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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 8CO7

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

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 **07/15/2016** (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 **49** (L18)
13.Total Certified Beds **49** (L17)

10.THE FACILITY IS CERTIFIED AS:
✓ 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 __ 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: **A** (L12)

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 :
Beth Nowling, HFE NEII 07/15/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 08/30/2016 (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
07/19/2016 (L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245329

August 30, 2016

Mr. Mark Bertilrud, Administrator
Warroad Care Center
1401 Lake Street Northwest
Warroad, Minnesota 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 July 1, 2016 the above facility is certified 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.

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

Sincerely,

Mark Meath

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

An equal opportunity employer.

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
July 29, 2016

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

RE: Project Number S5329025

Dear Mr.. Bertilrud:

On June 9, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on June 2, 2016. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On July 15, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on June 24, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on June 2, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 1, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on June 2, 2016, effective July 1, 2016 and therefore remedies outlined in our letter to you dated June 9, 2016, will not be imposed.

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

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

Sincerely,

Mark Meath

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245329 Y1	A. Building B. Wing Y2	7/15/2016 Y3

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0225	Correction	ID Prefix F0226	Correction	ID Prefix F0282	Correction
Reg. # 483.13(c)(1)(ii)-(iii), (c)(2) - (4)	Completed	Reg. # 483.13(c)	Completed	Reg. # 483.20(k)(3)(ii)	Completed
LSC	06/30/2016	LSC	06/30/2016	LSC	07/01/2016
ID Prefix F0312	Correction	ID Prefix F0314	Correction	ID Prefix	Correction
Reg. # 483.25(a)(3)	Completed	Reg. # 483.25(c)	Completed	Reg. #	Completed
LSC	06/30/2016	LSC	06/30/2016	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☒	LB/mm	07/29/2016	28035	07/15/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
6/2/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245329 Y1	A. Building 02 - WARROAD CARE CENTER B. Wing Y2	6/24/2016 Y3

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

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

ITEM Y4		DATE Y5	ITEM Y4		DATE Y5	ITEM Y4		DATE Y5
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	NFPA 101	Completed	Reg. #	NFPA 101	Completed	Reg. #	NFPA 101	Completed
LSC	K0022	06/06/2016	LSC	K0073	06/02/2016	LSC	K0144	06/03/2016
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	NFPA 101	Completed	Reg. #		Completed	Reg. #		Completed
LSC	K0147	06/02/2016	LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☒	LB/mm	07/29/2016	36536	06/24/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
6/1/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 8CO7

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

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: **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 **06/02/2016** (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 **49** (L18)
13.Total Certified Beds **49** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	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 :
Rebecca Haberle, HFE NEII 06/24/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 07/15/2016 (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

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
June 9, 2016

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

RE: Project Number S5329025

Dear Mr. Bertilrud:

On June 2, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

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

> **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

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 July 12, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by July 12, 2016 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have

been affected by the deficient practice;

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

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

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

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

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

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

• Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by September 2, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was

issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by December 2, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

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

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

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

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

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

Sincerely,

Mark Meath

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

Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245329	A. BUILDING _____ B. WING _____	06/02/2016

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 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 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report 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 to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).	F 225		6/30/16

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

Electronically Signed | 06/19/2016

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

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	245329	A. BUILDING _____ B. WING _____	06/02/2016

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F 225	Continued From page 1 The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification 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 to the State agency and administrator for 1 of 3 residents (R3) reviewed for abuse prohibition and was witnessed to have been hit by another resident which was not immediately report to the State agency and administrator, as required. Findings include: The investigative report dated 3/7/16, indicated on 3/4/16, R3 was struck on the shoulder with an open hand by another resident. Staff intervened and redirected the residents involved. The report revealed the administrator and the common entry point were both notified on 3/7/16. (three days after to incident occurred)	F 225	Current policy on vulnerable adult reporting to be reviewed with all staff. Review will include the expectation of reporting immediately any suspected mistreatment, abuse, neglect, injuries of unknown source or misappropriation of resident property so that timely decision making and reporting can be to facility staff and the state agency. This will include discussion and expectations that all incidents that happen on evening, night and weekend shifts will follow the same expectation of immediate reporting within the facility so that the determination of whether or not external reporting is required can be made by those designated in the policy. The Director of Social Services or designee will continue to review all incident reports to check for accuracy in	

