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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: X3Q1

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

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 **04/19/2018** (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:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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):

17. SURVEYOR SIGNATURE Date :
Susan Bachleitner, HFE NE II 05/08/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Michaelyn Bruer, Enforcement Specialist 05/08/2018 (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
04/30/2018
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245575

May 9, 2018

Ms. Jeanine Junker, Administrator
Barrett Care Center Inc
800 Spruce Avenue
Barrett, MN 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 April 16, 2018 the above facility is certified for or recommended 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.

Please contact me if you have any questions.

Sincerely,

Michaelyn Bruer, Enforcement Specialist
Minnesota Department of Health
Health Regulation Division
Program Assurance Unit
phone 651-201-4117 fax 651-215-9697
email: michaelyn.bruer@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 9, 2018

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

RE: Project Number S5575028

Dear Ms. Junker:

On March 23, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on March 9, 2018. 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 April 19, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on March 30, 2018 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 March 9, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 16, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on March 9, 2018, effective April 16, 2018 and therefore remedies outlined in our letter to you dated March 23, 2018, 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.

Sincerely,

Michaelyn Bruer, Enforcement Specialist
Minnesota Department of Health
Health Regulation Division
Program Assurance Unit
phone 651-201-4117 fax 651-215-9697
email: michaelyn.bruer@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

May 9, 2018

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

Re: Reinspection Results - Project Number S5575028

Dear Ms. Junker:

On April 19, 2018 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 March 9, 2018, with orders received by you on March 27, 2018. At this time these correction orders were found corrected.

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.

Please feel free to call me with any questions.

Sincerely,

Michaelyn Bruer, Enforcement Specialist
Minnesota Department of Health
Health Regulation Division
Program Assurance Unit
phone 651-201-4117 fax 651-215-9697
email: michaelyn.bruer@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: X3Q1

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00153

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2.STATE VENDOR OR MEDICAID NO.
(L2) **879240200**

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(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 **03/09/2018** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
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FISCAL YEAR ENDING DATE: (L35)
09/30

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From (a) :
To (b) :

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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 __ 6. Scope of Services Limit
__ 3. 24 Hour RN __ 7. Medical Director
__ 4. 7-Day RN (Rural SNF) __ 8. Patient Room Size
__ 5. Life Safety Code __ 9. Beds/Room

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
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(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):

17. SURVEYOR SIGNATURE Date :
Denise Erickson, HFE NE II 04/14/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Debby Baker, Enforcement Specialist 04/25/2018 (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)

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10/01/1991
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23. LTC AGREEMENT BEGINNING DATE
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(L25)

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(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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 23, 2018

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

RE: Project Number S5575028

Dear Ms. Junker:

On March 9, 2018, 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 electronically delivered CMS-2567 whereby corrections are required.

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:

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

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

Remedies - 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;

Potential Consequences - 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 an "F" tag) and emergency preparedness deficiencies (those preceded by an “E” 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
1505 Pebble Lake Road, Suite 300
Fergus Falls, Minnesota 56537-3858
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 April 18, 2018, 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 April 18, 2018 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 June 9, 2018 (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 September 9, 2018 (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
445 Minnesota Street, Suite 145

St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Michaelyn Bruer, Enforcement Specialist
Minnesota Department of Health
Health Regulation Division
Program Assurance Unit
phone 651-201-4117 fax 651-215-9697
email: michaelyn.bruer@state.mn.us

cc: Licensing and Certification File

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 _____	03/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BARRETT CARE CENTER INC	800 SPRUCE AVENUE BARRETT, MN 56311

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted March 6, 7, 8, 9, of 2018, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
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 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part.	F 561		4/16/18

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

Electronically Signed | 03/29/2018

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 _____	03/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BARRETT CARE CENTER INC	800 SPRUCE AVENUE BARRETT, MN 56311

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 561	Continued From page 1 §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure identified preferences for food choices were honored for 1 of 1 residents (R34) reviewed for choices. Findings include: R34's quarterly Minimum Data Set (MDS) dated 2/14/18, indicated R34 was cognitively intact, had diagnoses which included multiple sclerosis (MS), depression and fatigue. The MDS indicated R34 was able to understand others, express her ideas and wants with no difficulty, and was independent with eating after set up help from staff. During an interview on 3/6/18, at 1:22 p.m. R34 stated the food was "crap", lacked seasoning; the vegetables were not cooked and were hard. R34 indicated she had talked to the dietary manager (DM) several times at care conferences about this issue. R34 stated the DM did not say anything when the subject was brought up at care	F 561	Submission of the response and plan of correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited, and is not construed as an admission of fault by the facility, or any of its employees, or any individuals that may be discussed in the response and plan of correction. In addition, preparation and submission of this plan of correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly the facility has prepared and submitted this plan of correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a plan of correction within 10 days of the survey as a condition to participate in title 18 and title 19 programs. The Plan of	

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 _____	03/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BARRETT CARE CENTER INC	800 SPRUCE AVENUE BARRETT, MN 56311

