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: 8CO7 Facility ID: 00797

		TO BE COMIT			E SERVET TOET		rueinty 12. 00777	
1. MEDICARE/MEDICAID PROVIDE (L1) 245329	ER NO.	3. NAME AND AI (L3) WARROAD	CARE CENT	ER		4. TYPE OF ACTI	ON: 7 (L8) 2. Recertification	
2.STATE VENDOR OR MEDICAID (L2) 974840700	NO.	(L4) 1401 LAKE (L5) WARROAD		RTHWEST	(L6) 56763	3. Termination 5. Validation	4. CHOW 6. Complaint	
5. EFFECTIVE DATE CHANGE OF (L9)	OWNERSHIP	7. PROVIDER/SU 01 Hospital	JPPLIER CATEC	GORY 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	7. On-Site Visit 8. Full Survey After	9. Other er Complaint	
6. DATE OF SURVEY 8. ACCREDITATION STATUS: 0 Unaccredited 2 AOA 1 TJC 3 Other	5/ 2016 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR END	ING DATE: (L35)	
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds	49 (L18) 49 (L17)	Compliance1. A B. Not in Comp	ance With equirements e Based On: acceptable POC	ram	And/Or Approved Waivers Of 2. Technical Personnel3. 24 Hour RN4. 7-Day RN (Rural SN5. Life Safety Code		Services Limit Director om Size	
		Requirements	and/or Applied	waivers:	* Code: A	(L12)		
14. LTC CERTIFIED BED BREAKDO 18 SNF 18/19 SNF 49	WN 19 SNF	ICF	IID		15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)		
(L37) (L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY REM	ARKS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION	DATE):				
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL	Date:	
Beth Nowling, HFE N	IEII	0	07/15/2016	(L19)	Mark Weeth, Enforcement Specialist 08/30/2016 (L20)			
PA	RT II - TO BE	COMPLETED I	BY HCFA RI	EGIONAL	OFFICE OR SINGLE S	STATE AGENCY		
19. DETERMINATION OF ELIGIBII _X 1. Facility is Eligible to I 2. Facility is not Eligible	Participate		MPLIANCE WITH HTS ACT:	H CIVIL	21. 1. Statement of Fina2. Ownership/Contr3. Both of the Above	ol Interest Disclosure Stm		
22. ORIGINAL DATE	23. LTC AGREE	MENIT 2	4. LTC AGREEN	MENIT	26 TERMINATION ACTION		(120)	
OF PARTICIPATION 08/01/1986	BEGINNING		ENDING DA		26. TERMINATION ACTION VOLUNTARY 01-Merger, Closure	<u>INVOLU</u>	(L30) NTARY Meet Health/Safety	
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs	sement 06-Fail to	Meet Agreement	
25. LTC EXTENSION DATE:	27. ALTERNATI A. Suspension	VE SANCTIONS n of Admissions:	(L44)		03-Risk of Involuntary Terminatic 04-Other Reason for Withdrawal	OTHER	der Status Change e	
(L27)	B. Rescind St	uspension Date:	(L45)					
28. TERMINATION DATE:	29). INTERMEDIARY/	/CARRIER NO.		30. REMARKS			
		03001						
	(L28)	00001		(L31)				
31. RO RECEIPT OF CMS-1539		2. DETERMINATION 07/19/2016	N OF APPROVAI	_				
	(L32)			(L33)	DETERMINATION APP	ROVAL		



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 Weath

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

Email: mark.meath@state.mn.us

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



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered July 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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONSTRUCTION			DATE OF REV	ISIT
IDENTIFICATION NUMBER	A. Building				
245329 _{Y1}	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).

ITE Y4		DATE Y5	ITEM Y4		DATE Y5	ITEM Y4			DATE Y5
ID Prefix	F0225	Correction	ID Prefix F	0226	Correction	ID Prefix	F0282		Correction
Reg. #	483.13(c)(1)(ii)-(ii - (4)	i), (c)(2) Completed	Reg. #	33.13(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 F	0314	Correction	ID Prefix			Correction
Reg. #	483.25(a)(3)	Completed	Reg. #	33.25(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			
REVIEWI STATE A	ED BY GENCY 🔼	REVIEWED BY (INITIALS) LB/mm	DATE 07/29/201	SIGNATU 16	JRE OF SURVEYOR 28035		D	07/15	5/2016
REVIEWI CMS RO		REVIEWED BY (INITIALS)	DATE	TITLE				ATE	
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						в 🔲 но	

POST-CERTIFICATION REVISIT REPORT

	MULTIPLE CONSTRUCTION			DATE OF REV	VISIT
IDENTIFICATION NUMBER	A. Building 02 - WARROAD CARE CENTE B. Wing	Ξ K		6/24/2016	
245329 _{Y1}	B. Willig		Y2	0/24/2010	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).

ITE 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. #	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			
REVIEWI STATE A		REVIEWED BY (INITIALS) LB/mm	DATE 07/29/2016	SIGNATURE OF	SURVEYOR 3653	6		DATE 06/2	4/2016
REVIEWI CMS RO		REVIEWED BY (INITIALS)	DATE	TITLE				DATE	
FOLLOWUP TO SURVEY COMPLETED ON 6/1/2016				R ANY UNCORREC				YE	s 🗌 NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART 1- TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: 8CO7 Facility ID: 00797

