Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
December 19, 2024

Administrator
Warroad Care Center
1401 Lake Street Northwest
Warroad, MN 56763

RE: CCN: 245329
Cycle Start Date: October 29, 2024

Dear Administrator:

PLEASE NOTE THAT HEALTH AND LIFE SAFETY CODE SURVEYS ARE BEING PROCESSED IN SEPERATE ENFORCEMENT CYCLES.

On December 17, 2024, the Minnesota Department of Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Submitted
November 20, 2024

Administrator
Warroad Care Center
1401 Lake Street Northwest
Warroad, MN 56763

RE: CCN: 245329
Cycle Start Date: November 6, 2024

Dear Administrator:

On November 6, 2024, survey was completed at your facility by the Minnesota Department of Health 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.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On November 5, 2024, the situation of immediate jeopardy to potential health and safety cited at F600 was removed. However, continued non-compliance remains at the lower scope and severity of D.

In addition, on November 5, 2024, the situation of immediate jeopardy to potential health and safety cited at F689 was removed. Continued non-compliance remains at the lower scope and severity of D.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedies listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective December 5, 2024.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective December 5, 2024, (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective December 5, 2024, (42 CFR 488.417 (b)).

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $12,924; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective November 6, 2024. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with with one or more of the following: §483.10, Residents Rights, §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.15, Quality of Life and §483.25, Quality of Care, 483.40 Behavioral Health Services, §483.45 Pharmacy Services, §483.70 Administration, or §483.80 Infection control has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. **If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.**

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Warroad Care Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective November 6, 2024. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

Jen Bahr, RN, Regional Operations Supervisor
Bemidji District Office
Health Regulation Division

Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, Minnesota 56601-2933
Email: Jennifer.bahr@state.mn.us
Office: (218) 308-2104

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. 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 their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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.

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

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 May 6, 2025 (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.

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.

APPEAL RIGHTS DENIAL OF PAYMENT

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services,

Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Steven.Delich@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

Department of Health & Human Services

Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 **and Minnesota Statute 144A.10 subd 15**, 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: **https://forms.web.health.state.mn.us/form/NHDisputeResolution**

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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:
https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 20, 2024

Administrator
Warroad Care Center
1401 Lake Street Northwest
Warroad, MN 56763

Re: State Nursing Home Licensing Orders
Event ID: IXTO11

Dear Administrator:

The above facility was surveyed on October 28, 2024 through November 6, 2024 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

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

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

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

Jen Bahr, RN, Regional Operations Supervisor
Bemidji District Office
Health Regulation Division
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, Minnesota 56601-2933
Email: Jennifer.bahr@state.mn.us
Office: (218) 308-2104

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 feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 20, 2024

Administrator
Warroad Care Center
1401 Lake Street Northwest
Warroad, MN 56763

RE: CCN: 245329
Cycle Start Date: October 29, 2024

Dear Administrator:

PLEASE NOTE THAT HEALTH AND LIFE SAFETY CODE SURVEYS ARE BEING PROCESSED IN SEPERATE ENFORCEMENT CYCLES.

On October 29, 2024, a survey was completed at your facility by the Minnesota Department of 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 constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.

- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. 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, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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.

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 January 29, 2025 (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).

In addition, if substantial compliance with the regulations is not verified by April 29, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 **and Minnesota Statute 144A.10 subd 15**, 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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:

https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 10/28/24 through 11/6/24, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was not in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 1 identify the date when they will be completed. The following complaints were reviewed during the survey: H53299762C (MN106056). No licensing orders were issued. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 2 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.	2 000		
2 255	MN Rule 4658.0070 Quality Assessment and Assurance Committee A nursing home must maintain a quality assessment and assurance committee consisting of the administrator, the director of nursing services, the medical director or other physician designated by the medical director, and at least three other members of the nursing home's staff, representing disciplines directly involved in resident care. The quality assessment and assurance committee must identify issues with respect to which quality assurance activities are necessary and develop and implement appropriate plans of action to correct identified quality deficiencies. The committee must address, at a minimum, incident and accident reporting, infection control, and medications and pharmacy services. This MN Requirement is not met as evidenced by: Based on interview, and document review, the facility failed to develop and implement appropriate plans of action to correct quality deficiencies identified during the survey that the facility was aware of or should have been aware. This had the potential to adversely affect all 46 residents residing in the facility. Findings include:	2 255	Completed 12/11/2024	12/11/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 255	Continued From page 3 See also F600: The facility failed to ensure 1 of 1 resident (R39) with known sexual behaviors towards others was comprehensively assessed and interventions implemented to mitigate risk to others and prevent ongoing sexual abuse for 2 of 2 residents (R31, R6) who were cognitively impaired and dependent on staff for their care and were sexually abused by R39. See also F689: The facility failed to ensure staff were following care planned interventions when transferring residents with a ceiling lift; and complete therapy/or nursing assessments to determine the appropriate sling sizes per manufacturers guidelines for 3 of 4 residents (R12, R7, R2) to ensure resident and staff safety. These deficient practices resulted in immediate jeopardy for R12, R7 and R2 but had the potential to affect all 12 residents who used ceiling lifts. See also F880: The facility failed to develop and implement an infection control surveillance plan for identifying, tracking, monitoring and/or reporting infections and communicable disease along with a monthly analysis; failed to conduct COVID-19 testing of staff and residents per Centers for Disease Control (CDC) guideline; failed to implement contact precautions and/or enhanced barrier precautions (EBP) for 2 of 2 residents (R7, R30) reviewed with a multi drug resistant organism (MDRO) and chronic wounds; and failed to implement standard precautions while catheterizing 1 of 1 resident (R99) observed to be catheterized. In addition, the facility failed to review and update their infection control policies on an annual bases. These deificient practices had the potential to affect all 46 residents residing in the facility.	2 255		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 255	Continued From page 4 See also 725: The facility failed to provide sufficient staff to transfer residents in lifts according to their care plan for 3 of 4 residents (R12, R7, R2); failed to provide appropriate supervision to mitigate resident-to-resident abuse for 2 of 2 (R31, R6) residents abused by 1 of 1 residents (R39) reviewed for abuse: failed to provide sufficient staff to complete range of motion for 4 of 4 residents (R7, R19, R22, R43) reviewed for restorative therapy. In addition, 4 of 46 residents (R7, R30, R25, R34,) 8 of 8 staff members (RN-B, NA-D, LPN-A, NA-C, NA-A, SWD, RT-A, NA-H); 1 of 3 family members (FM-A) voiced concerns of lack of sufficient staffing in the facility. The lack of sufficient staffing had the potential to affect all 46 residents in the facility. The Facility Assessment 2023 dated 12/18/23, identified the facility had identified the need to develop and implement policies and procedures for the provision of care and the following areas of concern were identified: - Staff turnover rate: YTD as of December 11, 2023 was 22.95%. Turnover had declined from one year ago when it was 24.44%. Staff will continue to work on creating a great culture and sufficient staffing levels in all areas to be able to hire and keep good people on our team. We are impacted by the current labor shortages as well as students both leaving for and returning to school. Our goal was to reduce our number to approach 20%. However, the assessment failed to identify interventions to improve the staff turnover rate nor how to ensure safe resident care was provided. - An Infection Prevention Risk Asscssmenl is completed annually, which guides infection prevention improvements. APIC's Infection	2 255		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 255	Continued From page 5 Preventionists Guide to Long Tenn Care and the Centers for Disease Control are the primary resources that guide our Infection Prevention Program. The facility was registered with NHSN. Covid-19 reporting was being done. However, the facility assessment failed to identify changes in guidance related to Enhanced Barrier Precautions (EBP) and/or staff education needs related to infection prevention. The February QAPI Education Report dated 3/8/24, identified staff education compliance was at 72.8%, however, the facility could not provide evidence actions were taken to increase compliance. The Quality and Safety Meeting (Quarter 1 Data) dated 4/15/24, identified a table of QAPI team reviewed topics: emerging infectious disease, staff influenza vaccination program, emergency preparedness, environmental services, Minnesota Pollution Control Agency (MPCA), skilled nursing safety report (Casper, MDS, QIIP), safe resident handling, consultant pharmacist report, and performance improvment project (PIP) discussion. The data failed to identify goals and measurable actions taken regarding abuse, staffing concerns, accidents and/or infection prevention. The Quality and Safety Meeting (April Data) dated 5/20/24, identified a table of QAPI team reviewed topics: emerging infectious disease, staff influenza vaccination program, emergency preparedness, environmental services, Minnesota Pollution Control Agency (MPCA), skilled nursing safety report (Casper, MDS, QIIP), safe resident handling, consultant pharmacist report, and performance improvment project (PIP) discussion. The data failed to identify goals and	2 255		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 255	Continued From page 6 measurable actions taken regarding abuse, staffing concerns, accidents and/or infection prevention. The Quality and Safety Meeting (May Data) dated 4/15/24, identified a table of QAPI team reviewed topics: emerging infectious disease, staff influenza vaccination program, emergency preparedness, environmental services, Minnesota Pollution Control Agency (MPCA), skilled nursing safety report (Casper, MDS, QIIP), safe resident handling, consultant pharmacist report, and performance improvment project (PIP) discussion. The data failed to identify goals and measurable actions taken regarding abuse, staffing concerns, accidents and/or infection prevention. The Annual Safe Resident Handling Assessment completed on 5/15/24, idendentified poor attendance. NAR meetings would start being held on the 2nd Wed of each month at 1:30 p.m. and 3:00 p.m. and the following Thurs at 7:00 a.m. to accommodate night shift. The meetings were part of the Safe Resident Handling policy. Follow-up from previous meeting: lock-out-tag-out policy was going to be reviewed (r/t Sarah Steady lift had loose hardware). Update: Lock-out/Tag-out policy is primary designed for electrical equipment. Will be reviewing policies including equipment maintenance policies to ensure that protocols were in place for equipment such as the Sarah-Steady lifts. The data failed to identify goals and measurable actions taken for staffing concerns, accidents and/or infection prevention and no further data was provided regarding the NAR meeting attendance. The QAPI Meeting Minutes dated 8/12/24, identified the following:	2 255		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 255	Continued From page 7 - Falls- 26 falls documented in the month of July. PIP written and reviewed on 4/15/24 for fall reduction. PIP was ongoing and continued to be implemented. The fall committee initiated weekly meetings along with the introduction of the Falling star program and policy the week of 8/1/24. 13 less falls identified than the previous 60 days. - Resident Council- held 7/3/24 - All concerns have been communicated and completed. - Grievances - No formal family or resident in the month of July - Resident Quality of Life/Nursing Home report card-addressed with team and will continue in the month of August. The data failed to identify goals and measurable actions taken regarding abuse, staffing concerns, accidents and/or infection prevention. During an interview on 11/06/24 at 1:53 p.m., the administrator stated he was a contracted interim administrator and began his role at the facility on 10/9/24. The facility had undergone several administration changes since the previous survey and the administrator had been told the facility held a QAPI meeting in July or August but he could not find any data that reflected that. The administrator did find an agenda but nothing substantial that reflected how the facility was working towards improvement. The administrator stated he was unsure what happened to the facility files because even common items were missing. The QAPI plan should be reviewed at the end of every QAPI meeting and PIP discussed as well. Does it need to be changed? Is there improvement and, if not, why? The administrator expected staff to report concerns to discuss during QAPI, the minutes to reflect work done and to work towards improvement. The facility Quality Assurance Performance	2 255		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 255	Continued From page 8 Improvement Plan dated 2/24/17, identified the written QAPI plan provided guidance for the overall quality improvement program. Quality assurance and performance improvement principles w drive the decision making within our organization. Decisions will be made to promote excellence in quality of care, quality of life, resident choice, person directed care, and resident transitions. Focus areas will include all systems that affect resident and family satisfaction, quality of care and service provided, and all areas that affect the quality of life for persons living and working in our organization. The executive director will assure that the QAPI plan is reviewed minimally on an annual basis by the QAA committee. Revisions will be made to the plan ongoing, as the need arises, to reflect current practices within our organization. These revisions will be made by the QAA committee. Revisions to the QAPI plan will be communicated as they occur to board members, residents, families, and staff through meetings and newsletters as deemed appropriate by the QAA committee. A project charter will be developed for each PIP at the beginning of the project that clearly establishes the goals, scope, timing, milestones, team roles, and responsibilities. The PIP charter will be developed by the QAA committee and then will be given to the team that will carry out the PIP. For ongoing monitoring of the PIP, we will use the CMS PIP Inventory to include milestones, PDSAs, outcomes, and other lessons learned from the PIP. Information about PIPs will be shared via our quality improvement dashboard, quarterly newsletter provided to all residents, families, and staff, and discussed during the QAPI agenda items on all staff, resident, and family monthly meetings.	2 255		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 255	Continued From page 9 SUGGESTED METHOD OF CORRECTION: The administrator, or designee, could review applicable QA policies and procedures to ensure all lapsed high-risk areas are addressed through the appropriate, comprehensive QA processes to ensure adequate monitoring and resolution(s) are in place. They could then audit to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 255		
2 260	MN Rule 4658.0075 Outside Resources If a nursing home does not employ a qualified professional person to furnish a specific service to be provided by the nursing home, the nursing home must have that service furnished to residents under a written agreement with a person or agency outside the nursing home. The written agreement must specify that the service meets professional standards and principles that apply to professionals providing services in a nursing home, and that the service meets the same standards as required by this chapter. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to provide the facility agreements for contracted services which had the potential to affect all 46 residents residing in the facility reviewed during the extended survey. Findings include: A copy of any agreement the facility had such as dental, hospital transfer, and/or psychiatric	2 260	Completed 12/11/2024	12/11/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 260	Continued From page 10 services was requested. The only agreement received was a Nursing Facility Services Agreement dated 8/26/13, identified the facility had an agreement with LifeCare Medical Center for hospice services. During document review on 11/6/24, at 12:47 p.m. the administrator confirmed he had been unable to locate any current agreements other than the one hospice agreement. No further information was provided. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop/revise and implement policies and procedures related to dental agreements and educate staff on these requirements. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days	2 260		
2 302	MN State Statute 144.6503 Alzheimer's disease or related disorder train ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING: MN St. Statute 144.6503 (a) If a nursing facility serves persons with Alzheimer's disease or related disorders, whether in a segregated or general unit, the facility's direct care staff and their supervisors must be trained in dementia care.	2 302		12/11/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 302	Continued From page 11 (b) Areas of required training include: (1) an explanation of Alzheimer's disease and related disorders; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; and (4) communication skills. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. (d) The facility shall document compliance with this section. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure 3 of 10 staff (DON, RN-E, NA-B) received annual training on behaviors in Alzheimer's disease or related disorders, problem solving with challenging behaviors, and communication skills. Findings include: Review of personnel records identified the following: - Director of nursing (DON) completed no assigned staff education including behavioral health. - Registered nurse (RN)-E last completed behavioral health training 8/3/23. - Nursing assistant (NA)-B completed no assigned staff education including behavioral health in 2024. During an interview on 11/6/24 at 12:42 p.m.,	2 302	Completed 12/11/2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 302	Continued From page 12 human resources (HR)-A stated she used to assigned the annual staff education but registered nurse (RN)-C assigned staff education now. RN-C assigned the annual training for staff and presented some of the general orientation education. The annual training was according to staff hire date: - DON: HR-A stated the DON did not complete any of the new hire trainings. - RN-E: HR-A stated RN-E hire date was 8/29/13 and was "past due" for annual training. RN-C assigned annual trainings at the beginning of the staff's anniversary month and a reminder sheet with their log in was put in their box. However, HR-A stated it did not appear that RN-E had annual trainings assigned to RN-E. - NA-B: HR-A stated NA-B's hire date was 6/28/16 and annual training was assigned to NA-B on 11/9/23. However, NA-B had not completed any training since that time. During an interview on 11/6/24 at 1:09 p.m., RN-C stated she was responsible for staffing training and was aware staff were not compliant with staff education requirements including behavioral health training. During an interview on 11/06/24 at 2:17 p.m., the DON stated she was just informed of the need for staff education. The DON believed she only needed to provide her continuing education transcripts when she started her role and did not have log in information until now to complete the assigned education. The DON stated she was informed of the lack of education/training and staff were expected to complete as directed in the facility policy. During an interview on 11/6/24 at 2:18 p.m., the administrator stated staff were expected to	2 302		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 302	Continued From page 13 complete education as directed by the facility policy. The Facility Assessment 2023 dated 12/18/23, identified staff attend General Orientation upon hire and annually. However, the facility assessment failed to identify the need for staff education/training related to behavioral health. A facility policy related to staff training/education was requested but not provided. SUGGESTED METHOD: The administrator or designee could develop/revise and implement policies and procedures related to the required Alzheimer's training program requirements. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 302		
2 550	MN Rule 4658.0400 Subp. 4 Comprehensive Resident Assessment; Review Subp. 4. Review of assessments. A nursing home must examine each resident at least quarterly and must revise the resident's comprehensive assessment to ensure the continued accuracy of the assessment. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to ensure accurate coding of the Minimum Data Set (MDS) for 1 of 3 residents (R7) reviewed for catheters.	2 550	Completed 12/11/2024	12/11/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 550	Continued From page 14 Findings include: R7's significant change Minimum Data Set (MDS) dated 10/3/24, identified R7 had severely impaired cognition and an indwelling urinary catheter. Diagnoses included multiple sclerosis (MS), type 2 diabetes, and history of urinary tract infection (UTI). The MDS failed to identify R7 had a multi-drug resistant organism (MDRO). R7's care plan revised 8/9/24, identified R7 needed total assistance with toileting needs and catheter management. The care plan failed to identify R7 had an MDRO. R7's Physical Therapy Skilled Nursing Facility Treatment Note dated 9/12/24, identified R7 had an open wound on her right ischial tuberosity and had an increased risk of infection. Precautions/Restrictions: methicillin-resistant staphylococcus aureus (MRSA). During an interview on 10/30/24 at 10:06 a.m., the director of nursing (DON) stated staff were expected the staff to document and submit the MDS timely and accurately to ensure resident care was provided accurately and safely. Additionally, the facility's reimbursement depended on an accurate MDS submission. During an interview on 10/31/24 at 1:10 p.m., registered nurse (RN)-D stated you wouldn't know a resident's history of having an MDRO unless you were digging in their charts. RN-D had just found out the "other day" R7 was colonized for MRSA. During an interview on 11/6/24 at 2:34 a.m., registered nurse (RN)-C stated she did conduct	2 550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 550	Continued From page 15 and submit R7's MDS assessment, however, did not review R7's MDRO status because the MDS was related to R7's COVID-19 diagnosis. RN-C stated she guessed she missed it. RN-C could not say why an accurate MDS could affect a resident's care nor why the accurate MDS was important. "I don't understand what you mean." A facility policy regarding MDS assessments was requested but not received. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could educate the nursing staff on completion of the Minimum Data Set (MDS) in accordance with the Resident Assessment Instrument (RAI) manual. They could then audit to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	2 550		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to develop a comprehensive care plan for 1 of 2 residents (R7, R99); and failed to involve family during the care conference and document the care conference fully for 1 of 2	2 565	Completed 12/11/2024	12/11/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 565	Continued From page 16 residents (R7) reviewed for catheters. Findings include: R7's significant change Minimum Data Set (MDS) dated 10/3/24, identified R7 had severely impaired cognition and an indwelling urinary catheter. Diagnoses included multiple sclerosis (MS), type 2 diabetes, and history of urinary tract infection (UTI). However, the MDS failed to identify R7 had a multi-drug resistant organism (MDRO). R7's care plan revised 8/9/24, identified R7 needed total assistance with toileting needs and catheter management. The care plan failed to identify R7's preferences for family involvement with her care nor to identify R7 had an MDRO. R7's Physical Therapy Skilled Nursing Facility Treatment Note dated 9/12/24, identified R7 had an open wound on her right ischial tuberosity and had an increased risk of infection. Precautions/Restrictions: methicillin-resistant staphylococcus aureus (MRSA). R7's Care Conference Summary New dated 6/26/24, identified a nursing, dietary and activities summary. T The note failed to identify when the care conference was held, who attended and/or who was invited to attend. R7's Care Conference Summary New dated 10/3/24, identified an activities summary. The note failed to identify when the care conference was held, who attended and/or who was invited to attend. R7's Care Conference Summary New dated 10/21/24, identified an activities summary. The	2 565		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 565	Continued From page 17 note failed to identify when the care conference was held, who attended and/or who was invited to attend. During an interview on 10/28/24 at 3:54 p.m., family member (FM)-A stated the facility was supposed to notify R7's daughter by text with the date and time of R7's care conference so R7's daughter could participate. After all the changes in staff, that just did not happen anymore. FM-A stated he did get a letter but preferred R7's daughter be involved too. That's what the plan always was. Why can't they continue to do it that way? If R7's daughter received a text, R7's daughter could show her employer and the employer was good to give R7's daughter the time off to attend the care conference. During an interview on 10/31/24 at 1:10 p.m., registered nurse (RN)-D stated staff were expected to follow the facility's catheter care policy to prevent the spread of infection, however, RN-D did not update R7's care plan to direct staff regarding enhannced barrier precautions during catheter care. During an interview on 11/4/24 at 2:27 p.m., the social worker designee (SWD) stated RN-C did all the MDS assessments, scheduled the care conference meetings, documented the care conference notes and the care coordinator updated the care plan. The care coordinator was out of the building and unavailable during survey. The SWD stated she could not find where R7's history of MRSA was care planned and/or R7's completed care conference notes were completed. During an interview on 11/4/24 at 2:34 p.m., RN-C stated she only scheduled the care conference	2 565		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 565	Continued From page 18 meetings but did not attend them because she wasn't always onsite. Because of this, RN-C did not document the care conference note. RN-C updated the MDS calendar and sent that to the nurses, activities, and the SWD. Who updated the care plan and/or notified R7 or R7's family was between the care coordinator and SWD. During interview on 11/6/24 1:13 p.m. the director of nursing (DON) stated the previous care coordinator was really good about texting and communicating with residents' families regarding changes in condition and/or care conferences. The care coordinator had left the facility prior to the DON taking her role at the facility. "That's just what I've been told." However, the DON stated she was aware that was no longer taking place and communication needed to improve. Resident care plans should be updated timely and accurately, and care conference documentation needed to be complete to ensure the staff knew what to provide to ensure the resident received resident-centered care. A policy regarding resident care conferences and/or care planning was requested but not received. R99's admission MDS dated 10/25/24, identified R99 had moderate cognition and diagnoses including neurogenic bladder, Alzheimer's disease, and dementia. R99 required intermittent catheterization and did not participate in a bladder program. R99's care plan dated 10/22/24, failed to identify a care plan goal and measurable objectives for straight catheterizing R99. R99's Bowel and Bladder Comprehensive	2 565		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 565	Continued From page 19 Assessment dated 10/25/24, identified R99 required intermittent catheterization performed by nursing staff every shift and as needed. On 10/30/24 at 1:55 p.m., stated R99 required staff to use a straight catheter to empty his bladder. Observed while licensed practical nurse (LPN)-A used a straight catheter to empty R99's bladder. LPN-A wore gloves and used sterile technique but failed to wear a gown. LPN-A stated she had failed to wear a gown during R99's catheter cares. LPN-A stated she should have worn a gown to protect herself, other residents and R99 from splashing of urine and the potential spread of bacteria causing an infection. During interview on 11/6/24 1:13 p.m. the DON resident care plans should be updated timely and accurately and to ensure the staff knew what to provide and to ensure the resident received resident-centered care. A facility policy regarding care planning was requested but not received. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) and/or designee could review or revise policies and provide education for staff regarding care plan development and when it should be completed by. The Quality Assessment and Assurance (QAA) committee could do random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 800	Continued From page 20	2 800		
2 800	MN Rule 4658.0510 Subp. 1 Nursing Personnel; Staffing requirements Subpart 1. Staffing requirements. A nursing home must have on duty at all times a sufficient number of qualified nursing personnel, including registered nurses, licensed practical nurses, and nursing assistants to meet the needs of the residents at all nurses' stations, on all floors, and in all buildings if more than one building is involved. This includes relief duty, weekends, and vacation replacements. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide sufficient staff to transfer residents in lifts according to their care plan for 3 of 4 residents (R12, R7, R2); failed to provide appropriate supervision to mitigate resident-to-resident abuse for 2 of 2 (R31, R6) residents abused by 1 of 1 residents (R39) reviewed for abuse: failed to provide sufficient staff to complete range of motion for 4 of 4 residents (R7, R19, R22, R43) reviewed for restorative therapy. In addition, 4 of 46 residents (R7, R30, R25, R34,) 10 of 10 staff members (RN-A RN-B, NA-D, LPN-A, NA-C, NA-A, SWD, RT-A, NA-H, DON); 1 of 3 family members (FM-A) voiced concerns of lack of sufficient staffing in the facility. The lack of sufficient staffing had the potential to affect all 46 residents in the facility. Findings include: Transfer with Lifts: See also F689: Based on observation, interview	2 800	Completed 12/11/2024	12/11/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 800	Continued From page 21 and document review, the facility failed to ensure staff were following care planned interventions when transferring residents with a ceiling lift; and complete therapy/or nursing assessments to determine the appropriate sling sizes per manufacturers guidelines for 3 of 4 residents (R12, R7, R2) reviewed who were transferred via ceiling lifts. R12's quarterly Minimum Data Set (MDS) dated 8/22/24, identified R19 had severe cognitive impairment and R12 was dependent on staff (helper performed all the effort and resident does none of the effort to complete the activity) for toileting and bed to chair transfers. R12's care plan dated 8/9/24, identified R12 was cognitively impaired and required assist of two staff for ceiling lift transfers. R12's care plan did not identify the ceiling lift sling size to be used with the transfer. During an observation on 10/29/24 at 5:50 p.m., NA-E and registered nurse (RN)-B transferred R12 with the ceiling lift into the bathroom using a green (large sling). R12 was holding the sling straps with her shoulders extended 90 degrees with the sling bunched up in her underarms. R12's fingers were grasping the straps tightly and her knees were pointed up towards the ceiling and her bottom hanging from the bottom of the sling. R7's significant change MDS dated 10/3/24, identified R7 had severe cognitive impairment and was dependent for toileting, personal hygiene, and bed to chair transfers. R7's care plan dated 8/9/24, identified R7 was cognitively impaired and required assist of two for ceiling lift transfers and R7 used a size medium ceiling lift sling. R7's Kardex dated 10/29/24, directed staff	2 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 800	Continued From page 22 to provide assist of one with transfers using the ceiling lift. However, the Kardex additionally directed staff to use ceiling lift with total assist of two with a medium Arjo sling. During an observation on 10/29/24 at 12:23 p.m., nursing assistant (NA)-C assisted R7 to the bathroom using a ceiling lift, without another staff person present as care planned. R7 was in the ceiling lift and holding the sling straps with both hands. R7's shoulders were extended 90 degrees and R7's bottom was hanging from the bottom of the sling. R7 had facial grimacing and moaned "ooohh." NA-C asked R7 if she was having pain and R7 stated yes, along her ribcage. NA-C stated this was residual pain due to R7 having just recovered from COVID-19. NA-C stated she would report R7's pain to the nurse. R2's annual MDS dated 6/17/24, identified R2 had severe cognitive impairment and a diagnosis of dementia. R2 had functional limitation with range of motion in both lower extremities and was dependent on staff for bed mobility, toileting, and transfers. R2 had one fall with injury (including skin tears, abrasions, lacerations, superficial bruises, hematomas, and sprains) during assessment dates. R2's care plan dated 6/28/22, identified R2 required assist of two staff to move between surfaces using the ceiling lift. The ceiling lift sling size was not identified on the plan. During an interview on 10/29/24 at 6:55 p.m., registered nurse (RN)-B stated R7 and R12 were care planned for assist of two with ceiling lift transfers but with the way staffing was going, staff usually transferred using assist of one. Nursing helped as much as they could but there just wasn't enough staff.	2 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 800	Continued From page 23 On 10/30/24 at 8:22 a.m., nursing assistant (NA)-D was standing in R2's room. R2 was fully dressed in their wheelchair. The ceiling lift sheet, size unidentified, was underneath with the straps crossed between the resident's legs. NA-E proceeded to use the ceiling lift to transfer R2 from the bed to the toilet, without a second staff member present as care planned. NA-E stated when R2 was calm like today she would transfer the resident by herself using the ceiling lift. When R2 was resistive NA-D would ask for other staff assistance. The care plan provided direction that two staff were required for ceiling lift transfers. On 10/30/24 at 8:22 a.m., NA-D stated she had no time to check the care plan so was unaware what the care plan directed. During an interview on 10/30/24 at 9:20 a.m., licensed practical nurse (LPN)-A stated she was very concerned regarding resident and staff safety. The facility did not have enough staff to provide assist of 2 with ceiling lift transfers. . Residents were being left alone in the lifts in the bathrooms, staff were transferring resident by assist of one with the ceiling lifts, and not answering call lights timely. During an interview on 10/30/24 at 9:44 a.m., NA-C stated the facility was "always" short staffed. The A-wing was just too heavy of care for one nursing assistant. There was supposed to be a float nursing assistant that would go between the different units but that rarely happened and especially when the nurse had to "bounce" between units as well. Abuse: See also F600: Based on observation, interview	2 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 800	Continued From page 24 and document review, the facility failed to ensure 1 of 1 resident (R39) with a known history of sexual behaviors towards others was comprehensively assessed and interventions implemented to mitigate risk to prevent ongoing sexual abuse for 2 of 2 residents (R31, R6) who were cognitively impaired, dependent on staff for their care, and were sexually abused by R39. R31's quarterly Minimum Data Set (MDS) dated 7/31/24, identified R31 had severe cognitive impairment and exhibited physical behaviors of grabbing, hitting, scratching, or abusing others sexually one to three days per week, and verbal behaviors toward others one to three days per week. R31 required substantial assistance to dress and was independent with transfer and ambulation. Diagnoses included Alzheimer's disease, anxiety, mood disorder, dementia, restlessness, and agitation. R6's quarterly MDS dated 7/31/24, identified R6 had moderate cognitive impairment and exhibited delusions, physical behaviors of grabbing, hitting, scratching, or abusing others sexually one to three days per week, verbal behaviors toward others four to six days per week and other behaviors not directed toward others four to six days per week. R6 required substantial assistance to dress and partial assistance with transfers. R6 was independent with ambulation once standing. Diagnoses included depression, anxiety, dementia, and sever mood disturbance. R39's quarterly MDS dated 8/30/24, identified R39 had severe cognitive impairment with physical behaviors of grabbing, hitting, scratching, or abusing others sexually one to three days per week. R39 was able to transfer and ambulate independently. R39 diagnoses included dementia,	2 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 800	Continued From page 25 psychotic disturbance, mood disturbance and anxiety. R39's progress notes identified the following: - 8/23/24, R39 was observed to take R31 by her hands and lead R31 to his room and close the door. When staff entered the room, R39 was lying on his side in bed and R31 was just seated on R39's bed. Staff directed R31 out of room and reminded R39 they were not allowed alone in room with door shut. - 9/6/24, licensed practical nurse (LPN)-A documented R39 had approached a female resident [identified as R31 from interview] from behind and gave the resident what appeared to be a "bear hug" [identified in interview to be reaching from behind and grabbing breast] which staff observed from behind. The social service designee (SWD) was notified. - 9/18/24, R39 made attempts to enter an unidentified female resident's room when she was sleeping in bed with lights off. Staff redirected R39 out of the room several times. - 9/25/24, R39 was observed fondling R31's breast. Staff intervened and separated the two residents. - 10/11/24, R39 was walking back to his room when R39 approached a female resident [identified as R31 through interview] to grab her breast area. R39 was redirected away and reminded it was inappropriate to touch anyone without permission. The DON was notified. - 10/15/24, R6 was found in R39's room with the door closed. R6 was seated in her wheelchair	2 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 800	Continued From page 26 beside R39's bed and R39 was fondling R6's breast. R6 was removed from area and R39 was reminded the behavior was not appropriate. R6 stated the incident made her uncomfortable and R39 had been squeezing her breast pretty hard. The DON and SWD were notified. R39's medical record lacked evidence R39's inappropriate sexual behaviors toward other residents had been comprehensively assessed and interventions implemented to mitigate potential abuse toward other residents, despite R39 being independently mobile and displaying ongoing inappropriate sexual behaviors. R31's medical record lacked any assessment to ensure her psychosocial needs were met and interventions implemented. R6's medical record lacked any assessment to ensure her psychosocial needs were met and interventions implemented. On 10/29/24 at 11:00 a.m., NA-A stated R39 could get grabby and try to grab staff breasts, you just needed to watch for it and remind him the behavior was not appropriate. NA-A was not aware R39 had inappropriate sexual behaviors toward other residents. The facility usually staffed the locked unit with one nursing assistant and a nurse would come on the unit on and off to pass medications. Once in a while they would have a float nursing assistant that would come on the unit occasionally to see if help was needed, but that did not happen very often. When interviewed on 10/29/24, at 1:30 p.m. SWD stated she was notified of some incidents with R39's behavior toward residents. SWD received calls regarding incidents of R39 inappropriately	2 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 800	Continued From page 27 touching other residents on 10/14/24 and 10/15/24. SWD discussed the incidents regarding R31's behavior with the DON and it was determined there were no non-consensual type of feelings. The residents had not seemed upset, so SWD and the DON determined it would be ok to just document the incidents when they occurred. The MDS coordinator was going through all the resident care plans and trying to get them all updated and they were all just trying to catch up and survive. Range of Motion: See also F688: Based on observation, interview and document review, the facility failed to provide range of motion (ROM) services for 4 of 4 residents (R7, R19, R22 ,R43) reviewed for range of motion. R7's significant change Minimum Data Set (MDS) dated 10/3/24, identified R7 had severe cognitive impairment. Diagnoses included multiple sclerosis (MS) (a potentially disabling disease of the brain and spinal cord that affects nerve fibers and causes communication problems), type 2 diabetes and peripheral vascular disease (PVD) (reduced blood flow to the arms and legs). R7 had a restorative nursing program (RNP) but R7 did not participate during the look back period. R7's care plan revised 8/9/24, directed staff to provide: RT- UBC x15 mins (tension 90). Pulleys at level 2 (reps of 5 as tolerated). Red squeeze ball (30 second reps). Green level 3 Thera putty. 3# free weight bicep curls. AROM with green Thera Bands. Lower AROM (AAROM - marching, knee extensions, hip adductions and abductions, ankle pumps). 5 times a week or as tolerated.	2 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 800	Continued From page 28 R7's Range of Motion task documentation dated 10/7/24 through 11/1/24, identified R7 received RNP services 3 times, was unavailable 2 times, R7 refused 2 times and was not applicable for 5 times. During the time-period, R7 should have been offered RNP services a total of 17 times. R19's quarterly MDS dated 8/7/24, identified R19 had moderately impaired cognition and diagnoses included Alzheimer's disease, anxiety and heart failure. R19 had a restorative nursing program (RNP) but R19 did not participate during the look back period. R19's care plan revised 8/1/24, directed staff to provide seated general lower and upper extremity exercises to be completed 3 times a week. R19's Range of Motion task documentation dated 10/7/24 through 11/1/24, identified R19 received RNP services 3 times, was unavailable 1 time and not applicable 7 times. During the time period, R19 should have been offered RNP services a total of 11 times. R22's significant change MDS dated 9/9/24, identified severe cognitive impairment. R22 had no impairment in range of motion and required substantial to maximal (helper does more than half the effort) with bed mobility, transferring and toileting. R22's diagnoses included arthritis, Alzheimer's disease, and lumbago with sciatica (pain radiating from back to legs and feet which can be eased with range of motion/stretching). R22 did not have a restorative nursing program. R22's provider's order dated 10/2/24, identified R22 was to receive functional maintenance program (FMP) by restorative therapy (RT). The order directed staff to complete active ROM (AROM) (resident helping with range of motion) to	2 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 800	Continued From page 29 both arms and legs in all ranges and planes (normal range of motion) for all joints and to walk as tolerated with transfers five times a week. R22's restorative therapy documentation from 10/4/24 through 11/3/24, identified 21 opportunities for R22 to receive AROM. There was one documented occurrence of AROM being done, one documented resident not available, and 19 marked not applicable. R43's quarterly MDS dated 9/11/24, identified R43 had moderate cognitive impairment. R43 required supervision to touch assistance with transfers, toileting, and walking. R43 had a diagnosis of Parkinson's disease. R43 had one fall without injury since last assessment. R43 was not part of a restorative nursing program. R43's provider order dated 7/25/24, identified RT program-seated or standing general lower extremity exercises as tolerated. Nustep level 2-5 up to 15 minutes 3 times a week. R43's care plan dated 7/30/24, identified R43 was to receive RT seated or standing general lower extremity exercises as tolerated. Nustep (a low impact exercise machine) level 2-5 up to 15 minutes 3 times a week. R43's restorative therapy documentation from 10/4/24 through 11/3/24, identified 13 opportunities for R43 to receive RT. There were three documented occurrences of RT being done, one refusal, and 9 times were marked not applicable. During an interview on 11/4/24 at 11:51 a.m., restorative therapy (RT)-A stated RNP services were supposed to be offered Monday through Saturday every week and RT-A scheduled each resident according to their RNP on the calendar.	2 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 800	Continued From page 30 RT-A stated the RT department had staffing problems and RT-A was the most consistent staff member. Currently, there was another staff member trained and passed competency, but that person had not been at the facility often. RT-A worked at the facility Mondays, Wednesdays, and Fridays. The other days were not consistently staffed and no RNP was offered on those days unless a resident was independent enough to do the exercises on their own without staff assistance. "I just can't complete it." RT-A stated she did inform administration that she was not able to complete tasks but there were no other staff available. During an interview on 11/5/24 at 3:30 p.m., the director of nursing (DON) stated she was aware the facility's restorative aide was at the facility only three days a week even though there were residents requiring RNP 5 days a week. However, a plan to address the issue had not been implemented. Staff were expected to provide RNP to maintain a resident's abilities and/or to prevent contractures. General Resident/Staff and Family Staffing Concerns: During an interview on 10/28/24 at 12:43 p.m., R7 stated a lot of the time you wait at least a half hour for someone to come when you turn on your call light. R7 had times when she was incontinent of bowel because she didn't make it to the bathroom on time. "That makes me [R7] feel embarrassed. Dumb." R7 was weepy and wiped away tears. During an observation on 10/30/24 at 7:27 a.m., R7 was lying in bed with her lights off. R7's door was partially open and R7 was screaming "help"	2 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 800	Continued From page 31 over 10 times. - At 7:28 a.m., R7 screamed "help" 8 times. R7 can be clearly heard at each each of the unit. - At 7:29 a.m., R7 was again screaming "help". R27 came out of her room and asked if R7 was alright. No staff were in the area. - At 7:31 a.m., R7 continued to scream "help" repeatedly, however, there were no staff to assist R7. - At 7:32 a.m., R27 came out of her room and stood in her doorway rubbing at her eyes and stated she was worried for R7. "Is she ok?" - At 7:33 a.m., R7 screamed "help" 5 times in a row. R27 walked to R7's doorway and peeked in stating "What's going on?" R27 was barefoot on the right foot and a gripper sock on the left. No staff were in the area and R27 turned back to her room. - At 7:39 a.m., R7 screamed "help" and nursing assistant (NA)-B entered R7's room and asked R7 if she had a bad dream. Provided a blanket for R7 and told R7 she could go back to sleep. - At 7:42 a.m., NA-B stated she was the float nursing aide that day. NA-C was the nursing aide assigned to R7's wing and had a phone that NA-C carried that alerted her to the call lights. The float nursing aide used to have a phone but didn't anymore. NA-B did not know why. NA-B stated when she's in a room she was able to hear the call light box that announced call lights at the nurses' station. That's how she knew she needed to check on R7 because R27's bed alarm went off, or that's how NA-B heard R7 screams for help. When in a room, staff could turn on the call light if they needed help. There was no walkie system or any other way to request help unless staff left the room. On 10/28/24 at 3:27 p.m., NA-H stated there was usually one staff on either side and a float that	2 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 800	Continued From page 32 went back/forth between the two units. If there wasn't a float staff, then she would have to run over to the other side or find the medication nurse will help with two person