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 561	Continued From page 2 conferences, except you must be eating your gaining weight. R34 stated she was on a regular diet and stated, "I don't bother asking for something different, not worth saying." R34 stated this was what the facility cooked and you do not get a choice. R34 stated, "I don't really eat anymore. I am a picky eater." R34 stated she had told them (facility staff) what her favorite foods are. R34 stated, "They look at me like I'm crazy." R34 stated she liked steak, potatoes, coleslaw and raw carrots. R34 stated, "All you get is cooked carrots and green beans with no seasoning." R34 stated the food for the holidays was good and stated, "Why can't they make it that way all the time." R34 was observed on 3/6/18, at 6:17 p.m. during the supper meal. R34 was sitting in her wheelchair at the end of the dining room table by the window. R34 was eating her supper independently which consisted of macaroni and cheese, broccoli, fruit cocktail water and coffee. R34 ate everything except for her broccoli, which had not been touched. R34 was observed during the breakfast meal on 3/8/18, at 8:28 a.m. R34 was in her room sitting in a recliner by the window. Cook (C)-A knocked, entered R34's room to deliver her breakfast tray and sat it on the bedside table in front of her. C-A assisted R34 to put her clothing protector on, uncovered R34's drinks and set her breakfast up for her, which consisted of cream of wheat cereal, boiled egg, coffee, water and cranberry juice. C-A asked R34 if she needed anything else and R34 stated in a frustrated tone of voice "I guess it is ok." C-A left the room and did not respond to R34's comment about the food that was served to her. After C-A left the room, R34 was asked how	F 561	correction is submitted as the facility's credible allegation of compliance. The allegation of compliance is met as evidence by all residents have the right to choose activities, schedules, providers, and plan of care of his/her choosing. Resident preference sheets (which already include food preferences) are currently done and have been done upon admission, and updated at care conferences. Form updated to include resident signature and will be revised at each care conference and put in chart. The menu has been updated to include all options of food choices at meals on each day. All residents receive a copy of the menu for the week. All staff were educated on resident choices at meal times and other options available. Meals and the quality of meals have been and will continue to be on our annual customer satisfaction survey and reviewed and voted on at resident council meetings with no concerns. An audit will be done weekly for 3 months to assure compliance with monitoring resident preferences for food items and that second options are listed on the menu. This will be submitted to the QAPI committee for review and follow-up as needed. Date certain 4/16/2018	

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her breakfast was and she stated in frustrated voice "I like grape juice, but whatever." R34 indicated that she prefers grape juice but it all depends on who was doing the trays for the day. R34 began to eat her breakfast independently in her room.

Review of the Barret Care Center Menu from 3/5/18 to 3/11/18 only listed the main food entree served for the day. The menu did not list any other alternatives or food choices that were available.

R34 menu card indicated R34 was on a small portion, no added salt diet. The menu card indicated R34 likes for breakfast: 4 ounces of cranberry juice and 4 ounces of grape juice, poached egg, one-quarter cup of cereal and coffee for supper: R34 liked green beans or corn only for cooked vegetables. The menu card also listed dislikes such as milk, peppers, mushrooms and tomatoes.

R34's current care plan revised on 2/22/18, indicated R34 had potential nutritional problem related to MS, depression and disorder of cartilage. The care plan interventions included: assess likes and dislikes and alter menu to meet R34's needs and provide printed menu for R34 to make choices weekly and assist where necessary.

R34's Care Conference Review Notes reviewed from 6/13/17 to 2/20/18 indicated a check mark was noted for review of current weights, diet orders and nutritional supplements. The Care Conference Notes indicated, R34 would eat in room most of the time, had meal replacement shakes she can have when desired and

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continued to gain weight and will use clothing protector for meals. The care conference notes lack any discussion of R34's food choices, preferences or concerns regarding the food.

R34's dietary notes were reviewed from 6/20/17 to 2/20/18 and lacked any documentation regarding discussions with R34 about food choices, preferences or concerns regarding the food.

R34's quarterly Nutritional Assessment dated 2/20/18, indicated R34 was on a small portions, no added salt diet. The assessment indicated R43 ate in the dining room for evening meals and had room trays for breakfast and lunch. The assessment lacked any documentation about R34's food choices, preferences or concerns regarding food.

On 3/8/18, at 8:16 a.m. R34 stated she did get a menu every week and if there was something on the menu she did not like, she got a bowl of cheerios. R34 indicated there was no other options on the menu to pick from and stated the dietary staff had not talked to her about alternatives foods. R34 stated she had been frustrated because she had brought it up (her concerns with the food) many times in care conferences and stated, "They don't do anything, they say they will do it, but they don't."

On 3/8/18, at 9:12 a.m. cook (C)-A stated R34 was independent with eating, will tell you if she needed something or help setting up. C-A stated R34 ate all of her food if she liked it and if she did not like it, she won't touch it. C-A stated R34 had a menu card they followed in the kitchen and stated R34 liked greens beans and corn. C-A

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stated R34 asked for a bowl of oatmeal if she did not like what was on the menu. C-A stated R34 had complained about the vegetables and stated they usually had green beans for her as the other choice. C-A stated they (the facility) did not serve an alternative meal right now because they had tried it in the past and it caused a lot of confusion with the residents not knowing what they wanted.

On 3/8/18, at 9:21 a.m. the dietary manager (DM) stated she attended care conferences for R34 on a regular basis. The DM stated R34 did not like many vegetables and stated corn and green beans were her favorite. The DM stated R34 had voiced concerns about meals at care conferences in the past, but not at the last care conference. The DM stated R34 did have a menu in her room, and if R34 did not like what was being served, R34 was aware other choices were available which included, sandwiches, hamburger, or soup. The DM verified R34 had talked to her about the vegetables not being cooked; being hard and that she did not like them. The DM stated they had not come up with a resolution to fix the problem and stated R34, "says never mind." The DM stated she had never asked R34 why she says never mind. The DM indicated she thought R34 was frustrated in general and indicated that she would be visiting with R34 in the future about these issues.

Review of facility policy titled, Exercise Of Rights dated 11/16, indicated residents have the freedom of choice about how they wish to live their lives everyday lives and receive care, subject to out facility's rules and regulations affecting resident conduct and those regulations governing protection of the resident health and safety.