	TAKI I-	TO BE COMIT	JEIED DI	IIIE SIAI	ESURVETAGENCE	racinty ID. 00797	
MEDICARE/MEDICAID PROVID (L1) 245329		3. NAME AND AI (L3) WARROAD (L4) 1401 LAKE	CARE CENT	ΓER	,	4. TYPE OF ACTION: 2 (L8) 1. Initial 2. Recertification	
2.STATE VENDOR OR MEDICAID (L2) 974840700	NO.	(L5) WARROAD		KIHWESI	(L6) 56763	3. Termination 4. CHOW 5. Validation 6. Complaint	
			<u></u>			7. On-Site Visit 9. Other	
5. EFFECTIVE DATE CHANGE OF (L9)	OWNERSHIP	7. PROVIDER/SU 01 Hospital	JPPLIER CATEO 05 HHA	GORY 09 ESRD	02 (L7) 13 PTIP 22 CLIA	8. Full Survey After Complaint	
` ′	2/2016 (L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF		
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID		FISCAL YEAR ENDING DATE: (L35)	
0 Unaccredited 1 TJC	_ ()	04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	09/30	
2 AOA 3 Other							
11LTC PERIOD OF CERTIFICATIO	N	10.THE FACILITY		AS:	And/Or Amproved Weivers Of	The Fellowing Deguirements:	
From (a): To (b):		A. In Complia	equirements		And/Or Approved Waivers Of2. Technical Personnel		
10 (0).		_	e Based On:		3. 24 Hour RN	7. Medical Director	
		1. A	cceptable POC		4. 7-Day RN (Rural SN		
12. Total Facility Beds	49 (L18)	V n v i a			5. Life Safety Code	9. Beds/Room	
13.Total Certified Beds	49 (L17)	X B. Not in Con Requirements	and/or Applied	-	* Code: B*	(L12)	
14. LTC CERTIFIED BED BREAKDO	OWN	<u> </u>			15. FACILITY MEETS		
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)	
49							
(L37) (L38)	(L39)	(L42)	(L43)				
16. STATE SURVEY AGENCY REM	ARKS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION	DATE):			
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:	
Rebecca Haberle, HFE	NEII		06/24/2016	(L19)	Mark Meath	, Enforcement Specialist 07/15/2016 (L20	
PA	RT II - TO BE	COMPLETED I	BY HCFA R	EGIONAL	OFFICE OR SINGLE S	TATE AGENCY	
19. DETERMINATION OF ELIGIBI _X_ 1. Facility is Eligible to			IPLIANCE WIT HTS ACT:	H CIVIL	 Statement of Financial Solvency (HCFA-2572) Ownership/Control Interest Disclosure Stmt (HCFA-1513) Both of the Above : 		
2. Facility is not Eligibl	-				3. Both of the Above	···	
2. Tacinty is not Englor	(L21)						
22. ORIGINAL DATE	23. LTC AGREE!	MENT 24	4. LTC AGREE	MENT	26. TERMINATION ACTION:	(L30)	
OF PARTICIPATION	BEGINNING	DATE	ENDING DA	ATE .	VOLUNTARY 00	INVOLUNTARY	
08/01/1986					01-Merger, Closure	05-Fail to Meet Health/Safety	
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs		
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Termination	OTHER	
	A. Suspension	n of Admissions:			04-Other Reason for Withdrawal	07-Provider Status Change	
(L27)	D.D. : 10	· D.	(L44)			00-Active	
	B. Rescind Si	ispension Date:	(L45)				
28. TERMINATION DATE:	29	. INTERMEDIARY			30. REMARKS		
		03001					
	(L28)	05001		(L31)			
31 RO RECEIPT OF CMS 1520	21	DETERMINATION	I OE A PDROVA	I DATE			
31. RO RECEIPT OF CMS-1539	32 (L32)	. DETERMINATION	OF APPROVA	L DATE (L33)	DETERMINATION APP	DOVAL	



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:

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

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

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

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

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

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

DEPARTMENT CONTACT

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

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

Email: mark.meath@state.mn.us

Telephone: (651) 201-4118

Fax: (651) 215-9697

PRINTED: 06/24/2016 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY MPLETED
		245329	B. WING _	·····	06.	/02/2016
	PROVIDER OR SUPPLIER AD CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1401 LAKE STREET NORTHWEST WARROAD, MN 56763	·	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 000	INITIAL COMMEN	ΓS	F 00	00		
	as your allegation of Department's accelenrolled in ePOC, yat the bottom of the form. Your electron be used as verification	•				
F 225 SS=D	on-site revisit of you validate that substa regulations has bee your verification. 483.13(c)(1)(ii)-(iii),	PORT	F 22	25		6/30/16
	been found guilty o mistreating residen had a finding entere registry concerning of residents or misa and report any know court of law against indicate unfitness for	of employ individuals who have f abusing, neglecting, or ts by a court of law; or have ed into the State nurse aide abuse, neglect, mistreatment appropriation of their property; wledge it has of actions by a tan employee, which would or service as a nurse aide or the State nurse aide registry ties.				
ADODATOS	involving mistreatm including injuries of misappropriation of immediately to the to other officials in through established State survey and co	isure that all alleged violations tent, neglect, or abuse, unknown source and resident property are reported administrator of the facility and accordance with State law diprocedures (including to the ertification agency).	NATURE	TITLE		(X6) DATE

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

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.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPI A. BUILDING	·	(X3) DATE SURVEY COMPLETED	
		245329	B. WING		06/02/2016
	PROVIDER OR SUPPLIER AD CARE CENTER		1	STREET ADDRESS, CITY, STATE, ZIP CODE 401 LAKE STREET NORTHWEST WARROAD, MN 56763	00,02,200
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 225	violations are thoro prevent further pote investigation is in p The results of all in to the administrator representative and with State law (inclucertification agency incident, and if the	eve evidence that all alleged ughly investigated, and must ential abuse while the rogress.	F 225		
	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)			Current policy on vulnerable adult reporting to be reviewed with all staf Review will include the expectation of reporting immediately any suspected mistreatment, abuse, neglect, injuried unknown source or misappropriation resident property so that timely deciss making and reporting can be to facil staff and the state agency. This will include discussion and expectations all incidents that happen on evening and weekend shifts will follow the safe expectation of immediate reporting with the facility so that the determination 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	of d es of n of sion ity that , night ame within of

	OF DEFICIENCIES F CORRECTION	` '				E SURVEY IPLETED
		245329	B. WING _		06/	02/2016
	PROVIDER OR SUPPLIER AD CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP COL 1401 LAKE STREET NORTHWEST WARROAD, MN 56763		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 225	stated the incident of and was not reported weekend, therefored to the administrator thing the following Noverified the facility of procedure related to State agency and a The Vulnerable Adupolicy and Proceduradminister or direct services director shincident/allegation rincident." All incident MN statue are called	o.m. the social worker (SW) occurred on a Friday evening ed by facility staff over the the the second of the secon	F 2	timely reporting when the incide indicate circumstances that a should or may need to be filed deviation from policy will be dissoon as possible with the person completing the form. Random audits will be complete interview and by chart review direction of the Director of Social Services. These audits will for identification of items that are and the understanding of the process by the person involved the timeliness of making such Not less than 2 audits/week we conducted for 30 days and not 1/week for an additional 60 days the audits will be reviewed by Social Service Director and Addition results will be reported audition results will be reported audition and audition audition and audition and audition and audition and audition and audition audi	report either I. Any scussed as son Ited by staff under the cial cus on reportable reporting d to include reports. iil be t less than lys review and the DON, dministrator. rted at eetings. ing will be	
F 226 SS=D	483.13(c) DEVELO ABUSE/NEGLECT	, ETC POLICIES	F 2	Responsible Party: Director of Services	f Social	6/30/16
	policies and proced	velop and implement written lures that prohibit ect, and abuse of residents				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		245329	B. WING _		06/0	02/2016	
	PROVIDER OR SUPPLIER AD CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP 1401 LAKE STREET NORTHWEST WARROAD, MN 56763	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 226		age 3 on of resident property.	F 22	26			
	by: Based on interview facility failed to imprelated to the immediatercation by anoth agency (SA) for 1 cabuse prohibition. Findings include: The Vulnerable Addrolicy and Proceduabuse consisted of unreasonable confinity punishment with remental anguish. Thadminister or direct services director shincident/allegation incident." All incide MN statue were cat (CEP) and are sub Department of Hear Reporting System possible). The investigative reon 3/4/16, R3 was shoulder with an op Staff intervened an involved. The reporting to the investigative reon 3/4/16, R3 was shoulder with an op Staff intervened an involved. The reporting to the investigative reconsideration of the staff intervened an involved. The reporting to the investigative reconsideration of the staff intervened an involved. The reporting the investigative reconsideration of the staff intervened an involved. The reporting the investigative reconsideration of the staff intervened an involved. The reporting the investigative reconsideration of the staff intervened an involved. The reporting the investigative reconsideration of the staff intervened an involved. The reporting the involved intervened an involved.	NT is not met as evidenced and document review, the element their abuse policy ediate reporting of a physical ner resident to the State of 3 residents (R3) reviewed for a state of 3 residents of 3 reviewed for a state of 3 reviewed for 3 residents of 3 reviewed for 3 reviewed for 3 reportable and the criteria for "reportable of 3 report dated 3 reviewed for 3 residents of 3 reviewed for 3 reviewed f		Current policy on vulneral reporting to be reviewed we Review will include the experiment, abuse, negliunknown source or misappersident property so that the making and reporting can staff and the state agency include discussion and expectation of immediate the facility so that the determined can be made by designated in the policy. The Director of Social Service will continue to report to check for timely reporting when the indicate circumstances the should or may need to be deviation from policy will be soon as possible with the completing the form. Random audits will be continued in the policy. Random audits will be continued to report to the deviation from policy will be soon as possible with the completing the form.	with all staff. pectation of suspected lect, injuries of propriation of imely decision be to facility This will pectations that on evening, night llow the same reporting within ermination of porting is those vices or review all or accuracy in incident details at a report either filed. Any be discussed as person mpleted by staff iew under the Social Il focus on		

