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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: 3PML
Facility ID: 00797

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245329**

2. STATE VENDOR OR MEDICAID NO. (L2) **974840700**

3. NAME AND ADDRESS OF FACILITY
(L3) **WARROAD CARE CENTER**
(L4) **1401 LAKE STREET NORTHWEST**
(L5) **WARROAD, MN** (L6) **56763**

4. TYPE OF ACTION: **7** (L8)

1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other 8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **09/21/2017** (L34)

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	

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

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

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

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)

12.Total Facility Beds **49** (L18)

13.Total Certified Beds **49** (L17)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	49			
(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 :
Lyla Burkman, Unit Supervisor 09/29/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Certification Specialist 10/02/2017 (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 **08/01/1986** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

CMS Certification Number (CCN): 245329 September 28, 2017

Mr. Mark Bertilrud, Administrator
Warroad Care Center
1401 Lake Street Northwest
Warroad, MN 56763

Dear Mr. Bertilrud:

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

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

Effective September 15, 2017 the above facility is recommended for:

49 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 49 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,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

Electronically delivered
September 29, 2017

Mr. Mark Bertilrud, Administrator
Warroad Care Center
1401 Lake Street Northwest
Warroad, MN 56763

RE: Project Number S5329026

Dear Mr. Bertilrud:

On August 18, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 3, 2017. 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 September 21, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on September 27, 2017 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 August 3, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 15, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 3, 2017, effective September 15, 2017 and therefore remedies outlined in our letter to you dated August 18, 2017, 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,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@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: 3PML

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(L4) **1401 LAKE STREET NORTHWEST**
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4. CHOW
5. Validation
6. Complaint
7. On-Site Visit
9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

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2 AOA 3 Other

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

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

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13.Total Certified Beds **49** (L17)

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A. In Compliance With Program Requirements Compliance Based On:
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X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

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	49			
(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 :
Theresa Gilligsrud, HFE-NE II — 09/10/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Joanne Simon, Certification Specialist — 09/29/2017 (L20)

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

19. DETERMINATION OF ELIGIBILITY
_____ 1. Facility is Eligible to Participate
_____ 2. Facility is not Eligible
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26. TERMINATION ACTION: (L30)

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29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 18, 2017

Mr. Mark Bertilrud, Administrator
Warroad Care Center
1401 Lake Street Northwest
Warroad, MN 56763

RE: Project Number S5329026

Dear Mr. Bertilrud:

On August 3, 2017, 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

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

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

DEPARTMENT CONTACT

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

Lyla Burkman, Unit Supervisor
Bemidji Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
705 5th Street Northwest, Suite A
Bemidji, Minnesota 56601-2933
Email: lyla.burkman@state.mn.us
Phone: (218) 308-2104
Fax: (218) 308-2122

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 September 12, 2017, 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 September 12, 2017 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 November 3, 2017 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the

result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 3, 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,

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: kamala.fiske-downing@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
	245329	A. BUILDING ______ B. WING ______	08/03/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARROAD CARE CENTER	**1401 LAKE STREET NORTHWEST WARROAD, MN 56763**

(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 000	INITIAL COMMENTS On 8/1/17, 8/2/17, and 8/3/17, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. 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 your verification.	F 000		
F 225 SS=D	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 483.12(a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure	F 225		9/12/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 08/28/2017

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
	245329	A. BUILDING ______ B. WING ______	**08/03/2017**

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
F 225	Continued From page 1	F 225		

body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property.

(4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff.

(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:

(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.

(2) Have evidence that all alleged violations are thoroughly investigated.

(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.

(4) Report the results of all investigations to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245329	A. BUILDING ______ B. WING ______	08/03/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARROAD CARE CENTER	**1401 LAKE STREET NORTHWEST WARROAD, MN 56763**

