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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: QIOX
Facility ID: 00153

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245575**
2. STATE VENDOR OR MEDICAID NO. (L2) **879240200**

3. NAME AND ADDRESS OF FACILITY
(L3) **BARRETT CARE CENTER INC**
(L4) **800 SPRUCE AVENUE**
(L5) **BARRETT, MN** (L6) **56311**

4. TYPE OF ACTION: 7 (L8)
1. Initial **2. Recertification** **3. Termination** **4. CHOW** **5. Validation** **6. Complaint** **7. On-Site Visit** **9. Other** **8. Full Survey After Complaint**

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)
6. DATE OF SURVEY **09/23/2015** (L34)
8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC 2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)
01 Hospital **05 HHA** **09 ESRD** **13 PTIP** **22 CLIA** **02 SNF/NF/Dual** **06 PRTF** **10 NF** **14 CORF** **03 SNF/NF/Distinct** **07 X-Ray** **11 ICF/IID** **15 ASC** **04 SNF** **08 OPT/SP** **12 RHC** **16 HOSPICE**

FISCAL YEAR ENDING DATE: (L35) **09/30**

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :
12.Total Facility Beds **45** (L18)
13.Total Certified Beds **45** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
__ 2. Technical Personnel
__ 3. 24 Hour RN
__ 4. 7-Day RN (Rural SNF)
__ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room
* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	45			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Tammy Williams, HFE NEII 10/07/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 10/07/2015 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION **10/01/1991** (L24)
23. LTC AGREEMENT BEGINNING DATE (L41)
24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)
29. INTERMEDIARY/CARRIER NO. **03001** (L31)
30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)
32. DETERMINATION OF APPROVAL DATE **09/24/2015** (L33)

DETERMINATION APPROVAL

FORM CMS-1539 (7-84) (Destroy Prior Editions) 020499

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN: 24 5575

On September 23, 2015 a Post Certification Revisit (PCR) was completed to verify if the faciility had achieved and maintained compliance with Federal certification regulations. Based on our visit we have determined the facility has corrected deficiencies issued pursuant to the standard survey completed August 6, 2015, effective September 9, 2015. As a result that the facility has achieved complaince, this Department discontinued the Cateory 1 remedy of State monitoring, effective September 9, 2015.

In addition, the CMS Region V Office notified the facility of the imposed remedies and NATCEP loss.

Effective September 9, 2015 the facility is certified for 45 skilled nursing facility beds.

Refer to the CMS 2567b for the results of both the health and life safety code visits.

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245575

October 7, 2015

Ms. Jeanine Junker, Administrator
Barrett Care Center Inc
800 Spruce Avenue
Barrett, Minnesota 56311

Dear Ms. Junker:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective September 9, 2015 the above facility is certified for:

45 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 45 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
October 7, 2015

Ms. Jeanine Junker, Administrator
Barrett Care Center Inc
800 Spruce Avenue
Barrett, Minnesota 56311

RE: Project Number S5575025

Dear Ms. Junker:

On August 21, 2015, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective August 26, 2015. (42 CFR 488.422)

On October 1, 2015, the Centers for Medicare and Medicaid Services (CMS) informed you that the following enforcement remedies were being imposed:

- Civil money penalty of $4,150.00 for one (1) day, August 5, 2015

- Civil money penalty of $150.00 per day for the thirty-four (34) days beginning August 6, 2015 and continuing through September 8, 2015 for a total of $5,100.00

This was based on the deficiencies cited by this Department for a standard survey completed on August 6, 2015. At the time of the August 6, 2015 standard survey conditions in the facility constituted immediate jeopardy to resident health or safety. The most serious deficiency was found to be a pattern of deficiencies that constituted immediate jeopardy (Level K), whereby corrections were required.

On September 23, 2015, the Minnesota Department of Health completed a Post Certification Revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on August 6, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 9, 2015. We have determined, based on our visit, that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 6, 2015, as of September 9, 2015.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective September 9, 2015.

The CMS Region V Office notified you in their letter of October 2, 2015 regarding the following imposed remedies:

- Civil money penalty of $4,150.00 for one (1) day, August 5, 2015
- Civil money penalty of $150.00 per day for the thirty-four (34) days beginning August 6, 2015 and continuing through September 8, 2015 for a total of $5,100.00

The total amount of the CMP imosed by CMS Region V Office is $9, 250.00

In addition as CMS Region V Office notified you in their letter of October 2, 2015, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years.