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	,		COMPLETED		
		245329	B. WING			06/0	02/2016
	PROVIDER OR SUPPLIER			14	TREET ADDRESS, CITY, STATE, ZIP CODE 101 LAKE STREET NORTHWEST /ARROAD, MN 56763		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 226	3/7/16. (three days On 6/1/16, at 3:30 p stated the incident of and was not reported weekend, therefore to the administrator thing the following N verified the facility of	after to incident occurred) o.m. the social worker (SW) occurred on a Friday evening ed by facility staff over the , the SW reported the incident and State agency the first Monday morning. The SW did not follow their policy and o immediately reporting to the	F 2	26	and the understanding of the report process by the person involved to it the timeliness of making such repo Not less than 2 audits/week will be conducted for 30 days and not less 1/week for an additional 60 days thereafter. Results of the incident report review the audits will be reviewed by the D Social Service Director and Adminis In addition results will be reported a quarterly quality committee meeting. Follow up education and auditing w modified and/or extended as indicate audit results. Responsible Party: Director of Social Service Director Director Director Of Social Service Director Direc	than v and ON, strator. it js. ill be ted by	
F 282 SS=D	The services provided by accordance with eacare. This REQUIREMENT by: Based on observative review, the facility fawith repositioning for dependent upon standdition, the facility	led or arranged by the facility y qualified persons in ch resident's written plan of NT is not met as evidenced ion, interview and document ailed to provide assistance or 1 of 3 residents (R41) aff for repositioning. In failed to ensure oral hygiene of 1 residents (R22) who	F 2	82	R41 and R22 care plans were reviewed to assure accuracy of care	to care plan. and en	7/1/16

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		245329	B. WING _	 	06/	02/2016
	PROVIDER OR SUPPLIER AD CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1401 LAKE STREET NORTHWEST WARROAD, MN 56763		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 282	Finding include: R41 was not provid directed by the care R41's care plan dat at risk for skin brea development and d reposition at least e On 6/1/16, from 12: was continuously of wheelchair without so the continuously of the care o	ed repositioning assistance as e plan. ed 1/31/16, indicated R41 was kdown/pressure ulcer irected staff to assist R41 with	F 28	,	Policy apport the ag and in ation on following idents mly audit month dditional are of care ally, acted on ek for 1 week for pose of	
	earlier). NA-A confir R41 with reposition started at 1:00 p.m. On 6/1/16, at 3:50 p. assistance to reposition observed to transfe the toilet via a mechanic wheelchair was observed to be intained.	rmed she had not assisted ing during her shift which		The data collected from the audireviewed and analyzed by the DO designee and presented to the quality committee for their consic Changes in audit frequency, timin focus may be indicated based or results.	ON or uarterly leration. ng and	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SLIPPLIER/CLIA

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	TIPLE CONSTRUCTION NG			E SURVEY PLETED
		245329	B. WING			06/	02/2016
	PROVIDER OR SUPPLIER AD CARE CENTER			STREET ADDRESS, CITY, STATE, 1401 LAKE STREET NORTHWI WARROAD, MN 56763			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD THE APPROP	BE	(X5) COMPLETION DATE
F 282	On 6/2/16, from 6:3 continuously observed wheelchair without At 9:05 a.m. the direct approached LPN-C	ector of nurses (DON) and requested her to assist	F 2	82			
	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.						
	last repositioned at						
		a.m. registered nurse (RN)-A be repositioned every two y the care plan.					
	R22 was not provid as directed by the c	ed assistance with oral care are plan.					
	had an upper dentu	ited 2/22/16, indicated R22 ire and lower partial and sist R22 with personal hygiene					
	On 6/2/16, at 6:57 a	a.m. NA-C was observed to					

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		E SURVEY IPLETED
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	PROVIDER OR SUPPLIER AD CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1401 LAKE STREET NORTHWEST WARROAD, MN 56763		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROPRIES OF THE APPROPRIES OF T	D BE	(X5) COMPLETION DATE
F 282	provide R22 mornir observation, NA-C upper denture and R22 for placement completion of the mR22 into a wheelch At no time did NA-C brush her remaining mouth prior to inser	ng cares. During the was observed to brush R22's lower partial and hand them to in her mouth. Following the norning cares, NA-C assisted air and R22 exited the room. C offer R22 the opportunity to g lower teeth or rinse her ting the clean dentures. a.m. NA-C confirmed she had a opportunity to rinse her R22 to brush her lower teeth	F 28	2		
F 312 SS=D	would expect oral coby care plan. The Using the Care directed staff to follow ensure staff were placed resident. 483.25(a)(3) ADL COBPENDENT RES A resident who is undaily living receives maintain good nutriand oral hygiene.	p.m. the DON confirmed she ares be provided as directed. Plan policy dated 6/12/15, ow the resident care plans to roviding appropriate care for CARE PROVIDED FOR IDENTS nable to carry out activities of the necessary services to tion, grooming, and personal.	F 31	2		6/30/16

