiting, potential s/s of norovirus should have returned to work within 24 hours. She replied that the charge nurse had to assess staff and clear them to return to work. When asked about the facility return to work policy, which identified if symptoms are consistent with norovirus infection, employees should stay home for a minimum of 48 hours after symptom resolution. She reported she thought her s/s were more food poisoning. She identified she had reviewed the staff surveillance and determined that no staff had worked the same shift and	F0880		

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F0880 SS = F	Continued from page 6 there had been no correlation or pattern noted. She would provide documentation of the review for March employee call-ins. On 6/25/25, the ADON provided the first quarter 2025, infection control report brought forth to the QAPI meeting which identified for the month of March items reviewed in bullet points as: 1) Preparing for COVID booster clinic in April. 2) Educated on policy for employee emesis. 3) Identified 50% of infections were on the north end of the building. 4) Noted GI signs and symptoms in staff, potential trend, reviewed staff members/dates, but not noted to be correlated with each other. The infection control report lacked documentation of analysis of how the March GI staff illness were determined to not be correlated. Review of the 4/24/25, first quarter QAPI meeting minutes provided by QAPI coordinator. Included the infection control report brought forth to the QAPI meeting by infection preventionist (IP) and ADON which identified for the month of March items reviewed in bullet points as: 1) Preparing for COVID booster clinic in April. 2) There had been a noted trend of limited documentation of infections noted in chart besides on the MAR. This made it hard to paint a clear picture of what the signs and symptoms were, when they started, or how the specific signs and symptoms had improved or not. 3) Should consider monitoring all wounds for signs and symptoms of infection.	F0880		

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F0880 SS = F	Continued from page 7 4) Educated on policy for employee emesis. 5) Identified 50% of infections were on the north end of the building. There was no notation of the information provided by the ADON, in March 2025, on GI signs and symptoms in staff, potential trend, with no correlation noted in the report provided by QAPI coordinator. Interview on 6/24/25 at 12:40 p.m., with administrator identified that the charge nurse assessed an employee and had to clear the employee before they were allowed to return to work. The charge nurse had access to the staff illness form which identified the employee reason for call in and symptoms. The administer declined to confirm she would expect staff to follow the facility policy on return-to-work criteria. Review of undated, Employee Illnesses and Return to Work Criteria policy identified if symptoms are consistent with norovirus infection, employees should stay home for a minimum of 48 hours after symptom resolve. The policy identified that the IP would monitor staff illness log monthly or periodically for actions to be taken when trends are noted to prevent spread of infection. The policy lacked any mention that the IP should be monitoring staff illness on an ongoing basis to prevent potential outbreaks. REFRIDGERATORS Observation and interview on 6/25/25 at 4:30 p.m.., of R1's room where there was a small refrigerator larger than a dorm styled one, with multiple bottles of water stacked inside. There was a thermometer located inside the refrigerator but no sign of a temperature log within the room. R1 reported he was unsure if anyone cleaned his refrigerator or if anyone monitored the temperature of the refrigerator. He reported he only kept water in the refrigerator as he like cold water. Observation on 6/25/25 at 4:40 p.m., of R12's room where there was a small dorm style refrigerator. Inside the refrigerator was 3 individual containers of applesauce and a thermometer. There was no sign of a temperature log within the room.	F0880		