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F 225	Continued From page 2 On 6/1/16, at 3:30 p.m. the social worker (SW) stated the incident occurred on a Friday evening 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. The Vulnerable Adult Abuse/Neglect Prevention Policy and Procedure dated 6/15/15, 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 are submitted to MDH via the on-line Reporting System immediately (as soon as possible).	F 225	timely reporting when the incident details indicate circumstances that a report either should or may need to be filed. Any deviation from policy will be discussed as soon as possible with the person completing the form. Random audits will be completed by staff interview and by chart review under the direction of the Director of Social Services. These audits will focus on identification of items that are reportable and the understanding of the reporting process by the person involved to include the timeliness of making such reports. Not less than 2 audits/week will be conducted for 30 days and not less than 1/week for an additional 60 days thereafter. Results of the incident report review and the audits will be reviewed by the DON, Social Service Director and Administrator. In addition results will be reported at quarterly quality committee meetings. Follow up education and auditing will be modified and/or extended as indicated by audit results. Responsible Party: Director of Social Services	
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents	F 226		6/30/16

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F 226	Continued From page 3 and misappropriation of resident property. 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 a physical altercation by another resident to the State agency (SA) for 1 of 3 residents (R3) reviewed for abuse prohibition. Findings include: The Vulnerable Adult Abuse/Neglect Prevention Policy and Procedure dated 6/15/15, 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 (as soon as possible). The investigative report dated 3/7/16, indicated on 3/4/16, R3 was intentionally struck on the shoulder with an open hand by another resident. Staff intervened and redirected the residents involved. The report revealed the administrator and the common entry point were both notified on	F 226	Current policy on vulnerable adult reporting to be reviewed with all staff. Review will include the expectation of reporting immediately any suspected mistreatment, abuse, neglect, injuries of unknown source or misappropriation of resident property so that timely decision making and reporting can be to facility staff and the state agency. This will include discussion and expectations that all incidents that happen on evening, night and weekend shifts will follow the same expectation of immediate reporting within the facility so that the determination of whether or not external reporting is required can be made by those designated in the policy. The Director of Social Services or designee will continue to review all incident reports to check for accuracy in timely reporting when the incident details indicate circumstances that a report either should or may need to be filed. Any deviation from policy will be discussed as soon as possible with the person completing the form. Random audits will be completed by staff interview and by chart review under the direction of the Director of Social Services. These audits will focus on identification of items that are reportable	

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F 226	Continued From page 4 3/7/16. (three days after to incident occurred) On 6/1/16, at 3:30 p.m. the social worker (SW) stated the incident occurred on a Friday evening 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.	F 226	and the understanding of the reporting process by the person involved to include the timeliness of making such reports. Not less than 2 audits/week will be conducted for 30 days and not less than 1/week for an additional 60 days thereafter. Results of the incident report review and the audits will be reviewed by the DON, Social Service Director and Administrator. In addition results will be reported at quarterly quality committee meetings. Follow up education and auditing will be modified and/or extended as indicated by audit results. Responsible Party: Director of Social Services	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide assistance with repositioning for 1 of 3 residents (R41) dependent upon staff for repositioning. In addition, the facility failed to ensure oral hygiene was provided for 1 of 1 residents (R22) who required assistance with oral hygiene.	F 282	R41 and R22 care plans were reviewed for appropriateness and education to care givers was provided to follow care plan. All residents requiring repositioning and assistance with oral cares have been reviewed to assure accuracy of care	7/1/16

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F 282	Continued From page 5 Finding include: R41 was not provided repositioning assistance as directed by the care plan. R41's care plan dated 1/31/16, indicated R41 was at risk for skin breakdown/pressure ulcer development and directed staff to assist R41 with reposition at least every two hours. On 6/1/16, from 12:24 p.m. until 3:50 p.m. R41 was continuously observed to remain seated in a wheelchair without staff assistance to reposition. On 6/1/16, at 3:45 p.m. nursing assistant (NA)-A stated R41 was repositioned at 12:30 p.m. by the day shift staff. (three hours and 15 minutes earlier). NA-A confirmed she had not assisted R41 with repositioning during her shift which started at 1:00 p.m. On 6/1/16, at 3:50 p.m. NA-A requested assistance to reposition R41. At this time, licensed practical nurse (LPN)-B and NA-A were observed to transfer R41 from the wheelchair to the toilet via a mechanical standing lift. R41's wheelchair was observed to have a pressure redistribution cushion and his buttocks was observed to be intact. NA-A stated R41 was only to be repositioned as he requested.	F 282	planning and documentation of care providers following the care plan. Policy will be updated as indicated to support the need for accuracy in care planning and in follow up documentation. All nursing staff will receive education on the policy and the importance of following and updating as required the residents plan of care. The DON or designee will randomly audit 2 charts on a daily basis for one month and then 1 chart per day for an additional month to be sure that care plans are current and that documentation of care plan activity is in place. Additionally, observational audits will be conducted on not less than 4 residents per week for 1 month and then 2 residents per week for an additional 60 days for the purpose of observing actual care delivered vs. care plan instructions. The data collected from the audits will be reviewed and analyzed by the DON or designee and presented to the quarterly quality committee for their consideration. Changes in audit frequency, timing and focus may be indicated based on audit results.	