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F 561	Continued From page 6 Review of facility policy untitled and undated, indicated Barret Care Center (BCC) will offer an alternate meal equal to 3 ounces of protein at meals. Under number 1) alternate meal will consist of soup and sandwich unless otherwise posted, 2) BCC always has on hand other alternates such as: yogurt, cottage cheese, cheese, peanut butter and jelly, hot/dry cereals, Jell-O and beverages.	F 561		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in	F 755		4/16/18

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F 755	Continued From page 7 sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a system for reconciliation of controlled medications to prevent potential loss or diversion for 1 of 1 medication storage rooms in the facility. Findings include: On 3/6/18, at 5:33 p.m. a medication storage room tour was conducted with registered nurse (RN)-B, below the counter of the medication storage room was a locked cabinet. RN-B obtained the key and unlocked the cabinet located under the counter. Inside the locked cabinet contained a white sheet of paper titled, "Certificate Of The Inventory And Destruction Of Controlled Substances" and three bottles of medications. The three bottles of medication were Lorazepam (sedative) 2 milligrams (ml)/ milliliter (ml), which contained 26.5 ml left in the bottle, Morphine (pain medication) 20 mg/ml, which contained 25 ml left in the bottle and Roxicodone (pain medication) 5 mg which contained 73 tablets. The Certificate Of The Inventory And Destruction Of Controlled Substances sheet had columns listed on it to list the prescription (RX) number, drug name, strength, quantity, date, administrator/nurse and pharmacist. After review the Certificate it only listed RX number-0764847, drug name-Lorazepam, strength-2 mg/ml,	F 755	The allegation of compliance is met as evidence by: Policy and procedure for safely managing discontinued narcotic medications has been revised to include action of documenting the discontinued narcotic on the "The certificate of the inventory and destruction of controlled substances" sheet at the time of discontinuation. Nurses will be provided education on the revised policy and procedure. An audit will be conducted weekly for 3 months to monitor compliance. Audits will be reviewed by the Director of Nursing and results of the audit will be presented to the QAPI committee for review and follow up as needed. Director of Nursing is responsible to assure on-going compliance. Date Certain 04/16/2018	

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F 755	Continued From page 8 quantity-26.5 ml and the date was blank. The Certificate did not list the other two controlled medications Morphine or Roxicodone. On 3/6/18, at 6:03 p.m. RN-B stated the pharmacy came once a month to the facility to destroy controlled medications with another nurse and was just at the facility on 2/8/18. RN-B confirmed findings and indicated all controlled medications are to be logged on the Certificate, locked up in the cabinet until the pharmacy comes to destroy them with another nurse every month. RN-B stated her expectations of staff would be to fill out the Certificate and to log the controlled medication correctly. RN-B stated staff needed to log the controlled medications on the Certificate to track the controlled medications for accountability and to prevent diversion. RN-B stated the nursing staff were not always good about writing the controlled medications on the Certificate form to track On 3/8/18, at 1:34 p.m. the Administrator stated she expected staff to destroy medications with two staff members and follow the facility policy to prevent possible drug diversion. Review of the Destroying Medications policy revised on 9/2003, indicated the drug disposition record must contain as a minimum the following: residents name, date drug destroyed, name of the drug, strength, prescription number, issuing pharmacy, quantity destroyed, method of destruction, reason for destruction and signatures of witnesses.	F 755		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		4/16/18

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F 880	Continued From page 9 §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation,	F 880		

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F 880	Continued From page 10 depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to maintain an on-going infection control program, which included comprehensive surveillance of resident infections to identify and analyze possible patterns of infection in the facility, including identification of any patterns in residents, locations or pathogens in real time to prevent the spread of communicable disease and infections. This deficient practice had the potential to affect all 38 residents who resided in the facility.	F 880	The allegation of compliance is met as evidence by A standardized log will be used to monitor infections and analyze patterns to prevent the spread of communicable diseases and infections throughout the facility. Education was provided to staff related to logging non antibiotic symptoms/infections that are not treated with an antibiotic. Infection preventionist will audit the log 3 days per week for 3 months. The Director of Nursing will report results and trends of all	

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F 880	Continued From page 11 Findings include: Review of the facility's infection control surveillance program was conducted on 03/07/18, at 2:12 p.m. The infection logs included the following columns: date, resident name, signs/symptoms, culture/organism, treatment and date resolved. However, the logs failed to identify resident's room or unit location, location infection acquired, criteria met, date resolved, analysis of data or any follow up activities. Review of the Monthly Infection Reports from 5/17 through 3/18, included: -May 2017, infection log entries included ten residents and included date, resident's name, and signs/symptoms. The log listed various infections including skin/wound, upper respiratory, pneumonia, peritonitis and emesis. Six entries included antibiotic as a treatment. None of the entries listed on the infection log included the resident room number, if community or nursing home acquired or criteria met. In addition, the May 2017 infection log included entries for April 2017 and June 2017. -June 2017, infection log entries included eight residents listed with various infections including skin/wound, upper respiratory, urinary tract, ear and emesis. One entry did not identify symptoms. Seven entries included antibiotic as a treatment. None of the entries listed the resident room number, location acquired, culture, organism identified, criteria met and date resolved. In addition, the June 2017 infection log included one May 2017 entry between two 6/1/17, entries. -July 2017, infection log entries included twelve	F 880	audits for 3 months to the QAPI Committee for review and follow-up as need. Date certain 4/16/2018	

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residents listed with various infections including skin/wound, urinary tract, pneumonia, vomiting, and abnormal sputum. None of the entries listed the resident room number, criteria met and date resolved, did not consistently included acquired infection for resident. The logs also lacked inclusion of residents with infections not treated by antibiotics.

-August 2017, infection log entries included nine residents listed with various infections and/or symptoms including skin/wound, flank pain, emesis, disarticulates and unknown. None of the entries listed the resident room number, criteria met, location infection acquired or date resolved.

-September 2017, infection log entries included eight residents listed with various infections and/or symptoms listed including cellulitis, wound, eye, bronchitis, shortness of breath, cough and bad looking chest X-ray. One entry indicated a culture was performed, but no results listed. None of the entries listed the resident room number, criteria met, location infection acquired or date resolved.

-October 2017, infection log entries included six residents listed with various infections and/or symptoms including urinary tract infections, elevated temperature and diarrhea. One entry identified a resident returned from the hospital with antibiotic treatment, but no infection identified. None of the entries listed the resident room number, criteria met, location infection acquired or date resolved.