The CMS Region V Office will notify you of their determination regarding our recommendations, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245575	A. Building B. Wing	9/23/2015

Name of Facility	Street Address, City, State, Zip Code
BARRETT CARE CENTER INC	800 SPRUCE AVENUE BARRETT, MN 56311

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/ or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix F0241 Reg. # 483.15(a) LSC	09/09/2015	ID Prefix F0371 Reg. # 483.35(i) LSC	08/27/2015	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	LB/mm	10/07/2015	32603	09/23/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 8/6/2015

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245575	01 - MAIN BUILDING 01	8/28/2015

Name of Facility	Street Address, City, State, Zip Code
BARRETT CARE CENTER INC	800 SPRUCE AVENUE BARRETT, MN 56311

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/ or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # **NFPA 101** LSC K0056	**08/24/2015**	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	GS/mm	10/07/2015	27200	08/28/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:
8/5/2015

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: QIOX
Facility ID: 00153

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245575**
2. STATE VENDOR OR MEDICAID NO. (L2) **879240200**

3. NAME AND ADDRESS OF FACILITY
(L3) **BARRETT CARE CENTER INC**
(L4) **800 SPRUCE AVENUE**
(L5) **BARRETT, MN** (L6) **56311**

4. TYPE OF ACTION: **2** (L8)
1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other 8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)
6. DATE OF SURVEY **08/06/2015** (L34)
8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC 2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)
01 Hospital, 02 SNF/NF/Dual, 03 SNF/NF/Distinct, 04 SNF, 05 HHA, 06 PRTF, 07 X-Ray, 08 OPT/SP, 09 ESRD, 10 NF, 11 ICF/IID, 12 RHC, 13 PTIP, 14 CORF, 15 ASC, 16 HOSPICE, 22 CLIA

FISCAL YEAR ENDING DATE: (L35) **09/30**

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12. Total Facility Beds **45** (L18)
13. Total Certified Beds **45** (L17)

10. THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
__ 2. Technical Personnel
__ 3. 24 Hour RN
__ 4. 7-Day RN (Rural SNF)
__ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	45			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
See Attached Remarks

17. SURVEYOR SIGNATURE
Beth Nowling, HFE NEII
Date: 09/11/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL
Mark Meath
Enforcement Specialist
Date: 09/16/2015 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
_____ 1. Facility is Eligible to Participate
_____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21.
1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION **10/01/1991** (L24)
23. LTC AGREEMENT BEGINNING DATE (L41)
24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)
29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)
32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN: 24 5575

On August 6, 2015 a standard survey was conducted. At the time of the survey, conditions in the facility constituted Immediate Jeopardy (IJ) to resident health or safety. The IJ was abated on August 6, 2015.

The facility was not given an opportunity to correct before remedies were imposed. This Department imposed the Category 1 remedy of State monitoring, effective August 25, 2015. In addition, this Department recommended the following remedy to the CMS Region V Office of CMS for imposition:

CMP for the deficiency cited at F371, effective August 5, 2015 (this is the deficiency where the IJ was identified)

Refer to the CMS 2567 for both health and life safety code along with the facilitys plan of correction.

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Submitted
August 21, 2015

Ms. Jeanine Junker, Administrator
Barrett Care Center Inc
800 Spruce Avenue
Barrett, Minnesota 56311

RE: Project Number S5575025

Dear Ms. Junker:

On August 6, 2015, a standard survey was completed at your facility by the Minnesota Department 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.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constituted immediate jeopardy (Level K), whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

> **<u>Removal of Immediate Jeopardy</u> - date the Minnesota Department of Health verified that the conditions resulting in our notification of immediate jeopardy have been removed;**
>
> **<u>No Opportunity to Correct</u> - the facility will have remedies imposed immediately after a determination of noncompliance has been made;**
>
> **<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);**
>
> **<u>Appeal Rights</u> - the facility rights to appeal imposed remedies;**
>
> **<u>Electronic Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;**

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 6 months after the survey date; and

<u>Informal Dispute Resolution</u> - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

REMOVAL OF IMMEDIATE JEOPARDY

We also verified, on August 6, 2015, that the conditions resulting in our notification of immediate jeopardy have been removed. Therefore, we will notify the CMS Region V Office that the recommended remedy of termination of your facility's Medicare and Medicaid provider agreement not be imposed.

DEPARTMENT CONTACT

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

Gail Anderson, Unit Supervisor
Fergus Falls Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: gail.anderson@state.mn.us

Phone: (218) 332-5140
Fax: (218) 332-5196

NO OPPORTUNITY TO CORRECT - REMEDIES

CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when immediate jeopardy has been identified. Your facility meets this criterion. Therefore, this Department is imposing the following remedy:

- State Monitoring effective August 26, 2015. (42 CFR 488.422)

In addition, the Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

- Civil money penalty for the deficiency cited at F371, effective August 5, 2015. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding our recommendations and your appeal rights.

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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 remedy be imposed:

• Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

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 PoC 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 their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. 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 November 6, 2015 (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). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 6, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. 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.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, 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:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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.

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:

Mr. Gary Schroeder, Interim Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
email: gary.schroeder@state.mn.us

Telephone: (507) 361-6204
Fax: (507) 282-7899

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245575	A. BUILDING ______ B. WING ______	08/06/2015

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BARRETT CARE CENTER INC	800 SPRUCE AVENUE BARRETT, MN 56311

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F 000	INITIAL COMMENTS The Minnesota Department of Health conducted a standard survey on August, 3, 2015 through August 6, 2015. The survey resulted in an Immediate Jeopardy (IJ) at F371 related to the facility's failed response to prepare unpasteurized eggs in a safe manner which resulted in the high potential for harm or death. The IJ began August, 5, 2015 at 8:48 a.m. The Administrator and the Director of Nursing (DON) were notified of the IJ on August 5, 2015 at 2:20 p.m. The IJ was removed on August 6, 2015, at 12:21 p.m. However, noncompliance remained at the lower scope and severity level of E, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's 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 on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.	F 241		9/9/15

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

Electronically Signed — 08/27/2015

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 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.