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F 282	Continued From page 6 On 6/2/16, from 6:30 a.m. to 9:05 p.m. R41 was continuously observed to remain seated in a wheelchair without reposition assistance. At 9:05 a.m. the director of nurses (DON) approached LPN-C and requested her to assist R41 to the rest room. The DON and LPN-C were observed to transfer R41 from the wheelchair to the toilet via the standing lift. R41's buttocks was observed to be intact. On 6/2/16 at 9:20 a.m. NA-B verified R41 was last repositioned at 6:30 a.m. (two hours and 35 minutes earlier). NA-B stated R41 was not on a repositioning schedule and was to be repositioned as he requested. On 6/2/16, at 11:20 a.m. registered nurse (RN)-A stated R41 was to be repositioned every two hours as directed by the care plan. R22 was not provided assistance with oral care as directed by the care plan. R22's Care Plan dated 2/22/16, indicated R22 had an upper denture and lower partial and directed staff to assist R22 with personal hygiene and oral care. On 6/2/16, at 6:57 a.m. NA-C was observed to	F 282		

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F 282	Continued From page 7 provide R22 morning cares. During the observation, NA-C was observed to brush R22's upper denture and lower partial and hand them to R22 for placement in her mouth. Following the completion of the morning cares, NA-C assisted R22 into a wheelchair and R22 exited the room. At no time did NA-C offer R22 the opportunity to brush her remaining lower teeth or rinse her mouth prior to inserting the clean dentures. On 6/2/16, at 7:30 a.m. NA-C confirmed she had not offered R22 the opportunity to rinse her mouth or assisted R22 to brush her lower teeth and stated she should have done so. On 6/2/16, at 12:51 p.m. the DON confirmed she would expect oral cares be provided as directed by care plan. The Using the Care Plan policy dated 6/12/15, directed staff to follow the resident care plans to ensure staff were providing appropriate care for each resident.	F 282		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by:	F 312		6/30/16

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F 312	Continued From page 8 Based on observation, interview and document review, the facility failed to ensure oral hygiene was provided for 1 of 1 resident (R22) who required assistance with oral hygiene. Findings include: R22's annual Minimum Data Set (MDS) dated 2/12/16, indicated R22 had moderate cognitive impairment and diagnoses which included heart failure, dementia and shoulder pain. The MDS also indicated R22 required extensive assistance of one staff for bed mobility, transfers, dressing and personal hygiene. The MDS further indicated R22 had no dental concerns. R22's ADL [activities of daily living] Functional/Rehabilitation Potential Care Area Assessment (CAA) dated 2/12/16, indicated R22 needs\ed extensive assistance with dressing, grooming, and physical assistance with bathing. The CAA indicated R22 denied having any specific pain with ADL's, but admitted to becoming fatigued at times. R22 had dementia and needed frequent verbal cues during ADL's at times. The CAA further indicated R22's care plan would include interventions to promote as much participation with ADL's as R22 was able, while providing assistance as needed to ensure safe and adequate task completion. R22's Care Plan dated 2/22/16, indicated R22 had an upper denture and lower partial and directed staff R22 to provide extensive assistance with personal hygiene and oral care.	F 312	R22 care plan was reviewed for appropriateness and education to care givers was provided to follow care plan. All residents requiring assistance with oral cares have been reviewed to assure accuracy of care planning and documentation of care providers following the care plan. Policy and procedures on oral care and assessment will be reviewed and updated as necessary to support the need for accuracy in care planning and in care delivery and documentation. All nursing staff will receive education on the policy and the importance of following and updating as required the residents plan of care. The DON or designee will randomly audit 2 charts on a daily basis for one month and then 1 chart per day for an additional month to be sure that care plans are current and that documentation of care plan activity is in place. Additionally, observational audits will be conducted on not less than 4 residents per week for 1 month and then 2 residents per week for an additional 60 days for the purpose of observing actual care delivered vs. care plan instructions. The data collected from the audits will be reviewed and analyzed by the DON or designee and presented to the quarterly quality committee for their consideration. Changes in audit frequency, timing and focus may be indicated based on audit	

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F 312	Continued From page 9 On 6/2/16, at 6:57 a.m. nursing assistant (NA)-C was observed to provide R22 morning cares. During the observation, NA-C was observed to brush R22's upper denture and lower partial and hand them to R22 for placement in her mouth. Following the completion of the morning cares, NA-C assisted R22 into a wheelchair and R22 exited the room. At no time did NA-C offer R22 the opportunity to brush her remaining lower teeth or rinse her mouth prior to inserting the clean dentures. On 6/2/16, at 7:30 a.m. NA-C confirmed she had not offered R22 the opportunity to rinse her mouth or assist R22 to brush her lower teeth and should have done so. On 6/2/16, at 12:51 p.m. the director of nursing (DON) confirmed she would expect oral cares be provided as directed by care plan. A policy regarding oral hygiene was requested but none was provided. The Using the Care Plan policy dated 6/12/15, directed staff to follow the resident care plans to ensure staff were providing appropriate care for each resident.	F 312	results.	
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a	F 314		6/30/16