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F 225	Continued From page 2 administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to immediately report resident to resident abuse and bruising of unknown origin to the State agency and administrator for 2 of 4 residents (R31, R19) reviewed for abuse prohibition. In addition, the facility failed to complete pre-screenings on new employers for 5 of 5 (E-A, E-B, E-C, E-D, E-E) new employees reviewed. Findings include: R31 reported he was hit by R47, another resident on his unit. On 8/2/17, at 8:50 a.m. R31 stated R47 "hauled of and hit him" in the left shoulder. R31 stated he told staff and they were aware of him getting hit. R31 stated he still had pain in his shoulder, usually at night time. R31 stated the nurses told him to stay away from R47. On 8/2/17, at 3:20 p.m. registered nurse (RN)-B provided a "Non-Fall Incident Report" form, and stated she had it in her interdisciplinary book but had never informed nor given the form to the administrator or director of nursing (DON). The report indicated on 5/16/17, R31 had "reported to	F 225	WSLC s Abuse Prevention Policy has been updated to clarify timeliness of reporting and the need to report even allegations of abuse, whether or not employees feel that the alleged abuse actually occurred. This task was completed on 8/3/17. 2. Education will be provided to all WSLC employees regarding proper reporting of abuse by 9/12/17. Specifically, employees will be trained to report suspected abuse (including injuries of unknown cause) and allegations of abuse immediately, but not later than 2 hours after the allegation is made per state law. Also, education annually and upon hire will continue to include activities that constitute abuse, neglect, exploitation, and misappropriation of resident property ; procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property; and dementia management and resident abuse prevention. 3. WSLC s Incident Reporting Policy and Procedure has been updated. Incidents will be more consistently documented by all staff using a newly updated Incident Report form and will be used in addition to documentation in	

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	245329	A. BUILDING ______ B. WING ______	08/03/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARROAD CARE CENTER	1401 LAKE STREET NORTHWEST WARROAD, MN 56763

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F 225	Continued From page 3 charge nurse this morning that resident (R47) "hit me" in the right shoulder." On 8/2/2017 at 2:05 p.m. nursing assistant (NA)-F stated R31 had told her that R47 had hit him and had been saying this for quite some time. NA-F confirmed staff were aware of this incident, however the staff really did not know if R47 had hit him or not. -At 2:25 p.m. NA-G confirmed R31 had told her R47 had hit him and she had informed the charge nurse and was told this incident had already been charted on. -At 3:10 p.m. R31 again stated R47 had hit him in the right shoulder and told him he did not like his ancestors. R31 stated he had told the nurse, however, they never said anything to him about this incident. R31 stated it was a hit and now his right shoulder hurt near his pacemaker. On 8/3/17, at 8:55 a.m. the social worker (SW) verified the incident was not reported as directed and should have been The SW confirmed the staff did not follow facility policy. Bruise of unknown origin was not reported timely. The investigative report dated 3/31/17, indicated on 3/31/17, R19 was observed to have a large bruise on her left eye and there was no known cause for the bruising. The report revealed the administrator and common entry point were notified on 4/1/17. (three days after to incident occurred)	F 225	resident progress notes. This will be fully implemented by 9/12/17. 4. The Executive Director (Administrator) will be notified of all suspected or alleged abuse. Documentation of this step has been added to the newly created Incident Report form. 5. All reported incidents will be reviewed weekly by the multidisciplinary QAPI-High Risk Committee for trends/patterns and interventions will be reviewed for appropriateness and effectiveness. This process will be fully implemented by 8/31/17. 6. A summary of Incident Reports will be submitted monthly to the WSLC Safety Committee and quarterly to the WSLC QAPI Committee by the Social Services Director or designee. This process will be fully implemented by 8/31/17. 7. Beginning 9/1/17, resident High Risk progress notes will be reviewed at least weekly for 3 months by the Social Services Director or designee to ensure employee understanding and compliance with these policy/procedure changes. The Social Services Director or designee will make sure that: a. All incidents are documented in the electronic medical record (EMR) b. Incidents that are documented in the EMR also have the appropriate Incident Report completed per policy c. The Executive Director (Administrator) is notified in a timely manner of reportable incidents. d. Incident Reports are reviewed weekly by the High Risk Committee, monthly by	

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F 225	Continued From page 4	F 225		

On 8/4/17, at 9:00 a.m. the SW stated the incident occurred on a Friday and was not reported by facility staff over the weekend, therefore, the SW reported the incident to the administrator and State agency the first thing the following Monday morning. The SW verified the facility did not follow their policy and procedure related to immediately reporting to the State agency and administrator.

New employee pre-screenings:

New employee personnel records were reviewed and revealed the following:

-E-A was hired on 4/18/17. E-A's personnel record lacked indication reference checks had been completed.
-E-B was hired on 3/24/17. E-B's personnel record lacked indication reference checks had been completed.
-E-C was hired on 2/21/17. E-C's personnel record lacked indication reference checks had been completed.
-E-D was hired on 2/2/17. E-D's personnel record lacked indication reference checks had been completed.
-E-E was hired on 2/2/17. E-E's personnel record lacked indication reference checks had been completed.

