DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: RNJ7

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL
PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

PAR	Γ I - TO BE COMPLETED BY TH	IE STATE SURVEY	AGENCY	Fac	cility ID: 00153
1. MEDICARE/MEDICAID PROVIDER NO. (L1) 245575 2.STATE VENDOR OR MEDICAID NO. (L2) 879240200	3. NAME AND ADDRESS OF FACIL (L3) BARRETT CARE CENTER (L4) 800 SPRUCE AVENUE (L5) BARRETT, MN	RINC	56311	4. TYPE OF ACTION: 1. Initial 3. Termination 5. Validation	2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)	7. PROVIDER/SUPPLIER CATEGO 01 Hospital 05 HHA	RY <u>02</u> (L7 09 ESRD 13 PTIP) 22 CLIA	7. On-Site Visit 8. Full Survey After Co	9. Other omplaint
6. DATE OF SURVEY 07/15/2016 (L3 8. ACCREDITATION STATUS: (L10 0 Unaccredited	03 SNF/NF/Distinct 07 X-Ray	10 NF 14 CORF 11 ICF/IID 15 ASC 12 RHC 16 HOSPICE		FISCAL YEAR ENDING	G DATE: (L35)
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12. Total Facility Beds 45 (L13) 13. Total Certified Beds 45 (L13)	´	And/Or Appr 2. Tec 3. 24: 4. 7-E 5. Life	chnical Personnel		ices Limit etor
14. LTC CERTIFIED BED BREAKDOWN	1 (142) 11	15. FACILITY			
18 SNF 18/19 SNF 19 5 45	SNF ICF IID	1861 (e) (1) o	or 1861 (j) (1):	(L15)	
(L37) (L38) (L3	39) (L43)				
16. STATE SURVEY AGENCY REMARKS (IF APP	PLICABLE SHOW LTC CANCELLATION DA	ATE):			
17. SURVEYOR SIGNATURE	Date :	18. STATE SU	RVEY AGENCY	APPROVAL	Date:
Beth Nowling, HFE NEII	07/27/2016	(L19) Mark T	Seath, E	nforcement Specialist	08/31/2016 (L20
PART II - TO	BE COMPLETED BY HCFA REC	GIONAL OFFICE O	R SINGLE S	FATE AGENCY	
19. DETERMINATION OF ELIGIBILITY _X 1. Facility is Eligible to Participate 2. Facility is not Eligible (L	20. COMPLIANCE WITH RIGHTS ACT:	2.		cial Solvency (HCFA-2572) I Interest Disclosure Stmt (He:	CFA-1513)
22. ORIGINAL DATE 23. LTC AG	REEMENT 24. LTC AGREEME	ENT 26. TERMINA	ATION ACTION:	(L3	30)
OF PARTICIPATION BEGIN 10/01/1991	NING DATE ENDING DATE	VOLUNTARY 01-Merger, Clo			ARY eet Health/Safety
(L24) (L41)	(L25)		ion W/ Reimburse		eet Agreement
	NATIVE SANCTIONS ension of Admissions:		luntary Termination	OTHER	Status Change
(L27) B. Resc	ind Suspension Date: (L45)			00-7 tellve	
28. TERMINATION DATE:	29. INTERMEDIARY/CARRIER NO.	30. REMARKS	5		
	03001				
(L28)		(L31)			
31. RO RECEIPT OF CMS-1539	32. DETERMINATION OF APPROVAL I	DATE			
(L32)	07/12/2016	(L33) DETERMIN	NATION APPR	ROVAL	



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245575

August 31, 2016

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 June 2, 2016 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 Weath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division

Email: mark.meath@state.mn.us

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



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered July 27, 2016

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

RE: Project Number S5575026

Dear Ms. Junker:

On June 1, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on May 25, 2016 that included an investigation of complaint number . This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On July 15, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on June 15, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on May 25, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 2, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on May 25, 2016, effective June 2, 2016 and therefore remedies outlined in our letter to you dated June 1, 2016, will not be imposed.

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 letter / eNotice.

Sincerely,

Mark Weath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division

Email: mark.meath@state.mn.us

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

		POST-0	CERTIFICA	TION F	REVISIT F	REPORT		
	R/SUPPLIER/CLIA/	MULTIPLE CON	NSTRUCTION				DAT	E OF REVISIT
245575	CATION NUMBER	A. Building B. Wing					_{Y2} 7/15	5/2016 _{Y3}
-	FACILITY			STE	REET ADDRESS. (CITY, STATE, ZIP CO		10
_	T CARE CENTER INC	Э			SPRUCE AVENUE			
				BAF	RRETT, MN 56311			
program, corrected provision	ort is completed by a control of the completed by a control of the	encies previousl prrective action	y reported on the C was accomplished.	MS-2567, St Each deficie	atement of Defici ency should be fu	iencies and Plan of ully identified using	Correction, t either the rec	hat have been gulation or LSC
ITE	M	DATE	ITEM		DATE	ITEM		DATE
Y4		Y5	Y4		Y5	Y4		Y5
ID Prefix	F0441	Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	483.65	Completed	Reg. #		Completed	Reg. #		Completed
LSC		06/02/2016	LSC		<u></u>	LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC		_	LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC		_	LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed

FOLLOWUP TO SURVEY COMPLETED ON 5/25/2016 CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?