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F 241	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure 1 of 1 resident (R23) bed linens were changed in a dignified manner. In addition, the facility failed to provide a dignified dining experience for 3 of 3 residents (R13, R8, R28) observed wearing transfer belts during the evening meal. Findings Include: R23's quarterly Minimum Data Set (MDS) dated 5/13/15, identified R23 had diagnoses which included, Parkinson's disease, depression and anxiety. The MDS identified R23 had moderate cognitive impairment, required extensive assistance with bed mobility, dressing, toilet use and personal hygiene and was unable to maintain balance without physical support from facility staff. R23's Communication Care Area Assessment (CAA) dated 2/18/15, identified R23 was able to verbalize needs and had clear speech, was able to be understood by others. R23's ADL CAA dated 2/18/15, revealed R23 required extensive assistance with all ADL's, ambulated with extensive of one staff and use of a walker due to problems with balance and was at risk for falls. R23's care plan dated 9/18/14, identified R23 had been identified as a vulnerable adult related to physical limitations. R23's care plan directed facility staff to treat R23 with respect and dignity.	F 241	This facility's allegation of compliance for F-241 will include re-education and review of positioning policy on 9/9/15 for proper positioning of residents, to include assurance of maintaining resident's dignity, of identified resident and all residents requiring assistance with positioning. Staff will also be directed to seat residents in a chair if bed hasn't been made following breakfast. Audits will be conducted weekly to assure residents are positioned in a dignified manner. Findings will be reviewed by QA committee meetings quarterly to assure on-going compliance. DON and QA nurse responsible. Facility has updated the current "Transfer Belt Policy" to direct staff to remove transfer belts from residents following transfers and or ambulation. Staff will receive training 9/9/15 regarding updated policy for all residents who require use of a transfer belt for transfers and ambulation including identified residents. Visual audits will be conducted weekly to observe transfer belt and positioning as it relates to dignity procedures to assure compliance. Results of these audits will be reviewed at QA committee meetings quarterly to assure on-going compliance. DON and QA nurse are responsible.	

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On 08/04/15, during continuous observations from 9:45 a.m. to 10:00 a.m. R23 was observed lying on a blue, plastic mattress on the bed in his/her room bed with a transfer belt on his/her waist. R23's head was towards the end of the bed, with his/her head resting on the footboard covered with a bed spread draped over the foot of the bed. A four wheeled walker was next to the bed with the blue, plastic mattress. A staff member was observed to briefly enter R23's room and placed a stack of linens in the room, told R23 housekeeping staff would come to the room to make the bed and immediately exited the room. R23 remained lying on the blue, plastic mattress, with his/her head resting on bed spread on the foot of the bed. At 9:52 a.m. housekeeping staff (hskg-A) was observed to briefly stand at the doorway of R23's room and proceeded to walk down the hallway, away from R23's room. Hskg-A did not enter R23's room, or talk or interact with R23.

During interview at 9:55 a.m., R23 stated facility staff had assisted he/her back to her room from the dining room, and he/she had waited for a long time for staff to come back and make her bed. R23 stated the position he/she was in was very uncomfortable, but had been told to have staff with when getting up or down, so he/she needed to wait for them. R23 further stated he/she it bothered her to lay like that while people were walking by but needed to wait for staff.

At 10:00 a.m. a nursing assistant (NA)-D and NA-E, entered R23's room and assisted R23 to stand while NA-E placed linens on R23's mattress. NA-D then proceeded to assist R23 back into bed.

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On 8/4/15, at 10:10 a.m. NA-D stated R23 needed extensive assistance with all ADL's. NA-D verified R23 would have been unable to walk back to his/her room without staff assist and further stated R23 was not left in a dignified position by whomever assisted R23 back to the room. NA-D further confirmed R23 would not have been able to change position by self so would have needed to wait for staff assistance before changing positions in bed. and that was not common practice in the facility. NA-D stated it was not common practice in the facility to have unmade beds utilized by residents.

On 8/4/15, at 10:14 a.m., Hskg-A confirmed she had not assisted R23 by placing linens on the bare mattress. Hskg -A stated it was not common practice to leave residents in that position, however figured a nursing assistant would come by the help R23.

On 8/4/15, at 10:16 a.m. the director of nursing (DON) stated R23 should not have been left lying on the unmade bed, in a poor position on the bed. The DON further stated that housekeeping staff should have notified nursing staff of R23's positioning. The DON confirmed the position R23 was left in was undignified. The DON stated she expected all staff to treat all residents with dignity and to be cared for. The DON further stated R23's undignified positioning was unacceptable.

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R13's annual Minimum Data Set (MDS) dated 6/24/15, identified R13 had diagnoses which included dementia, anxiety and psychotic disorder. The MDS identified R13 had severe cognitive impairement and required extensive assistance with acivities of daily living (ADL's.)