On 8/2/17, at 12:40 p.m. the human resource staff member confirmed reference checks had not been completed for the aforementioned staff members.

the Safety Committee, and Quarterly by the QAPI Committee.
e. Reporting and Investigations are done per policy and in accordance with state and federal laws.
8. WSLC Onboarding Policy/Procedure now requires that reference checks be completed prior to the start date of each new employee. Reference checks will be done by the hiring manager or designee effective 8/28/17.
9. The Business Office Manager or designee will review new hire paperwork for every new employee to ensure that reference checks have been completed and properly documented. This will be fully implemented by 8/28/17 and will continue indefinitely.

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F 225	Continued From page 5 On 8/4/17, at 8:30 a.m. the DON verified pre employee screenings were not completed on the aforementioned employees and planned to start conducting these screening on future new employees. The Vulnerable Adult Abuse/Neglect Prevention Policy and Procedure, Exceptional Care, Meaningful Life, dated 3/1/17, indicated the administer or director of nursing and social services director shall determine if the incident/allegation met the criteria for "reportable incident." All incidents deemed reportable under MN statue are called to common entry point (CEP). All incidents deemed reportable are submitted to MDH via the on-line Reporting System immediately. The facility policy, Resident Protection Program, dated 3/1/17, indicated before new employees are permitted to work with residents, references provided by the prospective employee will be checked as well as appropriate board registrations and certifications regarding the prospective employee's background before permitted to work with residents.	F 225		
F 226 SS=D	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 483.12 (b) The facility must develop and implement written policies and procedures that:	F 226		9/12/17

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F 226	Continued From page 6 (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement their abuse policy related to the immediate reporting of resident to resident abuse and bruises of unknown origin to the State agency and adminstrator for 2 of 4 residents (R31, R19) reviewed for abuse prohibition. In addition, the facilty failed to perform new employee prescreenings prior to hire for 5 of 5 (E-A, E-B, E-C, E-D, E-E) new employees reviewed.	F 226	1. WSLC s Abuse Prevention Policy has been updated to clarify timeliness of reporting and the need to report even allegations of abuse, whether or not employees feel that the alleged abuse actually occurred. This task was completed on 8/3/17. 2. Education will be provided to all WSLC employees regarding proper reporting of abuse by 9/12/17.	

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F 226	Continued From page 7	F 226		

Findings include:

The Vulnerable Adult Abuse/Neglect Prevention Policy and Procedure labeled, Exceptional Care, Meaningful Life, dated 3/1/17, indicated abuse consisted of the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, or mental anguish. The policy also indicated the administer or director of nursing and social services director shall determine if the incident/allegation met the criteria for "reportable incident." All incidents deemed reportable under MN statue were called to the common entry point (CEP) and are submitted to Minnesota Department of Health (MDH) via the on-line Reporting System immediately.

The facility policy, Resident Protection Program, dated 3/1/17, indicated before new employees are permitted to work with residents, references provided by the prospective employee will be checked as well as appropriate board registrations and certifications regarding the prospective employee's background before permitted to work with residents.

R31 reported he was hit by R47, another resident on his unit.

On 8/2/17, at 8:50 a.m. R31 stated R47 "hauled of and hit him" in the left shoulder. R31 stated he told staff and they were aware of him getting hit.

Provider's Plan of Correction (F 226):

Specifically, employees will be trained to report suspected abuse (including injuries of unknown cause) and allegations of abuse immediately, but not later than 2 hours after the allegation is made per state law.

3. WSLC s Incident Reporting Policy and Procedure has been updated. Incidents will be more consistently documented by all staff using a newly updated Incident Report form and will be used in addition to documentation in resident progress notes. This will be fully implemented by 9/12/17.
4. The Executive Director (Administrator) will be notified of all suspected or alleged abuse immediately. Documentation of this step has been added to the newly created Incident Report form.
5. All reported incidents will be reviewed weekly by the multidisciplinary QAPI-High Risk Committee for trends/patterns and interventions will be reviewed for appropriateness and effectiveness. This process will be fully implemented by 8/31/17.
6. A summary of Incident Reports will be submitted monthly to the WSLC Safety Committee and quarterly to the WSLC QAPI Committee by the Social Services Director or designee. This process will be fully implemented by 8/31/17.
7. Beginning 9/1/17, resident High Risk progress notes will be reviewed at least weekly for 3 months by the Social Services Director or designee to ensure employee understanding and compliance with these policy/procedure changes. The