LSC

DATE

DATE

07/27/2016

EVENT ID: RNJ712

DATE

DATE

07/15/2016

☐ YES ☐ NO

LSC

34088

X

REVIEWED BY

REVIEWED BY

(INITIALS)

(INITIALS) GA/mm

LSC

REVIEWED BY

REVIEWED BY CMS RO

STATE AGENCY

TITLE

SIGNATURE OF SURVEYOR

POST-CERTIFICATION REVISIT REPORT

	MULTIPLE CONSTRUCTION			DATE OF REV	ISIT
IDENTIFICATION NUMBER	A. Building 01 - MAIN BUILDING 01				
245575 _{Y1}	B. Wing		Y2	6/15/2016	Y3
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).

ITE Y4		DATE Y5	ITEM Y4		DATE Y5	ITEM Y4			DATE Y5
ID Prefix	 NFPA 101	Correction	ID PrefixNFP	°A 101	Correction	ID Prefix	NFPA 101		Correction
Reg. # LSC	K0018	05/24/2016	Reg. # K002	25	O5/24/2016	Reg. # LSC	K0144		O5/24/2016
ID Prefix		Correction	ID Prefix		Correction	ID Prefix			Correction
Reg. # LSC		Completed	Reg. #		Completed	Reg. # LSC			Completed
ID Prefix		Correction	ID Prefix		Correction	ID Prefix			Correction
Reg. #		Completed	Reg. #		Completed	Reg. #			Completed
ID Prefix		Correction	ID Prefix		Correction	ID Prefix			Correction
Reg. #		Completed	Reg. #		Completed	Reg. # LSC			Completed
ID Prefix		Correction	ID Prefix		Correction	ID Prefix			Correction
Reg. # LSC		Completed	Reg. #		Completed	Reg. # LSC			Completed
REVIEWS		REVIEWED BY (INITIALS) TL/mm	DATE 07/27/2016	SIGNATURE OF	SURVEYOR 36536			DATE 06/1!	5/2016
REVIEWED BY CMS RO (INITIALS)			DATE	TITLE				DATE	
FOLLOWUP TO SURVEY COMPLETED ON 5/24/2016				OR ANY UNCORRECTED DEFICIENCI			IE E4 OU IT) (0	YE:	s 🗆 NO

POST-CERTIFICATION REVISIT REPORT

	MULTIPLE CONSTRUCTION A. Building 02 - 2015 ADDITION			DATE OF REV	/ISIT
	B. Wing	,	Y2	6/15/2016	Y3
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).

ITE Y4		DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DA Y	
ID Prefix		Correction	ID Prefix	Correction	ID Prefix	Corr	ection
Reg. #	NFPA 101	Completed	Reg. #	Completed	Reg. #	Con	pleted
LSC	K0144	05/24/2016	LSC		LSC		
ID Prefix		Correction	ID Prefix	Correction	ID Prefix	Corr	ection
Reg. #		Completed	Reg. #	Completed	Reg. #	Com	pleted
LSC			LSC		LSC		
ID Prefix		Correction	ID Prefix	Correction	ID Prefix	Corr	ection
Reg. #		Completed	Reg. #	Completed	Reg. #	Com	pleted
LSC			LSC		LSC		
ID Prefix		Correction	ID Prefix	Correction	ID Prefix	Corr	ection
Reg. #		Completed	Reg. #	Completed	Reg. #	Com	pleted
LSC			LSC		LSC		
ID Prefix		Correction	ID Prefix	Correction	ID Prefix	Corr	ection
Reg. #		Completed	Reg. #	Completed	Reg. #	Con	pleted
LSC			LSC		LSC	4	
REVIEWI STATE A		REVIEWED BY (INITIALS) TL/mm	DATE 07/27/2016	SIGNATURE OF SURVEYOR 3653	36	DATE 06/15/20	016
REVIEWED BY CMS RO (INITIALS)			DATE	TITLE		DATE	
FOLLOWUP TO SURVEY COMPLETED ON 5/24/2016				R ANY UNCORRECTED DEFICI TED DEFICIENCIES (CMS-256] NO



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered July 28, 2016

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

Re: Reinspection Results - Project Number S5575026

Dear Ms. Junker:

On July 15, 2016 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on May 25, 2016. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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

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

	STATE FORM: REVISIT REPORT										
PROVIDE				MULTIPLE CON	NSTRUCTION					DATE OF REVISIT	
00153	OAHONI	VOIVIDE	Y1	B. Wing					Y2	7/15/2016 _{Y3}	
NAME OF							STREET ADDRESS, C		IP CODE		
BARRET	T CARE	CEN	TER INC)			800 SPRUCE AVENUE BARRETT, MN 56311	Ē			
correctiv	e action ition pref	was a	ccomplis	shed. Each de	ficiency should	be fully iden	reviously reported that tified using either the refix codes shown to t	regulation or	LSC provision	n number and the	
ITEI	М			DATE	ITEM		DATE	ITEM		DATE	
Y4				Y5	Y4		Y5	Y4		Y5	
ID Prefix	21375			Correction	ID Prefix		Correction	ID Prefix		Correction	
Reg. #	MN Rule Subp. 1	4658.0	0080	Completed	Reg. #		Completed	Reg. #		Completed	
LSC	Cuop. 1			_ 07/15/2016	LSC		·	LSC _		·	
	-										
ID Prefix				Correction	ID Prefix		Correction	ID Prefix _		Correction	
Reg. #				Completed	Reg. #		Completed	Reg. #		Completed	
LSC				- -	LSC			LSC			
ID Prefix				Correction	ID Prefix		Correction	ID Prefix		Correction	
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Reg. #				Completed -	Reg. #		Completed	Reg. #		Completed	
LSC				=	LSC			LSC _			
ID Prefix				Correction	ID Prefix		Correction	ID Prefix		Correction	
Reg. #				Completed	Reg. #		Completed	Reg. #		Completed	
LSC				=	LSC			LSC			
ID Prefix				Correction	ID Prefix		Correction	ID Prefix		Correction	
Reg. #				Completed	Reg. #		Completed	Reg. #		Completed	
LSC				_	LSC			LSC			
STATE AC		X		WED BY LS) GA/mm	DATE 07/27/2016		JRE OF SURVEYOR 34088			DATE 07/15/2016	
REVIEWE CMS RO	ED BY		REVIE\ (INITIA	WED BY LS)	DATE	TITLE				DATE	
FOLLOWUP TO SURVEY COMPLETED ON 5/25/2016					CORRECTED DEFICIENCIES (CMS-2567)			☐YES ☐ NO			