R13's care plan dated 9/3/14, identified R13 was a vulnerable adult and directed facility staff to treat R13 with respect and dignity. R13's care plan further identified R13 had impaired cognitive function and directed facility staff to keep R13's environment and daily activities "homelike."

On 8/3/15, at 3:41 p.m. R13 was observed seated in an recliner chair in the common area of the facility, with several other residents present. R13 was calm, quiet, and had a transfer/gait belt (cotton belt 3 inches in width, cinched with a metal buckle) secured around the waist, over his/her street clothes.

On 8/3/15, at 5:17 p.m., R13 was observed seated in a recliner chair in his/her room. R13 had a transfer/gait belt secured around his/her waist, over the street clothes R13 wore.

On 8/3/15, at 5:33 p.m. R13 was assisted to ambulate to the dining room by a nursing assistant (NA)-D. After R13 was seated at a table, with several other residents at the table and at adjacent tables. NA-D exited the dining room, R13's transfer/gait belt remained attached at R13's waist.

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On 8/3/15, at 5:51 R13 remained seated at the table with other residents, calm and quiet, with the transfer/gait belt attached to his/her waist. NA-D sat down next to R13 and proceeded to assist R13 to eat the evening meal.

On 8/3/15, at 6:15 p.m., NA-D remained seated at R13's table, and continued to assist R13 to eat. The transfer/gait belt remained secured to R13's waist throughout the entire meal observation.

On 8/3/15, at 6:55 p.m., NA-A stated R13 had a transfer belt on in the evening due to self transfers and the need for staff to assist with ambulation. NA-A also stated R13 should not have had the transfer belt on during the evening meal.

R8's quarterly MDS, dated 5/5/15 identified R8 had diagnoses which included dementia, chronic kidney disease and hypoglycemia (low blood sugar.) The MDS identified R8 had severe cognitive impairment and further identified R8 had no behaviors.

R8's care plan dated 9/15/14, identified R8 had been identified as a vulnerable adult related to physical limitations, cognitive impairment and behavior problems. R8's care plan directed facility staff to treat R8 with respect, dignity and to use R8's given name when communicating.

During continuous observation on 8/3/15, from 5:00 p.m. to 6:18 p.m. R8 was observed seated at a table in th facility dining room with a

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transfer/gait belt attached at his/her waist, over colored slacks. R8 remained seated at a dining room table in the facility dining room, with several of residents, waiting for the evening meal to be served, with the transfer/gait belt secured at the waist. At 5:48 p.m. a nursing assistant sat down next to R8 at the table, and started to assist R8 to eat the evening meal. R8 continued to have the transfer/ gait belt secured around the waist. At 6:14 p.m. R8 continued to have the gait belt secured at the waist, eating the evening meal. At 6:18 p.m. R8 was assisted to exit the dining room. R8 had the transfer/gait belt secured on his/her waist during the entire observation.

On 8/3/15, at 6:51 p.m. nursing assistant (NA)-C stated staff usually removed the belt after transfer, "if we remember." NA-C confirmed R8 was unable to remove the gait belt on her own.

On 8/3/15, at 6:52 p.m. NA-B confirmed a gait belt had been secured on R8 during the evening meal and stated R8 was unable to make her needs known. She indicated R8 could move her hands and felt R8 could of removed the gait belt if she desired.

R28's quarterly MDS, dated 6/10/15, identified R28 had diagnoses which included dementia, esophageal reflux and cardiac dysrhythmias. The MDS identified R28 had severe cognitive impairment, revealed R28 had not behaviors.

R28's care plan dated 5/22/14, identified R28 had been identified as a vulnerable adult related to physical limitations and cognitive impairment.

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R28's care plan directed facility staff to treat R28 with respect and dignity.

During observations on 8/3/15, at 4:50 p.m. to 6:32 p.m., R28 had a transfer/gait belt secured at his/her waist, visible over his/her street clothes, for the entire observation of the evening meal. At 4:50 p.m.,R28 was assisted to walk into the dining room by staff member, utilizing a walker and a transfer/gait belt secured around R28's waist. R28 was assisted to sit at a table in the dining room, and At 5:49 p.m., R28 remained quiet,seated at the table, with the evening meal served to all of the residents in the dining room. The transfer/gait belt secured remained around R28's waist. At 6:18 p.m., nursing assistant (NA)-D approached R28, and encouraged him/her to drink a beverage. At 6:32 p.m. R28 was assisted to exit the dining room, staff stated to R28, "okay dear uncross your legs" then assisted R28 to stand, utilized a walker and transfer/gait belt remained secured around R28's waist.

On 8/ 3/15, at 6:45 p.m., trained medication assistant (TMA)-A confirmed R8 and R28's transfer/gait belt had remained on during the evening experience. TMA-A indicated the facility had quite a bit of new staff and indicated the transfer/gait belts got left on after the residents were ambulated to the dining room. She confirmed leaving the transfer belts on for meals is not the usual facility practice. TMA-A confirmed R8 and R28 were cognitively impaired and were not able to make their own decisions.