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F 226	Continued From page 8 R31 stated he still had pain in his shoulder, usually at night time. R31 stated the nurses told him to stay away from R47. On 8/2/17, at 3:20 p.m. registered nurse (RN)-B provided a "Non-Fall Incident Report" form, and stated she had it in her interdisciplinary book but had never informed nor given the form to the administrator or director of nursing (DON). The report indicated on 5/16/17, R31 had "reported to charge nurse this morning that resident (R47) "hit me" in the right shoulder." On 8/2/2017 at 2:05 p.m. nursing assistant (NA)-F stated R31 had told her that R47 had hit him and had been saying this for quite some time. NA-F confirmed staff were aware of this incident, however the staff really did not know if R47 had hit him or not. -At 2:25 p.m. NA-G confirmed R31 had told her R47 had hit him and she had informed the charge nurse and was told this incident had already been charted on. -At 3:10 p.m. R31 again stated R47 had hit him in the right shoulder and told him he did not like his ancestors. R31 stated he had told the nurse, however, they never said anything to him about this incident. R31 stated it was a hit and now his right shoulder hurt near his pacemaker. On 8/3/17, at 8:55 a.m. the social worker (SW) verified the incident was not reported as directed and should have been The SW confirmed the staff did not follow facility policy.	F 226	Social Services Director or designee will make sure that: a. All incidents are documented in the electronic medical record (EMR) b. Incidents that are documented in the EMR also have the appropriate Incident Report completed per policy c. The Executive Director (Administrator) is notified in a timely manner of reportable incidents. d. Incident Reports are reviewed weekly by the High Risk Committee, monthly by the Safety Committee, and Quarterly by the QAPI Committee. e. Reporting and Investigations are done per policy and in accordance with state and federal laws. 8. WSLC Onboarding Policy/Procedure now requires that reference checks be completed prior to the start date of each new employee. Reference checks will be done by the hiring manager or designee effective 8/28/17. 9. The Business Office Manager or designee will review new hire paperwork for every new employee to ensure that reference checks have been completed and properly documented. This will be fully implemented by 8/28/17 and will continue indefinitely.	

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F 226	Continued From page 9	F 226		

Bruise of unknown origin was not reported timely.

The investigative report dated 3/31/17, indicated on 3/31/17, R19 was observed to have a large bruise on her left eye and there was no known cause for the bruising. The report revealed the administrator and common entry point were notified on 4/1/17. (three days after to incident occurred)

On 8/4/17, at 9:00 a.m. the SW stated the incident occurred on a Friday and was not reported by facility staff over the weekend, therefore, the SW reported the incident to the administrator and State agency the first thing the following Monday morning. The SW verified the facility did not follow their policy and procedure related to immediately reporting to the State agency and administrator.

New employee pre-screenings:

New employee personnel records were reviewed and revealed the following:

-E-A was hired on 4/18/17. E-A's personnel record lacked indication reference checks had been completed.
-E-B was hired on 3/24/17. E-B's personnel record lacked indication reference checks had been completed.
-E-C was hired on 2/21/17. E-C's personnel record lacked indication reference checks had been completed.
-E-D was hired on 2/2/17. E-D's personnel record

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F 226	Continued From page 10 lacked indication reference checks had been completed. -E-E was hired on 2/2/17. E-E's personnel record lacked indication reference checks had been completed. On 8/2/17, at 12:40 p.m. the human resource staff member confirmed reference checks had not been completed for the aforementioned staff members. On 8/4/17, at 8:30 a.m. the DON verified pre employee screenings were not completed on the aforementioned employees and planned to start conducting these screening on future new employees.	F 226		
F 371 SS=F	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in	F 371		9/12/17