Page 1 of 1 EVENT ID: RNJ712

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: RNJ7 Facility ID: 00153

	TAKI I -	TO BE COMIT	DETED DI	THE STAI	IE SURVET AGENCI		racinty ID. 00155
1. MEDICARE/MEDICAID PROVID (L1) 245575 2.STATE VENDOR OR MEDICAID 1		3. NAME AND AI (L3) BARRETT ((L4) 800 SPRUC	CARE CENT E AVENUE		ao 5011	4. TYPE OF AC 1. Initial 3. Termination	2. Recertification 4. CHOW
(L2) 879240200		(L5) BARRETT ,	MN		(L6) 56311	5. Validation 7. On-Site Visit	6. Complaint9. Other
5. EFFECTIVE DATE CHANGE OF (L9)	OWNERSHIP	7. PROVIDER/SU	JPPLIER CATEO	GORY 09 ESRD	02 (L7) 13 PTIP 22 CLIA	8. Full Survey	
6. DATE OF SURVEY 05/2: 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	5/2016 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR EN	NDING DATE: (L35)
11LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds	45 (L18) 45 (L17)	Complianc1. A X B. Not in Con	equirements e Based On:	ogram	And/Or Approved Waivers Of 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SN 5. Life Safety Code * Code: B*	6. Scope o	of Services Limit I Director Room Size
14 AND CERTIFIED DED DREAMS	NIT I	requirements	and of rippined	varvers.		(E12)	
14. LTC CERTIFIED BED BREAKDO 18 SNF 18/19 SNF 45	19 SNF	ICF	IID		15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)	
(L37) (L38)	(L39)	(L42)	(L43)				
16. STATE SURVEY AGENCY REM	ARKS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION	DATE):			
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	Y APPROVAL	Date:
Denise Erickson, HFE N	IEII	0	06/13/2016	(L19)	Mark Meath	, Enforcement Sp	ecialist 07/11/2016 (L20)
PA	RT II - TO BE	COMPLETED I	BY HCFA R	EGIONAI	OFFICE OR SINGLE S	STATE AGENCY	,
DETERMINATION OF ELIGIBII 1. Facility is Eligible to I 2. Facility is not Eligible	Participate		MPLIANCE WIT HTS ACT:	H CIVIL	21. 1. Statement of Fina2. Ownership/Control3. Both of the Above	ol Interest Disclosure S	
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREE	MENT	26. TERMINATION ACTION	·	(L30)
OF PARTICIPATION 10/01/1991	BEGINNING		ENDING DA		VOLUNTARY 00 01-Merger, Closure	<u>INVO</u>	LUNTARY I to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs	sement 06-Fai	l to Meet Agreement
25. LTC EXTENSION DATE: (L27)	27. ALTERNATI A. Suspensio	VE SANCTIONS n of Admissions: uspension Date:	(L44) (L45)		03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	OTHE	ovider Status Change
28. TERMINATION DATE:	29). INTERMEDIARY	/CARRIER NO.		30. REMARKS		
		03001					
	(L28)			(L31)			
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	N OF APPROVA	L DATE			
	(L32)			(L33)	DETERMINATION APP	ROVAL	



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered June 1, 2016

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

RE: Project Number S5575026

Dear Ms. Junker:

On May 25, 2016, a standard 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 constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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.

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

<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

<u>Electronic Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 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.

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

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by July 4, 2016, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by July 4, 2016 the following remedy will be imposed:

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

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 remedies be imposed:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- 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. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. 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, 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. A Post Certification Revisit (PCR) 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 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.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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 August 25, 2016 (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 November 25, 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 electronic 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.

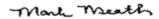
Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Tom Linhoff, Fire Safety Supervisor Health Care Fire Inspections Minnesota Department of Public Safety State Fire Marshal Division Email: tom.linhoff@state.mn.us