On 8/3/15, at 6:48 p.m. NA-D confirmed it was not common practice to leave the transfer/gait

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F 241	Continued From page 8 belt on during dining. She indicated she had received education in the past regarding removing the transfer/gait belts on when not in use for residents. On 8/6/15, at 3:05 p.m. the director of nursing (DON) confirmed R8 and R28 had impaired cognition, and stated the gait belts should have been removed for those resident during the dining experience. A facility policy titled, Dignity Policy dated 5/12, directed facility staff to proved dignity and respect to each and every resident and to promote self worth and resident rights. A facility policy titled, Transferring and positioning residents dated 1/11, directed facility staff to ensure residents were comfortable following a transfer to bed.	F 241		
F 371 SS=K	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 371	The allegation of compliance for tag 0371	8/27/15

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F 371	Continued From page 9 review, the facility failed to prepare food in a safe manner related to the use of unpasteurized eggs in the dietary department. This deficient practice resulted in an immediate jeopardy for 12 of 36 residents, including two residents (R26, R31) for whom undercooked unpasteurized eggs were observed to have been prepared; and 10 residents (R4, R6, R13, R14, R15, R33, R35, R39, R46, R50) who were identified by the facility to have received soft cooked, unpasteurized eggs. The preparation of these undercooked eggs placed all 12 residents at risk for the development of the food borne illness, Salmonella Enteritis. This practice had the potential to affect 36 out of 43 residents in the facility. The immediate jeopardy (IJ) began on 8/5/15, due to the systemic failure of the facility to appropriately prepare unpasteurized eggs during observation of the breakfast meal, when yellow, runny egg residue was observed to be smeared over the diameter of R26 and R31's breakfast plates. The practice of serving the undercooked eggs had the potential to cause Salmonella Enteritis. The administrator and the director of nursing (DON) were notified of the IJ on 8/5/15, at 2:20 p.m. The IJ was removed on 8/6/15, at 12:21 p.m. however, noncompliance remained at the lower scope and severity level of E, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: During the initial kitchen tour on 8/3/15, at 12:15 p.m. a large brown box was observed on the bottom left side of the refrigerator which contained unpasteurized shell eggs. The dietary manager (DM) stated all eggs currently used in the facility were unpasteurized, except the liquid	F 371	included the re-education of all dietary staff by phone to assure that they were all aware that the facility implemented a policy immediately that they would only use pasteurized eggs. All unpasteurized eggs that were in the building were disposed of. No cases of symptoms or illnesses were reported. If pasteurized eggs are unavailable the facility will only use liquid or powder pasteurized eggs. To assure compliance the dietary manager will audit eggs weekly when serving made to order eggs to assure they are only pasteurized eggs. Audits will include the ordering process to assure only pasteurized eggs are selected for purchase by weekly review of invoices. The facility randomly checks all temperatures of cooked eggs and monitors temperatures to assure safe handling of all eggs. The audits will be reviewed quarterly at QA committee meetings to assure on-going compliance. Dietary Manager and QA nurse are responsible.	

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F 371	Continued From page 10 eggs which were pasteurized. The DM reported the facility was having a difficult time obtaining shelled, pasteurized eggs, but stated the facility was just not preparing any soft cooked eggs during this time. On 8/5/15, at 8:48 a.m. during the breakfast meal, R31 was seated at a table in the facility's dining room. R31's breakfast plate was observed with yellow runny egg yolk residue and small white particles of egg on the plate. R31 confirmed he had eaten his breakfast. On 8/5/15, at 9:05 a.m. R26 was observed leaving a table in the facility dining room. R26's breakfast plate remained on the table, and was observed to be covered with yellow, thin, runny egg residue smeared across the entire plate. On 8/5/15, at 9:06 a.m. dietary aide (DA)-A was present in the dining room and confirmed the yellow, thin and runny residue on R26 and R31's breakfast plates was from over easy eggs the residents had been served and eaten for breakfast. DA-A stated the facility normally had pasteurized eggs, but did not currently have any pasteurized eggs. On 8/5/15, at 9:07 a.m. cook (C)-A reported she had prepared the over easy eggs for breakfast for the facility's "sunny day cafe" event which was held every Wednesday. C-A explained that during the "sunny day cafe" eggs were made to order for any residents who requested them. C-A was able to verify 20 eggs were cooked over easy that morning, stating some residents had been served 2 eggs. C-A confirmed the eggs she had used that morning for the over easy eggs were unpasteurized. C-A stated the facility had been having a very hard time getting pasteurized eggs and stated she was aware they were supposed to only use pasteurized eggs when preparing the over easy eggs. C-A stated she had questioned	F 371		