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION		SURVEY PLETED
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDERICIENCY)	D BE	(X5) COMPLETION DATE
F 312	Continued From pa	age 8	F 312			
	Based on observareview, the facility f	tion, interview and document ailed to ensure oral hygiene of 1 resident (R22) who		R22 care plan was reviewed for appropriateness and education to givers was provided to follow care All residents requiring assistance	plan.	
	Findings include:			cares have been reviewed to assu accuracy of care planning and documentation of care providers f the care plan. Policy and procedu	ire ollowing	
	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			oral care and assessment will be reviewed and updated as necessary support the need for accuracy in or planning and in care delivery and documentation.		
	and personal hygie R22 had no dental	ne. The MDS further indicated concerns.		All nursing staff will receive educa the policy and the importance of for and updating as required the residual plan of care.	ollowing	
	Assessment (CAA) needs\ed extensive grooming, and physometric pain with A becoming fatigued and needed freque times. The CAA fur would include interparticipation with A	itation Potential Care Area dated 2/12/16, indicated R22 assistance with dressing, sical assistance with bathing. R22 denied having any DL's, but admitted to at times. R22 had dementia nt verbal cues during ADL's at ther indicated R22's care plan ventions to promote as much DL's as R22 was able, while se as needed to ensure safe		The DON or designee will random 2 charts on a daily basis for one mand then 1 chart per day for an admonth to be sure that care plans a current and that documentation of plan activity is in place. Additional observational audits will be condunct less than 4 residents per weekmonth and then 2 residents per wan additional 60 days for the purpobserving actual care delivered verblan instructions.	nonth ditional are care lly, cted on c for 1 eek for ose of s. care	
	had an upper dentu	ated 2/22/16, indicated R22 ure and lower partial and o provide extensive assistance one and oral care.		The data collected from the audits reviewed and analyzed by the DO designee and presented to the qu quality committee for their consider Changes in audit frequency, timing focus may be indicated based on	N or arterly eration. g and	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ') MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
		245329	B. WING			06/02/2016	
	PROVIDER OR SUPPLIER AD CARE CENTER			14	TREET ADDRESS, CITY, STATE, ZIP CODE 401 LAKE STREET NORTHWEST /ARROAD, MN 56763		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 312	,		F 3	12	results.		
	was observed to pr During the observa brush R22's upper hand them to R22 the Following the comp NA-C assisted R22 exited the room. At the opportunity to be	a.m. nursing assistant (NA)-C ovide R22 morning cares. tion, NA-C was observed to denture and lower partial and for placement in her mouth. eletion of the morning cares, into a wheelchair and R22 no time did NA-C offer R22 rush her remaining lower teeth prior to inserting the clean					
	not offered R22 the	a.m. NA-C confirmed she had opportunity to rinse her 2 to brush her lower teeth and so.					
		p.m. the director of nursing he would expect oral cares be d by care plan.					
	A policy regarding of none was provided	oral hygiene was requested but					
F 314 SS=D	directed staff to foll ensure staff were p each resident. 483.25(c) TREATM	e Plan policy dated 6/12/15, ow the resident care plans to roviding appropriate care for IENT/SVCS TO RESSURE SORES	F 3	14			6/30/16
	Based on the comp	prehensive assessment of a					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245329	B. WING		06/02/2016
	PROVIDER OR SUPPLIER AD CARE CENTER		1	TREET ADDRESS, CITY, STATE, ZIP CODE 401 LAKE STREET NORTHWEST VARROAD, MN 56763	
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F 314	resident, the facility who enters the faci does not develop p individual's clinical they were unavoida pressure sores reciservices to promote prevent new sores This REQUIREMEI by: Based on observareview, the facility fand repositioning a care plan for 1 of 3 identified as at risk staff assistance to repositioned every care plan. Findings include: R41's quarterly Minindicated R41 had diagnosed with AlzI mellitus. The MDS for the development and required extens mobility, transfers at R41's Pressure Ulc (CAA) dated 10/22 for the development and required extens mobility.	must ensure that a resident lity without pressure sores ressure sores unless the condition demonstrates that able; and a resident having eives necessary treatment and e healing, prevent infection and from developing. NT is not met as evidenced tion, interview and document ailed to provide timely turning ssistance as directed by the residents (R41) who was for pressure ulcers, required reposition and was not two hours as directed by the dimum Data Set dated 4/11/16, cognitive impairment and was neimer's disease and diabetes also indicated R41 was at risk at of pressure related ulcers sive assistance with bed	F 314	,	olan. rith o nd flowing and e y to are on on lowing ents / audit onth fitional e care

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		E SURVEY PLETED
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314	o o i i i i i i i i i i i i i i i i i i	ge 11 ositioning every two hours.	F3	314	not less than 4 residents per week		
	at risk for skin brea development and d	an dated 1/31/16, indicated R41 was breakdown/pressure ulcer and directed staff to assist R41 to east every two hours.			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 wil be placed on residents with a Braden score indicating increased risk.		
		e for Predicting Pressure Sore 5, identified R41 at risk for the essure ulcers.			The data collected from the audits reviewed and analyzed by the DON designee and presented to the qua quality committee for their consider Changes in audit frequency, timing focus may be indicated based on a	l or arterly ration. and	
	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.				results.	luun	
	was continuously of At 12:45 p.m. R41 from the toilet to his assistant (NA)-D. If watching television activity aide (AA)-B area for stretching to participate in the however, at no time buttocks out of the At 2:37 p.m. AA-B Beach dining room At 2:50 p.m. R41 v watch TV. At 3:45 p.m. NA-A facility at 1:00 p.m. assisted to reposition	was observed to be assisted s wheelchair by nursing R41 remained in his room until 1:52 p.m. at which time wheeled him to the Lodge exercises. R41 was observed stretching exercises, was he observed to lift his					

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION ING		TE SURVEY MPLETED
		245329	B. WING		06	6/02/2016
	PROVIDER OR SUPPLIER AD CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP 1401 LAKE STREET NORTHWEST WARROAD, MN 56763	CODE	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		N SHOULD BE	(X5) COMPLETION DATE
F 314	R41 at 2:00 p.m. to his room and she him. At this time, Noffered to reposition-At 3:50 p.m. NA-A (LPN)-B were obsewheelchair to the tolift. R41's wheelchair to the tolift. R41's wheelchair to gressure redistribut was observed to be only to be reposition. Review of the Birch Reposition form dato be repositioned a form revealed R41 at 12:45 p.m. (three On 6/1/16, at 4:00 p. Beach Toileting and compared it to R41 the reposition shee for repositioning did was to receive assitwo hours as direct. On 6/2/16, at 6:30 a remain in his room, was visiting with the remained in his room, was visiting with the remained in the din which time R41 wheroom. -At 9:05 a.m. the di	reposition, but he was out of rad not returned to check on JA-A entered R41's room and in him. and licensed practical nurse rived to transfer R41 from the bilet via a mechanical standing air was observed to have a tion cushion and his buttocks intact. NA-A stated R41 was ned as he requested. Beach Toileting and ted 6/1/16, indicated R41 was as he requested (PRN). The had last received assistance				

	OF DEFICIENCIES OF CORRECTION				ATE SURVEY OMPLETED	
		245329	B. WING	 	06	/02/2016
	PROVIDER OR SUPPLIER AD CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 1401 LAKE STREET NORTHWEST WARROAD, MN 56763		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE ((EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 314	R41 to the rest roor were observed to tr wheelchair to the to buttocks was obser-At 9:20 a.m. NA-B assisted LPN-C wit toilet and transferred. On 6/2/16 at 9:20 a been repositioned a hours and 35 minut was not on a repositioned as the reposition of F 6/11/15, directed the repositio	m. The DON and LPN)-C ansfer R41 from the bilet via the standing lift. R41's wed to be intact. relieved the DON and he transferring R41 off of the ed him to a recliner in his room. I.M. NA-B verified R41 had last at 6:30 a.m. a total of two less earlier. She stated R41 itioning schedule and was to the requested. a.m. registered nurse (RN)-A per repositioned every two by the care plan. Pressure Ulcer policy dated the staff to change position in a two hours for the prevention	F 3	14		

F5329024

PRINTED: 06/21/2016 FORM APPROVED OMB NO. 0938-0391

(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING 02 - WARROAD CARE CENTER B. WING 245329 06/01/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1401 LAKE STREET NORTHWEST WARROAD CARE CENTER WARROAD, MN 56763 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 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, By email to: Marian.Whitney@state.mn.us (X6) DATE LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE

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.