transfers. STAFF INTERVIEWS: On 10/28/24 at 3:27 p.m., NA-H stated there was usually one staff on either side and a float that went back/forth between the two units. If there wasn't a float staff, then she would have to run over to the other side or find the medication nurse will help with two person transfers. During an interview on 10/28/24 at 4:07 p.m., family member (FM)-A stated R7 had wounds and a physical therapist changed the dressings at 1:00 p.m. Because of that, there was a lot of days R7 didn't get out of bed until after that because there wasn't enough staff. During interview on 10/30/24 at 8:22 a.m. NA-D stated she was uncertain if R2 needed assist of one or two for ceiling transfers. NA-D stated she had not reviewed the care plan prior to transferring R2 because she did not have time. On 10/30/24 at 9:58 a.m., a resident council meeting was held and R34, R25 and R20 expressed concerns regarding staffing. - R34 stated she had to wait a long time for her food at meals. R34 was unable or unwilling to share specific date/times of incidents, although stated it happened frequently. R34's significant change MDS dated 8/26/24, identified R34 had intact cognition and was dependent on staff for toileting; partial/moderate assistance with bathing; and substantial/maximal assistance for	2 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 800	Continued From page 33 dressing. - R25 stated more times than not there were not enough staff. R25 was unable or unwilling to share specific date/times of incidents, although stated it happened frequently. R25's quarterly MDS dated 9/10/24, identified R25 had intact cognition and needed substantial/ maximal assistance with for toileting, bathing, and dressing. - R20 stated the wait time of call lights at times was too long. R20 was unable or unwilling to share specific date/times of incidents, although stated it happened frequently. R20's annual MDS dated 10/9/24, identified R20 had intact cognition and was dependent on staff for toileting, bathing; and substantial to dependent on staff for dressing. During interview on 10/31/24 at 10:14 a.m. RN-A stated she was trying to do the DON position and work the floor. Staffing took up so much time and there was only so much a person could do and they were trying to get done what they could. The Payroll Based Journal (PBJ) Staffing Data Report for the third quarter of 2024, identified excessively low weekend staffing. The daily staffing/working schedules from 8/1/24 thru 10/28/24 were reviewed. The facility was unable to provide a working schedule for 8/3/24, 8/4/24, 8/10/24, and 8/11/24. The Facility Assessment dated 2023, identified a need for a ratio of nurse (RN/LPN) to resident was 1:16 to 1:24 for day shift and evening shift and 1:24-1:48 for overnight shift. The assessment also identified a ratio of NA's to residents	2 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 800	Continued From page 34 including: 1:12 -1:13 during each shift (day, evening, overnight) and each shift would consist of a minimum of 4 NA's. The facility daily staffing/working schedules dated 8/17/24 and 8/25/24 identified only 2 NA's were scheduled for the overnight shift; and the nurse staff posting observed on 10/29/24 at 4:53 p.m. identified there was one nurse for A-wing (Pine Island, and The Angle), one for B-wing (Birch-Lake of the Woods) during day and evening. B-wing also had a TMA for day. Each wing had three nursing assistants a.m. and two nursing assistants for B-wing and 2.5 nursing assistants for A-Wing in evening. There was 1 nurse and three nursing assistants combined for the A and B wings. During an interview on 10/30/24 at 9:58 a.m., the DON stated when the DON first started at the facility, she approached the former administrator because they were using 70% agency staff and had lost many experienced staff. To determine resident to staff ratios, they looked at resident acuity and the number of residents requiring lifts. The previous administrator insisted all lifts required assist of 2 staff to complete. However, it took one aide away from a wing entirely to help the other side if the nurse was busy. "It's a mess." The DON stated she went to the administrator and requested to add two nursing assistants to A-wing as "That's what I needed." The DON needed two staff on another unit as well. That was the goal. "I'll be honest with you, it's difficult." Sometimes, there was a float but it hadn't come to fruition yet and hasn't been consistent. The DON also went to the board and explained staff couldn't be retained and/or incentivized, especially when the facility was losing agency staff as well, when the facility's wages were $5 lower than all the other facilities around. The facility finally approved a pay increase but it was	2 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 800	Continued From page 35 "on pause" due to the start of survey. The DON stated she was excited because the former administrator just would not let that happen. The DON stated she also needed a care coordinator for a unit. Ultimately, the DON's plan was to incentivize to get staff to come and get agency staff out of the facility. Some agency staff were great and most worked evenings. A policy on staffing was requested but none were received. SUGGESTED METHOD OF CORRECTION: The administrator and DON and/or designee could review current and ongoing staffing patterns to evaluate if addition or relocation of staff is needed to ensure all resident cares needs are met. Review the plan with QA committee and then audit to ensure there is enough staff to meet resident needs. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 800		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed.	2 830		12/11/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 36 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure staff were following care planned interventions of 2 staff assist when transferring residents with a ceiling lift; and failed to complete therapy/or nursing assessments to determine the appropriate sling sizes per manufacturers guidelines for 3 of 4 residents (R12, R7, R2) reviewed who were transferred via ceiling lifts. Findings include: The Maxi Sky 440 Instruction for Use revised 3/2020, identified the lift was designed to assist caregiver in hospitals, long-term care, nursing homes and home care environments, including private homes and patients with reduced mobility. Patient transfers must be done under the supervision of appropriately trained caregivers in accordance the instructions. Constant attention to the patient was required from caregiver during the whole transfer. In the unlikely event of a failure of the device, the caregiver must be ready to react. The Maxi Sky 440 Portable Lift and Charger Station Product Description undated, identified ceiling lifts enabled a single caregiver to transfer patients or residents smoothly without any manual lifting. All slings are color coded for size by having a different colored edge binding or attachment strap coloring: - Grey or Teal -Extra Extra Small -XXS [weight range 0-55 pounds (lbs)] - White or Brown -Extra Small -XS [weight range 55-77 pounds (lbs)]	2 830	Completed 12/11/2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 37 - Red -Small -S [weight range 77-132 pounds (lbs)] - Yellow -Medium -M [weight range 121-165 pounds (lbs)] - Green -Large -L [weight range 154-264 pounds (lbs)] - Blue -Extra Large -XL [weight range 308-440pounds (lbs)] - Terracotta -Extra Extra Large -XXL [weight range 440-500 pounds (lbs)] The option of a headrest for many slings was available if it is considered necessary for a particular patient. A range of special purpose slings were available as accessories. R12: R12's quarterly Minimum Data Set (MDS) dated 8/22/24, identified R12 had severe cognitive impairment and R12 was dependent on staff (helper performed all the effort and resident does none of the effort to complete the activity) for toileting and bed to chair transfers. R12's care plan dated 8/9/24, identified R12 was cognitively impaired and required assist of two staff for ceiling lift transfers. R12's care plan did not identify the ceiling lift sling size to be used with the transfer. R12's Rehabilitation Services Physical Therapy Out-Patient Treatment Note dated 5/10/23, identified a mechanical lift was used with assistance x 2 to transfer. The note failed to identify what ceiling lift sling size staff should use for R12. R12's medical record identified R12 weighed 167.1 lb.	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 38 During an interview on 10/28/24 at 2:38 p.m., R12 stated, last week a nursing assistant left R12 in the bathroom in the ceiling lift alone. R12 was unable to say a name or date but R12 was crying and stated R12 waited at least 20 minutes. R12 was in the bathroom already in the lift, up in the air, and R12's feet were dangling and "going numb." R12 stated staff usually left R12 in the ceiling lift, hanging over the toilet, but usually not for that long. R12 stated she urinated almost immediately when she got to the toilet and could have gone back to bed. R12 did report the incident to facility staff and was told by facility staff it always felt longer when you're in the lift, but it wasn't that long. R12 was crying and stated she felt "neglected." "I don't like to complain and get people in trouble, but I can't put up with this either. I just can't." R12 was grasping her bed linens in her hands and stated she was told there were many other people to help take care of. During an observation on 10/29/24 at 5:50 p.m., NA-E and registered nurse (RN)-B transferred R12 with the ceiling lift into the bathroom using a green (large sling). R12 was holding the sling straps with her shoulders extended 90 degrees with the sling bunched up in her underarms. R12's fingers were grasping the straps tightly and her knees were pointed up towards the ceiling and her bottom hanging from the bottom of the sling. During an observation on 10/30/24 at 5:20 p.m., R12 had a green (large) sling laying in her bathroom. R7: R7's significant change MDS dated 10/3/24, identified R7 had severe cognitive impairment	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 39 and was dependent for toileting, personal hygiene, and bed to chair transfers. R7's care plan dated 8/9/24, identified R7 was cognitively impaired and required assist of two for ceiling lift transfers and R7 used a size medium ceiling lift sling. R7's Kardex dated 10/29/24, directed staff to provide assist of one with transfers using the ceiling lift. However, the Kardex additionally directed staff to use ceiling lift with total assist of two with a medium Arjo sling. R7's medical record failed to identify a physical therapy or nursing evaluation was completed to determine safe transferring of R7 or what ceiling lift size should be used. R7's medical record identified R7 weighed 130.1 lb. During an observation on 10/29/24 at 12:23 p.m., nursing assistant (NA)-C assisted R7 to the bathroom using a ceiling lift, without another staff person present as care planned. R7 was in the ceiling lift and holding the sling straps with both hands. R7's shoulders were extended 90 degrees and R7's bottom was hanging from the bottom of the sling. R7 had facial grimacing and moaned "ooohh." NA-C asked R7 if she was having pain and R7 stated yes, along her ribcage. NA-C stated this was residual pain due to R7 having just recovered from COVID-19. NA-C stated she would report R7's pain to the nurse. During an interview on 10/29/24 at 12:45 p.m., NA-C stated R7 had been an assist of one with the ceiling lift since NA-C started working at the facility two years ago. NA-C stated R7's care plan	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 40 contradicted itself and NA-C wasn't even sure what R7's care planned need for transfer was. NA-C never asked anyone what R7 needed because she felt safe transferring R7 in the ceiling lift by herself. NA-C stated she used the sling in her room. Laundry replaced the sling if it was soiled, and NA-C didn't have to get a new one. NA-C stated she didn't even know how to tell what size the sling was. During an interview on 10/29/24 at 6:46 p.m., NA-E stated R12 was never to be left alone while in the ceiling lift. Staff routinely transferred R12 using the ceiling lift with assist of one, but NA-E wasn't comfortable with this because "you saw. She [R12] has chicken wings sticking out." NA-E didn't trust R12 not to fall. R7 was the same way. NA-E wouldn't transfer R7 alone either. NA-E stated she always just asked the nurse to help her because if R7 or R12 raised their arms due to the pressure of the sling they would slip right out and fall. NA-E stated staff transferred residents with assist of one because they can't find anyone to help. During an interview on 10/29/24 at 6:55 p.m., RN-B stated R7 and R12 were care planned for assist of two with ceiling lift transfers but with the way staffing was going, staff usually transferred using assist of one. Nursing helped as much as they could but there just wasn't enough staff. If the nurse couldn't help with transfers, the nursing assistants had been doing assist of one. R12 had lost a lot of muscle tone and just kind of "hung" in the sling like that. Hanging in the sling like that could potentially lead to a shoulder dislocation or a rotator cuff injury. If that happened, R12 could slip out of the sling and fall, however, RN-B had never heard of that happening. RN-B never reported any safety concerns for R7 or R12	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 41 during ceiling lift transfers to the unit coordinator nor had requested a physical/occupational therapy evaluation to determine if they were safe to transfer. "I'm just a floor nurse so I'm not the one to ask about that." R2: R2's annual MDS dated 6/17/24, identified R2 had severe cognitive impairment and a diagnosis of dementia. R2 had functional limitation with range of motion in both lower extremities and was dependent on staff for bed mobility, toileting, and transfers. R2 had one fall with injury (including skin tears, abrasions, lacerations, superficial bruises, hematoma's, and sprains) during assessment dates. R2's care plan dated 6/28/22, identified R2 required assist of two staff to move between surfaces using the ceiling lift. The ceiling lift sling size was not identified on the plan. R2's therapy orders dated 8/1/24, recommended staff use the ceiling lift or total mechanical lift to transfer the resident. The orders failed to identify how many staff were required for transfers and what size sling to use. R2's medical record lacked any other assessment to identify how many staff were needed to transfer and what size lift sling to use. R2's medical record identified R2 weighed 166 lbs. On 10/30/24 at 8:22 a.m., nursing assistant (NA)-D was standing in R2's room. R2 was fully dressed in their wheelchair. The ceiling lift sheet, size unidentified, was underneath with the straps	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 42 crossed between the resident's legs. NA-E proceeded to use the ceiling lift to transfer R2 from the bed to the toilet, without a second staff member present as care planned. NA-E stated when R2 was calm like today she would transfer the resident by herself using the ceiling lift. When R2 was resistive NA-D would ask for other staff assistance. The care plan provided direction that two staff were required for ceiling lift transfers. NA-E stated she did not have any problems and the transfer went as it usually did when R2 was calm. NA-E stated she had not looked at the care plan and was uncertain how many staff were required to safely transfer R2 with the ceiling lift. On 10/30/24 at 8:22 a.m., NA-D stated she had no time to check the care plan so was unaware what the care plan directed. On 10/30/24 at 9:17 a.m., the director of nursing (DON) stated all staff were aware all mechanical lifts, including the ceiling lifts, required two staff to safely transfer a resident. During an observation on 10/30/24 at 5:20 p.m. R7 had a yellow (medium) sling folded in a chair in her room. During an interview on 10/30/24 at 9:20 a.m., licensed practical nurse (LPN)-A stated she was very concerned regarding resident and staff safety. The facility did not have enough staff to provide assist of 2 with ceiling lift transfers. Residents were being left alone in the lifts in the bathrooms, staff were transferring resident by assist of 1 with the ceiling lifts, and not answering call lights timely. LPN-A stated she knew of an incident on 10/25/24, between R12 and NA-D where R12 was left alone in the bathroom hanging from the ceiling lift. LPN-A did not report	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 43 this to anyone but stated R12 was not safe to be left unattended in the ceiling lift in the bathroom. R12 did not have the ability to sit up and could have fallen. LPN-A further stated there were five residents who required assist of two for ceiling lift transfers and staff routinely transferred using assist of one. Staff were supposed to ask for assistance, but who were they going to ask? By the time a staff person was found to help, the resident only waited even longer. Plus, with call lights, bed alarms and chair alarms going off, what were staff supposed to do? That's what happened when R12 was left in the bathroom, NA-D was answering call lights. During an interview on 10/30/24 at 9:44 a.m., NA-C stated the facility was "always" short staffed. The A-wing was just too heavy of care for one nursing assistant. There was supposed to be a float nursing assistant that would go between the different units but that rarely happened and especially when the nurse had to "bounce" between units as well. Again, NA-C stated she got confused by the "rules" for ceiling lift transfers. One day, staff are told it's ok to use assist of one then they're told only use assist of two. NA-C just did her thing and, besides, NA-C couldn't magically pick up a staff member to help. When directed to use assist of two for ceiling lift transfers, NA-C stated she told administration that the workload was too heavy to do that. NA-C stated she felt it was safe to transfer using assist of one and/or to leave a resident in the bathroom while in the ceiling lift. NA-C routinely transferred R12 and R7 in the ceiling lift by herself without assistance of another staff person. NA-C stated she had heard about an incident on 10/25/24, where R12 was left alone in the bathroom because staff were answering call lights because there wasn't enough staff. NA-C stated she felt	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 44 R12 was safe to be in the bathroom alone and had left R12 alone as well to answer call lights. There were residents who were at risk for falling and staff had to check on them. Who else would do it? During an interview on 10/30/24 at 9:58 a.m., the DON stated staff were expected to follow care planned interventions for ceiling lift transfers for the resident and staff safety. "That's so unsafe." During an interview on 10/30/24 at 10:34 a.m., NA-D stated she had worked at the facility a little over a month as an agency nursing assistant. NA-D was trained by another traveler and wasn't told where they could find care plans or "cheat sheets." NA-D had to go to the interim DON and ask where to find it. NA-D was not going to transfer someone until NA-D knew how it was supposed to be done. NA-D stated she was told to look at the kardex, but with twelve residents to care for it was hard to be read through each one. NA-D stated she asked for a little sheet for like teeth, diet, transfers and was told there was a sheet but it was not up to date. There were residents that the sheet said were sit-to-stands but because things happened and they became weaker, they can't do it. The sheet needed to be updated. NA-D would have liked better training. Agency nursing assistants knew what their job consisted of but haven't cared for these residents before. NA-D told the interim DON that the facility needed staff who were employees of the facility to train agency nursing assistants. When NA-D asked the nurse or the float nursing assistant to help with assist of two transfers. NA-D was told the ceiling lifts required assist of two, then it changed to assist of one, and now it was assist of two again. NA-D needed a definite answer for this because NA-D didn't want to lose her certificate	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 45 for something that was out of her control. Regarding the 10/25/24, incident with R12, NA-D wouldn't call it an incident. R12 wanted to sit on the toilet because she was smearing bowel movement (BM). NA-A transferred R12 to the toilet via the ceiling lift but had never worked with R12 before. NA-D didn't know R12 got anxiety in the bathroom if left alone. NA-D left R12 in the ceiling lift sling and left her in the bathroom alone and answered other call lights. NA-D went back into R12 and R12 was like "what took you so long." NA-D stated she told R12 NA-D tried to get to R12 as fast as NA-D could. The float nursing assistant couldn't use the lift because she was 17 years old. It was probably 10 minutes. NA-D did someone's cares and went back and did "my thing." The next day NA-D reported the bathroom thing.The staff were shorthanded. NA-D did the best she could. R12 should have been assist of two and staff should have stayed with R12 while she was in the bathroom. NA-D did not know why they didn't stay because it was dangerous to leave R12. R12's feet were literally up in the air, not resting on the floor, because R12 was unstable. R12 was unstable and flailing and moving all the time so R12 needed assist of two with ceiling lift transfers. Staff have said if R12 was calm he could be assist of one. On 10/30/24, R12 was calm so NA-D transferred him in the ceiling lift by herself. "No, I shouldn't have." NA-D stated she had no idea where it said there were times R12 could be assist of one because NA-D had never been able to read all the care plans. During an interview on 10/30/24 at 1:25 p.m., NA-B stated R12 reported the 10/25/24, bathroom incident to her and NA-B reported it to the nurse. After that, NA-B didn't know what happened.	