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F 371	Continued From page 11 the DM about whether the staff should continue to use the unpasteurized eggs when making over easy eggs, and stated the DM had told her to continue to use the unpasteurized eggs for preparing the over easy eggs. C-A stated the facility had been preparing the over easy eggs using unpasteurized eggs for approximately the past 3 weeks. On 8/5/15, at 10:17 a.m. C-A stated when she cooks the over easy eggs using the unpasteurized eggs she does not check the temperature of the eggs before serving, and does not cook the eggs for any specific time. C-A stated she flipped the eggs over once on the griddle and goes by the "look" to determine when the eggs are done. On 8/5/15, at 10:45 a.m. the administrator stated she had contacted the food supplier utilized by the facility and had been told the supplier did have pasteurized eggs available for purchase. The administrator stated she was aware the DM and C-A had verified the eggs prepared for residents during the breakfast meal were not pasteurized and indicated she doubted the accuracy of the information. The administrator requested the surveyors look into the cooler in the kitchen to see if the eggs were pasteurized. The administrator did not enter the kitchen with the surveyor to visualize the eggs. DA-B and the surveyor visually verified the eggs in the facility refrigerator were not pasteurized. The administrator stated she would obtain a list of residents who consumed the eggs at the breakfast meal. On 8/5/15, at 11:05 a.m. DM stated C-A made a lot of soft cooked eggs today, and confirmed all the eggs prepared were unpasteurized. The DM stated during the initial tour conducted in the	F 371		

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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
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facility, she had forgotten about the "sunny day cafe" and had inaccurately reported the facility did not prepare soft cooked eggs for the residents with unpasteurized eggs. The DM confirmed that every Wednesday the facility designated the breakfast meal as "sunny day cafe," and verified the residents could order eggs any way they wanted them. The DM reiterated the facility had been having a difficult time getting pasteurized eggs "since the bird flu began." She stated she had stressed to the cooks that when a resident chose to have an over easy egg, the whites had to be set, and the yolk had to be cooked to 140 degrees. The DM stated the facility did not check the temperature of each individual egg served, and stated each individual egg was not checked because there would have a mess on the plate, because the yolk would run all over the plate. The DM said the cook would check one sample egg for temperature, document the temperature on a log, then discard the temperature sampled egg. The DM indicated she had informed the kitchen staff the facility was having a difficult time acquiring pasteurized eggs, and told them it would not be their standard practice to cook over easy eggs with unpasteurized eggs, but at the current time they had to use the unpasterized eggs anyway because that is the way the residents want their eggs prepared.
During this interview with the DM, when she was asked if any of the cooks had questioned whether they should continue using the unpasteurized eggs for the over easy style eggs, the DM replied, "I am going to plead the fifth." The DM stated she had told the cooks that if the whites of the eggs were set, the egg would be adequate to serve to the residents. The DM also stated she had difficulty ordering pasteurized shell eggs from the food vendor in the past. The DM stated she

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	245575	A. BUILDING ______ B. WING ______	08/06/2015

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utilized a computer order system for food orders and when entering the facility order, the vendor software program would automatically default the order to a substitution category of unpasteurized eggs. The DM stated she had tried to order a different brand of egg to see if the pasteurized eggs would be available, but since the facility did not regularly purchase that brand, the food vendor software had indicated they were not authorized to buy those products. The DM did not provide any information regarding attempting to contact the food vendor directly by telephone.

On 8/5/15, at 11:15 a.m. the facility provided a list of residents who consumed the unpasteurized eggs. The list identified R4, R6, R13, R14, R15, R33, R35, R39, R46, R50 had consumed the unpasteurized eggs at the breakfast meal on 8/5/15.

Review of the facility Food Temperature Record forms provided by the facility, from 5/4/15 to 6/28/15, 7/6/15 to 7/25/15 and 8/2 to 8/5/15, revealed the following documentation for the breakfast meal:
-5/4/15 to 5/10/15: on 5/6/15 sunny day cafe, no food items were listed and no temperatures were recorded.
-5/11/15 to 5/17/15: on 5/13/15 sunny day cafe, no food items were listed and no temperatures were recorded.
-5/18/15 to 5/24/15: on 5/20/15 sunny day cafe, no food items were listed and no temperatures were recorded.
-5/25/15 to 5/31/15: on 5/27/15, sunny day cafe, identified test 144, however, did not identify what food item had been tested and had not include any further testing for eggs.
-6/1/15 to 6/7/15: on 6/3/15, sunny day cafe,

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identified test egg 150, however, did not identify what type of egg had been tested and did not identify whether any further eggs had been tested.
-6/8/15 to 6/14/15: on 6/10/15, sunny day cafe, however, did not identify what type of eggs were utilized (pasteurized or not) and did not list any further eggs had been tested.
-6/15/15 to 6/21/15: on 6/17/15, sunny day cafe, test 150, however, did not identify what type of egg had been tested and did not list any further eggs had been tested.
-6/22/15 to 6/28/15: on 6/24/15, sunny day cafe, test 152, however, did not identify what type of egg had ben tested and did not list any further eggs had been tested.
-7/6/15 to 7/12/15: on 7/8/15, sunny day cafe, eggs 143, however, did not identify what type of egg had been tested and did not list any further eggs had been tested.
-7/13/15 to 7/19/15: on 7/15/25, sunny day cafe, eggs 146, however, did not identify what type of egg had been tested and did not list any further eggs had been tested.
-7/20/15 to 7/24/15: on 7/22/15, sunny day cafe, fried egg 149, however, did not identify what type of fried egg had been tested and did not list any further eggs had been tested.
-8/3/15 to 8/5/15: on 8/5/15 at 9:15 a.m., the record was reviewed with C-A. The Food Temperature Record on 8/5/15, listed the scrambled eggs temperature had reached 170 degree,s however, lacked documentation of any sample egg test temperatures for the over easy cooked eggs. C-A confirmed she had served many over easy eggs and had not checked the temperature of any of the eggs. C-A indicated she determined by "looks" as to whether the unpasteurized eggs were cooked and ready to be