If continuation sheet Page 1 of 5

06/19/2016

Electronically Signed

PRINTED: 06/21/2016 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	02 - WARROAD CARE CENTER		IPLETED	
		245329	B. WING		06/	01/2016	
	PROVIDER OR SUPPLIER	3	STREET ADDRESS, CITY, STATE, ZIP CODE 1401 LAKE STREET NORTHWEST WARROAD, MN 56763				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
K 000	DEFICIENCY MU FOLLOWING INF 1. A description of to correct the defice 2. The actual, or possible for comprehent a reoccurrent and assisted living with a 2-hour fire lasenior apartment 2-hour fire barriers. The facility is fully accordance with Noustallation of Autoedition. A manual with smoke detection and areas in National Fire Alarra automatic fire deprooms have smokareas have automatic fire deficience.	PRRECTION FOR EACH ST INCLUDE ALL OF THE ORMATION: what has been, or will be, done ciency. proposed, completion date. or title of the person rrection and monitoring to rence of the deficiency. e Center is a 1-story building nt. The building was 199 and is of Type V(111) are south west of the building is apartment which is separated parrier and to the south east a building which is separated by a 1 The building is divided into 19 with 1-hour and 2-hour fire 19 sprinkler protected installed in 19 with 19 stems 19 fire alarm system is installed the 19 matic Sprinkler Systems 19 fire alarm system is installed the 19 matic Sprinkler Systems 19 fire alarm system is installed the 19 matic Sprinkler Systems 19 matic S	K 000				

Event ID: 8CO721

			X3) DATE COMP	SURVEY		
		245329	B. WING		06/0	1/2016
	NAME OF PROVIDER OR SUPPLIER WARROAD CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1401 LAKE STREET NORTHWEST WARROAD, MN 56763		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
K 000	Continued From pa	age 2	K 000			
		apacity of 49 beds. At the time ensus was 48 residents.				
K 022 SS=F	NOT MET as evide NFPA 101 LIFE SA Access to exits share readily visible signs way to reach exit is occupants. Doors, not a way of exit than exit have a sign 18.2.10.1, 19.2.10. This STANDARD Based on observate facility has failed to exit doors leading extend to the publication of the publication o	AFETY CODE STANDARD all be marked by approved, in all cases where the exit or is not readily apparent to the passages or stairways that are lat are likely to be mistaken for indesignating "No Exit". 7.10, 1 is not met as evidenced by: attion and staff interview, the interview in accordance with NFPA 7.10.1.7 and 7.10.8.1. These could negatively affect all it is visitors, by causing confusion from the building to the public	K 022	 Doors leading to the patios have marked with signage indicating "No Correction Date: 06/06/2016 Responsible Person for Complet and Monitoring: Environmental Ser Director. 	e been Exit".	6/6/16
		between 7:45 am to 11:30 am				
K 073 SS=E	revealed the doors have "No Exit" sign This deficient prac Environmental Ser	to the enclosed patios did not ns.	K 073			6/2/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - WARROAD CARE CENTER			(X3) DATE SURVEY COMPLETED	
		245329	B. WING		06/0	01/2016	
	PROVIDER OR SUPPLIER AD CARE CENTER		1	TREET ADDRESS, CITY, STATE, ZIP COD 401 LAKE STREET NORTHWEST VARROAD, MN 56763	E		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
K 073	unless they are flar quantity that hazard is not present. 18.7 This STANDARD is Based on observate facility failed to main accordance with (00) section 18.7.5 could allow smoke through the corridor egress capability in 12 of the 48 reside amount of visitors a Findings include: On the facility tour on 06/01/2016 obs revealed untreated the corridor doors (A109.	ations shall be prohibited me-retardant or in such limited d of fire development or spread 7.5.4, 19.7.5.4 s not met as evidenced by: tions and staff interview, the intain combustible decorations NFPA Life Safety Code 101.4. This deficient practice and fire to rapidly migrate are and negatively affect the other than the event of an emergency for ints and an undetermined and staff. between 7:45 am to 11:30 am ervations and staff interview combustible decorations on to resident rooms, A103 and	K 073	1. Decorations on rooms A10 were removed, treated, labele replaced. 2. Correction Date: 06/02/201 3. Responsible Person for Coand Monitoring: Environment Director. Additionally the Safe Committee and its members were minded to observe for this is throughout the building and renoted problems to the Environ Services Director.	d and 6 mpletion al Service ety vill be ssue port any		
K 144 SS=F	Generators inspect under load for 30 m in accordance with 3-4.4.1 and 8-4.2 (110) This STANDARD Based on docume interview, the facility generators in according 2000 NFPA 101 6-4.2 (a) & (b) and	ted weekly and exercised ninutes per month and shall be NFPA 99 and NFPA 110. NFPA 99), Chapter 6 (NFPA is not met as evidenced by: entation review and staff ty failed to test the emergency rdance with the requirements - 9.1.3 and 1999 NFPA 110 6-4.2.2. The deficient practice residents, staff, and visitors.	K 144	 A new column has been a generator check list to include down time. Correction Date: 06/03/20/3. Responsible Person for Coand Monitoring: Environment 	the cool ompletion	6/3/16	

PRINTED: 06/21/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION G 02 - WARROAD CARE CENTER		TE SURVEY MPLETED	
		245329	B. WING _		06	/01/2016
	PROVIDER OR SUPPLIER AD CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1401 LAKE STREET NORTHWEST WARROAD, MN 56763		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
	on 06/01/2016 recorevealed the gener being logged on the This deficient cond Environmental Ser NFPA 101 LIFE SA Electrical wiring an accordance with N (NFPA 99) 18.9.1, This STANDARD Based on observathe facility was usin place of permanen that is not in accordational Electrical could negatively afterisidents, staff and Findings include: On the facility tour on 06/01/2016 observealed the use of the lounge area of	between 7:45 am to 11:30 am ord review and staff interview ator cool down cycle was not e monthly reports. ition was verified by the the vice Director. FETY CODE STANDARD d equipment shall be in ational Electrical Code. 9-1.2 19.9.1 is not met as evidenced by: tion and interview with the staffing a multiple plug adapter in t wiring or listed power strip, dance with NFPA 70 (99), Code. This deficient practice fect the safety of 12 of 49 it visitors. between 7:45 am to 11:30 am ervations and staff interview f a non listed 3 plug adapter in the memory care wing.	K 14		and strip.	6/2/16