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F0880 SS = F	Continued from page 8 Observation and interview on 6/25/25 at 4:43 p.m., of R19's room where there was a small dorm style refrigerator. Inside the refrigerator was a can of soda and a thermometer. There was no sign of a temperature log within the room. R19 was unsure if anyone cleaned the refrigerator or if anyone checked the temperature of the refrigerator, he had not seen anyone ever do that. Observation on 6/23/25 at 2:00 p.m., the following was observed: 1.) R5's had a small refrigerator with a freezer located in her room. The freezer had ice cream bars and a small container of sherbet. The freezer had 1-2 inches of frost built up around the top and the freezer door was difficult to close. The refrigerator had a container of yogurt and 2 containers of apple juice. On the bottom shelf was 4 glass flower vases that had a unknown green and black substance dried on the inside of them. The bottom shelves had a pink stick substance with dirt/dust particles noted on the inner shelves and sides of the refrigerator. There was no thermometer located in the refrigerator or freezer. 2.) R6 had a small refrigerator with a freezer in her room. The refrigerator contained jelly, pop, fruit juice, fruit cups, and chocolate bars. The thermometer read 41 degrees. The freezer did not have a thermometer. 3.) R9 had a small refrigerator with a freezer located in his room, the freezer contained 2 frozen Ribeye steaks. The freezer did not have a thermometer. The refrigerator contained jelly and summer sausage. The refrigerator had a thermometer that read 39 degrees. 4.) R10 had a small refrigerator with a freezer located in her room. The refrigerator contained Gatorade, yogurt, and ranch dressing. A thermometer was in the refrigerator that read 39 degrees. The freezer did not have a thermometer. 5.) R26 had a refrigerator inside her room, the refrigerator had ranch dressing and cheese inside. There was no thermometer observed in the refrigerator	F0880		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0880 SS = F	Continued from page 9 or freezer. None of the refrigerators were observed to have a log present for monitoring temperature, nor was there any dating on food items to ensure food was discarded appropriately to prevent food-borne illness. . Observation on 6/23/25 at 7:06 p.m., of R11's room fridge identified a small thermometer positioned on bottom floor of the fridge with a temperature of 39 degrees. The fridge appeared clean and had several unopened cans of Coca-Cola soda that was stored. Observation and interview on 6/24/25 at 4:51 p.m., of R135's room fridge identified a small thermometer that was placed on the second shelf of the fridge with a temperature of 39 degrees. Family member (FM)-A grabbed a small plastic container of carrots and with a date of 5/16/25 on the lid. FM-A opened the lid and identified small white fuzzy coat surrounding the outside of the carrots. FM-A stated to R135 that R135's carrots were expired. R135 replied, "throw it away". FM-A discarded the item. FM-A discovered a four-ounce container of blueberry yogurt with an expiration date of 6/10/25. FM-A had informed R135, the yogurt may not be "safe to eat". R135 stated none of the employees come in and check the food products in R135's fridge and was not aware what the normal temperature of R135's fridge should be for R135's food to stay cold when stored. Neither R11 and R135's room had no evidence temperatures were logged or recorded daily to ensure food remained at safe temperatures. Interview on 6/24/25 at 7:50 a.m., with housekeeper (HK)-A identified they do not have a schedule for checking refrigerators temps or cleaning but she says she does check them "maybe every couple weeks" Interview on 6/24/25 at 8:00 p.m., with the administrator identified she agreed with the above findings, and thought housekeeping was monitoring the resident refrigerators and had a process to ientify when food shoud be discarded, however, when she had spoken to the supervisor, she was told they had not been logging any temps or signing off the resident refrigerators had been cleaned or checked for expired foods.	F0880		

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 06/25/2025

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F0880 SS = F	Continued from page 10 Interview on 6/25/25 at 8:15 a.m., with the housekeeping supervisor they check the refrigerators every Thursday and if there is old food in the fridge, they ask the resident if they can throw it away. If the resident says no, they leave the expired food in the refrigerator and go back and ask on another day. She identified she had no logs to show when the refrigerators were checked and had not audited to ensure the task was being completed. Review of the undated Resident Refrigerator policy was one paragraph as follows: Refrigerators and freezers will be examined by staff on bath day. The staff will make sure fridge looks clean and that there is no old food. The refrigerators will be thoroughly cleaned, old food thrown and wiped down when resident discharges form the facility. The policy made no mention of how the facility would monitor temperatures of resident refrigerators or freezers to ensure food could be safely stored.	F0880		

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

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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

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	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		

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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

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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. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0353		
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 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
July 9, 2025

Administrator
Barrett Care Center Inc
800 Spruce Avenue
Barrett, MN 56311

Re: State Nursing Home Licensing Orders
Event ID: JX4M11

Dear Administrator:

The above facility was surveyed on June 23, 2025 through June 25, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Nicole Dahl, RN, Regional Operations Supervisor
Marshall District Office
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102
Marshall, MN 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230
Mobile: (507) 251-6264 Mobile: (605) 881-6192

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **06/25/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BARRETT CARE CENTER INC	**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
20000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 6/23/25 through 6/25/25, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT compliance with the MN State Licensure and the following correction orders are issued. The following complaints were reviewed: H55757469 (MN112484). NO licensing orders were issued.	20000		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **06/25/2025**

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20000	Continued from page 1 Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	20000		
21375	Infection Control; Program CFR(s): MN Rule 4658.0800 Subp. 1 Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to analyze the data from the employee illnesses tracking to determine a potential outbreak of Norovirus when 3 of 4 employees (nursing assistant (NA)-B, licensed practical nurse (LPN)-A, assistant director of nursing (ADON)) were out ill with diarrhea and emesis who returned to work within 24 hours. Additionally, the facility failed to have a system in place to monitor resident room refrigerators for cleanliness, expired food, and appropriate temperatures for safe storage of food for 10 of 10 residents (R1, R5, R6, R9, R10, R11, R12, R19, R26, and R135) with in-room refrigerators. The deficient practices has the ability to affect all 35 residents. Findings include: EMPLOYEE SURVEILLANCE Review of the 2024-2025 Norovirus Information for Long-term Care Facilities, located at, https://www.health.state.mn.us/diseases/foodborne/outbreak/facility/ltcfnorotoolkit.pdf, identified Norovirus common symptoms as diarrhea, vomiting, nausea, abdominal pain, low-grade fever, headache, body aches. Monitor for staff illness and restrict ill staff/volunteers from patient care and food handling duties until 72 hours after their vomiting/diarrhea has	21375		