-November 2017, infection log entries included eight residents listed with various infections and/or symptoms including urinary tract infection,

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abscess tooth, elevated temperature, lethargy, crying out and eye discharge. None of the entries listed resident room number, criteria met, pathogen identified, location infection acquired or date resolved.

-December 2017, infection log entries included sixteen residents listed with various infections and/or symptoms including skin, sore throat, lethargy, cough, shingles, diminished lung sounds, low-grade temperature, increased behaviors, pneumonia, wound e-coli, congestion and yellow phlegm. None of the entries listed resident room number, criteria met, location infection acquired or date resolved.

-January 2018, infection log entries included six residents listed with infections and/or symptoms including urinary tract infection, low-grade temperature, confusion, rash, increased phlegm, chest x-ray and pneumonia. None of the entries listed resident room number, pathogen identified, criteria met, location infection acquired or date resolved.

-February 2018, infection log entries included eight residents listed with infections and/or symptoms including increased white blood count, aspiration pneumonia, paronychia (nail disease), cough, lower respiratory infection/CHF (congestive heart failure), exacerbated COPD (chronic obstructive pulmonary disease) and abscess of abdomen. None of the entries listed resident room number, pathogen identified, criteria met, location infection acquired or date resolved.

-March 2018, infection log entry included one resident listed with infections and/or symptoms

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including pneumonia, kidney, dehydration and upper respiratory infection. The entry did not include pathogen identified, resident room number, criteria met, location infection acquired or date resolved.

On 3/7/18, at 2:12 p.m. registered nurse (RN)-A confirmed she was the infection control nurse for the facility, stated she was new to the position and was currently taking on-line education courses for the infection preventionist position. RN-A reviewed the infection log entries with surveyor, and confirmed she had just made the March entry prior to the review. RN-A confirmed she was the only one who made entries on the form and no one did tracking while she was gone. RN-A indicated they do not track resident locations, since she knew where the residents' rooms were and confirmed she only tracked residents who had infections treated by antibiotics. RN-A confirmed the facility currently had a resident on isolation precautions for MRSA, but had not started to track the wound infections. RN-A stated she was aware the infection log tracking forms were not thorough. RN-A stated the infection control logs were completed and shared at quality assurance meetings. RN-A indicated she had just received training that day on what to do if a pattern was found with infections in the facility. RN-A indicated the facility was working on starting over their infection control program including the policy and procedures.

On 3/7/18, at 2:56 p.m. the administrator confirmed RN-A just started in her role for the infection control program. The administrator stated the last RN in charge left in November. The administrator stated RN-A was still in training

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BARRETT CARE CENTER INC	800 SPRUCE AVENUE BARRETT, MN 56311

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 15 and stated the tracking form was reviewed and discussed quarterly at Quality Assurance meetings to see if a pattern was found. The administrator would neither confirm nor deny the infection control program was not fully functioning. The Surveillance for Healthcare-Associated Infections Barrett Care Center policy reviewed 8/30/17, included surveillance would include gathering of surveillance data, calculation of infection rates and interpretation of surveillance data. Multiple data listed to include as appropriate identifying information, including resident room number, unit, attending physician, pathogens, preventative measures and comments. The policy also instructed staff to analyze the data to identify trends.	F 880		
F 881 SS=F	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to fully implement an antibiotic stewardship program. This deficient practice had the potential to affect all 38 residents who resided in the facility.	F 881	The allegation of compliance is met as evidence by the Infection Preventionist will be educated on the antibiotic stewardship program. The Antibiotic Stewardship Program Policy will be followed when developing the program the Minnesota	4/16/18

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 _____	03/09/2018

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F 881	Continued From page 16 Findings include: A review of the facility's infection control surveillance program was conducted on 03/07/18, at 2:12 p.m. which identified the facility lacked an antibiotic stewardship program. The infection control program lacked protocols for a facility-wide system to monitor the use of antibiotics which included (but not limited to) appropriate prescribing of antibiotics and periodic review of antibiotic use by physicians. The program also lacked protocols for review of signs and symptoms, labs, determination of appropriate antibiotic use and reporting of any patterns identified. On 3/07/18, 2:12 p.m. registered nurse (RN)-A confirmed she was the facility infection control nurse. RN-A indicated she was new to the position and was currently in training. RN-A confirmed the facility did not have an antibiotic stewardship program in place, but had begun some protocols. RN-A stated the nurses had a form with criteria to use prior to contacting the physician related to resident infections. RN-A indicated the facility had usually not obtained cultures prior to antibiotic use or received antibiotic sensitivity reports. RN-A stated she wanted to meet with the director of nursing, medical director and administrator to decide on what protocol the facility would use in the future for their antibiotic stewardship program. RN-A stated letters were sent out to families and physicians to provide education on antibiotic stewardship, but no further tracking or analysis of antibiotic use had been started. On 3/07/18, at 2:56 p.m. the administrator confirmed she was aware some pieces of the	F 881	Department of Health web will be viewed by the infection control preventionist on the Antibiotic stewardship program. Audits will be conducted 2 x per week for 3 months to ensure antibiotic stewardship program has been effectively implemented. Director of Nursing will report results and trends of all audits to the QAPI Committee for review and follow-up as need. Date certain 4/16/2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 881	Continued From page 17 antibiotic stewardship program was missing. The administrator confirmed RN-A had just started the infection prevention program the first of the year and confirmed RN-A was still in training for the position. The administrator stated more education and re-education was needed for the facility staff and physicians. The administrator stated the facility had sent out letters to families and physicians with antibiotic stewardship education, but indicated she intended to send out letters again. The Antibiotic Stewardship Program (ASP) undated policy included, the Barrett Care Center ASP included core elements of leadership, accountability, drug expertise, actions, tracking, reporting and education. The facility would review and discuss data and use an antibiotic use algorithm. The ASP would be a standing agenda item of the facility quality assurance quarterly meeting. The policy included monitoring, tracking and review of providers, pharmacy and lab reports and antibiotic resistance patterns.	F 881		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245575	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/06/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BARRETT CARE CENTER INC	**800 SPRUCE AVENUE** **BARRETT, MN 56311**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS	K 000		

Baumann, Robert
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 compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code.