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F 314	Continued From page 10 resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide timely turning and repositioning assistance as directed by the care plan for 1 of 3 residents (R41) who was identified as at risk for pressure ulcers, required staff assistance to reposition and was not repositioned every two hours as directed by the care plan. Findings include: R41's quarterly Minimum Data Set dated 4/11/16, indicated R41 had cognitive impairment and was diagnosed with Alzheimer's disease and diabetes mellitus. The MDS also indicated R41 was at risk for the development of pressure related ulcers and required extensive assistance with bed mobility, transfers and ambulation. R41's Pressure Ulcer Care Area Assessment (CAA) dated 10/22/15, indicated R41 was at risk for the development of pressure ulcers due to limited mobility, obesity, diabetes and occasional urinary incontinence. The CAA directed staff to	F 314	R41 care plan was reviewed for appropriateness and education to care givers was provided to follow care plan. All residents requiring assistance with repositioning have been reviewed to assure accuracy of care planning and documentation of care providers following the care plan. Policy, procedures and assessment on repositioning will be reviewed and updated as necessary to support the need for accuracy in care planning and in care delivery and documentation. All nursing staff will receive education on the policy and the importance of following and updating as required the residents plan of care. The DON or designee will randomly audit 2 charts on a daily basis for one month and then 1 chart per day for an additional month to be sure that care plans are current and that documentation of care plan activity is in place. Additionally, observational audits will be conducted on	

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F 314	Continued From page 11 assist R41 with repositioning every two hours. R41's care plan dated 1/31/16, indicated R41 was at risk for skin breakdown/pressure ulcer development and directed staff to assist R41 to reposition at least every two hours. R41's Braden Scale for Predicting Pressure Sore Risks dated 4/11/16, identified R41 at risk for the development of pressure ulcers. R41's Tissue Tolerance (tissue perfusion) observation completed on 4/11/16, indicated R41 required a two hour repositioning schedule while in lying or sitting. On 6/1/16, from 12:45 p.m. until 3:50 p.m. R41 was continuously observed. -At 12:45 p.m. R41 was observed to be assisted from the toilet to his wheelchair by nursing assistant (NA)-D. R41 remained in his room watching television until 1:52 p.m. at which time activity aide (AA)-B wheeled him to the Lodge area for stretching exercises. R41 was observed to participate in the stretching exercises, however, at no time was he observed to lift his buttocks out of the wheelchair. -At 2:37 p.m. AA-B wheeled R41 to the Birch Beach dining room for coffee and a snack. -At 2:50 p.m. R41 wheeled himself to his room to watch TV. -At 3:45 p.m. NA-A stated she had arrived at the facility at 1:00 p.m. She stated R41 had last been assisted to reposition at 12:30 p.m. by the day shift staff. NA-A stated she had wanted to assist	F 314	not less than 4 residents per week for 1 month and then 2 residents per week for an additional 60 days for the purpose of observing actual care delivered vs. care plan instructions. Particular emphasis will be placed on residents with a Braden score indicating increased risk. The data collected from the audits will be reviewed and analyzed by the DON or designee and presented to the quarterly quality committee for their consideration. Changes in audit frequency, timing and focus may be indicated based on audit results.	

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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 314	Continued From page 12	F 314		

R41 at 2:00 p.m. to reposition, but he was out of his room and she had not returned to check on him. At this time, NA-A entered R41's room and offered to reposition him.
-At 3:50 p.m. NA-A and licensed practical nurse (LPN)-B were observed to transfer R41 from the wheelchair to the toilet via a mechanical standing lift. R41's wheelchair was observed to have a pressure redistribution cushion and his buttocks was observed to be intact. NA-A stated R41 was only to be repositioned as he requested.

Review of the Birch Beach Toileting and Reposition form dated 6/1/16, indicated R41 was to be repositioned as he requested (PRN). The form revealed R41 had last received assistance at 12:45 p.m. (three hours earlier)

On 6/1/16, at 4:00 p.m. LPN-B reviewed the Birch Beach Toileting and Reposition sheet and compared it to R41's care plan. LPN-B verified the reposition sheet and the care plan directive for repositioning did not match. LPN-B stated R41 was to receive assistance with repositioning every two hours as directed on the care plan.