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21375	Continued from page 2 ended. Review of Staff Illness surveillance for the month of March 2025, identified: 1) 3/18/25, LPN-A called in with signs/symptoms (s/s) of diarrhea and vomiting. NA-A returned to work on 3/19/25, the next day. 2) 3/24/25, NA-B called in with s/s of diarrhea, vomiting, and body aches. NA-B returned to work on 3/25/25, the next day. 3) 3/25/25, NA-A called in with s/s of diarrhea, vomiting, and sore throat. NA-A returned to work on 4/4/25, 9 days later. 4) 3/27/25, the assistant director of nursing (ADON) called in with s/s diarrhea and vomiting. The ADON returned to work on 3/28/25, the next day. Review of Resident illness surveillance for the month of March 2025, identified no residents with gastrointestinal (GI) symptoms. Interview on 6/24/25 at 2:38 p.m., with the director of nursing (DON) identified that the charge nurse determined if a staff could return to work. The charge nurse assessed the staff and made that determination prior to the staff working. When asked about the body aches, diarrhea, and vomiting symptom, if those could potentially be the symptoms of norovirus, the DON said she would need to review the policy. When asked about following the facility return to work policy the DON responded stated she would need to review the policy. Interview on 6/24/25 at 2:43 p.m., with ADON when asked if staff with s/s of diarrhea and vomiting, potential s/s of norovirus should have returned to work within 24 hours. She replied that the charge nurse had to assess staff and clear them to return to work. When asked about the facility return to work policy, which identified if symptoms are consistent with norovirus infection, employees should stay home for a minimum of 48 hours after symptom resolution. She reported she thought her s/s were more food poisoning. She	21375		

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21375	Continued from page 3 identified she had reviewed the staff surveillance and determined that no staff had worked the same shift and there had been no correlation or pattern noted. She would provide documentation of the review for March employee call-ins. On 6/25/25, the ADON provided the first quarter 2025, infection control report brought forth to the QAPI meeting which identified for the month of March items reviewed in bullet points as: 1) Preparing for COVID booster clinic in April. 2) Educated on policy for employee emesis. 3) Identified 50% of infections were on the north end of the building. 4) Noted GI signs and symptoms in staff, potential trend, reviewed staff members/dates, but not noted to be correlated with each other. The infection control report lacked documentation of analysis of how the March GI staff illness were determined to not be correlated. Review of the 4/24/25, first quarter QAPI meeting minutes provided by QAPI coordinator. Included the infection control report brought forth to the QAPI meeting by infection preventionist (IP) and ADON which identified for the month of March items reviewed in bullet points as: 1) Preparing for COVID booster clinic in April. 2) There had been a noted trend of limited documentation of infections noted in chart besides on the MAR. This made it hard to paint a clear picture of what the signs and symptoms were, when they started, or how the specific signs and symptoms had improved or not. 3) Should consider monitoring all wounds for signs and symptoms of infection.	21375		

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21375	Continued from page 4 4) Educated on policy for employee emesis. 5) Identified 50% of infections were on the north end of the building. There was no notation of the information provided by the ADON, in March 2025, on GI signs and symptoms in staff, potential trend, with no correlation noted in the report provided by QAPI coordinator. Interview on 6/24/25 at 12:40 p.m., with administrator identified that the charge nurse assessed an employee and had to clear the employee before they were allowed to return to work. The charge nurse had access to the staff illness form which identified the employee reason for call in and symptoms. The administer declined to confirm she would expect staff to follow the facility policy on return-to-work criteria. Review of undated, Employee Illnesses and Return to Work Criteria policy identified if symptoms are consistent with norovirus infection, employees should stay home for a minimum of 48 hours after symptom resolve. The policy identified that the IP would monitor staff illness log monthly or periodically for actions to be taken when trends are noted to prevent spread of infection. The policy lacked any mention that the IP should be monitoring staff illness on an ongoing basis to prevent potential outbreaks. REFRIDGERATORS Observation and interview on 6/25/25 at 4:30 p.m.., of R1's room where there was a small refrigerator larger than a dorm styled one, with multiple bottles of water stacked inside. There was a thermometer located inside the refrigerator but no sign of a temperature log within the room. R1 reported he was unsure if anyone cleaned his refrigerator or if anyone monitored the temperature of the refrigerator. He reported he only kept water in the refrigerator as he like cold water. Observation on 6/25/25 at 4:40 p.m., of R12's room where there was a small dorm style refrigerator. Inside the refrigerator was 3 individual containers of	21375		