"If participating in the E-POC process, a paper copy of the plan of correction is not required."

PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:

Health Care Fire Inspections

EPOC

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/27/2018

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245575	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/06/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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
K 000	Continued From page 1 State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101 Or by e-mail to: Marian.Whitney@state.mn.us and 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 an addition was constructed to the North Wing is Type II (111) construction. In 2015 a wing addition was added to the Northeast corner of	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245575	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/06/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BARRETT CARE CENTER INC	**800 SPRUCE AVENUE** **BARRETT, MN 56311**

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K 000	Continued From page 2 the building and is type V (111). The building is fully sprinkler protected in accordance with NFPA 13 Standard for the Installation of Automatic Sprinkler Systems. The facility has a manual fire alarm system with smoke detection in the corridors of 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". Since the original building and earlier additions are differenct construction types and the latest construction was 2015 it was surveyed as as two buildings and as of July 5, 2016 all buildings are considered existing. The facility has a capacity of 45 beds and had a census of 39 the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 353 SS=E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked	K 353		3/27/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245575	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/06/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 353	Continued From page 3 b) Who provided system test c) Water system supply source Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the sprinkler system in accordance with the 2012 Life Safety Code (NFPA 101) and NFPA 25 section 5.2.1.1.2. The standard for testing and maintenance of sprinkler systems. This deficient condition could cause the sprinkler system not to function properly and allow for the spread of fire. This could affect all of the 22 of the 45 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 12:00 pm and 3:00 pm on 03/06/2018 observations revealed three sprinkler heads in the kitchen were covered with dust and dirt. This deficient condition was confirmed by the Facility Administrator and the Maintenance Supervisor.	K 353	Preparation, submission, and implementation of this plan of correction does not constitute admission or agreement with the facts and conclusions set forth on the survey report. Our Plan of correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. The facility does assure that the three sprinkler heads in the kitchen are clean and in working order. All of the sprinklers are checked, tested, maintained and recorded per requirements. Date certain 3/26/2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245575	A. BUILDING **02 - 2015 ADDITION** B. WING _____	**03/06/2018**

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K 000	INITIAL COMMENTS FIRE SAFETY Bldg 2 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 in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. 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 an addition was constructed to the North Wing is Type II (111) construction. In 2015 a wing addition was added to the Northeast corner of the building and is type V (111). The building is fully sprinkler protected in accordance with NFPA 13 Standard for the Installation of Automatic Sprinkler Systems. The facility has a manual fire alarm system with smoke detection in the corridors of the 1982	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/27/2018

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245575	A. BUILDING **02 - 2015 ADDITION** B. WING _____	**03/06/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	Continued From page 1 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". Since the original building and earlier additions are differenct construction types and the latest construction was 2015 it was surveyed as as two buildings and as of July 5, 2016 all buildings are considered existing. The facility has a capacity of 45 beds and had a census of 39 the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET as evidenced by:	K 000		

Electronically delivered
March 23, 2018

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

Re: State Nursing Home Licensing Orders - Project Number S5575028

Dear Ms. Junker:

The above facility was surveyed on March 6, 2018 through March 9, 2018 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

the Suggested Method of Correction and the Time Period For Correction.

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Gail Anderson, Unit Supervisor, at (218) 332-5140 or 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.

Please feel free to call me with any questions.

Sincerely,

Michaelyn Bruer, Enforcement Specialist
Minnesota Department of Health
Health Regulation Division
Program Assurance Unit
phone 651-201-4117 fax 651-215-9697
email: michaelyn.bruer@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00153	A. BUILDING: _____ B. WING _____	03/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BARRETT CARE CENTER INC	800 SPRUCE AVENUE BARRETT, MN 56311

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: 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	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. 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. On 3/6/18-3/9/18, surveyors of this Department's staff visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. 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 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 which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and 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.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by:	21390		4/16/18

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21390	Continued From page 3 Based on interview and document review, the facility failed to maintain an on-going infection control program, which included comprehensive surveillance of resident infections to identify and analyze possible patterns of infection in the facility, including identification of any patterns in residents, locations or pathogens in real time to prevent the spread of communicable disease and infections. In addition, the facility failed to fully implement an antibiotic stewardship program for the facility. This deficient practice had the potential to affect all 38 residents who resided in the facility. Findings include: Review of the facility's infection control surveillance program was conducted on 03/07/18, at 2:12 p.m. The infection logs included the following columns: date, resident name, signs/symptoms, culture/organism, treatment and date resolved. However, the logs failed to identify resident's room or unit location, location infection acquired, criteria met, date resolved, analysis of data or any follow up activities. The infection control program lacked protocols for a facility-wide system to monitor the use of antibiotics which included (but not limited to) appropriate prescribing of antibiotics and periodic review of antibiotic use by physicians. The program also lacked protocols for review of signs and symptoms, labs, determination of appropriate antibiotic use and reporting of any patterns identified. Review of the Monthly Infection Reports from 5/17 through 3/18, included: -May 2017, infection log entries included ten residents and included date, resident's name, and	21390	Corrected	

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signs/symptoms. The log listed various infections including skin/wound, upper respiratory, pneumonia, peritonitis and emesis. Six entries included antibiotic as a treatment. None of the entries listed on the infection log included the resident room number, if community or nursing home acquired or criteria met. In addition, the May 2017 infection log included entries for April 2017 and June 2017.

-June 2017, infection log entries included eight residents listed with various infections including skin/wound, upper respiratory, urinary tract, ear and emesis. One entry did not identify symptoms. Seven entries included antibiotic as a treatment. None of the entries listed the resident room number, location acquired, culture, organism identified, criteria met and date resolved. In addition, the June 2017 infection log included one May 2017 entry between two 6/1/17, entries.