On 6/2/16, at 6:30 a.m. R41 was observed to remain in his room, seated in the wheelchair. R41 was visiting with three staff members. R41 remained in his room until 7:41 a.m. at which time R41 wheeled himself to the dining room. He remained in the dining room until 8:41 a.m. at which time R41 wheeled himself back to his room.
-At 9:05 a.m. the director of nurses (DON) approached LPN-C and requested her to assist

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 _____	06/02/2016

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 314	Continued From page 13 R41 to the rest room. The DON and LPN)-C were observed to transfer R41 from the wheelchair to the toilet via the standing lift. R41's buttocks was observed to be intact. -At 9:20 a.m. NA-B relieved the DON and assisted LPN-C with transferring R41 off of the toilet and transferred him to a recliner in his room. On 6/2/16 at 9:20 a.m. NA-B verified R41 had last been repositioned at 6:30 a.m. a total of two hours and 35 minutes earlier. She stated R41 was not on a repositioning schedule and was to be repositioned as he requested. On 6/2/16, at 11:20 a.m. registered nurse (RN)-A stated R41 was to be repositioned every two hours as directed by the care plan. The Prevention of Pressure Ulcer policy dated 6/11/15, directed the staff to change position in a chair at least every two hours for the prevention of pressure ulcer development. The Using the Care Plan policy dated 6/12/15, directed staff to follow the resident care plans to ensure staff were providing appropriate care for each resident.	F 314		

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	245329	A. BUILDING **02 - WARROAD CARE CENTER** B. WING _____	**06/01/2016**

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 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 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. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey Warroad Care Center 02 Main Building was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Cedar St., Suite 145 St Paul, MN 55101-5145, or By email to: Marian.Whitney@state.mn.us	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/19/2016

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

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	245329	A. BUILDING **02 - WARROAD CARE CENTER** B. WING _____	**06/01/2016**

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K 000	Continued From page 1 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 The Warroad Care Center is a 1-story building without a basement. The building was constructed in 2009 and is of Type V(111) construction. To the south west of the building is an assisted living apartment which is separated with a 2-hour fire barrier and to the south east a senior apartment building which is separated by a 2-hour fire barrier. The building is divided into three smoke zones with 1-hour and 2-hour fire barriers. The facility is fully sprinkler protected installed in accordance with NFPA 13 Standard for the Installation of Automatic Sprinkler Systems 1999 edition. A manual fire alarm system is installed with smoke detection in the corridors and all common areas in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition with automatic fire department notification. All sleeping rooms have smoke detection and hazardous areas have automatic fire detection installed in accordance with the Minnesota State Fire Code (MSFC) 2007 edition.	K 000		

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	245329	A. BUILDING **02 - WARROAD CARE CENTER** B. WING _____	**06/01/2016**

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K 000	Continued From page 2 The facility has a capacity of 49 beds. At the time of the survey the census was 48 residents. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 022 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. Doors, passages or stairways that are not a way of exit that are likely to be mistaken for an exit have a sign designating "No Exit". 7.10, 18.2.10.1, 19.2.10.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility has failed to properly identify non-required exit doors leading to the outside that do not extend to the public way in accordance with NFPA 101 (00) sections 7.10.1.7 and 7.10.8.1. These deficient practices could negatively affect all residents, staff and visitors, by causing confusion in locating an exit from the building to the public way in the event of an emergency. Findings include: On the facility tour between 7:45 am to 11:30 am on 06/01/2016 observations and staff interview revealed the doors to the enclosed patios did not have "No Exit" signs. This deficient practice was verified by the Environmental Service Director.	K 022	1. Doors leading to the patios have been marked with signage indicating "No Exit". 2. Correction Date: 06/06/2016 3. Responsible Person for Completion and Monitoring: Environmental Services Director.	6/6/16
K 073 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD	K 073		6/2/16

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	245329	A. BUILDING **02 - WARROAD CARE CENTER** B. WING _____	**06/01/2016**

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K 073	Continued From page 3 Combustible decorations shall be prohibited unless they are flame-retardant or in such limited quantity that hazard of fire development or spread is not present. 18.7.5.4, 19.7.5.4 This STANDARD is not met as evidenced by: Based on observations and staff interview, the facility failed to maintain combustible decorations in accordance with NFPA Life Safety Code 101 (00) section 18.7.5.4. This deficient practice could allow smoke and fire to rapidly migrate through the corridors and negatively affect the egress capability in the event of an emergency for 12 of the 48 residents and an undetermined amount of visitors and staff. Findings include: On the facility tour between 7:45 am to 11:30 am on 06/01/2016 observations and staff interview revealed untreated combustible decorations on the corridor doors to resident rooms, A103 and A109. This deficient condition was verified by the Environmental Service Director.	K 073	1. Decorations on rooms A103 and A109 were removed, treated, labeled and replaced. 2. Correction Date: 06/02/2016 3. Responsible Person for Completion and Monitoring: Environmental Service Director. Additionally the Safety Committee and its members will be reminded to observe for this issue throughout the building and report any noted problems to the Environmental Services Director.	
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to test the emergency generators in accordance with the requirements of 2000 NFPA 101 - 9.1.3 and 1999 NFPA 110 6-4.2 (a) & (b) and 6-4.2.2. The deficient practice could affect all 49 residents, staff, and visitors.	K 144	1. A new column has been added to the generator check list to include the cool down time. 2. Correction Date: 06/03/2016 3. Responsible Person for Completion and Monitoring: Environmental Service Director	6/3/16