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21375	Continued from page 5 applesauce and a thermometer. There was no sign of a temperature log within the room. Observation and interview on 6/25/25 at 4:43 p.m., of R19's room where there was a small dorm style refrigerator. Inside the refrigerator was a can of soda and a thermometer. There was no sign of a temperature log within the room. R19 was unsure if anyone cleaned the refrigerator or if anyone checked the temperature of the refrigerator, he had not seen anyone ever do that. Observation on 6/23/25 at 2:00 p.m., the following was observed: 1.) R5's had a small refrigerator with a freezer located in her room. The freezer had ice cream bars and a small container of sherbet. The freezer had 1-2 inches of frost built up around the top and the freezer door was difficult to close. The refrigerator had a container of yogurt and 2 containers of apple juice. On the bottom shelf was 4 glass flower vases that had a unknown green and black substance dried on the inside of them. The bottom shelves had a pink stick substance with dirt/dust particles noted on the inner shelves and sides of the refrigerator. There was no thermometer located in the refrigerator or freezer. 2.) R6 had a small refrigerator with a freezer in her room. The refrigerator contained jelly, pop, fruit juice, fruit cups, and chocolate bars. The thermometer read 41 degrees. The freezer did not have a thermometer. 3.) R9 had a small refrigerator with a freezer located in his room, the freezer contained 2 frozen Ribeye steaks. The freezer did not have a thermometer. The refrigerator contained jelly and summer sausage. The refrigerator had a thermometer that read 39 degrees. 4.) R10 had a small refrigerator with a freezer located in her room. The refrigerator contained Gatorade, yogurt, and ranch dressing. A thermometer was in the refrigerator that read 39 degrees. The freezer did not have a thermometer. 5.) R26 had a refrigerator inside her room, the	21375		

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21375	Continued from page 6 refrigerator had ranch dressing and cheese inside. There was no thermometer observed in the refrigerator or freezer. None of the refrigerators were observed to have a log present for monitoring temperature, nor was there any dating on food items to ensure food was discarded appropriately to prevent food-borne illness. . Observation on 6/23/25 at 7:06 p.m., of R11's room fridge identified a small thermometer positioned on bottom floor of the fridge with a temperature of 39 degrees. The fridge appeared clean and had several unopened cans of Coca-Cola soda that was stored. Observation and interview on 6/24/25 at 4:51 p.m., of R135's room fridge identified a small thermometer that was placed on the second shelf of the fridge with a temperature of 39 degrees. Family member (FM)-A grabbed a small plastic container of carrots and with a date of 5/16/25 on the lid. FM-A opened the lid and identified small white fuzzy coat surrounding the outside of the carrots. FM-A stated to R135 that R135's carrots were expired. R135 replied, "throw it away". FM-A discarded the item. FM-A discovered a four-ounce container of blueberry yogurt with an expiration date of 6/10/25. FM-A had informed R135, the yogurt may not be "safe to eat". R135 stated none of the employees come in and check the food products in R135's fridge and was not aware what the normal temperature of R135's fridge should be for R135's food to stay cold when stored. Neither R11 and R135's room had no evidence temperatures were logged or recorded daily to ensure food remained at safe temperatures. Interview on 6/24/25 at 7:50 a.m., with housekeeper (HK)-A identified they do not have a schedule for checking refrigerators temps or cleaning but she says she does check them "maybe every couple weeks" Interview on 6/24/25 at 8:00 p.m., with the administrator identified she agreed with the above findings, and thought housekeeping was monitoring the resident refrigerators and had a process to ientify when food shoud be discarded, however, when she had spoken to the supervisor, she was told they had not been logging any temps or signing off the resident	21375		