-July 2017, infection log entries included twelve residents listed with various infections including skin/wound, urinary tract, pneumonia, vomiting, and abnormal sputum. None of the entries listed the resident room number, criteria met and date resolved, did not consistently included acquired infection for resident. The logs also lacked inclusion of residents with infections not treated by antibiotics.

-August 2017, infection log entries included nine residents listed with various infections and/or symptoms including skin/wound, flank pain, emesis, disarticulates and unknown. None of the entries listed the resident room number, criteria met, location infection acquired or date resolved.

-September 2017, infection log entries included eight residents listed with various infections

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and/or symptoms listed including cellulitis, wound, eye, bronchitis, shortness of breath, cough and bad looking chest X-ray. One entry indicated a culture was performed, but no results listed. None of the entries listed the resident room number, criteria met, location infection acquired or date resolved.

-October 2017, infection log entries included six residents listed with various infections and/or symptoms including urinary tract infections, elevated temperature and diarrhea. One entry identified a resident returned from the hospital with antibiotic treatment, but no infection identified. None of the entries listed the resident room number, criteria met, location infection acquired or date resolved.

-November 2017, infection log entries included eight residents listed with various infections and/or symptoms including urinary tract infection, abscess tooth, elevated temperature, lethargy, crying out and eye discharge. None of the entries listed resident room number, criteria met, pathogen identified, location infection acquired or date resolved.

-December 2017, infection log entries included sixteen residents listed with various infections and/or symptoms including skin, sore throat, lethargy, cough, shingles, diminished lung sounds, low-grade temperature, increased behaviors, pneumonia, wound e-coli, congestion and yellow phlegm. None of the entries listed resident room number, criteria met, location infection acquired or date resolved.

-January 2018, infection log entries included six residents listed with infections and/or symptoms including urinary tract infection, low-grade

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temperature, confusion, rash, increased phlegm, chest x-ray and pneumonia. None of the entries listed resident room number, pathogen identified, criteria met, location infection acquired or date resolved.

-February 2018, infection log entries included eight residents listed with infections and/or symptoms including increased white blood count, aspiration pneumonia, paronychia (nail disease), cough, lower respiratory infection/CHF (congestive heart failure), exacerbated COPD (chronic obstructive pulmonary disease) and abscess of abdomen. None of the entries listed resident room number, pathogen identified, criteria met, location infection acquired or date resolved.

-March 2018, infection log entry included one resident listed with infections and/or symptoms including pneumonia, kidney, dehydration and upper respiratory infection. The entry did not include pathogen identified, resident room number, criteria met, location infection acquired or date resolved.

On 3/7/18, at 2:12 p.m. registered nurse (RN)-A confirmed she was the infection control nurse for the facility, stated she was new to the position and was currently taking on-line education courses for the infection preventionist position. RN-A reviewed the infection log entries with surveyor, and confirmed she had just made the March entry prior to the review. RN-A confirmed she was the only one who made entries on the form and no one did tracking while she was gone. RN-A indicated they do not track resident locations, since she knew where the residents' rooms were and confirmed she only tracked residents who had infections treated by

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antibiotics. RN-A confirmed the facility currently had a resident on isolation precautions for MRSA, but had not started to track the wound infections. RN-A stated she was aware the infection log tracking forms were not thorough. RN-A stated the infection control logs were completed and shared at quality assurance meetings. RN-A indicated she had just received training that day on what to do if a pattern was found with infections in the facility. RN-A indicated the facility was working on starting over their infection control program including the policy and procedures.

Further, RN-A confirmed the facility did not have an antibiotic stewardship program in place, but had begun some protocols. RN-A stated the nurses had a form with criteria to use prior to contacting the physician related to resident infections. RN-A indicated the facility had usually not obtained cultures prior to antibiotic use or received antibiotic sensitivity reports. RN-A stated she wanted to meet with the director of nursing, medical director and administrator to decide on what protocol the facility would use in the future for their antibiotic stewardship program. RN-A stated letters were sent out to families and physicians to provide education on antibiotic stewardship, but no further tracking or analysis of antibiotic use had been started.

On 3/7/18, at 2:56 p.m. the administrator confirmed RN-A just started in her role for the infection control program. The administrator stated the last RN in charge left in November. The administrator stated RN-A was still in training and stated the tracking form was reviewed and discussed quarterly at Quality Assurance meetings to see if a pattern was found. The administrator would neither confirm nor deny the

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infection control program was not fully functioning.
the administrator confirmed she was aware some pieces of the antibiotic stewardship program was missing. The administrator stated more education and re-education was needed for the facility staff and physicians. The administrator stated the facility had sent out letters to families and physicians with antibiotic stewardship education, but indicated she intended to send out letters again.

The Surveillance for Healthcare-Associated Infections Barrett Care Center policy reviewed 8/30/17, included surveillance would include gathering of surveillance data, calculation of infection rates and interpretation of surveillance data. Multiple data listed to include as appropriate identifying information, including resident room number, unit, attending physician, pathogens, preventative measures and comments. The policy also instructed staff to analyze the data to identify trends.

The Antibiotic Stewardship Program (ASP) undated policy included, the Barrett Care Center ASP included core elements of leadership, accountability, drug expertise, actions, tracking, reporting and education. The facility would review and discuss data and use an antibiotic use algorithm. The ASP would be a standing agenda item of the facility quality assurance quarterly meeting. The policy included monitoring, tracking and review of providers, pharmacy and lab reports and antibiotic resistance patterns.