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K 144	Continued From page 4 Findings include: On the facility tour between 7:45 am to 11:30 am on 06/01/2016 record review and staff interview revealed the generator cool down cycle was not being logged on the monthly reports. This deficient condition was verified by the the Environmental Service Director.	K 144		
K 147 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 This STANDARD is not met as evidenced by: Based on observation and interview with the staff the facility was using a multiple plug adapter in place of permanent wiring or listed power strip, that is not in accordance with NFPA 70 (99), National Electrical Code. This deficient practice could negatively affect the safety of 12 of 49 residents, staff and visitors. Findings include: On the facility tour between 7:45 am to 11:30 am on 06/01/2016 observations and staff interview revealed the use of a non listed 3 plug adapter in the lounge area of the memory care wing. This deficient practice was verified by the Environmental Service Director.	K 147	1. The three way plug in the memory care lounge has been removed and replaced with a UL listed power strip. 2. Correction Date: 06/02/2016 3. Responsible Person for Completion and Monitoring: Environmental Service Director. Additionally the Safety Committee and its members will be reminded to observe for this issue throughout the building and report any noted problems to the Environmental Services Director.	6/2/16

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
June 9, 2016

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5329025

Dear Mr. Bertilrud:

The above facility was surveyed on May 31, 2016 through June 2, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is 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 deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the

statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, **you should immediately contact Lyla Burkman at (218) 308-2104 or email: lyla.burkman@state.mn.us**.

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

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

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

Sincerely,

Mark Meath

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

Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	06/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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		

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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		

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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 5/31/16, 6/1/16, and 6/2/16, 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	2 000		

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2 000	Continued From page 2 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.	2 000		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide assistance with repositioning for 1 of 3 residents (R41) dependent upon staff for repositioning. In addition, the facility failed to ensure oral hygiene was provided for 1 of 1 residents (R22) who required assistance with oral hygiene. Finding include: R41 was not provided repositioning assistance as directed by the care plan. R41's care plan dated 1/31/16, indicated R41 was at risk for skin breakdown/pressure ulcer development and directed staff to assist R41 with reposition at least every two hours.	2 565	Corrected	6/30/16

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2 565	Continued From page 3 On 6/1/16, from 12:24 p.m. until 3:50 p.m. R41 was continuously observed to remain seated in a wheelchair without staff assistance to reposition. On 6/1/16, at 3:45 p.m. nursing assistant (NA)-A stated R41 was repositioned at 12:30 p.m. by the day shift staff. (three hours and 15 minutes earlier). NA-A confirmed she had not assisted R41 with repositioning during her shift which started at 1:00 p.m. On 6/1/16, at 3:50 p.m. NA-A requested assistance to reposition R41. At this time, licensed practical nurse (LPN)-B and NA-A were observed to transfer R41 from the wheelchair to the toilet via a mechanical standing lift. R41's wheelchair was observed to have a pressure redistribution cushion and his buttocks was observed to be intact. NA-A stated R41 was only to be repositioned as he requested. On 6/2/16, from 6:30 a.m. to 9:05 p.m. R41 was continuously observed to remain seated in a wheelchair without reposition assistance. At 9:05 a.m. the director of nurses (DON) approached LPN-C and requested her to assist R41 to the rest room. The DON and LPN-C were observed to transfer R41 from the wheelchair to the toilet via the standing lift. R41's buttocks was observed to be intact. On 6/2/16 at 9:20 a.m. NA-B verified R41 was	2 565		

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2 565	Continued From page 4 last repositioned at 6:30 a.m. (two hours and 35 minutes earlier). NA-B stated R41 was not on a repositioning schedule and was to be repositioned as he requested. On 6/2/16, at 11:20 a.m. registered nurse (RN)-A stated R41 was to be repositioned every two hours as directed by the care plan. R22 was not provided assistance with oral care as directed by the care plan. R22's Care Plan dated 2/22/16, indicated R22 had an upper denture and lower partial and directed staff to assist R22 with personal hygiene and oral care. On 6/2/16, at 6:57 a.m. NA-C was observed to provide R22 morning cares. During the observation, NA-C was observed to brush R22's upper denture and lower partial and hand them to R22 for placement in her mouth. Following the completion of the morning cares, NA-C assisted R22 into a wheelchair and R22 exited the room. At no time did NA-C offer R22 the opportunity to brush her remaining lower teeth or rinse her mouth prior to inserting the clean dentures. On 6/2/16, at 7:30 a.m. NA-C confirmed she had not offered R22 the opportunity to rinse her mouth or assisted R22 to brush her lower teeth and stated she should have done so.	2 565		