Telephone: (651) 430-3012 Fax: (651) 215-0525

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

Fax: (651) 215-9697

Telephone: (651) 201-4118

PRINTED: 06/13/2016 FORM APPROVED OMB NO. 0938-0391

F 000 INITIAL COMMENTS 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 441 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it: (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
STREET ADDRESS, CITY, STATE, ZIP CODE BOARRETT CARE CENTER INC SUMMARY STATEMENT OF DEFICIENCIES PREFERY TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFOIC NOT YOU'S TEE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 000 INITIAL COMMENTS 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 441 SS=F SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it: (1) Investigates, controls, and prevents infections in the facility. (2) Decides what procedures, such as isolation, should be applied to an individual resident, and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.			245575	B. WING	·····	05	/25/2016		
PRIEFIX TAG REQUILATORY OR LSC IDENTIFYING INFORMATION) FOOD INITIAL COMMENTS 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 441 SS=F The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility, (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.			· · · · · · · · · · · · · · · · · · ·		800 SPRUCE AVENUE				
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Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility, (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.		regulations has been your verification. 483.65 INFECTION	en attained in accordance with	F 4	41		6/2/16		
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(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.		The facility must es Program under whi (1) Investigates, co in the facility; (2) Decides what poshould be applied to (3) Maintains a reco	stablish an Infection Control ch it - ntrols, and prevents infections rocedures, such as isolation, o an individual resident; and ord of incidents and corrective						
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE		(1) When the Infect determines that a re prevent the spread isolate the resident	tion Control Program esident needs isolation to of infection, the facility must .		TITLE		(X6) DATE		

Electronically Signed

06/06/2016

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.

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG		DATE SURVEY COMPLETED
		245575	B. WING _			05/25/2016
	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP 800 SPRUCE AVENUE BARRETT, MN 56311		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 441	communicable dise from direct contact direct contact will tr (3) The facility mus hands after each di hand washing is inc professional practic (c) Linens Personnel must hand	t prohibit employees with a ase or infected skin lesions with residents or their food, if ansmit the disease. It require staff to wash their rect resident contact for which licated by accepted	F 4-	41		
	by: Based on interview facility failed to ens program included of resident infection infections. This defipotential to affect a the facility. Findings include: The facility's Infective reviewed from Septimentation of a patterns identified. The facility utilized a Log; however, the facility of resident infections for which is the facility utilized and t	v and document review, the ure the infection control ngoing tracking and analysis and to prevent the spread of cient practice had the last residents who resided in on Control Logs were tember 2015, through March antified tracked only residents which antibiotics were more, the facility lacked nalysis and/or investigation of a form titled Infection Control orm was not completed until a use was performed by the		Barrett Care Center's alleg compliance is an updated procedure for the Infection monitoring and tracking wit to include all residents with symptoms of infection with use of antibiotics. Tracking ongoing at regular daily tea but will now include an upoform when a resident displ symptom of a possible infeinclude the date of onset, sinclude the date of onset, sinclude the date of oreso be done by the charge nurcontinue to be reviewed at meetings and at shift report infection Control nurse will data obtained to determine trends, or clusters are occiompare for possible further	policy and control thin the facility and or without the gram meetings dated tracking as a sign of ection. This was a ted, culture fulution. This was but will at the daily tearts. The lanalyze the erif patterns, urring to	ne g will if vill

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION ING	` '	E SURVEY IPLETED
		245575	B. WING		05/	25/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COE 800 SPRUCE AVENUE BARRETT, MN 56311		
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F 441	late as quarterly. To fanalysis and invof the infections. Review of the Infections. Infections The resinculated a list of variance for each infections and trends with infection of include a list of infections that were on the Infection of Infections that were logs and identified application in the paystem to find resinstated "at least quasearch and documan antibiotic, hower monthly. RN-A identified the complete the infections that were documented in a culture was was added to the Infections that were documented in the Infection of t	age 2 urse one time a month or as he log lacked documentation estigation of possible pattens ction Control Quarterly Quality s, from 7/1/15 to 3/16 was sident quarterly reviews arious infections such as ons, pneumonia, cellulitis, and and listed the individual antibiotic ctions. The report lacked cultures completed, specific cked analysis of any patterns or ans. In addition, the report did residents with symptoms of a not treated with antibiotics. 2:05 p.m. registered nurse she was the person anaging the infection control infirmed the infection control he/she utilized a search point click care computer dents antibiotic use. RN-A carterly" he/she completed this ented the infections treated by ver; attempted to complete it e following procedure to tion control logs; a resident a prescription for an antibiotic, deded to the infection control ct infection was being treated completed the culture report og. RN-A verified infections on the log only if treated with a identified a resident with	F 4	and surveillance to help preveor spread of infection within the The program will track the preinfections both old and new. A data that will be reviewed with committee at the quarterly me Infection Control nurse will perof the tracking forms weekly to staff are properly utilizing the Audit tool was created immed 05/25/2016 and includes mak staff are using the form and the tracking staff if necessary to compliance. The first audit was on 05/26/2016 and again on 05/26/2016 and again on 05/26/2016. All nursing staff were the updated Policy and proces 05/25/2016 and the new form implemented immediately and the daily team meetings. DON Infection Control nurse are reassure ongoing compliance of	te facility. Evalence of analyzing the the QA setting. The rform audits assure system. The iately on ing sure all acking what g it and assure is complete 6/2/2016 by a Barrett ongoing F441 on the trained on the trained on the trained at l and sponsible to	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION ING			E SURVEY IPLETED
		245575	B. WING			05/	25/2016
	PROVIDER OR SUPPLIER T CARE CENTER INC			STREET ADDRESS, C 800 SPRUCE AVEN BARRETT, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH COF	ER'S PLAN OF CORRECTION RRECTIVE ACTION SHOUL ERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
F 441	added to the list unobtained and treate information regarding. On 5/25/2016, at 1 nursing (DON) identification control prospread of infection and trending of infer RN-A reviewed all infections and was the antibiotics used Regarding only trade antibiotics the DON is being treated with indicated she was uillnesses with out an symptoms of flu like (GI) problems. The were reviewed months and the control of the facility form title Nurse Job Description identified #6. Be will where infectious disinfluenza, GI upset, rashes, fungal infectiviral disorders. #9 Expression of the control of the	ge 3 GI, or influenza would not be less a positive culture is d. RN-A offered no further ng the infection control log. 1:18 a.m. the director of tified the expectation of the ogram was to prevent the land surveillance with tracking ctions. The DON indicated information regarding aware of culture results and for those infections. In the land surveillance with stated "generally an infection in an antibiotic." The DON inaware if the facility tracked intibiotic use including and gastrointestinal DON indicated infections they and quarterly tracked. The Infection/Exposure Control ion signed and dated 8/1/16, ling to work in an environment sease may be present such as HIV, Hepatitis A,B,C, skin stions, and other bacterial or the staff and residents.	F4	41	DEFICIENCY)		