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F 371	Continued From page 11 accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure the blender, measuring utensils and pot holders were cleaned and in good repair to prevent cross-contamination of food. This had the potential to affect all 47 residents who ate food served from the facility's kitchen. Findings include: On 8/1/17, at 2:53 p.m. an initial tour of the kitchen was conducted with cook (C)-B. The following was noted and confirmed with C-B: -The open shelving unit on the bottom of the steamer was covered with a thick layer of white, flaky debris that was adhered to the bottom of the shelf, the legs of the steamer, and the casings of the wheels specifically on the left side of the steamer. On this shelf was a clear uncovered bin (measuring about one foot by two feet) that was filled with pot holders. C-B slightly repositioned the bin of pot holders which left a distinct mark of where the bin had been positioned on the shelf. The sides of the bin were also coated with the same thick, white, flaky debris that was adhered to the shelving unit. C-B confirmed the pot holders were used several times a day and stated they were washed three	F 371	1. Open shelving unit on the bottom of the steamer was cleaned. a. Dietary staff was educated on the importance of a safe, clean work/cooking environment. A cleaning chart was put in place to ensure employees remember to wash steamer rack regularly and change pot holders at the end of each shift. b. Completion date:8/22/2017 c. Dietary director or designee is responsible for completing audits twice a week to ensure staff are following through with tasks. This will stay on an ongoing cleaning guide for kitchen cleanliness. Results will be monitored by the director and will be shared with the QAPI committee for trending of results. Audit time frames will be adjusted based on results. 2. The blender canister was thrown out and replaced with a new one. a. Kitchen staff was educated on maintaining kitchen equipment. A kitchen equipment cleaning/maintenance sheet was made for staff to make sure regular inspections of all kitchen equipment are done. b. Completion date:8/21/2017 c. Dietary director or designee is responsible for auditing the checklist and	

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F 371	Continued From page 12 times a week. -Located on the counter by the microwave was a commercial blender. The blender canister had several chips all around the rim of the canister and had two large star break cracks (series of short radial cracks coming off of an impact point, resembling a star) on the sides of the blender canister. The C-B confirmed the blender was used daily to prepare the pureed food items and that the canister was chipped. -Located on the bottom shelf of the shelving unit in the baking area was a clear bin with a blue lid which contained brown sugar. A red measuring scoop was laying directly in the sugar. C-B confirmed the brown sugar bin held about 15 pounds of brown sugar and that there was currently about five pounds in the bin along with the measuring scoop. C-B opened two drop down drawers one which held an opened 25 pound bag of granulated sugar and one which held an opened 25 pound bag of flour. The 2/3's full bag of granulated sugar had a clear measuring scoop laying directly in the sugar. In the drawer which held the flour, there was a white measuring scoop that was located in the bottom of the drawer, positioned next to the opened bag of flour and lying in a layer of flour which had accumulated at the bottom of the drawer. On 8/2/17, at 2:19 p.m. a follow up tour of the kitchen was conducted with C-A and the areas of concern noted above remained. C-A confirmed: - The uncovered bin which held pot holders was coated with lime scale. C-A estimated there were 15 pot holders in the bin which were used several	F 371	equipment once a month. Results will be monitored by the director and will be shared with the QAPI committee for trending of results. Audit time frames will be adjusted based on results. 3. Scoops in the flour, sugar and brown sugar were removed a. Signs are posted on bins to remind staff not to leave scoops in bins. Staff was educated on sanitary practices and cross contamination. b. Completion date:8/24/2017 c. Bins will be added to the cleaning checklist and bins will be checked for scoops every evening by the cook s helper or designee. 4. An overall cleaning and maintenance schedule for kitchen equipment including, but not limited to, steamer, ovens, dishwasher, blender, chopper, has been made. a. Completion date:8/20/2017 b. Dietary director or designee are responsible for audits of the cleaning schedule, as well as physically check equipment to ensure staff is following through with procedure. This ttol will be initially used daily for 14 days, weekly for 4 weeks, bi-monthly, and prn long term. Results will be monitored by the director and will be shared with the QAPI committee for trending of results. Audit time frames will be adjusted based on results.	

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F 371	Continued From page 13 times a day that could be contaminated by the lime scale and had the potential to contaminate food items. - C-A confirmed the blender canister was chipped up and agreed there was a potential for plastic to get into food items. - C-A confirmed the measuring scoops remained in the bins of brown sugar, flour and granulated sugar and the scoops should be stored in a bin on the baking shelf and not in the sugar and flour. On 8/2/17, at 4:06 p.m. the director of nursing (DON) verified the facility lacked a specific policy on proper storage of measuring utensils and lacked a cleaning or maintenance schedule for equipment in the kitchen.	F 371		
F 465 SS=F	483.90(i)(5) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON (i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. (5) Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also take into account non-smoking residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure kitchen	F 465	1. Open shelving unit on the bottom of the steamer was cleaned.	9/12/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245329	A. BUILDING ______ B. WING ______	08/03/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARROAD CARE CENTER	1401 LAKE STREET NORTHWEST WARROAD, MN 56763

(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 465 Continued From page 14

equipment was maintained in a clean and sanitary manner. This had the potential to affect all 47 residents who had their meals prepared in the facility's kitchen.