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 46 During a telephone interview on 10/30/24 at 2:36 p.m., the medical director stated staff were expected to follow a resident's care plan to ensure safety. During an interview on 10/30/24 at 2:39 p.m., the social worker designee (SWD) stated she was informed of R12's bathroom incident and staff were expected to not leave residents unattended in the bathroom while in the ceiling lift and were expected to follow the resident's care plan during ceiling lift transfers to ensure safety. On 10/30/24 at 5:09 p.m., RN-A stated the nursing assistants were trained to size slings for residents. The slings were color coded for size. However, RN-A stated she did not know if the size was documented in the resident's care plan or not. She would have to ask. During an interview on 10/30/24 at 5:24 p.m., NA-E stated she "just knew" what size a resident needed. For example, a reddish pink color was an extra small, a yellow was a small and a green was a medium. For R12, she used a green and it was kind of big and NA-E had considered getting a different size for her to try. Staff just went in the "cage" and got one. NA-E stated she didn't know if there was a size listed for the residents anywhere, even the care plan or Kardex. NA-E stated that was a good question, but NA-E just went by her "gut". For example, another resident in the facility had a pink sling in his room. NA-E knew that was way too small, so NA-E just grabbed a bigger sized sling to be safe. "I go by my gut," During an interview on 10/30/24 at 5:26 p.m., NA-F stated staff were usually assigned to a certain wing all the time and staff just "knew"	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 47 what sling a resident used. Like R12, used a green sling and, if it was dirty, staff just went to the "cage" and got a new one. If staff were floated to a different wing and they didn't know what sling to use, they would just ask the nurse or another aide which sling to use. NA-F didn't know if sling size was "written down" anywhere. NA-F knew the nurses did check the slings and would put different ones in the rooms sometimes, but NA-F stated she didn't know if they put that anywhere either. "You just know." During an interview on 10/30/24 at 6:14 p.m., the DON stated R12 and R2 did not have a ceiling lift sling size care planned. R7's care plan directed staff to use a size medium sling, however, R7 had lost weight since admission and her size may be incorrect. It was important to have a resident's sling size care planned so all staff were able to easily determine the correct size to ensure safe transferring of the resident. Unsafe ceiling lift transfers could result in resident injury or a fall. Any nurse could request a physical therapy (PT) evaluation for sizing, and it was important for sling size to be care planned for safety for everyone to see. Further, no unlicensed staff member should attempt to size a ceiling lift sling for a resident. During an interview on 10/30/24 at 6:21 p.m., the administrator stated staff were expected to report concerns with sling size and to request a PT evaluation to ensure resident safety. The facilities Safe Resident Handling Program dated 5/14/24, identified it was the policy of the facility that when residents required assistance to move, the assistance would be provided in a manner that was safe for both the resident and employee.	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 48 A facility policy regarding ceiling lift slings and transfers was requested but the facility did not have one to provide. The IJ was removed on 11/6/24 at 9:09 p.m., when it could be verified through observation, interview and document review the facility implemented the following immediate interventions of: assessing R12, R7 and R2 for correct amount of staff to ensure safe transfers, assessed for the appropriate sling size per manufacturers recommendation's, educated nursing staff and created a policy for ceiling lift assessments and ensured there were enough staff to transfer residents according to their care plans. SUGGESTED METHOD OF CORRECTION: The DON, or designee, could review and revise applicable policies and procedures pertaining to comprehensive transfer assessments; then assess all resident that use lifts to ensure they are fitted with the correct sling and the appropriate number of staff were identified to ensure a safe transfer. Then educate staff and on ensuring timely completion of such assessments; then audit staff to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 890	MN Rule 4658.0525 Subp. 2 A Rehab - Range of Motion Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the	2 890		12/11/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 890	Continued From page 49 comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without a limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide range of motion (ROM) services for 4 of 4 residents (R7, R19, R22 ,R43) reviewed for range of motion. Findings include: R7's significant change Minimum Data Set (MDS) dated 10/3/24, identified R7 had severe cognitive impairment. Diagnoses included multiple sclerosis (MS) (a potentially disabling disease of the brain and spinal cord that affects nerve fibers and causes communication problems), type 2 diabetes and peripheral vascular disease (PVD) (reduced blood flow to the arms and legs). R7 had a restorative nursing program (RNP) but R7 did not participate during the look back period. R7's care plan revised 8/9/24, identified R7 had a RNP. Restorative Therapy nursing assistant would monitor R7's progress and tolerance daily and document. RT staff were to report concerns to nursing and/or physical therapy/occupational therapy for assessment and recommendations. Staff were directed to provide: RT- UBC x15 mins	2 890	Completed 12/11/2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 890	Continued From page 50 (tension 90). Pulleys at level 2 (reps of 5 as tolerated). Red squeeze ball (30 second reps). Green level 3 Thera putty. 3# free weight bicep curls. AROM with green Thera Bands. Lower AROM (AAROM - marching, knee extensions, hip adductions and abductions, ankle pumps). 5 times a week or as tolerated. R7's Range of Motion task documentation dated 10/7/24 through 11/1/24, identified R7 received RNP services 3 times, was unavailable 2 times, R7 refused 2 times and was not applicable for 5 times. During the time-period, R7 should have been offered RNP services a total of 17 times. During an observation on 10/29/24 at 12:30 p.m., R7 did not have visible contractures and was able to lift/extend arms during a ceiling lift transfer. R19's quarterly Minimum Data Set (MDS) dated 8/7/24, identified R19 had moderately impaired cognition and diagnoses included Alzheimer's disease, anxiety and heart failure. R19 had a restorative nursing program (RNP) but R19 did not participate during the look back period. R19's care plan revised 8/1/24, directed staff to provide seated general lower and upper extremity exercises to be completed 3 times a week. R19's Range of Motion task documentation dated 10/7/24 through 11/1/24, identified R19 received RNP services 3 times, was unavailable 1 time and not applicable 7 times. During the time period, R19 should have been offered RNP services a total of 11 times. During an observation on 10/29/24 at 1:22 p.m., NA-C and licensed practical nurse (LPN)-A transferred R19 to the toilet using the ceiling lift.	2 890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 890	Continued From page 51 R19 had no visible contractures and was able to extend her upper and lower extremities. R22's significant change MDS dated 9/9/24, identified severe cognitive impairment. R22 had no impairment in range of motion and required substantial to maximal (helper does more than half the effort) with bed mobility, transferring and toileting. R22's diagnoses included arthritis, Alzheimer's disease, and lumbago with sciatica (pain radiating from back to legs and feet which can be eased with range of motion/stretching). R22 did not have a restorative nursing program. R22's care plan dated 6/23/23, identified R22 had chronic pain related to arthritis and lumbago with sciatica. Staff were to monitor and report any decrease in range of motion (ROM). R22's provider's order dated 10/2/24, identified R22 was to receive functional maintenance program (FMP) by restorative therapy (RT). The order directed staff to complete active ROM (AROM) (resident helping with range of motion) to both arms and legs in all ranges and planes (normal range of motion) for all joints and to walk as tolerated with transfers five times a week. R22's restorative therapy documentation from 10/4/24 through 11/3/24, identified 21 opportunities for R22 to receive AROM. There was one documented occurrence of AROM being done, one documented resident not available, and 19 marked not applicable. During observation on 11/4/24 at 1:58 p.m., R22 was sitting in her wheelchair and there we no visible contractures. R22 was able to move hands and feet without restriction.	2 890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 890	Continued From page 52 R43's quarterly MDS dated 9/11/24, identified R43 had moderate cognitive impairment. R43 required supervision to touch assistance with transfers, toileting, and walking. R43 had a diagnosis of Parkinson's disease. R43 had one fall without injury since last assessment. R43 was not part of a restorative nursing program. R43's provider order dated 7/25/24, identified RT program-seated or standing general lower extremity exercises as tolerated. Nustep level 2-5 up to 15 minutes 3 times a week. R43's care plan dated 7/30/24, identified R43 was to receive RT seated or standing general lower extremity exercises as tolerated. Nustep (a low impact exercise machine) level 2-5 up to 15 minutes 3 times a week. R43's restorative therapy documentation from 10/4/24 through 11/3/24, identified 13 opportunities for R43 to receive RT. There were three documented occurrences of RT being done, one refusal, and 9 times were marked not applicable. During observation on 11/4/24 at 1:54 p.m., R43 was sitting in her recliner in her room scrolling through her phone. R43 had no visible contractures. During an interview on 11/4/24 at 11:51 a.m., restorative therapy (RT)-A stated "not applicable" in the Range of Motion task documentation meant a resident was not offered RNP services. RT-A stated when a resident was admitted to the facility, they're asked if they wanted to participate in exercise. If so, the physical therapist did an evaluation and entered the orders in the	2 890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 890	Continued From page 53 resident's chart. RT-A followed those orders during RNP services. RNP services were supposed to be offered Monday through Saturday every week and RT-A scheduled each resident according to their RNP on the calendar. RT-A stated the RT department had staffing problems and RT-A was the most consistent staff member. Currently, there was another staff member trained and passed competency, but that person had not been at the facility often. RT-A worked at the facility Mondays, Wednesdays, and Fridays. The other days were not consistently staffed and no RNP was offered on those days unless a resident was independent enough to do the exercises on their own without staff assistance. - The residents were welcome to come down to the RT department and get on the machines and do exercises. The door was always open, and the residents had access if they wanted. Because of limited time, RT-A started with residents who had contractures to prevent worsening and ambulatory residents. RT-A stated there were 37 residents who had an RNP program ordered, and RT-A was getting to 18-20 per day. "I just can't complete it." RT-A stated she had not reported any refusals and/or inability to complete RNP services so the residents were re-evaluated and/or RNP orders changed. RT-A stated she did inform administration that she was not able to complete tasks but there were no other staff available. During an interview on 11/5/24 at 3:30 p.m., the director of nursing (DON) stated she was aware the facility's restorative aide was at the facility only three days a week even though there were residents requiring RNP 5 days a week. However, a plan to address the issue had not been implemented. Staff were expected to provide RNP to maintain a resident's abilities and/or to	2 890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 890	Continued From page 54 prevent contractures. A policy regarding restorative therapy was requested but not received. SUGGESTED METHOD OF CORRECTION: The DON or designee could audit all residents to ensure ordered exercises were being implemented. The DON or designee could review the process for implementing ordered exercises and how that is communicated, then educate the staff on the process. The DON or designee could perform audits to ensure the exercises were completed as ordered. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 890		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.	2 910		12/11/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 910	Continued From page 55 This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to follow provider's orders for intermittent catheterization for 1 of 1 resident (R99); and failed to ensure catheter care was provided in a manner to prevent potential urinary tract infection (UTI) for 1 of 3 residents (R7) reviewed for catheters. Findings include: R99's admission Minimum Data Set (MDS) dated 10/25/24, identified R99 had moderate cognition. R99 required intermittent catheterization and did not participate in a bladder program. Diagnoses included neurogenic bladder, Alzheimer's disease and dementia. R99's interagency transfer orders signed 10/24/24, identified orders for staff to perform scheduled straight catheterizations 4 times a day; If staff were consistently draining >500 mL per catheterization, then add a scheduled catheterization. R99's Bowel and Bladder Comprehensive Assessment dated 10/25/24 identified R99 required intermittent catheterization every shift and as needed, requires extensive assist from staff with transfers on/off the toilet and peri cares. Intermittent catheterization performed by nursing every shift and as needed. R99's care plan 10/22/24, failed to identify R99's catheterization. R99's October electronic treatment administration record (TAR), directed staff to straight catheterize R99 every shift or as requested by resident,	2 910	Completed 12/11/2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 910	Continued From page 56 related to neuromuscular dysfunction of bladder, with a start date 10/24/24 at 3:00 p.m., signed by care coordinator (CC)-G. CC-G was out of the office and unable to be interviewed during the survey dates. On 10/29/24 at 10:17 a.m., R99 was seated in a wheelchair in his room. R99 stated he used a catheter to empty his bladder due to being unable to urinate on his own. There were individually wrapped sterile straight catheters and sterile glove kits on the bathroom counter. On 10/30/24 at 7:04 a.m., licensed practical nurse (LPN)-A stated staff assisted resident with straight catheterization every shift because R99 was not able to complete it himself. On 10/30/24 at 4:48 p.m., LPN-B stated R99 was unable to urinate on the toilet and staff were using a straight catheter to empty R99's bladder three times per day; although, the original orders dated 10/24/24, were as follows: straight catheterizations 4 times a day; If staff are consistently draining >500 mL per catheterization, then add a scheduled catheterization. LPN-B stated the orders entered into the computer system on 10/24/24, for intermittent catheterization every shift and as needed were incorrect and not as originally ordered. On 10/30/24 at 5:18 p.m., the director of nursing (DON) stated R99 had been using a straight catheter to empty his bladder since before admission. The DON reviewed the original order and the order that was entered by the nursing staff and stated the orders entered by the staff were incorrect and staff should have assisted R99 with catheterization 4 times per day and as ordered by the doctor on 10/24/24. The risk of	2 910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 910	Continued From page 57 incorrectly completing the orders as directed were a high risk for infection. On 10/30/24 at 6:03 p.m., the medical doctor stated he was not notified that staff were only assisting R99 with catheterization once per shift and not four times daily as originally ordered. R99's medical record did not identify any pain or hospitalizations related to not providing catheterization four times a day as ordered. R7's significant change MDS dated 10/3/24, identified R7 had severe cognitive impairment with diagnoses of multiple sclerosis (MS), type 2 diabetes, history of UTI, and peripheral vascular disease. R7 had two stage 3 pressure ulcers and had a suprapubic indwelling urinary catheter (a tube that drains from your bladder through a small incision in your abdomen). The MDS failed to identify R7 had an MDRO. R7's care plan revised 8/9/24, identified R7 had an activities of daily living self-care performance deficit due to weakness related to MS. The care plan directed staff to provide assist of 1-2 for repositioning, dressing, grooming, and toileting/catheter care. During an observation on 10/29/24 at 10:17 a.m., nursing assistant (NA)-B was providing morning cares for R7. R7's catheter bag was uncovered and lying on the floor. During an interview on 10/29/24 at 10:34 a.m., NA-B stated yea, the catheter bag was on the floor, but NA-B had just wiped it down with	2 910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 910	Continued From page 58 alcohol. NA-B stated she "guessed" there could be residual urine on the catheter bag that could soil the floor. NA-B also "guessed" there was dirt on the floor and there could be "germs" in the "dirt" that could potentially cause a UTI. "It doesn't make sense but there's so many by-the-book rules in nursing homes. The bag touching the floor was overkill. To tell you the truth, in a nursing home, care was never going to be perfect and just too much was expected." During an interview on 10/29/24 at 10:39 a.m., LPN-A stated a catheter bag should never touch the floor due to infection control because it can lead to an infection. During an interview on 10/31/24 at 1:10 p.m., registered nurse (RN)-A stated staff were expected to follow the facility's catheter care policy. During an interview on 10/31/24 at 2:18 p.m., DON stated staff were expected to provide catheter care per facility policy and to demonstrate understanding of infection control to prevent the spread of microorganisms in the facility to prevent possible infections. The facility policy Suprapubic Catheter Placement dated 3/1/17, identified the purpose of this procedure was to relieve the retention of urine in the bladder in a resident who required a permanent or long-term catheter. However, the policy/procedure failed to address catheter care after placement. SUGGESTED METHOD OF CORRECTION: The DON could review/revise bowel and bladder assessment policies and procedures, educate staff, and then audit to ensure compliance. In	2 910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 910	Continued From page 59 addition the DON could review/revise catheter protocols, educate staff and then audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 910		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop and implement an infection control surveillance plan for identifying, tracking, monitoring and/or reporting infections and communicable disease along with a monthly analysis; failed to conduct COVID-19 testing of staff and residents per Centers for Disease Control (CDC) guideline; failed to implement contact precautions and/or enhanced barrier precautions (EBP) for 2 of 2 residents (R7, R30) reviewed with a multi drug resistant organism (MDRO) and chronic wounds; and failed to implement standard precautions while catheterizing 1 of 1 resident (R99) observed to be catheterized. In addition, the facility failed to review and update their infection control policies on an annual bases. These deificient practices had the potential to affect all 46 residents residing in the facility. Findings include:	21375	Completed 12/11/2024	12/11/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 60 Surveillance: The Monthly Infection Control Log (Line List) September 2024, for Unit A, identified resident name, date of onset, body site, and type of infection, antibiotic start date and type, date resolved and type of isolation. The log identified one resident (R7) with skin infection which was treated with antibiotic. The isolation type initiated and date the infection was resolved was not documented. The log further identified two residents (R7, R5) both who had tested postive for COVID-19 and placed on contact precautions. There were no listed infections or resident infection symptoms which were not treated with antibiotics (i.e. common cold symptoms, viral infections). The facility did not provide an analysis of the infections to include patterns or what interventions were implemented to reduce incidences of further infection. The Monthly Infection Control Log (Line List) September 2024, for Unit B, identified resident name, date of onset, body site, and type of infection, antibiotic start date and type, date resolved and type of isolation. The log failed to identify any resident not treated with an antimicrobial. The log identified three residents (R30, R32, R40,) with skin infections requiring antibiotics, Organisms or culture results were not identified for the wounds. The residents were placed on barrier precautions and date resolved was listed as ongoing. The log further identified one resident (R10) with respiratory infection requiring antibiotic treatment. The resident was placed on precautions and resolved date was recorded. There were no listed infections or resident infection symptoms which were not treated with antibiotics (i.e. common cold	21375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 61 symptoms, viral infections). The facility did not provide an analysis of the infections to include patterns or what interventions were implemented to reduce incidences of further infection. The Monthly Infection Control Log (Line List) October 2024, for Unit A, identified resident name, date of onset, body site, and type of infection, antibiotic start date and type, date resolved and type of isolation. The log failed to identify any resident not treated with an antimicrobial. The log identified three residents (R19, R7, R99) with urinary tract infections, one with colonized Methicillin-resistant Staphylococcus Aureus (MRSA), all three requiring antibiotics. Barrier isolation was identified and the infections were listed as ongoing. There were no listed infections or resident infection symptoms which were not treated with antibiotics (i.e. common cold symptoms, viral infections). The facility did not provide an analysis of the infections to include patterns or what interventions were implemented to reduce incidences of further infection. The log failed to identify R7 and R19 signs and symptoms of potential infection (identified below). The Monthly Infection Control Log (Line List) October 2024, for Unit B, identified resident name, date of onset, body site, and type of infection, antibiotic start date and type, date resolved and type of isolation. The log failed to identify any resident not treated with an antimicrobial. The log identified two residents (R32, R43,) with urinary tract infections, with the same organism, requiring antibiotics. Isolation and date resolved was not docuemented. The log further identified one resident (R30) with a wound infection and organism identified as MRSA requiring antibiotic treatment. The log identified a	21375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 62 date of resolved infection and that isolation was required, however, did not list type of isolation implemented. There were no listed infections or resident infection symptoms which were not treated with antibiotics (i.e. common cold symptoms, viral infections). The facility did not provide an analysis of the infections to include patterns or what interventions were implemented to reduce incidences of further infection. R7's significant change Minimum Data Set (MDS) dated 10/3/24, identified R7 was 73 years of age. Diagnoses included multiple sclerosis, peripheral vascular disease, pulmonary edema and diabetes. R7's nursing progress note dated 10/27/24, identified R7 