Facility ID: 00797

FORM CMS-2567(02-99) Previous Versions Obsolete



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 <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

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

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

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

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

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

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

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

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

Fax: (651) 215-9697

PRINTED: 06/24/2016 FORM APPROVED

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				3) DATE SURVEY COMPLETED	
		00797	B. WING		06/0	2/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	1 00/0	_,	
WARROAD CARE CENTER 1401 LAKE STREET NORTHWEST WARROAD, MN 56763							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE	
2 000	Initial Comments		2 000				
	****ATTE	NTION*****					
	NH LICENSING CORRECTION ORDER						
	144A.10, this correspursuant to a surver found that the deficiency herein are not correspond to corrected shall with a schedule of the Minnesota Department of the Minnesota Department of the number and MN Ruwhen a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	hether a violation has been					
	that may result fron orders provided tha the Department wit	hearing on any assessments n non-compliance with these at a written request is made to hin 15 days of receipt of a ent for non-compliance.					
	receipt of State lice the Minnesota Dep Informational Bullet http://www.health.s	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are					

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

Electronically Signed 06/19/16

STATE FORM 6899 8CO711 If continuation sheet 1 of 16

TITLE

(X6) DATE

PRINTED: 07/19/2016 FORM APPROVED

Minnesota Department of Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA

(X2) MULTIPLE CONSTRUCTION A. BUILDING:

(X3) DATE SURVEY COMPLETED

00797

IDENTIFICATION NUMBER:

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 REGULATORY OR LSC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE		
2 000	Initial Comments		2 000				
	*****ATTENTION*****						
	NH LICENSING CORRECTION ORD	ER					
	In accordance with Minnesota Statute, s 144A.10, this correction order has been pursuant to a survey. If, upon reinspectifound that the deficiency or deficiencies herein are not corrected, a fine for each not corrected shall be assessed in accordinate with a schedule of fines promulgated by the Minnesota Department of Health.	issued on, it is cited violation rdance					
	Determination of whether a violation has corrected requires compliance with all requirements of the rule provided at the number and MN Rule number indicated When a rule contains several items, failt comply with any of the items will be conslack of compliance. Lack of compliance re-inspection with any item of multi-part result in the assessment of a fine even it that was violated during the initial inspectorrected.	tag below. ure to sidered upon rule will f the item					
	You may request a hearing on any asset that may result from non-compliance wit orders provided that a written request is the Department within 15 days of receip notice of assessment for non-compliance	h these made to t of a					
	INITIAL COMMENTS: You have agreed to participate in the electron receipt of State licensure orders consiste the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/pobul.htm The State licensing orders are delineated on the attached Minnesota	ent with					

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

TITLE

(X6) DATE

Electronically Signed

STATE FORM

06/19/16

6899

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(3) DATE SURVEY COMPLETED	
	00797	B. WING		06/0	2/2016	
NAME OF PROVIDER OR SUPPLIER			STATE, ZIP CODE			
WARROAD CARE CENTER	WARROAD CARE CENTER 1401 LAKE STREET NORTHWEST WARROAD, MN 56763					
PREFIX (EACH DEFICIENCY)	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL CO IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
you electronically. A is necessary for State enter the word "corretext. You must then it State licensure processor completion date, the corrected prior to element of Minnesota Department." On 5/31/16, 6/1/16, a Department's staff of the following correction. Please indicate in you correction that you hand identify the date. Minnesota Department of the State Licensing of federal software. Tagassigned to Minnesota Nursing Homes. The assigned tag nut column entitled "ID statute/rule out of complete state of the statement of the statement, after the statement, evidence by." Follow are the Suggested Minnesota Department of the statement, evidence by." Follow are the Suggested Minnesota Department of the statement	th orders being submitted to Although no plan of correction te Statutes/Rules, please ected" in the box available for indicate in the electronic ess, under the heading date your orders will be ectronically submitting to the ent of Health. and 6/2/16, surveyors of this risited the above provider and ion orders are issued. Our electronic plan of nave reviewed these orders, when they will be completed. ent of Health is documenting Correction Orders using gnumbers have been of a state statutes/rules for umber appears in the far left Prefix Tag." The state ompliance is listed in the int of Deficiencies" column to Comply" portion of the is column also includes the in violation of the state statute. "This Rule is not met as wing the surveyors findings Method of Correction and rection. RD THE HEADING OF THE	2 000				

6899

Minnesota Department of Health STATE FORM

8CO711 If continuation sheet 2 of 16

			SURVEY PLETED			
		00797	B. WING		06/0	02/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
WARRO	AD CARE CENTER		D, MN 5676	NORTHWEST 3		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 000	APPLIES TO FEDE THIS WILL APPEA THERE IS NO REC PLAN OF CORREC	ge 2 ERAL DEFICIENCIES ONLY. R ON EACH PAGE. QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.	2 000			
2 565	Plan of Care; Use Subp. 3. Use. A co	5 Subp. 3 Comprehensive omprehensive plan of care personnel involved in the	2 565			6/30/16
	by: Based on observati review, the facility facility facility from the facility from	ent is not met as evidenced on, interview and document ailed to provide assistance or 1 of 3 residents (R41) aff for repositioning. In failed to ensure oral hygiene of 1 residents (R22) who e with oral hygiene.		Corrected		
	Finding include:					
	R41 was not provid directed by the care	ed repositioning assistance as plan.				
	at risk for skin brea	red 1/31/16, indicated R41 was kdown/pressure ulcer irected staff to assist R41 with every two hours.				

Minnesota Department of Health

STATE FORM 8CO711 If continuation sheet 3 of 16

-	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00797	B. WING	·····	06/0	2/2016
	PROVIDER OR SUPPLIER AD CARE CENTER	1401 LAK		STATE, ZIP CODE IORTHWEST 3		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 565	Continued From pa	ge 3	2 565			
	was continuously of wheelchair without a On 6/1/16, at 3:45 p stated R41 was rep	24 p.m. until 3:50 p.m. R41 pserved to remain seated in a staff assistance to reposition. D.m. nursing assistant (NA)-A positioned at 12:30 p.m. by the				
	earlier). NA-A confir	e hours and 15 minutes rmed she had not assisted ing during her shift which				
	assistance to repos licensed practical n observed to transfe the toilet via a mech wheelchair was obs redistribution cushio observed to be inta-	o.m. NA-A requested ition R41. At this time, urse (LPN)-B and NA-A were r R41 from the wheelchair to nanical standing lift. R41's served to have a pressure on and his buttocks was ct. NA-A stated R41 was ned as he requested.				
	continuously observ	0 a.m. to 9:05 p.m. R41 was yed to remain seated in a reposition assistance.				
	approached LPN-C R41 to the rest roor observed to transfe	ector of nurses (DON) and requested her to assist m. The DON and LPN-C were r R41 from the wheelchair to nding lift. R41's buttocks was ct.				
	On 6/2/16 at 9·20 a	.m. NA-B verified B41 was				

Minnesota Department of Health

STATE FORM 8CO711 If continuation sheet 4 of 16

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDING.			
		00797	B. WING		06/0	2/2016
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
WARRO	AD CARE CENTER		E STREET N D, MN 5676	ORTHWEST 3		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 565	Continued From pa	ge 4	2 565			
		a.m. registered nurse (RN)-A be repositioned every two y the care plan.				
	R22 was not provid as directed by the o	ed assistance with oral care 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.					
	provide R22 mornir observation, NA-C upper denture and R22 for placement completion of the m R22 into a wheelch At no time did NA-C brush her remaining	a.m. NA-C was observed to ng cares. During the was observed to brush R22's lower partial and hand them to in her mouth. Following the norning cares, NA-C assisted air and R22 exited the room. C offer R22 the opportunity to g lower teeth or rinse her ting the clean dentures.				
	not offered R22 the	a.m. NA-C confirmed she had opportunity to rinse her R22 to brush her lower teeth uld have done so.				