Findings include:

On 8/1/17, at 2:53 p.m. an initial tour of the kitchen was conducted with cook (C)-B. The following was noted and confirmed with C-B:

- The open shelving unit on the bottom of the steamer was covered with a thick layer of white flaky debris that was adhered to the bottom of the shelf, legs of the steamer, and the casings of the wheels specifically on the left side of the steamer. On this shelf, was a clear uncovered bin (measuring about one foot by two feet) that was filled with pot holders. C-B slightly repositioned the bin of pot holders which left a distinct mark of where the bin had been positioned on the shelf. The sides of the bin were also coated with the same thick white flaky debris that was adhered to the shelving unit. C-B stated she thought the steamer was cleaned weekly.

- The stainless steel back splash on the six burner stove had a large, black, grease spot measuring approximately ten inches by 12 inches.

- The two ovens located under the stove top had dried food particles and dark brown/black stains adhered to the bottom and sides of both ovens. C-B stated they tried to clean the ovens once a week.

F 465

a. Dietary staff was educated on the importance of a safe, clean work/cooking environment. A cleaning chart was put in place to ensure employees remember to wash steamer rack regularly and change pot holders at the end of each shift as indicated in policy.
b. Completion date:8/22/2017
c. Dietary director or designee is responsible for completing audits twice a week to ensure staff are following through with said tasks. This will stay on an ongoing cleaning guide for kitchen cleanliness. Results will be monitored by the director and will be shared with the QAPI committee for trending of results. Audit time frames will be adjusted based on results.

2. Stainless steel back splash on six burner stove was cleaned
a. A cleaning chart was put into place to ensure employees remember to wash the backsplash regularly.
b. Completion date:8/22/2017
c. Dietary director or designee is responsible for completing audits twice a week to ensure staff are following through with tasks. Results will be monitored by the director and will be shared with the QAPI committee for trending of results. Audit time frames will be adjusted based on results.

3. The sides of the deep fryer and both sides of the flat top griddle were scrubbed clean
a. A cleaning chart was put into place to ensure the cook remembers to wash the deep fryer and griddle at the end of their

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	245329	A. BUILDING ______ B. WING ______	08/03/2017

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F 465	Continued From page 15 - The sides of the deep fryer were covered from top to bottom with raised strips of a thick layer of dried/hardened; yellow/brown gelatinous substance. Also, the right side panel of the flat top griddle, which was adjacent to the deep fryer, had a coating of this same substance adhered to its side. - The top compartment of the dishwasher which housed the motor of the dishwasher had a thick layer of rust/yellow colored debris corroded around this portion of the dishwasher. On 8/2/17, at 2:19 p.m. a follow up tour of the kitchen was conducted with C-A. The areas of concern noted above remained. C-A confirmed: - The open shelving unit on the bottom of the steamer was covered with a thick coat of lime scale from hard water buildup from the steamer. C-A stated the facility had problems with hard water. C-A was unsure of when the steamer had been cleaned last. - C-A stated the stove and its burners were cleaned weekly. C-A was unsure of when the stove top and back splash had been cleaned last. C-A confirmed the back splash on the stove had a ten inch by 12 inch area of what appeared to be dried, burnt on grease that should be cleaned off. - C-A confirmed both ovens had several dark, dried on stains and crumbs of dried food debris adhered to the bottom and sides of the ovens. C-A was unsure of the cleaning schedule for the ovens or when they had been cleaned last. C-A stated they looked like they should be cleaned. - C-A stated the sides of the deep fryer and the	F 465	shift. b. Completion date:8/23/2017 c. Dietary director or designee is responsible for completing audits twice a week to ensure staff are following through with tasks. Results will be monitored by the director and will be shared with the QAPI committee for trending of results. Audit time frames will be adjusted based on results. 4. Top compartment of dishwasher was scrubbed clean with Lime-A-Way a. A cleaning chart was put into place to ensure employees remember to wash the dishwasher b. Completion date:8/24/2017 c. Dietary director or designee is responsible for completing audits twice a week to ensure staff are following through with said tasks. 5. The two ovens under the stovetop were scrubbed clean using oven cleaner a. A cleaning chart was put into place to ensure the cook remembers to clean the ovens b. Completion date:8/21/2017 c. Dietary director or designee is responsible for completing audits twice a week to ensure staff are following through with tasks. Results will be monitored by the director and will be shared with the QAPI committee for trending of results. Audit time frames will be adjusted based on results.	