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2 565	Continued From page 5 On 6/2/16, at 12:51 p.m. the DON confirmed she would expect oral cares be provided as directed by care plan. The Using the Care Plan policy dated 6/12/15, directed staff to follow the resident care plans to ensure staff were providing appropriate care for each resident. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could develop and implement policies and procedures related to implementation of the care plan. The DON or designee, could provide training for all nursing staff related to care plan implementation. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 855	MN Rule 4658.0520 Subp. 2 E. Adequate and Proper Nursing Care;Oral Hygiene Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: E. Assistance as needed with oral hygiene to keep the mouth, teeth, or dentures clean. Measures must be used to prevent dry, cracked lips This MN Requirement is not met as evidenced	2 855		6/30/16

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2 855	Continued From page 6 by: Based on observation, interview and document review, the facility failed to ensure oral hygiene was provided for 1 of 1 resident (R22) who required assistance with oral hygiene. Findings include: R22's annual Minimum Data Set (MDS) dated 2/12/16, indicated R22 had moderate cognitive impairment and diagnoses which included heart failure, dementia and shoulder pain. The MDS also indicated R22 required extensive assistance of one staff for bed mobility, transfers, dressing and personal hygiene. The MDS further indicated R22 had no dental concerns. R22's ADL [activities of daily living] Functional/Rehabilitation Potential Care Area Assessment (CAA) dated 2/12/16, indicated R22 needs\ed extensive assistance with dressing, grooming, and physical assistance with bathing. The CAA indicated R22 denied having any specific pain with ADL's, but admitted to becoming fatigued at times. R22 had dementia and needed frequent verbal cues during ADL's at times. The CAA further indicated R22's care plan would include interventions to promote as much participation with ADL's as R22 was able, while providing assistance as needed to ensure safe and adequate task completion. R22's Care Plan dated 2/22/16, indicated R22 had an upper denture and lower partial and directed staff R22 to provide extensive assistance with personal hygiene and oral care.	2 855	Corrected.	

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2 855	Continued From page 7 On 6/2/16, at 6:57 a.m. nursing assistant (NA)-C was observed to provide R22 morning cares. During the observation, NA-C was observed to brush R22's upper denture and lower partial and hand them to R22 for placement in her mouth. Following the completion of the morning cares, NA-C assisted R22 into a wheelchair and R22 exited the room. At no time did NA-C offer R22 the opportunity to brush her remaining lower teeth or rinse her mouth prior to inserting the clean dentures. On 6/2/16, at 7:30 a.m. NA-C confirmed she had not offered R22 the opportunity to rinse her mouth or assist R22 to brush her lower teeth and should have done so. On 6/2/16, at 12:51 p.m. the director of nursing (DON) confirmed she would expect oral cares be provided as directed by care plan. A policy regarding oral hygiene was requested but none was provided. The Using the Care Plan policy dated 6/12/15, directed staff to follow the resident care plans to ensure staff were providing appropriate care for each resident. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could develop and implement policies and procedures	2 855		

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2 855	Continued From page 8 related oral hygiene. The DON or designee, could provide training for all nursing staff related to oral cares. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 855		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide timely turning and repositioning assistance as directed by the care plan for 1 of 3 residents (R41) who was identified as at risk for pressure ulcers, required staff assistance to reposition and was not	2 900	Corrected.	6/30/16

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2 900	Continued From page 9 repositioned every two hours as directed by the care plan. Findings include: R41's quarterly Minimum Data Set dated 4/11/16, indicated R41 had cognitive impairment and was diagnosed with Alzheimer's disease and diabetes mellitus. The MDS also indicated R41 was at risk for the development of pressure related ulcers and required extensive assistance with bed mobility, transfers and ambulation. R41's Pressure Ulcer Care Area Assessment (CAA) dated 10/22/15, indicated R41 was at risk for the development of pressure ulcers due to limited mobility, obesity, diabetes and occasional urinary incontinence. The CAA directed staff to assist R41 with repositioning every two hours. R41's care plan dated 1/31/16, indicated R41 was at risk for skin breakdown/pressure ulcer development and directed staff to assist R41 to reposition at least every two hours. R41's Braden Scale for Predicting Pressure Sore Risks dated 4/11/16, identified R41 at risk for the development of pressure ulcers. R41's Tissue Tolerance (tissue perfusion) observation completed on 4/11/16, indicated R41 required a two hour repositioning schedule while in lying or sitting.	2 900		