-	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		00797	B. WING		06/0	2/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
WARRO	AD CARE CENTER		E STREET N D, MN 5676	NORTHWEST 3		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 565	On 6/2/16, at 12:51 would expect oral c by care plan.	p.m. the DON confirmed she ares be provided as directed	2 565			
	directed staff to follo	e Plan policy dated 6/12/15, ow the resident care plans to roviding appropriate care for				
	The director of nursing develop and implementated to implement DON or designee, on nursing staff related. The quality assessments	CHOD OF CORRECTION: sing (DON) or designee, could nent policies and procedures ntation of the care plan. The could provide training for all d to care plan implementation. ment and assurance erform random audits to				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
2 855	MN Rule 4658.0520 Proper Nursing Car	O Subp. 2 E. Adequate and re;Oral Hygiene	2 855			6/30/16
	proper care. The cadequate and proper E. Assistance as n keep the mouth, tee Measures must be lips	eeded with oral hygiene to eth, or dentures clean. used to prevent dry, cracked				
	This MN Requireme	ent is not met as evidenced				

Minnesota Department of Health

STATE FORM 8CO711 If continuation sheet 6 of 16

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
		00797	B. WING	·····	06/0	2/2016
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE	•	
WARRO	AD CARE CENTER		E STREET N D, MN 5676	NORTHWEST 3		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 855	by: Based on observatireview, the facility fawas provided for 1 or required assistance. Findings include: R22's annual Minim 2/12/16, indicated Fimpairment and diafailure, dementia aralso indicated R22 of one staff for bed and personal hygiet R22 had no dental of R22's ADL [activitie Functional/Rehabilith Assessment (CAA) needs\ed extensive grooming, and phys The CAA indicated specific pain with Albecoming fatigued and needed frequentimes. The CAA furtiwould include interviparticipation with Albertal providing assistance and adequate task R22's Care Plan da	on, interview and document ailed to ensure oral hygiene of 1 resident (R22) who with oral hygiene. The MDS dated are assistance mobility, transfers, dressing ne. The MDS further indicated concerns. The MDS further indicated R22 assistance with dressing, sical assistance with bathing. R22 denied having any DL's, but admitted to at times. R22 had dementia nt verbal cues during ADL's at ther indicated R22's care plan ventions to promote as much DL's as R22 was able, while e as needed to ensure safe completion.	2 855	Corrected.		
		re and lower partial and provide extensive assistance ne and oral care.				

Minnesota Department of Health

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING:			
		00797	B. WING		06/0	2/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
WARRO	AD CARE CENTER		E STREET N .D, MN 5676	IORTHWEST		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECT	ION	(X5)
PREFIX TAG	(EACH DEFICIENCY	W MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	COMPLETE DATE
2 855	Continued From pa	ge 7	2 855			
	was observed to pr During the observa brush R22's upper hand them to R22 f Following the comp NA-C assisted R22 exited the room. At the opportunity to b or rinse her mouth dentures. On 6/2/16, at 7:30 a not offered R22 the	a.m. nursing assistant (NA)-C ovide R22 morning cares. tion, NA-C was observed to denture and lower partial and or placement in her mouth. eletion of the morning cares, into a wheelchair and R22 no time did NA-C offer R22 rush her remaining lower teeth prior to inserting the clean a.m. NA-C confirmed she had opportunity to rinse her 2 to brush her lower teeth and				
		p.m. the director of nursing he would expect oral cares be				
	A policy regarding on none was provided.	oral hygiene was requested but				
	directed staff to foll	e Plan policy dated 6/12/15, ow the resident care plans to roviding appropriate care for				
	The director of nurs	THOD OF CORRECTION: sing (DON) or designee, could nent policies and procedures				

Minnesota Department of Health

STATE FORM 8CO711 If continuation sheet 8 of 16

-	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDING.			
		00797	B. WING		06/0	2/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
WARRO	AD CARE CENTER		E STREET N D, MN 5676	IORTHWEST 3		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 855	provide training for cares. The quality a committee could pe ensure compliance	e. The DON or designee, could all nursing staff related to oral assessment and assurance erform random audits to	2 855			
2 900	Subp. 3. Pressure comprehensive res of nursing services development of a nursing services development of a nursing services development of a nursing services that:	Subp. 3 Rehab - Pressure sores. Based on the ident assessment, the director must coordinate the ursing care plan which o enters the nursing home ores does not develop	2 900			6/30/16
	pressure sores unle condition demonstrauthenticates, that B. a resident wreceives necessary promote healing, promote healing, promote sores from device the sores from device with the facility for the sore of the facility for t	ess the individual's clinical ates, and a physician they were unavoidable; and tho has pressure sores by treatment and services to revent infection, and prevent		Corrected.		

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		00797	B. WING	····	06/0	2/2016
	PROVIDER OR SUPPLIER	1401 LAK		STATE, ZIP CODE NORTHWEST 3		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 900	repositioned every t care plan.	ge 9 two hours as directed by the	2 900			
	indicated R41 had of diagnosed with Alzh mellitus. The MDS for the developmen	imum Data Set dated 4/11/16, cognitive impairment and was neimer's disease and diabetes also indicated R41 was at risk t of pressure related ulcers sive assistance with bed and ambulation.				
	(CAA) dated 10/22/ for the developmen limited mobility, obe urinary incontinence	er Care Area Assessment 15, indicated R41 was at risk t of pressure ulcers due to esity, diabetes and occasional e. The CAA directed staff to ositioning every two hours.				
	at risk for skin brea	ed 1/31/16, indicated R41 was kdown/pressure ulcer irected staff to assist R41 to every two hours.				
		e for Predicting Pressure Sore 5, identified R41 at risk for the ssure ulcers.				
	observation comple	ance (tissue perfusion) sted on 4/11/16, indicated R41 repositioning schedule while				