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	245329	A. BUILDING _____ B. WING _____	08/03/2017

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F 465	Continued From page 16	F 465		

adjacent side of the flat top grill were coated with a layer of grease. C-A took a metal grill spatula and attempted to scrape off some of the substance which had coated the sides of the fryer. C-A, with much force, pulled the metal grill spatula across the left side panel of the deep fryer and a small amount of yellow/brown shavings curled up and adhered to the blade of the spatula. C-A stated the grease build up was stuck on pretty good.

- C-A confirmed the top compartment of the dishwasher which housed the motor of the dishwasher was surrounded by a thick layer of rust and lime scale build up. C-A took a knife and scraped along the edges of the dishwasher that had this visible buildup. C-A was able to dislodge bits of lime/rust buildup particles. C-A estimated the lime scale/rust buildup which surrounded the motor casing measured 18 by 36 inches. C-A was unsure of the dishwasher cleaning schedule.

A paper sign was observed taped to the ledge over the prep area in the kitchen across from the stove, steamer, flat top grill and deep fryer area. The sign directed staff to clean up the stove top and sides of the grill at the end of their shift.

On 8/2/17, at 4:06 p.m. the director of nursing (DON) verified the facility did not have a cleaning or maintenance schedule for kitchen equipment.

Cleaning Instructions: Steam Tables policy dated 2010, indicated the steam tables would be maintained in a clean and sanitary condition. In addition, de-limer may be needed to remove lime deposits.

Cleaning Instructions: Ranges policy dated 2010,

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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	245329	A. BUILDING ______ B. WING ______	**08/03/2017**

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F 465	Continued From page 17 indicated the range would be cleaned after each use; spills and food particles would be wiped up as they occur; and burned particles and grease would be scraped off with a non-metal scouring pad. Cleaning Instructions: Ovens policy dated 2010, directed staff to clean the ovens according to the cleaning schedule (at least once every two weeks). Cleaning Instructions: Fryers dated 2010, indicated fryers would be cleaned on a regular basis. Cleaning Instructions: Maintenance of Dish Machine dated 2010, indicated the dish machine would be cleaned and delimed regularly and as needed.	F 465		