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2 900	Continued From page 10 On 6/1/16, from 12:45 p.m. until 3:50 p.m. R41 was continuously observed. -At 12:45 p.m. R41 was observed to be assisted from the toilet to his wheelchair by nursing assistant (NA)-D. R41 remained in his room watching television until 1:52 p.m. at which time activity aide (AA)-B wheeled him to the Lodge area for stretching exercises. R41 was observed to participate in the stretching exercises, however, at no time was he observed to lift his buttocks out of the wheelchair. -At 2:37 p.m. AA-B wheeled R41 to the Birch Beach dining room for coffee and a snack. -At 2:50 p.m. R41 wheeled himself to his room to watch TV. -At 3:45 p.m. NA-A stated she had arrived at the facility at 1:00 p.m. She stated R41 had last been assisted to reposition at 12:30 p.m. by the day shift staff. NA-A stated she had wanted to assist R41 at 2:00 p.m. to reposition, but he was out of his room and she had not returned to check on him. At this time, NA-A entered R41's room and offered to reposition him. -At 3:50 p.m. NA-A and licensed practical nurse (LPN)-B were observed to transfer R41 from the wheelchair to the toilet via a mechanical standing lift. R41's wheelchair was observed to have a pressure redistribution cushion and his buttocks was observed to be intact. NA-A stated R41 was only to be repositioned as he requested. Review of the Birch Beach Toileting and Reposition form dated 6/1/16, indicated R41 was to be repositioned as he requested (PRN). The form revealed R41 had last received assistance at 12:45 p.m. (three hours earlier)	2 900		

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2 900	Continued From page 11 On 6/1/16, at 4:00 p.m. LPN-B reviewed the Birch Beach Toileting and Reposition sheet and compared it to R41's care plan. LPN-B verified the reposition sheet and the care plan directive for repositioning did not match. LPN-B stated R41 was to receive assistance with repositioning every two hours as directed on the care plan. On 6/2/16, at 6:30 a.m. R41 was observed to remain in his room, seated in the wheelchair. R41 was visiting with three staff members. R41 remained in his room until 7:41 a.m. at which time R41 wheeled himself to the dining room. He remained in the dining room until 8:41 a.m. at which time R41 wheeled himself back to his room. -At 9:05 a.m. the director of nurses (DON) approached LPN-C and requested her to assist R41 to the rest room. The DON and LPN)-C were observed to transfer R41 from the wheelchair to the toilet via the standing lift. R41's buttocks was observed to be intact. -At 9:20 a.m. NA-B relieved the DON and assisted LPN-C with transferring R41 off of the toilet and transferred him to a recliner in his room. On 6/2/16 at 9:20 a.m. NA-B verified R41 had last been repositioned at 6:30 a.m. a total of two hours and 35 minutes earlier. She stated R41 was not on a repositioning schedule and was to be repositioned as he requested. On 6/2/16, at 11:20 a.m. registered nurse (RN)-A stated R41 was to be repositioned every two hours as directed by the care plan.	2 900		

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2 900	Continued From page 12 The Prevention of Pressure Ulcer policy dated 6/11/15, directed the staff to change position in a chair at least every two hours for the prevention of pressure ulcer development. The Using the Care Plan policy dated 6/12/15, directed staff to follow the resident care plans to ensure staff were providing appropriate care for each resident. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could develop and implement policies and procedures related to pressure ulcer prevention. The DON or designee, could provide training for all nursing staff related to pressure ulcers and the importance of repositioning. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		
21980	MN St. Statute 626.557 Subd. 3 Reporting - Maltreatment of Vulnerable Adults Subd. 3. Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because	21980		6/30/16

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21980	Continued From page 13 the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c.	21980		

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21980	Continued From page 14 This MN 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 a physical altercation by another resident to the State agency (SA) for 1 of 3 residents (R3) reviewed for abuse prohibition. Findings include: The Vulnerable Adult Abuse/Neglect Prevention Policy and Procedure dated 6/15/15, 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 (as soon as possible). The investigative report dated 3/7/16, indicated on 3/4/16, R3 was intentionally struck on the shoulder with an open hand by another resident. Staff intervened and redirected the residents involved. The report revealed the administrator and the common entry point were both notified on 3/7/16. (three days after to incident occurred)	21980	Corrected.	

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21980	Continued From page 15 On 6/1/16, at 3:30 p.m. the social worker (SW) stated the incident occurred on a Friday evening 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. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could implement policies and procedures related to reporting of allegations of abuse or neglect. The DON or designee, could provide training for all nursing staff related to reporting abuse. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21980		