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served.
A copy of the Food Temperature Record for the week of 8/5/15 was provided on 8/6/15, with an added notation for 8/5/15 which noted OE (over easy) 145.
On 8/5/2015, at 1:19 p.m. the DM confirmed the food temperature records and the current facility policy. The DM confirmed on 7/8/15, a sample OE egg temperature had been tested to reach 143 degrees. The DM verified the food temperature record did not indicate whether unpasteurized eggs had been used on 7/8/15, or not and stated she had understood the unpasteurized eggs only needed to be cooked to 140 degrees, and not until the yolk was firm. The DM reiterated she had understood the yolk only needed to reach 140 degrees just like any other hazardous foods.
During a telephone interview on 8/6/15, at 5:44 p.m. the facility's registered dietician (RD) consultant stated she comes to the facility monthly and was not aware the facility utilized any unpasteurized eggs for made to order eggs for residents. The RD indicated she was aware the facility had been having a difficult time getting the pasteurized eggs through their usual food vendor. In addition, the RD stated the DM had not discussed with her preparation education, or regulatory guidance, regarding cooking made to order unpasteurized eggs for the facility's residents. The RD stated use of unpasteurized eggs for making made to order eggs was an unacceptable practice.
Review of the facility's policy Monitoring Egg Preparation for Sunny Day Cafe, dated 5/5/15, indicated staff had been directed to check random temperatures of eggs ordered by residents for over-easy or over-medium eggs. The policy identified the temperature checks

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F 371	Continued From page 16 would be in place during times when pasteurized eggs were unavailable to ensure the egg temperature was at or above 140 degrees internally. The policy lacked direction to cook an unpasteurized egg until both the yolk and white were firm. Review of the facility's US Food invoices dated 6/14, 6/21, 6/24, 7/1, 7/5, 7/8 and 7/26/15, all indicated each shipment had been received for 15 dozen shelled unpasteurized eggs. The invoices did not include any orders for shelled, pasteurized eggs. Review of the facility's policy Preventing Food Borne Illness-Food Handling dated 3/2010, indicated food would be "stored, prepared, handled and served so that the risk of foodborne illness is minimized." The policy identified critical factors implicated in food borne illness to include: "poor personal hygiene of food service employees, inadequate temperatures, contaminated equipment and unsafe food sources." Further, the policy identified critical factors as the primary focus of preventative measures to minimize the risk of foodborne illness for the residents. The immediate jeopardy that began on 8/5/15, was removed on 8/6/15, when it was determined the facility had provided education to all of the dietary staff regarding use of unpasteurized eggs, had revised facility policies regarding the use of unpasteurized eggs, and had a plan in place for auditing eggs served made to order with the results reported to the quality assurance committee. Interview with staff verified all dietary staff had been re-educated to the use of unpasteurized eggs. In addition, on 8/6/15 an observation of the facility's food storage revealed 15 dozen pasteurized eggs and a carton of liquid pasteurized eggs. An observation of a meal	F 371		

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F 371	Continued From page 17 revealed no made to order eggs were served and a dietary aid verified only scrambled eggs had been served. However, non-compliance remains at the lower scope and severity of E, a pattern with no actual harm, but potential for more than minimal harm.	F 371		

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

F5575024

PRINTED: 08/27/2015
FORM APPROVED
OMB NO. 0938-0391

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	245575	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**08/05/2015**