SUGGESTED METHOD FOR CORRECTION:
The director of nursing could review and revise the policies and procedures related to infection control surveillance and antibotic stewardship

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21390	Continued From page 9 program. The director of nursing or designee could provide education to all involved staff. The facility could develop a monitoring system to ensure ongoing compliance and report the findings to the Qualify Assurance Committee. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21390		
21550	MN Rule 4658.1325 Subp. 1 Adminiatration of Medications; Pharmacy Serv. Subpart 1. Pharmacy services. A nursing home must arrange for the provision of pharmacy services. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a system for reconciliation of controlled medications to prevent potential loss or diversion for 1 of 1 medication storage rooms. This deficient practice had potential to affect all 38 residents who resided in the facility. Findings include: On 3/6/18, at 5:33 p.m. a medication storage room tour was conducted with registered nurse (RN)-B, below the counter of the medication storage room was a locked cabinet. RN-B obtained the key and unlocked the cabinet located under the counter. Inside the locked cabinet contained a white sheet of paper titled, "Certificate Of The Inventory And Destruction Of Controlled Substances" and three bottles of	21550	Corrected	4/16/18

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21550	Continued From page 10 medications. The three bottles of medication were Lorazepam (sedative) 2 milligrams (ml)/ milliliter (ml), which contained 26.5 ml left in the bottle, Morphine (pain medication) 20 mg/ml, which contained 25 ml left in the bottle and Roxicodone (pain medication) 5 mg which contained 73 tablets. The Certificate Of The Inventory And Destruction Of Controlled Substances sheet had columns listed on it to list the prescription (RX) number, drug name, strength, quantity, date, administrator/nurse and pharmacist. After review the Certificate it only listed RX number-0764847, drug name-Lorazepam, strength-2 mg/ml, quantity-26.5 ml and the date was blank. The Certificate did not list the other two controlled medications Morphine or Roxicodone. On 3/6/18, at 6:03 p.m. RN-B stated the pharmacy came once a month to the facility to destroy controlled medications with another nurse and was just at the facility on 2/8/18. RN-B confirmed findings and indicated all controlled medications are to be logged on the Certificate, locked up in the cabinet until the pharmacy comes to destroy them with another nurse every month. RN-B stated her expectations of staff would be to fill out the Certificate and to log the controlled medication correctly. RN-B stated staff needed to log the controlled medications on the Certificate to track the controlled medications for accountability and to prevent diversion. RN-B stated the nursing staff were not always good about writing the controlled medications on the Certificate form to track On 3/8/18, at 1:34 p.m. the Administrator stated she expected staff to destroy medications with two staff members and follow the facility policy to prevent possible drug diversion.	21550		

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21550	Continued From page 11 Review of the Destroying Medications policy revised on 9/2003, indicated the drug disposition record must contain as a minimum the following: residents name, date drug destroyed, name of the drug, strength, prescription number, issuing pharmacy, quantity destroyed, method of destruction, reason for destruction and signatures of witnesses. SUGGESTED METHOD OF CORRECTION: The director of nursing and or pharmacist can develop policies, procedures and educated appropriate staff, to safely manage discontinued narcotic medications until they are destroyed. The DON or designee could audit medications to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21550		
21830	MN St. Statute 144.651 Subd. 10 Patients & Residents of HC Fac.Bill of Rights Subd. 10. Participation in planning treatment; notification of family members. (a) Residents shall have the right to participate in the planning of their health care. This right includes the opportunity to discuss treatment and alternatives with individual caregivers, the opportunity to request and participate in formal care conferences, and the right to include a family member or other chosen representative or both. In the event that the resident cannot be present, a family member or other representative chosen by the resident may be included in such conferences.	21830		4/16/18

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21830	Continued From page 12 (b) If a resident who enters a facility is unconscious or comatose or is unable to communicate, the facility shall make reasonable efforts as required under paragraph (c) to notify either a family member or a person designated in writing by the resident as the person to contact in an emergency that the resident has been admitted to the facility. The facility shall allow the family member to participate in treatment planning, unless the facility knows or has reason to believe the resident has an effective advance directive to the contrary or knows the resident has specified in writing that they do not want a family member included in treatment planning. After notifying a family member but prior to allowing a family member to participate in treatment planning, the facility must make reasonable efforts, consistent with reasonable medical practice, to determine if the resident has executed an advance directive relative to the esident's health care decisions. For purposes of this paragraph, "reasonable efforts" include: (1) examining the personal effects of the resident; (2) examining the medical records of the resident in the possession of the facility; (3) inquiring of any emergency contact or family member contacted under this section whether the resident has executed an advance directive and whether the resident has a physician to whom the resident normally goes for care; and (4) inquiring of the physician to whom the resident normally goes for care, if known, whether the resident has executed an advance directive. If a facility notifies a family member or designated emergency contact or allows a family member to participate in treatment planning in accordance with this paragraph, the facility is not	21830		

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21830	Continued From page 13 liable to resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights. (c) In making reasonable efforts to notify a family member or designated emergency contact, the facility shall attempt to identify family members or a designated emergency contact by examining the personal effects of the resident and the medical records of the resident in the possession of the facility. If the facility is unable to notify a family member or designated emergency contact within 24 hours after the admission, the facility shall notify the county social service agency or local law enforcement agency that the resident has been admitted and the facility has been unable to notify a family member or designated emergency contact. The county social service agency and local law enforcement agency shall assist the facility in identifying and notifying a family member or designated emergency contact. A county social service agency or local law enforcement agency that assists a facility in implementing this subdivision is not liable to the resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure identified preferences for food choices were honored for 1 of 1 residents (R34) reviewed for choices.	21830	Corrected	

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21830	Continued From page 14 Findings include: R34's quarterly Minimum Data Set (MDS) dated 2/14/18, indicated R34 was cognitively intact, had diagnoses which included multiple sclerosis (MS), depression and fatigue. The MDS indicated R34 was able to understand others, express her ideas and wants with no difficulty, and was independent with eating after set up help from staff. During an interview on 3/6/18, at 1:22 p.m. R34 stated the food was "crap", lacked seasoning; the vegetables were not cooked and were hard. R34 indicated she had talked to the dietary manager (DM) several times at care conferences about this issue. R34 stated the DM did not say anything when the subject was brought up at care conferences, except you must be eating your gaining weight. R34 stated she was on a regular diet and stated, "I don't bother asking for something different, not worth saying." R34 stated this was what the facility cooked and you do not get a choice. R34 stated, "I don't really eat anymore. I am a picky eater." R34 stated she had told them (facility staff) what her favorite foods are. R34 stated, "They look at me like I'm crazy." R34 stated she liked steak, potatoes, coleslaw and raw carrots. R34 stated, "All you get is cooked carrots and green beans with no seasoning." R34 stated the food for the holidays was good and stated, "Why can't they make it that way all the time." R34 was observed on 3/6/18, at 6:17 p.m. during the supper meal. R34 was sitting in her wheelchair at the end of the dining room table by the window. R34 was eating her supper independently which consisted of macaroni and cheese, broccoli, fruit cocktail water and coffee. R34 ate everything except for her broccoli, which	21830		