F5575025

PRINTED: 06/07/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A: BUILDING 01 - MAIN BUILDING 01 245575 B. WING 05/24/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **800 SPRUCE AVENUE BARRETT CARE CENTER INC** BARRETT, MN 56311 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X5) COMPLETION DATE (X4) ID PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 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: Marian.Whitney@state.mn.us

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

06/03/2016

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.

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING 01 - Main Building 01		(X3) DATE SURVEY COMPLETED	
*		245575	B. WING		05	05/24/2016	
	NAME OF PROVIDER OR SUPPLIER BARRETT CARE CENTER INC			STREET ADDRESS, CITY, STATE, ZIP CO 800 SPRUCE AVENUE BARRETT, MN 56311	DDE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETION DATE	
K 000	Continued From pa and Angela.Kappenmar		κo	000			
		RRECTION FOR EACH T INCLUDE ALL OF THE DRMATION:					
	A description of value to correct the deficition.	what has been, or will be, done ency.					
	2. The actual, or pr	oposed, completion date.					
E.		r title of the person rection and monitoring to ence of the deficiency.					
	partial basement. T constructed in 1967 was determined to with mono-lithic cei additions were additions were additions to the eart from the original but be of Type II(111) c addition was constructed administration officidetermined to be Ty 2002 the an addition Wing is Type II (111).	r is a 1-story building with a The original building was 7, has a partial basement and be of Type II(111) construction lings throughout. In 1982, ed to the south of the dining st wing that are not separated wilding and were determined to construction. In 2000 an exceed to the West Wing for eas and PT, that was type V(111) construction. In n was constructed to the North 1) construction. In 2015 a wing 1 to the Northeast corner of type V (111).				*	
	accordance with NI Installation of Autor edition). The facility	sprinkler protected in FPA 13 Standard for the matic Sprinkler Systems (1999 has a manual fire alarm detection in the corridors of					

CENTE	49 FOR MEDICARE	& MEDICAID SERVICES	,		OIVID INC	. 0936-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l , ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - Main Building 01		TE SURVEY MPLETED
		245575	B. WING		05	/24/2016
NAME OF PROVIDER OR SUPPLIER BARRETT CARE CENTER INC			STREET ADDRESS, CITY, STATE, ZIP COD 800 SPRUCE AVENUE BARRETT, MN 56311			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
K 000	are held open and and common living automatic fire depa accordance with N Alarm Code" (1999 areas have automathe fire alarm syste Minnesota State Fi sleeping rooms had detectors that are but The facility has a consus of 41 the till Since the original but are differenct consumptions.	t all cross corridor doors that in spaces open to the corridors areas that is monitored for artment notification, installed in FPA 72 "The National Fire 0 edition). Other hazardous atic fire detectors, that are on arm in accordance with the ire Code (2007 edition). The ve single station smoke pattery operated. apacity of 45 beds and had a	KO	00		
K 018 SS=E	The requirement a NOT MET as evide NFPA 101 LIFE SA Doors protecting or required enclosure hazardous areas s as those construct core wood, or capa 20 minutes. Cleara and floor covering in fully sprinklered required to resist the no impediment to to open devices that in pushed or pulled a provided with a medoor closed. Dutch permitted. Door fra	t 42 CFR, Subpart 483.70(a) is enced by: AFETY CODE STANDARD orridor openings in other than is of vertical openings, exits, or hall be substantial doors, such ed of 13/4 inch solid-bonded able of resisting fire for at least ance between bottom of door is not exceeding 1 inch. Doors smoke compartments are only ne passage of smoke. There is the closing of the doors. Hold release when the door is re permitted. Doors shall be eans suitable for keeping the indoors meeting 19.3.6.3.6 are the smes shall be labeled and ther materials in compliance	Κ0	18		5/24/16

TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	(X3) DATE SURVEY COMPLETED		
ND FLAN C	OF CORRECTION	IDENTIFICATION NUMBER:		01 - MAIN BUILDING 01		
NAME OF I	245575 IAME OF PROVIDER OR SUPPLIER		B, WING	TREET ADDRESS, CITY, STATE, ZIP CODE	05/2	24/2016
BARRETT CARE CENTER INC			00 SPRUCE AVENUE ARRETT, MN 56311			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
K 018	with 8.2.3.2.1. Rolle CMS regulations in 19.3.6.3 This STANDARD is Based on observate facility failed to mai 2 corridor doors acception 19.3.6.3.1. affect the safety of undetermined amos moke from a fire vaccess corridors multiple states of the facility tour on 05/24/2016 observations.	er latches are prohibited by all health care facilities. s not met as evidenced by: tion and staff interview, the ntain the smoke resistance of cording to NFPA 101 LSC (00) This deficient practice could 24 of the 41 residents and an unt of staff and visitors, if were allowed to enter the exit aking it untenable. between 8:00 am to 10:30 am ervations and staff interview ent room doors, 302 and 413	K 018	Barrett Care Center's allegation of compliance is that the resident row frames were replaced with smoke stripping by Mark Soberg, Mainter Director to secure a impediment a passage of smoke on resident row doors 302 and 413 to fit tight and according to NFPA 101 LSC section 19.3.6.3.1. Barrett Care Center we substantial compliance on 05/24/2000.	om door e secure nance and oms secure ion as in	
K 025 SS=E	Administrator and the NFPA 101 LIFE SA Smoke barriers shall be peatrium wall. Window fire-rated glazing of steel frames. 8.3, 19.3.7.3, 19.3. This STANDARD is Based on observadetermined that the smoke barrier walls 101-2000 edition, \$8.3.2, and 8.3.6. The STANDARD is smoke barrier walls 101-2000 edition, \$8.3.2, and 8.3.6. The STANDARD is smoke barrier walls 101-2000 edition, \$8.3.2, and 8.3.6. The STANDARD is the smoke barrier walls 101-2000 edition, \$8.3.2, and 8.3.6. The STANDARD is the smoke barrier walls 101-2000 edition, \$8.3.2, and 8.3.6. The STANDARD is the smoke barrier walls 101-2000 edition, \$8.3.2, and 8.3.6. The STANDARD is the smoke barrier walls 101-2000 edition, \$8.3.2, and 8.3.6. The STANDARD is the smoke barrier walls 101-2000 edition, \$8.3.2, and 8.3.6. The smoke barrier walls 101-2000 edition, \$8.3.2, and 8.3.6. The smoke barrier walls 101-2000 edition, \$8.3.2, and 8.3.6. The smoke barrier walls 101-2000 edition, \$8.3.2, and 8.3.6. The smoke barrier walls 101-2000 edition, \$8.3.2, and 8.3.6. The smoke barrier walls 101-2000 edition, \$8.3.2, and \$8.3.6. The smoke barrier walls 101-2000 edition, \$8.3.2, and \$8.3.6. The smoke barrier walls 101-2000 edition, \$8.3.2, and \$8.3.6. The smoke barrier walls 101-2000 edition, \$8.3.2, and \$8.3.6. The smoke barrier walls 101-2000 edition, \$8.3.2, and \$8.3.6. The smoke barrier walls 101-2000 edition	ition was verified by the Facility he Maintenance Supervisor. FETY CODE STANDARD all be constructed to provide at ur fire resistance rating and ordance with 8.3. Smoke emitted to terminate at an ws shall be protected by r by wired glass panels and 7.5 s not met as evidenced by: tions and staff interview, it was a facility failed to maintain in accordance with NFPA Sections 19.3.7.1, 19.3.7.3, his deficient practice could of combustion spread	K 025	Barrett Care Center's allegation of compliance is that the penetration smoke barrier by the day room #2 filled in and covered with fire caus smoke barrier by Mark Soberg, Maintenance Director and is in	n of the 203 was	5/24/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION G 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED	
		245575	B. WING_		05/	05/24/2016	
NAME OF PROVIDER OR SUPPLIER BARRETT CARE CENTER INC			STREET ADDRESS, CITY, STATE, ZIP CO 800 SPRUCE AVENUE BARRETT, MN 56311	DDE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO D _A TE	
	undetermined number Findings include: On the facility tour to on 05/24/2016 observealed penetration the cross corridor of This deficient condict Administrator and the NFPA 101 LIFE SA Generators inspect under load for 30 min accordance with 3-4.4.1 and 8-4.2 (for 110) This STANDARD is Based on docume interview, the facility generators in according for 2000 NFPA 101-6-4.2 (a) & (b) and could affect all 41 medians include: On the facility tour lone 05-24-2016 recrevealed the generators being logged on the This deficient condictions.	between 8:00 am to 10:30 amerivations and staff interview ons in the smoke barrier above loors by day room #203 ition was verified by the Facility he Maintenance Supervisor. FETY CODE STANDARD ed weekly and exercised annutes per month and shall be NFPA 99 and NFPA 110. NFPA 99), Chapter 6 (NFPA in the shall be not met as evidenced by: intation review and staff by failed to test the emergency redance with the requirements and 1999 NFPA 110 6-4.2.2. The deficient practice esidents, staff, and visitors.	K 02	was in substantial complianc 05/24/2016	e for the se log record spected load for 30 cool down sutes ime. Barrett ial 101-9.1.3 on rator and monthly by	5/24/16	

PRINTED: 06/07/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A, BUILDING 02 - 2015 ADDITION 245575 B. WING 05/24/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **800 SPRUCE AVENUE BARRETT CARE CENTER INC** BARRETT, MN 56311 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX (X5) COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 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 18 New 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: Marian.Whitney@state.mn.us

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

06/03/2016

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.