had nausea and vomiting after supper. R7's medical record failed to identify if any further follow up was completed or if R7 had been placed in isolation. R19's quarterly MDS dated 8/7/24, identified R19 was 84 years of age. Diagnoses included diabetes, hypertension, atrial fibrillation and dementia. R19's nursing progress note dated 10/21/24, identified R19 complianed of not feeling good. R19 was flushed and having difficulty staying awake. Afebrile and tested negative for COVID antigen test. R19's medical record failed to identify in any further follow up was completed or if R19 had a confirmatory COVID-19 test or if R19 had been placed in isolation. There was no documented, provided evidence which demonstrated the facility had a system for tracking non-antibiotic treated infections (i.e. viral infections); nor any evidence demonstrating a comprehensive analysis of the identified infections was completed despite have two UTI	21375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 63 with the same causative organism. Further, there was no provided evidence the facility had reviewed or investigated the developed infections for potential causes and addressed any subsequent action needed to reduce the risk of recurrence to the same and/or other resident(s). When interviewed on 10/31/24, at 3:00 p.m. registered nurse (RN)-A stated she had not been tracking or trending resident or staff illness/symptoms. The nurse responsible for infection control quit in September and RN-A had not taken the program over until about two weeks ago. RN-A was trying to get resident antibiotic use logged and tracked and had not started on tracking resident or employee symptoms of illness or infection. RN-A told the director of nursing (DON) the facility should be tracking when a resident had diarrhea or a fever, but RN-A had not been able to get tracking of infections implemented. The facility was using an infection control program called Peerlytics, but RN-A was unable to access that program. The facility was working on getting RN-A access to the computerized infection control program. - RN-A was not tracking employee illness and only recorded when staff called in with positive COVID-19. The facility did not require confirmation of test results when employees reported symptom of illness. RN-A stated it would be important to track other illness in both staff and residents to determine the source of illness and track if it could spread. RN-A just did not have the time and had only recently taken the infection preventionist role. The facility did not isolate residents for symptoms of illness. Residents were only isolated if they tested positive for COVID-19. RN-A felt the residents all had a private room and so were kind of isolated	21375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 64 anyway. If a resident exhibited symptoms such as a cough, fever, or diarrhea the facility did not isolate them and did not require staff to wear personal protective equipment (PPE) when providing care to symptomatic residents. RN-A supposed some of the symptom's residents exhibited should require some PPE, but the facility did not direct staff to wear PPE when residents exhibited symptoms of illness. Staff should wear PPE when caring for residents with potentially contagious symptoms. Staffing took up so much of RN-A's time, there was only so much a person could do. RN-A was just trying to get what she could done. At this time, the surveillance and analysis of the facility's infection prevention and control program was requested. During interview on 10/31/24, at 2:40 p.m. the DON stated tracking and trending of resident and employee illness should be done and it was not currently being completed. The tracking and trending of illness was important so the facility could quickly recognize when they had a problem. The facility should be isolating and implementing PPE with any resident that was noted with infectious type of symptoms such as cough, fever, or diarrhea. The facility's policy Infection Control Surveillance with revision date 4/4/24, identified infection prevention began with ongoing surveillance to identify infections that were causing or have the potential to cause an outbreak. The facility would establish routine, ongoing and systematic collection, analysis, interpretation, and dissemination of surveillance data to identify infections, infection risks, communicable disease outbreaks, and to maintain or improve resident health status. The facility nurses would identify residents with symptoms or identified infections	21375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 65 and complete a wait and watch in Peerlytics and in the residents' medical record, documenting the signs and symptoms the resident was exhibiting. The infection preventionist would be alerted to identify any necessary interventions and add to Peerlytics for follow up and data collection. The infection preventionist would utilize the information to monitor infection sit, type, pathogen if known, signs and symptoms and resident location to identify trends or clusters for action. COVID-19 Testing: Centers for Disease Control (CDC) website Infection Control Guidance: SARS-CoV-2 (COVID-19) dated 6/24/24, identified a single new case of COVID-19 infection in any health care provider (HCP) or resident should be evaluated to determine if others in the facility could have been exposed. Perform testing for all residents and HCP identified as close contacts or on the affected unit. Testing was recommended at day 1, day 3 and day 5, where day of exposure is day 0. If additional cases were identified, testing should continue on affected units or facility-wide every 3 to 7 days until there were no new cases for 14 days. A facility Employee COVID Line List Spread Sheet for months of September and October 2024 identified employee name, age, sex, onset date, positive testing collection date, day one isolation, day 7 test result, day 10 test result and date return to work. The spread sheet identified eight employees with onset positive dates which included: maintenance (maint)-A on 9/22/24, housekeeper (HSK)-A on 9/25/24, cook (CK)-A on 9/26/24, the director of nursing (DON) on 9/26/24, nursing assistant (NA)-F on 9/26/24,	21375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 66 registered nurse (RN)-D on 9/27/24, NA-B 10/14/24 and care coordinator (CC)-G on 10/27/24. A facility Resident COVID Line List Spread Sheet for the month of September 2024 identified resident name, age, sex, onset date, positive testing collection date, day one isolation, day 7 test result, day 10 test result and date out of isolation. The spread sheet identified two resident names with positive test results; R5 on 9/24/24 and R7 on 9/25/24. A facility October calendar listed resident testing dates for all units on 10/2/24, 10/4/24, 10/7/24, 10/9/24, 10/11/24. Residents who resided on unit A were tested on 10/15/24 due to an exposure with NA-B on 10/14/24, however, the facility failed to continue COVID-19 testing day 3 and day 5 to determine if there were any additional positive cases as required. Unit A residents were tested again on 10/28/24 due to an exposure with CC-G on 10/27/24, however, the facility failed to continue COVID-19 testing day 3 and day 5 to determine if there were any additional positive cases as required. On the bottom of the calendar it was indicated any other resident testing would be done randomly with any resident that exhibited symptoms and not every three to seven days until no further new cases were identified as required. The facility documented when testing occured on resident units, the facility failed to track which residents were tested and results of individual tests. The facility documented positive employees COVID-19 test results when the tests results were reported by the employee. The facility failed to produce evidence of any employee testing. The	21375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 67 facility failed to track and document which employees tested, when and how the employees tested as well as employee COVID-19 test results. Furthermore, the facility failed to track and document if employees tested and/or results of COVID-19 testing prior to working their scheduled shifts . The testing of residents was not completed on day 1, day 3 and day 5, after a known exposure from a positive staff members 10/14/24 and 10/28/24, as required. Nor did testing occur every three to seven days until no further additional staff or residents tested positive for COVID-19. During interview on 10/29/24, at 9:30 a.m. RN-A stated she did not have documentation of residents testing or testing results other than individual entries in each resident's chart that were tested. RN-A was unable to identify exactly which residents had tested without going into each individual resident medical record and was unable to identify if any residents had refused or were absent when COVID-19 testing was conducted. RN-A stated she thought the facility was in outbreak when three employees all tested positive on 9/26/24, despite having been notified an employee (maintenace (maint)-A) had tested positive on 9/22/24, after working the day prior. RN-A instructed all employees to test when the facility was in outbreak, however did not track or record which employees tested or their results. The facility continued testing all residents and employees were reminded to test for COVID-19 until 10/12/24. RN-A felt, because the facility had not had any further positive COVID-19 test results since 9/27/24, the facility completed outbreak testing and were out of outbreak status on 10/12/24. On 10/14/24, NA-B reported fatigue,	21375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 68 sore throat and a positive COVID-19 test. NA-B had worked the weekend (10/12/24 & 10/13/24) prior to positive test result on 10/14/24. RN-A did not conduct or record any formal contact tracing, other than review of where NA-B had been scheduled. RN-A felt only residents on unit A had been exposed to NA-B, because that was the unit NA-B was scheduled, so RN-A tested all residents on unit A on 10/15/24. RN-A had instructed staff to test if they knew they had exposure to NA-B, however, did not track or document which staff had contact with NA-B and/or tested. RN-A felt staff would know if they had an exposure and test accordingly. RN-A did not do formal contact tracing of who NA-B had contact with when she worked on 10/13/24 and 10/14/24, prior to having symptoms of fatigue and sore throat on 10/14/24, and positive test result. All residents on unit A tested negative for COVID-19 on 10/15/24, and no further testing was conducted. RN-A did not know why testing exposed residents was not completed on day 3 and day 5 of exposure as required. RN-A did not conduct contact tracing on employees who may have been exposed to NA-B and did not know which employees had tested when NA-B had reported positive on 10/14/24. RN-A stated CC-G reported nausea, vomiting, headache and positive COVID-19 test result on 10/27/24. RN-A did not conduct or record any formal contact tracing, other than review of where CC-G had been scheduled. RN-A felt only residents on unit A had been exposed to CC-G, so RN-A tested all residents on that unit on 10/28/24. All residents on unit A tested negative for COVID-19 on 10/28/24, and no further testing was conducted. RN-A did not know why testing exposed residents was not completed on day 3 and day 5 of exposure as required. RN-A did not conduct contact tracing on employees who may have	21375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 69 been exposed to CC-G and did not know which employees had tested when CC-G had reported positive on 10/28/24. RN-A felt staff would know if they had an exposure and test accordingly. RN-A could not say if all staff were tested prior to starting their shift, even during the outbreak. RN-A had given all staff instructions via communication email, to test prior to their shift and so all staff were aware they needed to test. Tracking or documentation of staff testing had not been completed to ensure testing had been completed, other than documentation of the positive tests that were reported to RN-A. Employees were not required to provide proof of testing When interviewed on 10/31/24, at 2:30 p.m. the DON stated staff testing should have been tracked to keep the transmission of COVID-19 to a minimum and to keep residents safe. All testing for COVID-19 should have been documented. The facility's Long Term Care and Assisted Living Response Plan for COVID-19 Testing, approved 9/1/20, identified an outbreak and testing trigger as one or more residents confirmed to have COVID-19, a direct care staff member who tested positive for COVID-19 and worked in the facility while ill or 48 hours prior to development of symptoms or a symptomatic resident who has tested negative. MDH and CDC would be consulted for current recommendations for the particular disease epistemology at the time that testing was considered. The infection preventionist would ensure that records were maintained regarding the testing process, resident and staff consent for testing and test results.	21375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 70 Contact/Enhanced Barrier Precautions: R7's significant change MDS dated 10/3/24, identified R7 had severe cognitive imairment R7 had two stage 3 pressure ulcers and had a suprapubic indwelling urinary catheter (a tube that drains from your bladder through a small incision in your abdomen). The MDS failed to identify R7 had an MDRO. Diagnoses included multiple sclerosis (MS), type 2 diabetes, history of UTI, and peripheral vascular disease. R7's care plan revised 8/9/24, identified R7 had an activities of daily living self-care performance deficit due to weakness related to MS. The care plan directed staff to provide assist of 1-2 for repositioning, dressing, grooming, and toileting/catheter care. However, the care plan failed to address R7's need for contact precautions or enhanced barrier precautions (EBP). R7's Physical Therapy Skilled Nursing Facility Treatment Note dated 9/12/24, identified R7 had an open wound on her right ischial tuberosity and had an increased risk of infection. Precautions/Restrictions: methicillin-resistant staphylococcus aureus (MRSA). During an observation on 10/29/24 at 10:17 a.m., nursing assistant (NA)-B was providing morning cares for R7. There was a 3-drawer plastic bin outside of R7's door containing gowns, gloves, facemasks and face shields. No signage was on R7's door directing staff what personal protective equipment (PPE) was required or when it was required. R7's catheter bag was uncovered and lying on the floor. NA-B did not apply a gown or gloves and stated the only time she needed to do	21375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 71 so was if she was emptying R7's urinary catheter bag because "pee could get on me." Wearing gowns and gloves for catheters was something new, but NA-B could not remember what "it" was called. No one had ever explained why sometimes staff needed to wear personal protective equipment (PPE) and it was something staff never did before. "It's just something to be 'extra'". "It doesn't make sense but there's so many by-the-book rules in nursing homes." The bag touching the floor was overkill. To tell you the truth, in a nursing home, care was never going to be perfect and just too much was expected. NA-B could not explain what an MDRO was and/or if R7 was known to have a history of MRSA. During an observation on 10/29/24 at 12:23 p.m., NA-C assisted R7 to the toilet using the ceiling lift. NA-C did not don a gown and gloves. - At 12:28 p.m., NA-C put on gloves and pulled down R7's pants, then lowered R7 onto the toilet. NA-C then hung R7's catheter bag from the toilet handrail. - At 12:29 p.m., R7's catheter bag fell onto the floor. NA-C picked up the bag and again hung it from the toilet handrail. "I don't know if it will hang there or not." NA-C did not clean R7's catheter bag. NA-C did not remove her soiled gloves and was touching scrubs and high touch areas in the bathroom. - At 12:33 p.m., NA-C straightened R7's pillows and bed linens. NA-C continued to wear the same soiled gloves. - At 12:35 p.m., NA-C raised R7 off the toilet and pulled up R7's pants. NA-C stated R7 didn't have a bowel movement so did not need wiping. NA-C continued to wear the same gloves. NA-C transferred R7 to bed using the ceiling lift and continued touching high touch areas with the same soiled gloves.	21375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 72 During an interview on 10/29/24 at 12:23 p.m., NA-C stated you only need to wear a gown when you empty R7's catheter. That's it. NA-C stated she wore gloves, but the 3-drawer bin outside R7's room was left over from when R7 had COVID-19 in previous weeks. Someone just forgot to take it away. NA-C stated she was unaware if R7 had a history of a MRSA or any type of infection. NA-C stated she had never been told why sometimes staff wore PPE and other times they didn't need to. During an interview on 10/29/24 at 10:39 a.m., licensed practical nurse (LPN)-A could not recall what EBP was called or when it was required but only staff needed to wear a gown when doing anything with the catheter. "I don't know why but that's what we were told." It started about a year ago, when staff needed to wear a gown when doing anything with a wound and/or a catheter. Staff were given a bunch of papers to review. LPN-A stated she asked for a simple explanation and not a stack of papers because it was just too much to understand, but LPN-A was told "it's just the rules". That was just it. Staff should be wearing a gown and gloves every time they're in R7's room because "we're supposed to." That's just what staff were told. During an observation on 10/30/24 at 7:42 a.m., NA-B did not gown or glove and entered R7's room to answer R7's yell for help. NA-B stated she did not gown or glove because she was told she only needed to do that if she was doing catheter care, but "now that's changed." "I don't know what I'm supposed to do now." NA-B pointed to R7's 3 drawer plastic bin that contained PPE and stated, "I really don't know what that's about." NA-B stated she had not received any	21375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 73 education regarding infection prevention precautions. "You're my education." During an interview on 10/30/24 at 9:14 a.m., LPN-A stated anytime staff go into R7's room and provide care, staff were supposed to wear a gown. "We need to work on that." LPN-A stated R7 had MRSA in her (R7) wounds. LPN-A could not explain the different types of precautions: standard, contact, droplet, and/or EBP. LPN-A became tearful and stated staff did not receive education. It started at the top and never trickled down to staff on the floor. "We're not safe." During an interview on 10/31/24 at 1:10 p.m., registered nurse (RN)-A stated she took over the role of facility infection preventionist two weeks prior for the duration of her contract. "I inherited this." Staff needed education regarding precautions. Any resident with a catheter or a wound (because there could also be an unknown organism) needed Enhanced Barrier Precautions (EBP). However, RN-A did not have a listing of residents with a known MDRO, a wound or a catheter. RN-A went room to room to look for a catheter. "I just know." For MDRO, staff wouldn't know that unless they went digging in the charts. RN-A had just found out the other day R7 was colonized with MRSA and should be on Contact Precautions. "Well, I guess staff did need to dig in charts." "You know you are asking me for information. I find it hard to I know I'm accountable for speaking for the previous IP nurse." Staff were expected to follow Centers for Disease Control and Prevention (CDC) guidance to prevent the spread of infection. During an interview on 10/31/24 at 2:18 p.m., the director of nursing (DON) stated staff were expected to follow CDC precautions guidance for	21375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 74 donning/doffing PPE per facility policy and to demonstrate understanding of infection control to prevent the spread of microorganisms in the facility to prevent possible infections. R30's admission MDS dated 9/27/24, identified R30 was cognitively intact and had a stage 3 pressure ulcer with a multi-drug resistant organism (MDRO). R30's care plan dated 10/1/24, identified Methicillin-resistant Staphylococcus aureus (MRSA) (an infection which is caused by a type of staph bacteria that's become resistant to many of the antibiotics used to treat ordinary staph infections. A type of MDRO) Intervention included contact isolation(precautions): wear gown, gloves and mask when providing any cares. Mask or face shield to be worn during procedures. The care plan did not address EBP for having a chronic wound. R30's provider's order dated 9/26/24, identified dressing change to right residual limb (the limb with stage 3 pressure ulcer and MRSA): cleanse with wound cleaner, Aquacel ribbon (a wound dressing that absorbs wound fluid and creates a moist environment to help wounds heal) lightly packed into wound bed and cover with a large Tegaderm foam (a highly absorbent, breathable wound dressing). During observation on 10/29/24 at 10:19 a.m., there was a sign on R30's door identifying resident was on contact precautions. An isolation cart was located outside her door and held gowns, gloves, face masks, and eye protection. During an interview on 10/29/24 at 12:40 p.m., nursing assistant (NA)-A stated R30 was on	21375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 75 contact precautions and whenever NA-A would go into the room to assist the resident with cares, bed mobility, transfers, toileting or changing linens NA-A would wear a gown and gloves to help. During observations on 10/30/24 at 8:43 a.m., physical therapy assistant (PTA)-A approached R30's room and took gloves from the isolation cart outside of the door. PTA-A then entered the room without putting on gloves. PTA-A gathered the supplied for the dressing change and prepared them for the dressing change. With the ungloved hands, PTA-A removed the ace bandage, lymph wrap (a wrap for legs to offer management of swelling and surgical areas) and stump sock (a compression stocking placed on a recently amputated limb). PTA-A then sanitized her hands and put gloves on and removed the final dressing over the wound. The bandage had some red drainage on it and the surgical site wound had a pencil eraser size hole with a small amount of purulent (pus) drainage. Wearing the same gloves, she cleaned the wound with saline spray and a 4 x 4 gauze dressing. PTA-A then removed the gloves and sanitized her hands. PTA-A took a cell phone from her pocket and took a picture of the wound for R30's chart and then placed the cell phone directly on R30's bed. PTA-A then sanitized her hand and placed clean gloves on. PTA-A then placed iodoform gauze (an antiseptic), then covered with an Aquacel dressing (a dressing to help contain drainage) and then placed foam dressing over the wound. PTA-A then removed the dirty gloves and sanitized her hands and gathered the remaining supplies and put them away in R30's room and placed the cell phone in her bag and then sanitized her hands.	