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21830	Continued From page 15 had not been touched. R34 was observed during the breakfast meal on 3/8/18, at 8:28 a.m. R34 was in her room sitting in a recliner by the window. Cook (C)-A knocked, entered R34's room to deliver her breakfast tray and sat it on the bedside table in front of her. C-A assisted R34 to put her clothing protector on, uncovered R34's drinks and set her breakfast up for her, which consisted of cream of wheat cereal, boiled egg, coffee, water and cranberry juice. C-A asked R34 if she needed anything else and R34 stated in a frustrated tone of voice "I guess it is ok." C-A left the room and did not respond to R34's comment about the food that was served to her. After C-A left the room, R34 was asked how her breakfast was and she stated in frustrated voice "I like grape juice, but whatever." R34 indicated that she prefers grape juice but it all depends on who was doing the trays for the day. R34 began to eat her breakfast independently in her room. Review of the Barret Care Center Menu from 3/5/18 to 3/11/18 only listed the main food entree served for the day. The menu did not list any other alternatives or food choices that were available. R34 menu card indicated R34 was on a small portion, no added salt diet. The menu card indicated R34 likes for breakfast: 4 ounces of cranberry juice and 4 ounces of grape juice, poached egg, one-quarter cup of cereal and coffee for supper: R34 liked green beans or corn only for cooked vegetables. The menu card also listed dislikes such as milk, peppers, mushrooms and tomatoes. R34's current care plan revised on 2/22/18,	21830		

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indicated R34 had potential nutritional problem related to MS, depression and disorder of cartilage. The care plan interventions included: assess likes and dislikes and alter menu to meet R34's needs and provide printed menu for R34 to make choices weekly and assist where necessary.

R34's Care Conference Review Notes reviewed from 6/13/17 to 2/20/18 indicated a check mark was noted for review of current weights, diet orders and nutritional supplements. The Care Conference Notes indicated, R34 would eat in room most of the time, had meal replacement shakes she can have when desired and continued to gain weight and will use clothing protector for meals. The care conference notes lack any discussion of R34's food choices, preferences or concerns regarding the food.

R34's dietary notes were reviewed from 6/20/17 to 2/20/18 and lacked any documentation regarding discussions with R34 about food choices, preferences or concerns regarding the food.

R34's quarterly Nutritional Assessment dated 2/20/18, indicated R34 was on a small portions, no added salt diet. The assessment indicated R43 ate in the dining room for evening meals and had room trays for breakfast and lunch. The assessment lacked any documentation about R34's food choices, preferences or concerns regarding food.

On 3/8/18, at 8:16 a.m. R34 stated she did get a menu every week and if there was something on the menu she did not like, she got a bowl of cheerios. R34 indicated there was no other options on the menu to pick from and stated the

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BARRETT CARE CENTER INC	800 SPRUCE AVENUE BARRETT, MN 56311

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21830	Continued From page 17	21830		

dietary staff had not talked to her about alternatives foods. R34 stated she had been frustrated because she had brought it up (her concerns with the food) many times in care conferences and stated, "They don't do anything, they say they will do it, but they don't."

On 3/8/18, at 9:12 a.m. cook (C)-A stated R34 was independent with eating, will tell you if she needed something or help setting up. C-A stated R34 ate all of her food if she liked it and if she did not like it, she won't touch it. C-A stated R34 had a menu card they followed in the kitchen and stated R34 liked greens beans and corn. C-A stated R34 asked for a bowl of oatmeal if she did not like what was on the menu. C-A stated R34 had complained about the vegetables and stated they usually had green beans for her as the other choice. C-A stated they (the facility) did not serve an alternative meal right now because they had tried it in the past and it caused a lot of confusion with the residents not knowing what they wanted.

On 3/8/18, at 9:21 a.m. the dietary manager (DM) stated she attended care conferences for R34 on a regular basis. The DM stated R34 did not like many vegetables and stated corn and green beans were her favorite. The DM stated R34 had voiced concerns about meals at care conferences in the past, but not at the last care conference. The DM stated R34 did have a menu in her room, and if R34 did not like what was being served, R34 was aware other choices were available which included, sandwiches, hamburger, or soup. The DM verified R34 had talked to her about the vegetables not being cooked; being hard and that she did not like them. The DM stated they had not come up with a resolution to fix the problem and stated R34, "says never mind." The DM stated she had never asked R34 why she says never

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21830	Continued From page 18 mind. The DM indicated she thought R34 was frustrated in general and indicated that she would be visiting with R34 in the future about these issues. Review of facility policy titled, Exercise Of Rights dated 11/16, indicated residents have the freedom of choice about how they wish to live their lives everyday lives and receive care, subject to out facility's rules and regulations affecting resident conduct and those regulations governing protection of the resident health and safety. Review of facility policy untitled and undated, indicated Barret Care Center (BCC) will offer an alternate meal equal to 3 ounces of protein at meals. Under number 1) alternate meal will consist of soup and sandwich unless otherwise posted, 2) BCC always has on hand other alternates such as: yogurt, cottage cheese, cheese, peanut butter and jelly, hot/dry cereals, Jell-O and beverages. SUGGESTED METHOD OF CORRECTION: The DON or designee could develop policies and procedures regarding resident choices, educate staff, and conduct audits to ensure resident likes, and dislikes are honored by staff. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21830		