Electronically Signed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A, BUILDING 02 - 2015 ADDITION			(X3) DATE SURVEY COMPLETED		
		245575	B, WING	_		05/	05/24/2016	
	NAME OF PROVIDER OR SUPPLIER BARRETT CARE CENTER INC				STREET ADDRESS, CITY, STATE, ZIP CODE 800 SPRUCE AVENUE BARRETT, MN 56311			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
K 000	Continued From pa and Angela.Kappenmar		K	000				
		RRECTION FOR EACH T INCLUDE ALL OF THE DRMATION:						
	 Á description of what has been, or will be, done to correct the deficiency. 							
	2. The actual, or proposed, completion date.							
		r title of the person rection and monitoring to ence of the deficiency.						
	partial basement. T constructed in 1967 was determined to with mono-lithic cei additions were additions were additions were addition and to the east from the original but be of Type II(111) caddition was constructed addition was constructed addition to be Ty 2002 the an addition wing is Type II (111).	r is a 1-story building with a he original building was 7, has a partial basement and be of Type II(111) construction lings throughout. In 1982, ed to the south of the dining st wing that are not separated ilding and were determined to onstruction. In 2000 an ucted to the West Wing for es and PT, that was ype V(111) construction. In n was constructed to the North) construction. In 2015 a wing to the Northeast corner of ype V (111).						
	accordance with NF Installation of Auton edition). The facility	sprinkler protected in FPA 13 Standard for the natic Sprinkler Systems (1999 has a manual fire alarm detection in the corridors of						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A, BUILDING 02 - 2015 ADDITION			(X3) DATE SURVEY COMPLETED	
		245575	B, WING		05/	05/24/2016	
	NAME OF PROVIDER OR SUPPLIER BARRETT CARE CENTER INC			STREET ADDRESS, CITY, STATE, 800 SPRUCE AVENUE BARRETT, MN 56311	ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
K 000	the 1982 edition, at are held open and and common living automatic fire depa accordance with NI Alarm Code" (1999 areas have automathe fire alarm syste Minnesota State Fi	a all cross corridor doors that in spaces open to the corridors areas that is monitored for artment notification, installed in FPA 72 "The National Fire edition). Other hazardous atic fire detectors, that are on m in accordance with the re Code (2007 edition). The ve single station smoke	KO	00			
	Since the original bare differenct consi	apacity of 45 beds and had a me of the survey, uilding and earlier additions truction types and the latest 015 it was surveyed as as two	-				
K 144 SS=F	NOT MET as evide NFPA 101 LIFE SA Generators inspect under load for 30 m in accordance with	42 CFR, Subpart 483.70(a) is enced by: FETY CODE STANDARD ed weekly and exercised an annual shall be NFPA 99 and NFPA 110. NFPA 99), Chapter 6 (NFPA	K 1	44		5/24/16	
	This STANDARD is Based on docume interview, the facility generators in accordance of 2000 NFPA 101 6-4.2 (a) & (b) and could affect all 41 refindings include:	s not met as evidenced by: ntation review and staff y failed to test the emergency rdance with the requirements - 9.1.3 and 1999 NFPA 110 6-4.2.2. The deficient practice esidents, staff, and visitors.		The allegation of comp Barrett Care Center is the standard been recorded as reper time. The generato weekly and exercised umin. Now it will state the cycle is logged the last recorded as cumulative Care Center was in sub compliance with NFPA 2	nat the log record unning for 35min r is inspected inder load for 30 at the cool down 5 minutes run time. Barrett stantial		

AND PLAN OF CORRECTION IDENTIFICATION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING 02 - 2015 ADDITION	(X3) DAT	(X3) DATE SURVEY COMPLETED 05/24/2016	
		245575	B. WING	<u> </u>	05		
	NAME OF PROVIDER OR SUPPLIER BARRETT CARE CENTER INC			STREET ADDRESS, CITY, STATE, ZII 800 SPRUCE AVENUE BARRETT, MN 56311			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF C X (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
K 144	revealed the generation being logged on the This deficient conditions.	ecord review and staff interview rator cool down cycle was not	K 1	5-24-2016 per running ge logging the cool down cyc Mark Soberg, Maintenanc	cle monthly by		



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered June 1, 2016

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5575026

Dear Ms. Junker:

The above facility was surveyed on May 22, 2016 through May 25, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. 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 that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 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 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 <u>only a suggestion</u> 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 deficiency 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted 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 after the

statement, "This Rule 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 Gail Anderson at: (218) 332-5140 or email: gail.anderson@state.mn.us.

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 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 Meeth

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

PRINTED: 06/13/2016 FORM APPROVED

Minnesota Department of Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING: ___

		00153	B. WING		05/25/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE	
BARRET	T CARE CENTER INC		JCE AVENUE		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	T, MN 56311	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETE
2 000	Initial Comments		2 000		
	****ATTEN	NTION*****			
	NH LICENSING	CORRECTION ORDER			
	144A.10, this correct pursuant to a surver found that the deficit herein are not corrected shall be a surver of corrected shall be a surver of the surver of	Minnesota Statute, section ction order has been issued y. If, upon reinspection, it is ency or deficiencies cited octed, a fine for each violation be assessed in accordance ines promulgated by rule of artment of Health.			
	corrected requires of requirements of the number and MN Ru When a rule contain comply with any of tlack of compliance. re-inspection with a result in the assess	nether a violation has been compliance with all rule provided at the tag alle number indicated below. It is several items, failure to the items will be considered Lack of compliance upon any item of multi-part rule will ment of a fine even if the item aring the initial inspection was			
	that may result from orders provided tha the Department with	hearing on any assessments n non-compliance with these t a written request is made to nin 15 days of receipt of a nt for non-compliance.			
	receipt of State lice the Minnesota Depa Informational Bullet http://www.health.st	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at ate.mn.us/divs/fpc/profinfo/infe licensing orders are			

Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

06/06/16 **Electronically Signed**

STATE FORM 6899 If continuation sheet 1 of 6 RNJ711

TITLE

(X6) DATE

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00153	B. WING		05/25/2016	
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE	•	
BARRET	T CARE CENTER INC		ICE AVENUE T, MN 56311			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 000	Department of Hea you electronically, is necessary for Sta enter the word "cortext. You must then State licensure procompletion date, the corrected prior to electronic Department on May 22th, 23th surveyors of this Deabove provider and orders are issued. electronic plan of coreviewed these ord they will be complement of the State Licensing federal software. The assigned to Minnes Nursing Homes. The assigned tag in column entitled "ID statute/rule out of complement of the statement of the State Correction order. The statement of the Suggested of Time period for Correction of the Suggested of the Suggested of Time period for Correction of the Suggested of the Sugge	Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be lectronically submitting to the nent of Health. 24th and 25th 2016, epartment's staff, visited the the following correction Please indicate in your orrection that you have ers, and identify the date when ted. The of Health is documenting and numbers have been so ta state statutes/rules for the order to perfix Tag." The state ompliance is listed in the ent of Deficiencies" column to Comply" portion of the state statute and includes the notion of the state statute and includes the notion of the state statute and includes the notion of the state statute and the surveyors findings wing the surveyors findings method of Correction and rection. ARD THE HEADING OF THE	2 000			

Minnesota Department of Health

STATE FORM 6899 RNJ711 If continuation sheet 2 of 6

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00153	B. WING	B. WING		05/25/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
BARRET	T CARE CENTER INC	1	ICE AVENUE 「, MN 56311				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 000	Continued From pa	ge 2	2 000				
	THIS WILL APPEA	R ON EACH PAGE.					
	PLAN OF CORREC	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.					
21375	MN Rule 4658.0800 Program	Subp. 1 Infection Control;	21375			5/25/16	
	home must establis	on control program. A nursing sh and maintain an infection signed to provide a safe and nt.					
	by: Based on interview facility failed to ensipprogram included o of resident infection infections. This defi	ent is not met as evidenced and document review, the ure the infection control engoing tracking and analysis ns to prevent the spread of icient practice had the II 42 residents who resided in		Corrected			
	Findings include:						
	reviewed from Sept 2016. The logs ider with infections for w prescribed. Further	on Control Logs were tember 2015, through March ntified tracked only residents which antibiotics were more, the facility lacked nalysis and/or investigation of					
	Log; however, the f review of antibiotic	a form titled Infection Control orm was not completed until a use was performed by the rse one time a month or as					

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00153	B. WING		05/	25/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
BARRE	TT CARE CENTER INC		JCE AVENUE T, MN 56311			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
21375	late as quarterly. The of analysis and invest of the infections. Review of the Infect Assurance Reports completed. The resincluded a list of valurinary tract infections in used for each infect documentation of corganisms, and lact trends with infection not include a list of infections that were Con 5/24/2016, at 12 (RN)-A verified he/s responsible for mar program. RN-A corlogs and identified lapplication in the posystem to find residual search and docume an antibiotic, however monthly. RN-A identified the complete the infect was found to have a the resident was action, if a urinary tract and a culture was of was added to the lower documented of an antibiotic. RN-A	ne log lacked documentation estigation of possible pattens tion Control Quarterly Quality, from 7/1/15 to 3/16 was ident quarterly reviews rious infections such as ons, pneumonia, cellulitis, and d listed the individual antibiotic tions. The report lacked cultures completed, specific ked analysis of any patterns or as. In addition, the report did residents with symptoms of a not treated with antibiotics.				

Minnesota Department of Health

STATE FORM 6899 RNJ711 If continuation sheet 4 of 6

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00153	B. WING		05/25/2016	
NAME OF				STATE, ZIP CODE	1 05/2	3/2016
	PROVIDER OR SUPPLIER	800 SPRI	JCE AVENUE	,		
BARRET	T CARE CENTER INC	I	Γ, MN 56311			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21375	75 Continued From page 4					
		ed. RN-A offered no further ng the infection control log.				
	nursing (DON) ider infection control prospread of infection and trending of infer RN-A reviewed all infections and was the antibiotics used Regarding only traditional antibiotics the DON is being treated with indicated she was uillnesses with out a symptoms of flullike (GI) problems. The were reviewed more The facility form title Nurse Job Description identified #6. Be with where infectious disinfluenza, GI upset rashes, fungal infectiviral disorders. #9 I	1:18 a.m. the director of ntified the expectation of the orgam was to prevent the and surveillance with tracking ections. The DON indicated information regarding aware of culture results and if for those infections. Exing infections treated with it stated "generally an infection in an antibiotic." The DON unaware if the facility tracked intibiotic use including e and gastrointestinal DON indicated infections inthly and quarterly tracked. The ded infection/Exposure Control tion signed and dated 8/1/16, lling to work in an environment sease may be present such as the HIV, Hepatitis A,B,C, skin ctions, and other bacterial or Do monthly surveillance of the staff and residents.				
	review and revise p to components of the Facility staff could be surveillance for res The director of nurs	of Correction: sing and/or designee could policies and procedures related the infection control program. the educated on the proper tident infections in the facility. The sing and/or designee could the system to ensure				

Minnesota Department of Health

STATE FORM 6899 RNJ711 If continuation sheet 5 of 6

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE COMP	(X3) DATE SURVEY COMPLETED	
		00153	B. WING		05/2	25/2016	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 800 SPRUCE AVENUE BARRETT, MN 56311							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE	
21375	Continued From page 5		21375				
	compliance						
	Time Period For Codays.	orrection: Twenty one- (21)					

Minnesota Department of Health

STATE FORM 6899 RNJ711 If continuation sheet 6 of 6