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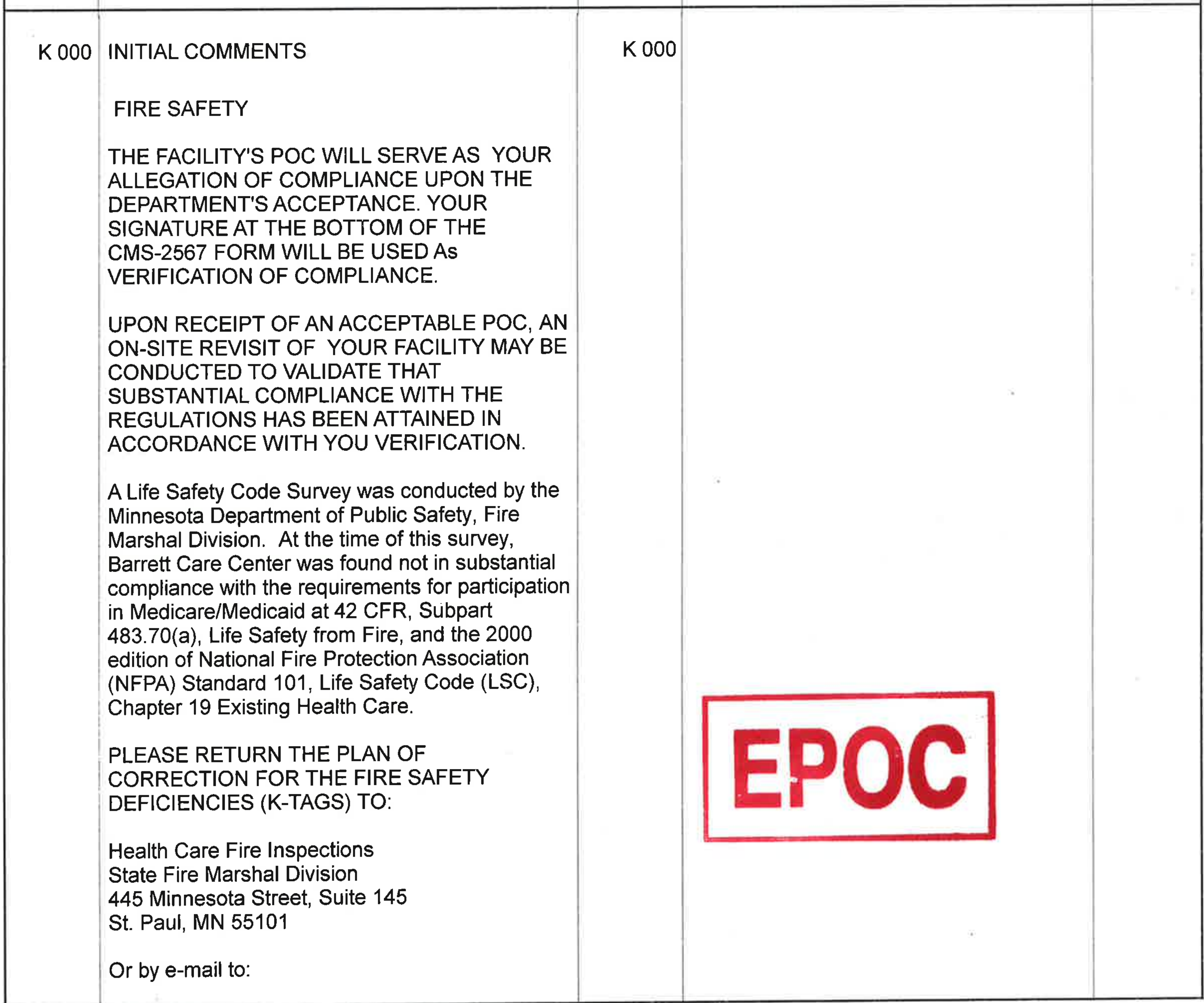

K 000 INITIAL COMMENTS — K 000

FIRE SAFETY

THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE CMS-2567 FORM WILL BE USED As VERIFICATION OF COMPLIANCE.

UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOU VERIFICATION.

A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Fire Marshal Division. At the time of this survey, Barrett Care Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care.

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

Or by e-mail to:

EPOC

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

Electronically Signed — 08/24/2015

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 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.

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K 000	Continued From page 1 Marian.Whitney@state.mn.us or Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Barrett Care Center is a 1-story building with a partial basement. The original building was constructed in 1967, has a partial basement and was determined to be of Type II(111) construction with mono-lithic ceilings throughout. In 1982, additions were added to the south of the dining room and to the east wing that are not separated from the original building and were determined to be of Type II(111) construction. In 2000 an addition was constructed to the West Wing for administration offices and PT, that was determined to be Type V(111) construction. In 2002 the latest addition was constructed to the North Wing is Type II (111) construction. The building is fully sprinkler protected in accordance with NFPA 13 Standard for the Installation of Automatic Sprinkler Systems (1999 edition). The facility has a manual fire alarm system with smoke detection in the corridors of	K 000		

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K 000	Continued From page 2 the 1982 edition, at all cross corridor doors that are held open and in spaces open to the corridors and common living areas that is monitored for automatic fire department notification, installed in accordance with NFPA 72 "The National Fire Alarm Code" (1999 edition). Other hazardous areas have automatic fire detectors, that are on the fire alarm system in accordance with the Minnesota State Fire Code (2007 edition). The sleeping rooms have single station smoke detectors that are battery operated. The facility has a capacity of 45 beds and had a census of 42 the time of the survey. Since the original building and all additions meet the building construction types of NFPA 101 and the facility is fully sprinkler protected it was surveyed as a single building. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 056 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5	K 056		8/24/15

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K 056	Continued From page 3 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was found that the automatic sprinkler system is not installed and maintained in accordance with NFPA 13 the Standard for the Installation of Sprinkler Systems (99). The failure to maintain the sprinkler system in compliance with NFPA 13 (99) could allow system being place out of service causing a decrease in the fire protection system capability in the event of an emergency that would affect the residents, visitors and staff of the facility. Findings include: On facility tour between 10:30 AM to 1:30 PM on 08/05/2015, observations revealed that there are two different type of sprinkler heads located in the basement boiler room. The fire sprinkler that are located in the boiler room consist of both standard response and quick response which are combined in one compartment. This deficient condition was verified by the Maintenance Supervisor (MS).	K 056	Barrett Care Center's allegation of compliance to NFPA 101 Tag 0056: Nova Fire Protection systems installed a new sprinkler head in the basement in the furnace room to replace the quick response head with a standard response that now match in one compartment to be all of standard response sprinkler heads in basement furnace room. The correction was complete on 08-20-2015.	