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21375	Continued from page 7 refrigerators had been cleaned or checked for expired foods. Interview on 6/25/25 at 8:15 a.m., with the housekeeping supervisor they check the refrigerators every Thursday and if there is old food in the fridge, they ask the resident if they can throw it away. If the resident says no, they leave the expired food in the refrigerator and go back and ask on another day. She identified she had no logs to show when the refrigerators were checked and had not audited to ensure the task was being completed. Review of the undated Resident Refrigerator policy was one paragraph as follows: Refrigerators and freezers will be examined by staff on bath day. The staff will make sure fridge looks clean and that there is no old food. The refrigerators will be thoroughly cleaned, old food thrown and wiped down when resident discharges form the facility. The policy made no mention of how the facility would monitor temperatures of resident refrigerators or freezers to ensure food could be safely stored. SUGGESTED METHOD OF CORRECTION: The DON (Director of Nursing) or designee should review/revise facility policies to ensure employees are monitored for illness and measures are placed to identify when an appropriate return to work may occur. The DON or designee could educate all staff on existing or revised policies and perform audits to ensure the policies are being followed. The DON and designee should also review policies and procedures for resident refrigerators, develop a policy, and educate staff to that policy. The DON and/or designee should perform measurable audits on the above. The results of those audits should be taken to Quality Assurance Performance Improvement committee to determine compliance and the need for further monitoring. Time Period for Correction: Twenty-one (21) days.	21375		
21620	Labeling of Drugs CFR(s): MN Rule 4658.1345 Drugs used in the nursing home must be labeled in accordance with part 6800.6300.	21620		

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21620	Continued from page 8 This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to follow manufacturer's instructions and label liquid gabapentin (used to treat seizures) solution with an open and discard date for 1 of 1 resident (R24) reviewed for medication storage for 1 of 1 medication rooms. Findings include: Observation on 6/23/25 at 7:15 p.m., identified 1 of 1 medication room fridge had a opened bottle of liquid gabapentin with R24's name on the label had no open or discard date on the bottle. R24's current, undated diagnoses sheet identified R24 had dementia, anxiety, and idiopathic peripheral autonomic neuropathy (nerve damage that affects body functions, such as the heart rate, blood pressure, digestion and temperature). R24's June 2025, medication administration report (MAR) identified R24 was to receive gabapentin 250 milligram (mg)/ 5 milliliter (ml), give 2 mls by mouth daily, 2 mls equals 100mg and gabapentin 250 mg/5 ml, give 6 mls by mouth daily, 6 mls equals 300mg can be given in water for anxiety. Interview on 6/23/25 at 7:22 p.m., with licensed practical nurse (LPN)-A identified R24's solution bottle had no open date or discard date on the label. LPN-A identified R24 medication bottle last up to 90 days, once the seal had been broken. Interview on 6/23/25 at 7:39 p.m., with registered nurse (RN)-B had initially opened the bottle to administer the medication to R24 during his shift, however, RN-B forgot to label the bottle before returning it to the medication fridge. RN-B identified R24's medication was delivered to the facility on 6/14/25, however, RN-B could not provide documentation to support when the medication was delivered. Observation and interview on 6/24/25 at 3:08 p.m., with director of nursing (DON) confirmed R24's solution	21620		

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21620	Continued from page 9 bottle had no open or discard date on the label. The local pharmacy was called for instructions to identify when R24's solution bottle was to be expired. The pharmacy directed the facility to use the manufacture's label on the bottle, as directed. When asked if there was supporting documentation of when the pharmacy was notified, the DON could not provide documentation of when the call was placed. Interview on 6/24/25 at 3:55 p.m., with licensed pharmacist would expect medications to be labeled with an open or discard date to identify medication use before it expired. Interview on 6/24/25 at 4:02 p.m., with local pharmacy identified R24's gabapentin solution bottle had a highlighted bold date of 6/15/25. The date listed on the bottle was when the medication was prepared and was to be used within one year before it expired. Interview on 6/25/25 at 11:02 a.m., with registered nurse (RN)-A identified the local pharmacy was contacted during the survey to find out when R24's medication was to be expired. RN-A would expect nursing staff to label medications with an open or discard date, when used. Review of September 2003, Labeling of Medications policy identified the facility was to have procedures in place to ensure medications was properly labeled in accordance with state and federal regulations. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist should review, revise, or create policies and procedures for proper labeling and storage of medications and or/ storage of items in the medication room or refrigerators. Nursing and/or medication aide staff should be educated to those changes. The DON or designee, and pharmacist, should routinely audit all medications and storage to ensure compliance. The results of those audits should be taken to QAPI ongoing to determine compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21620		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
September 3, 2025

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

RE: CCN: 245575
Cycle Start Date: June 25, 2025

Dear Administrator:

On July 24, 2025, 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,

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 3, 2025

Administrator
BARRETT CARE CENTER INC

800 SPRUCE AVENUE
BARRETT, MN 56311

Re: Reinspection Results
Event ID: JX4M11

Dear Administrator:

On July 24, 2025 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on June 25, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

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