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

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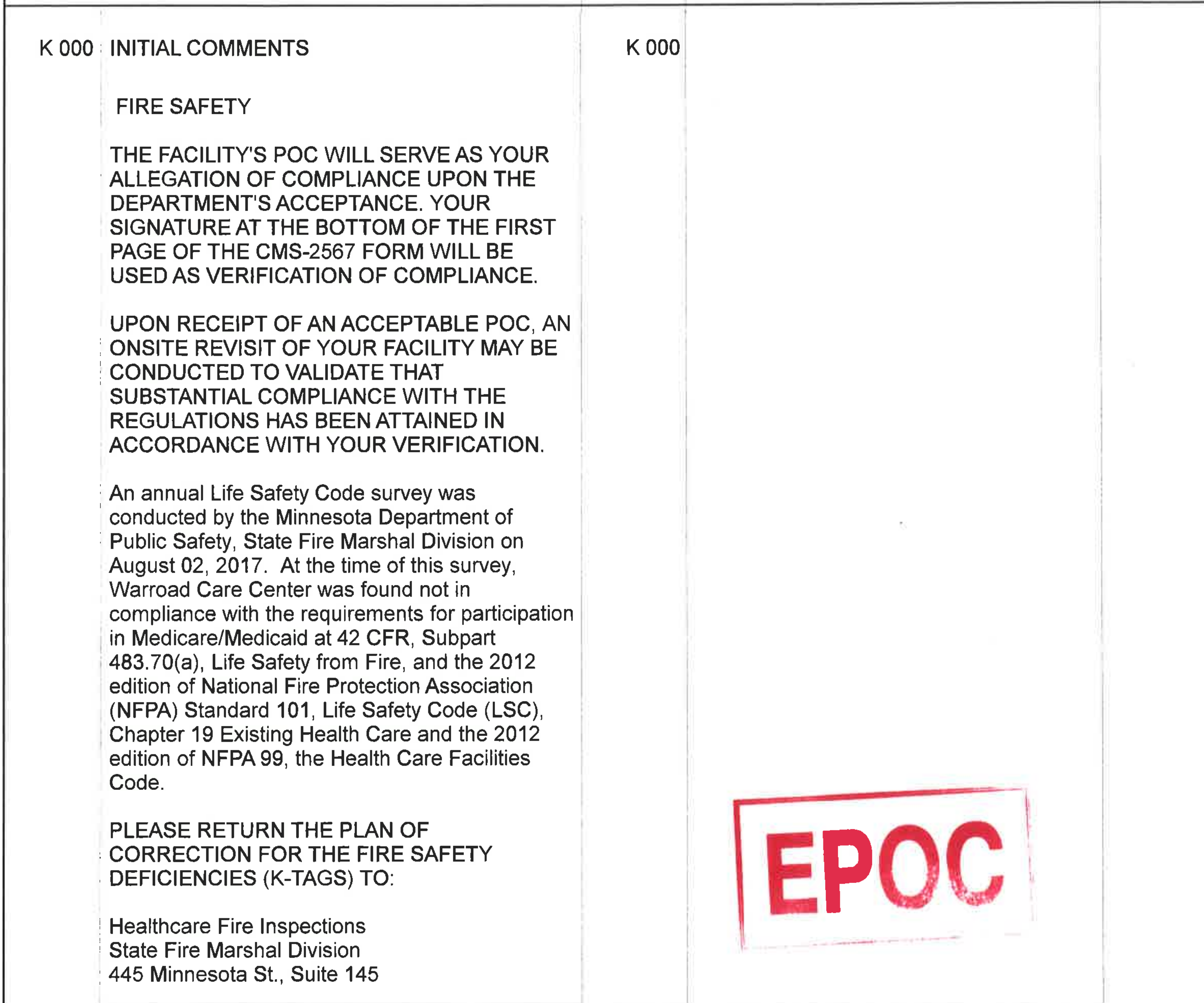
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245329	A. BUILDING **02 - WARROAD CARE CENTER** B. WING ______	**08/02/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARROAD CARE CENTER	**1401 LAKE STREET NORTHWEST** **WARROAD, MN 56763**



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K 000	INITIAL COMMENTS	K 000		

FIRE SAFETY

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

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

An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on August 02, 2017. At the time of this survey, Warroad 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, the Health Care Facilities Code.

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

Healthcare Fire Inspections
State Fire Marshal Division
445 Minnesota St., Suite 145

EPOC

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 08/28/2017

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

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	245329	A. BUILDING 02 - WARROAD CARE CENTER B. WING	08/02/2017

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K 000	Continued From page 1 St. Paul, MN 55101-5145, OR By email 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. Warroad Care Center is a 1-story building without a basement that was built in 2009 and was determined to be built of Type V(111) construction. The facility is fully protected throughout by an automatic fire sprinkler system and has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility also has smoke detection in the resident rooms that is tied into the nurse call system. The facility has a capacity of 50 beds and had a census of 42 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 223	NFPA 101 Doors with Self-Closing Devices	K 223		9/15/17

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	245329	A. BUILDING **02 - WARROAD CARE CENTER** B. WING ______	**08/02/2017**

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K 223 SS=D	Continued From page 2 Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This **STANDARD** is not met as evidenced by: Based on observation and staff interview, the facility did not maintain self-closing doors in exit passageways, stairway enclosures, horizontal exits, smoke barriers, or hazardous areas. 19.2.2.2.7, 19.2.2.2.8. This deficient practice could affect all staff in the kitchen area. Findings include: On a facility tour between the hours of 1000 and 1400 on August 02, 2017, observation revealed that the dry storage room in the kitchen had a door closer that as disassembled and had large items blocking the door from closing. This deficient practice was verified by a Maintenance Director at the time of discovery.	K 223	All items blocking the door from closure have been removed as of 08-02-17. Door is to remain closed and is monitored for the same. Automatic door closure hardware has been ordered and will be installed by facility staff upon arrival.	