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-	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00797	B. WING		06/0	2/2016
	PROVIDER OR SUPPLIER AD CARE CENTER	1401 LAK	, ,	STATE, ZIP CODE IORTHWEST 3		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 900	On 6/1/16, from 12: was continuously of At 12:45 p.m. R41 from the toilet to his assistant (NA)-D. If watching television activity aide (AA)-B area for stretching to participate in the however, at no time buttocks out of the At 2:37 p.m. AA-B Beach dining room At 2:50 p.m. R41 watch TV. At 3:45 p.m. NA-A facility at 1:00 p.m. assisted to reposition shift staff. NA-A star R41 at 2:00 p.m. to his room and she hhim. At this time, Noffered to reposition—At 3:50 p.m. NA-A (LPN)-B were obsewheelchair to the tolift. R41's wheelchair to the tolift.	45 p.m. until 3:50 p.m. R41 pserved. was observed to be assisted wheelchair by nursing R41 remained in his room until 1:52 p.m. at which time wheeled him to the Lodge exercises. R41 was observed stretching exercises, was he observed to lift his wheelchair. wheeled R41 to the Birch for coffee and a snack. Wheeled himself to his room to stated she had arrived at the She stated R41 had last been on at 12:30 p.m. by the day ated she had wanted to assist reposition, but he was out of ad not returned to check on A-A entered R41's room and in him. and licensed practical nurse rived to transfer R41 from the illet via a mechanical standing air was observed to have a ion cushion and his buttocks intact. NA-A stated R41 was ned as he requested. Beach Toileting and ted 6/1/16, indicated R41 was as he requested (PRN). The had last received assistance	2 900			

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NAME OF PROVIDER OR SUPPLIER WARROAD CARE CENTER **TOTAL LAKE STREET NATHWEST** WARROAD, MN 56763 PAPER PROVIDER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFINITE MEAN OF CORRECTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE COMMENTE PRINCEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) 2 900 Continued From page 11 2 900	-	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
WARROAD CARE CENTER MARROAD, MN 85763 MAR			00797	B. WING		06/0	2/2016
PRÉFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) 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 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 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.			1401 LAK	E STREET N	IORTHWEST		
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 intactAt 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.	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	LD BE	COMPLETE
stated R41 was to be repositioned every two hours as directed by the care plan.	2 900	On 6/1/16, at 4:00 p Beach Toileting and compared it to R41' the reposition sheet for repositioning did was to receive assist two hours as directed. On 6/2/16, at 6:30 a remain in his room, was visiting with thr remained in his room. At 9:05 a.m. the din which time R41 whe room. -At 9:05 a.m. the din approached LPN-C R41 to the rest room were observed to tr wheelchair to the to buttocks was obser -At 9:20 a.m. NA-B assisted LPN-C with toilet and transferred. On 6/2/16 at 9:20 a been repositioned a hours and 35 minut was not on a reposi- be repositioned as I	o.m. LPN-B reviewed the Birch of Reposition sheet and its care plan. LPN-B verified and the care plan directive in not match. LPN-B stated R41 stance with repositioning every ed on the care plan. a.m. R41 was observed to seated in the wheelchair. R41 ee staff members. R41 m until 7:41 a.m. at which time elf to the dining room. He ing room until 8:41 a.m. at eeled himself back to his rector of nurses (DON) and requested her to assist m. The DON and LPN)-C ansfer R41 from the elfet via the standing lift. R41's eved to be intact. relieved the DON and h transferring R41 off of the ed him to a recliner in his room. I.m. NA-B verified R41 had last at 6:30 a.m. a total of two es earlier. She stated R41 itioning schedule and was to the requested. a.m. registered nurse (RN)-A per repositioned every two	2 900			

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00797	B. WING		06/0	2/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI		STATE, ZIP CODE	1 00/0	
WARRO	AD CARE CENTER		E STREET N D, MN 5676	IORTHWEST 3		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE	(X5) COMPLETE DATE
2 900	6/11/15, directed the chair at least every of pressure ulcer do The Using the Care directed staff to follow	Pressure Ulcer policy dated e staff to change position in a two hours for the prevention	2 900			
	The director of nursing develop and implementated to pressure designee, could prostaff related to presimportance of repostance assessment and as	THOD OF CORRECTION: sing (DON) or designee, could nent policies and procedures ulcer prevention. The DON or ovide training for all nursing sure ulcers and the sitioning. The quality surance committee could dits to ensure compliance.				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
21980	MN St. Statute 626 Maltreatment of Vul	.557 Subd. 3 Reporting - Inerable Adults	21980			6/30/16
	reporter who has revulnerable adult is to or who has knowled has sustained a phyreasonably explained information to the content of the conten	of report. (a) A mandated eason to believe that a peing or has been maltreated, dge that a vulnerable adult eysical injury which is not ed shall immediately report the formon entry point. If an erable adult solely because				

Minnesota Department of Health STATE FORM

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-	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00797	B. WING		06/0	2/2016
NAME OF F	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
WARRO	AD CARE CENTER		D, MN 5676			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21980	Continued From pa	ge 13	21980			
	reporter is not requi maltreatment of the to admission, unles					
	another facility and believe the vulneral previous facility; or (2) the reporter k that the individual is in section 626.5572	as admitted to the facility from the reporter has reason to ble adult was maltreated in the nows or has reason to believe a vulnerable adult as defined t, subdivision 21, clause (4).				
	provisions of this so as described above (c) Nothing in this known or suspected knows or has reaso	s section requires a report of d maltreatment, if the reporter on to know that a report has				
		ommon entry point. s section shall preclude a eporting to a law enforcement				
	reason to believe the 626.5572, subdivision (5), occurred must a subdivision. If the retime believes that a agency will determine the reported error will be the subdivision of the subdivision.	eporter who knows or has leat an error under section on 17, paragraph (c), clause make a report under this reporter or a facility, at any in investigation by a lead ne or should determine that was not neglect according to section 626.5572, subdivision				
	facility may provide directly to the lead a how the event meet 626.5572, subdivisi (5). The lead agen	clause (5), the reporter or to the common entry point or agency information explaining to the criteria under section on 17, paragraph (c), clause acy shall consider this taking an initial disposition of bodivision 9c.				

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		00797	B. WING		06/0	2/2016		
NAME OF I	PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	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 SHOUL CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	SHOULD BE COMPLETE			
21980	Continued From page 14		21980					
	by: Based on interview facility failed to impl related to the imme altercation by anoth agency (SA) for 1 o abuse prohibition.	and document review, the lement their abuse policy diate reporting of a physical ler resident to the State f 3 residents (R3) reviewed for		Corrected.				
	Findings include:							
	Policy and Procedu abuse consisted of unreasonable confinements with resumental anguish. The administer or direct services director she incident/allegation resident." All incider MN statue were cal (CEP) and are subsequents.	net the criteria for "reportable nts deemed reportable under led to the common entry point						
	on 3/4/16, R3 was i shoulder with an op Staff intervened and involved. The report and the common er	sport dated 3/7/16, indicated ntentionally struck on the sen hand by another resident. It redirected the residents trevealed the administrator ntry point were both notified on after to incident occurred)						

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Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

AND PLAN OF CORRECTION IDENTIFICATION NOMBER. A. BUILDING:		PLETED						
00797 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) SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE						
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.								

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