21375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 76 - At 9:00 a.m., PTA-A was finished with the dressing change and proceeded to work on exercises with R30 without wearing gloves. Exercises included marching in place while sitting on the edge of the bed by lifting her knees. Then asked resident to kick out with amputated limb and was placing ungloved hand on the dressing she just changed. PTA-A then rubbed her hands together and placed them on the outside of each knee and had R30 push against her hands. PTA-A then moved to the inside of the knees and did the same. A gait belt was then placed on R30 and with a walker PTA-A assisted R30 to stand while she held the gait belt and walker with her ungloved hands. R30 then proceeded to exercise her amputated limb. PTA-A was standing by R30 with on ungloved hand on the gait belt and one on the walker and did that exercise twice. R30 was then seated on the edge of her bed and repeated the initial exercises done with ungloved hands, which included placing the ungloved hands on the dressing which was just changed. When finished with the exercises PTA-A with her ungloved hands rolled up the Ace bandage which was originally wrapped around the amputated limb at the beginning of the observation. PTA-A then sanitized her hands and left the room. PTA-A did not wear a gown at any time during the encounter. During an interview on 10/30/24 at 7:56 a.m., PTA-A stated she seen the sign on door indicating contact precautions and knew it was for an infection in the wound. Since it had been mostly contained, she had been only wearing gloves during the dressing changes and was unsure of why a gown would be needed. PTA-A stated nobody reviewed contact precautions, and the only times a gown was worn is if wounds were worse than R30's, if the resident had a catheter	21375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 77 or covid. R30 was on contact precautions, and she should probably have been wearing a gown and gloves. During and interview on 10/31/24 at 12:50 a.m., RN-A stated residents who were colonized with MDRO in urine and had a catheter or had an MDRO in a wound would be expected to be on contact precautions. Meaning any staff doing close contact cares, bed mobility, or dressing changes with a resident on contact precautions would be wearing a gown and gloves. The importance of contact precautions is to protect the resident on any infections that staff my unknowing bring into the room, and to protect the staff and other resident after contact with infected resident. R30 was on contact precautions for a MDRO in a wound on her leg and would expect all staff to follow contact precautions. During an interview on 10/31 24 at 1:07 p.m., the DON stated it was the expectation that all staff would follow infection control policies, and this included contact precautions. This was to protect the resident on contact precautions and all the other residents in the building. The facility's Transmission Based Precautions policy dated 4/4/24 identified contact precautions were intended to prevent transmission of infections and require the use of gown and gloves upon entering the room. The facility's Multidrug Resistant Organisms (MDROs) policy dated copyright 2009 identified contact precautions shall be considered for residents infected or colonized with a MDRO. Standard Precautions:	21375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 78 R99's admission MDS dated 10/25/24, identified R99 had moderate cognition and required intermittent catheterization. Diagnoses included neurogenic bladder, Alzheimer's disease, and dementia. R99's physician notes dated 10/17/24, identified R99 performed catheterization by himself as needed to empty his bladder. R99's care plan dated 10/22/24, failed to identify R99's catheterization plan and goals including what personal protective equipment was needed. R99's medication administration report (MAR) dated 10/1/24 through 10/31/24, identified staff were required to perform catheterization for R99 every shift or as requested by the resident due to the resident's neuromuscular dysfunction of the bladder. On 10/29/24 at 10:17 a.m., R99 was seated in a wheelchair in his room. R99 stated he used a catheter to empty his bladder due to being unable to urinate on his own. Staff used gloves but did not wear gowns when catheterizing him. On 10/30/24 at 1:30 p.m., registered nurse (RN)-A stated when providing direct cares for R99, including being straight cathed, staff were required to wear a gown and gloves. On 10/30/24 at 1:55 p.m., licensed practical nurse (LPN)-A stated R99 required staff to use a straight catheter to empty his bladder. LPN-A used a straight catheter to empty R99's bladder. LPN-A wore gloves and used sterile technique but failed to wear a gown. LPN-A stated she had failed to wear a gown during catheterization and should of to protect herself, other resident. As	21375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 79 splashing of urine could potentially spread bacteria causing aninfection. On 10/31/24 at 2:18 p.m., the DON stated staff were expected to follow the Center for Disease Control (CDC) precautions guidance for personal protective equipment during catheter care. Further, the DON stated the facility policy directed staff to demonstrate understanding of infection control to prevent the spread of microorganisms in the facility to prevent possible infections. The Standard Precautions policy revision 2009 identified all resident blood, body fluids, excretions, and secretions other than sweat were considered potentially infections and standard precautions would be used for all residents. The policy further identified gowns/aprons (fluid resistant) should be worn when there was a potential for soiling clothing with blood/body fluids. The facility policy Standard and Transmission Based Precautions revised 4/4/24, identified Transmission-based precautions must be used when a resident developed signs and symptoms of a transmissible infection, arrived with symptoms of an infection (pending laboratory confirmation), or has a laboratory confirmed infection and was at risk of transmitting the infection to other residents. The diagnosis of many infections is based on clinical signs and symptoms, but often required laboratory confirmation. However, since laboratory tests {especially those that depend on culture techniques) may require two or more days to complete, transmission-based precautions may be implemented while test results were pending, based on the clinical presentation and the likely category of pathogens. Nurses would identify the	21375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 80 type (i.e., contact, droplet, airborne) and duration of the transmission-based precautions required, depending upon the infectious agent or organism involved. Contact Precautions Contact precautions are intended to prevent transmission of infections that were spread by direct (e.g., person-to-person) or indirect contact with the resident or environment, and required the use of appropriate PPE, including a gown and gloves upon entering the room. Prior to leaving the resident's room, the PPE was removed, and hand hygiene was performed. Contact precautions were indicated for gastrointestinal illnesses such as C. difficile or norovirus, infected draining wounds, or secretions. Policies: A review of the facility infection control policies identified the following policies were not reviewed or updated in the past year: The Standard Precautions policy revision 2009, Multidrug Resistant Organisms (MDROs) policy dated 2009, Infectious Disease Outbreak Policy last revised 10/23/20, Infection Preventionist Responsibilities revised 7/25/17, Infection Control Plan revision date 3/10/20, C. Difficile policy dated 8/17/18, Antimicrobial Stewardship Program dated 12/4/18, Hand Hygiene dated 3/10/20, Personal Protective Equipment-using gloves dated 7/25/17, Personal Protective Equipment- using protective eyewear dated 7/25/17, Personal Protective Equipment- using face masks dated 7/25/17, Influenza, Prevention and Control of Seasonal Influenza dated 7/25/17, Infection Control Education dated 7/25/17,	21375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 81 Pneumococcal Vaccination dated 4/14/17, and Long Term Care and Assisted Living Response Plan for Supporting COVID-19 Testing dated 9/1/20. The facility lacked documentation their infection control policies had been reviewed annually as required. When interviewed on 10/31/24, at 10:15 a.m. RN-A stated she had never updated any of the facility policies or procedures as she had just taken over her position a few weeks prior. There was only so much a person could do and RN-A was just trying to complete what she could. During interview on 10/31/24, at 2:40 p.m. the DON stated infection control policies should be updated annually. Updating infection control policies should have been completed by the DON or infection preventionist. It was important to update infection control policies because things changed so much within the infection control program. The facility's Infection Prevention Plan Policy, dated 3/10/20, identified an annual review would be conducted to review the Infection Prevention and Control Program and the program would be updated as necessary, including necessary updates as national standards changed. SUGGESTED METHOD OF CORRECTION: The DON or designee could review applicable policies and procedures to ensure the comprehensive infection control (IC) program contains on-going analysis of collected data to prevent potential spread of illness and that policies are appropriately implemented; along with contact, transmission based, standard and	21375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 82 enhanced barrier precautions. The DON could inservice staff regarding proper infection control measures are implemented. The DON or designee could implement audits to ensure ongoing compliance and report those results to the quality assurance group. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21375		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the	21426	Completed 12/11/2024	12/11/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21426	Continued From page 83 facility failed to ensure a tuberculosis (TB) symptom screening was completed upon admission for 4 of 5 residents (R8, R15, R43, R99); and accurately record the results of a tuberculin skin test (TST) for 1 of 5 residents (R43); and failed to administer a 2nd step Mantoux for 1 of 5 residents (R43). In addition, the facility failed to ensure TB symptom screening was completed on hire for 3 of 5 employees (DA-A, DON, AA-B); and ensure a tuberculin skin test (TST) was administered to 2 of 5 employees (DA-A, AA-B) prior to working with residents of the facility. Findings include: Residents: R8 was admitted 1/25/24. R8's medical record indicated her TST test that was given 1/26/24 and 2/9/24, was documented as negative. R8's medical record lacked evidence that an assessment for risk factors and physical screening for active symptoms of TB had been completed. R30 was admitted 9/24/24. R30's medical record indicated her TST test that was given 9/24/24 and 10/9/24, was documented as negative. R30's medical record lacked evidence that an assessment for risk factors and physical screening for active symptoms of TB had been completed. R43 was admitted 6/5/24. R43's medical record indicated her TST test that was given 6/19/24 did not have results of the TST documented. R43's medical record lacked documentation her second TST had been completed as required. Further, R43's medical record lacked evidence that an	21426		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21426	Continued From page 84 assessment for risk factors and physical screening for active symptoms of TB had been completed. R99 was admitted 10/15/24. R99's medical record indicated his TST test that was given 10/15/24 and 10/29/24, was documented as negative. R99's medical record lacked evidence that an assessment for risk factors and physical screening for active symptoms of TB had been completed. Employees: Dietary aide (DA)-A's hire date was 1/11/24. DA-A's employee file identified DA-A had a T spot TB test on 6/24/24, which was negative. DA-A's employee file lacked evidence that an assessment for risk factors and physical screening for active symptoms of TB had been completed or that a tuberculin test had been completed prior to working with residents. Director of nursing's (DON) hire date was 8/12/24. DON's employee file identified DON had a Quantiferon TB test on 4/4/24, prior to hire. The DON's employee file lacked evidence that an assessment for risk factors and physical screening for active symptoms of TB had been completed. Activity aide (AA)-B's hire date was 1/3/24. AA-B's employee file identified AA-B had a T spot TB test on 6/26/24, which was negative. AA-B's employee file lacked evidence that an assessment for risk factors and physical screening for active symptoms of TB had been completed or that a tuberculin test had been completed prior to working with residents.	21426		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21426	Continued From page 85 When interviewed on 10/29/24, at 4:12 p.m. registered nurse (RN)-A stated the facility had to go through all the employee records in June 2024, because someone had mistakenly destroyed a bunch of employee files. The facility had redone some of the employee TB testing to be sure to have everyone recorded. She was unsure of why there was no documentation for resident screening and R43's testing must have just gotten missed. RN-A was unable to find any of the missing documentation and stated most had occurred prior to RN-A taking her position. RN-A stated it would be important to complete TB testing and monitoring to remain in compliance with regulations. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) and/or designee could review current CDC guidelines for tuberculosis control within health care facilities, audit resident and staff for requirements, update/complete any steps missing and complete ongoing monitoring of new admissions and new hires to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced	21805		12/11/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21805	Continued From page 86 by: Based on interview and document review, the facility failed to provide toileting cares in a dignified manner for 1 of 1 resident (R12) reviewed for dignity. Findings include: R12's quarterly Minimum Data Set (MDS) dated 8/22/24, identified R19 was severely cognitively impaired and R12 was dependent (helper performed all the effort and resident does none of the effort to complete the activity) for toileting and bed to chair transfers. R12 required substantial/maximal assistance (helper does more than half the effort) for personal hygiene. R12's care plan dated 8/9/24, identified R12 was cognitively impaired and required assist of two staff for ceiling lift transfers. During an interview on 10/28/24 at 2:38 p.m., R12 stated, last week, a nursing assistant left R12 in the bathroom in the ceiling lift alone. R12 was unable to say a name or date but R12 was crying and stated R12 waited at least 20 minutes. R12 was in the bathroom already in the lift, up in the air, and R12's feet were dangling and "going numb". Staff usually left R12 in the ceiling lift, hanging over the toilet, but usually not for that long. R12 stated she urinated almost immediately when she got to the toilet and could have gone back to bed. R12 did report the incident to facility staff and stated she was told by facility staff it always felt longer when you're in the lift, but it wasn't that long. R12 was crying and stated she felt "neglected. "I don't like to complain and get people in trouble, but I can't put up with this either. I just can't." R12 was grasping her bed linens in her hands and stated she was told there	21805	Completed 12/11/2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21805	Continued From page 87 were many other people to help take care of. During an interview on 10/30/24 at 9:20 a.m., licensed practical nurse (LPN)-A stated she was very concerned regarding resident and staff safety. The facility did not have enough staff to provide assist of two with ceiling lift transfers. Residents were being left alone in the lifts in the bathrooms and not answering call lights timely. LPN-A stated she knew of an incident on 10/25/24 between R12 and NA-D, where R12 was left alone in the bathroom hanging from the ceiling lift. LPN-A did not report this to anyone but stated R12 was not safe to be left unattended in the ceiling lift in the bathroom nor was it dignified.R12 had a history of depression as well. During an interview on 10/30/24 at 9:44 a.m., NA-C stated the facility was "always" short staffed. NA-C stated she had heard about an incident where R12 was left alone in the bathroom because staff were answering call lights because there wasn't enough staff. During an interview on 10/30/24 at 1:25 p.m., NA-B stated R12 reported the bathroom incident to her, and NA-B reported it to the nurse. After that, NA-B didn't know what happened. During an interview on 10/30/24 at 2:39 p.m., the social worker designee (SWD)-A stated she was informed of R12's bathroom incident and staff were expected to not leave residents unattended in the bathroom to ensure resident's safety and to provide comfort to the resident. However, there was no documented grievance for R12's concerns or follow up. During an interview on 10/30/24 at 6:21 p.m., the administrator stated staff were expected to	21805		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21805	Continued From page 88 provide cares in a dignified manner to maintain the resident's individuality and to provide comfort. A facility policy regarding dignity was requested but not received. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) could inservice staff about ensuring cares are initiated and complete timely for each resident, then complete audits of care to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21805		
21880	MN St. Statute 144.651 Subd. 20 Patients & Residents of HC Fac.Bill of Rights Subd. 20. Grievances. Patients and residents shall be encouraged and assisted, throughout their stay in a facility or their course of treatment, to understand and exercise their rights as patients, residents, and citizens. Patients and residents may voice grievances and recommend changes in policies and services to facility staff and others of their choice, free from restraint, interference, coercion, discrimination, or reprisal, including threat of discharge. Notice of the grievance procedure of the facility or program, as well as addresses and telephone numbers for the Office of Health Facility Complaints and the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12) shall be posted in a conspicuous place. Every acute care inpatient facility, every residential program as defined in section 253C.01, every nonacute care facility, and every facility employing more than two people that	21880		12/11/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21880	Continued From page 89 provides outpatient mental health services shall have a written internal grievance procedure that, at a minimum, sets forth the process to be followed; specifies time limits, including time limits for facility response; provides for the patient or resident to have the assistance of an advocate; requires a written response to written grievances; and provides for a timely decision by an impartial decision maker if the grievance is not otherwise resolved. Compliance by hospitals, residential programs as defined in section 253C.01 which are hospital-based primary treatment programs, and outpatient surgery centers with section 144.691 and compliance by health maintenance organizations with section 62D.11 is deemed to be compliance with the requirement for a written internal grievance procedure. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed ensure a voiced grievance was acted upon; and provide a written policy for how the facility would handle grievances for 1 of 1 resident (R20) reviewed for missing property Findings include: R20's quarterly Minimum Data Set (MDS) dated 7/19/24, identified R20 was cognitively intact and demonstrated no delusional behavior and/or thinking. The facility 8/7/24, resident council minutes identified R20 was missing a long white, lacy nightgown that had been gone for an	21880	Completed 12/11/2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21880	Continued From page 90 undetermined length of time. On 10/30/24 at 9:58 a.m., during a resident council discussion R20 stated she reported a missing night gown a few months ago at a resident council meeting. R20 stated she asked staff about the gown a couple weeks ago but had not received any follow up. An interview was completed on 10/30/24 at 2:45 PM, with environmental services manager (EVS) and laundry aide (LA)-A. LA-A stated in August 2024, the facility changed the laundry process, and all personal and facility laundry was done in the large laundry room and not on the units as previously done. Staff and/or family were instructed to label all the residents clothing and any unlabeled and/or unclaimed items were folded/hung on the cart and brought to the units for the nurses, residents, and family to look through and identify. EVS stated residents/families/staff notified the laundry staff of missing items. Residents also voiced concerns of missing items during resident council and laundry staff were notified to watch for the item/s. After an undetermined amount of time, the concern would be discussed with administration to make a decision regarding compensation. During interview on 11/4/24 2:32 p.m., nursing assistant (NA)-E stated staff would search for any missing items and notify the nurse and laundry staff. NA-E was unaware that R20 was missing a night gown and was uncertain if there was a form to fill out for missing items. During interview on 11/4/24 at 1:52 P.M., the activities director (AD) stated when missing items were brought to resident council meetings she would make a note in the minutes, highlights the	21880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21880	Continued From page 91 concern, and placed a copy of the minutes in the appropriate manager's mailbox as well as the director of nursing (DON)'s for follow up. If the concern came up again at future resident council meeting would make another note in the minutes and place a highlighted copy in the administrator's mailbox. The AD stated once the copies were placed in the appropriate mailbox, the AD would not follow up any further. Missing items were discussed at the interdisciplinary meeting but did not recall that R20's missing night gown had been discussed. On 11/4/24 at 2:16 p.m., EVS stated she was unaware of R20 having any missing clothing items and if it had been prior to 8/24, the nursing staff would have tracked and followed through with the item. A facility grievance policy was requested but not received. SUGGESTED METHOD OF CORRECTION: The DON and/or designee could review and revise policies pertaining to handling resident grievances, educate staff on these policies and perform audits to ensure each resident grievance has been addressed by the facility. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245329	A. BUILDING **02 - WARROAD CARE CENTER** B. WING _____	**10/29/2024**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 10/29/2024. At the time of this survey, Warroad Care Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

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

Electronically Signed | 11/26/2024

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245329	A. BUILDING **02 - WARROAD CARE CENTER** B. WING _____	**10/29/2024**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Warroad Care Center is a 1-story building without a basement that was built in 2009 and was determined to be built of Type V(111) construction. The facility is divided into four separate smoke compartments by smoke barrier walls. The facility is fully protected throughout by an automatic fire sprinkler system and has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility also has smoke detection	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245329	A. BUILDING **02 - WARROAD CARE CENTER** B. WING _____	**10/29/2024**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 in the resident rooms that is tied into the nurse call system. The facility has a capacity of 49 beds and had a census of 42 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K 000		
K 293 SS=D	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain and/or install proper exit signage under NFPA 101 (2012 edition), Life Safety Code sections 19.2.10.1, 7.10.1.2.2, 7.10.83, 7.10.8.31 and 7.10.8.3.2. These deficient findings could have an isolated impact on the residents within the facility. Findings include: On 10/29/2024, between 9:30am and 12:30pm, it was revealed by observation that the door leading to the Courtyard outside the employee break room was missing a "NO EXIT" sign.	K 293	No residents were affected by this deficient practice. All residents had the potential to be affected by this deficient practice. In the employee breakroom there was no 'No Exit' sign on the door to the patio. Maintenance Director put a 'No Exit' sign up on the employee breakroom door on 10/30/2024. The Maintenance Director or assigned personnel will check doors for 'No Exit' signs immediately, then once every 6 months a routine check will be completed. The Maintenance Director will monitor for compliance. This will be completed on 11/28/2024	11/28/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245329	A. BUILDING **02 - WARROAD CARE CENTER** B. WING _____	**10/29/2024**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 293	Continued From page 3 An interview with Maintenance Director verified these deficient findings at the time of discovery.	K 293		
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain their smoke barrier per	K 321	No residents were affected by this deficient practice. All residents had the	11/28/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245329	A. BUILDING **02 - WARROAD CARE CENTER** B. WING _____	**10/29/2024**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 321	Continued From page 4 NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.3, 8.5.6.5 and 8.5.6.2. These deficient findings could have an isolated impact on the residents within the facility. Findings include: On 10/29/2024, between 9:30am and 12:30pm, it was revealed by observation that there was a penetration running from one smoke compartment to another above doors leading to Pine Island. An interview with Maintenance Director verified these deficient findings at the time of discovery.	K 321	potential to be affected by this deficient practice. Hazardous areas-enclosures we had a smoke penetration from 1 smoke compartment to another smoke compartment above the doors leading to our Pine Island Unit. The smoke penetration was fixed by our Maintenance Director with fire caulk on 10/29/2024. Maintenance Director or assigned staff will check all 6 fire doors immediately and then audit the 6 fire doors 1 time a year for smoke penetrations. The completion date is 11/28/2024.	
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor.	K 324		11/28/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245329	A. BUILDING **02 - WARROAD CARE CENTER** B. WING _____	**10/29/2024**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 324	Continued From page 5 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on documentation review and staff interview, the facility failed to test and inspect the kitchen hood ventilation and fire suppression system per NFPA 101 (2012 edition), Life Safety Code, section 9.2.3 and NFPA 96 (2011 edition), Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, section 11.2.1. This deficient finding could have an isolated impact on the residents within the facility. Findings Include: On 10/29/2024, between 9:30am and 12:30pm, it was revealed by a review of available documentation that inspection documentation for the kitchen hood ventilation and fire suppression system was not available. The facility could not provide completed test/inspection documentation for both of the semi-annual kitchen hood suppression system inspections for the last 12 months. An interview with Maintenance Director verified these deficient findings at the time of discovery.	K 324	No residents were affected by this deficient practice. All residents had the potential to be affected by this deficient practice. The kitchen hood ventilation and fire suppression inspection documentation of the semi-annual reports was completed and the information was sent to Maintenance Director on 10/30/2024. We contract with Northland Fire Protection and both our hoods were inspected on 1/12/24 and again on 08/13/24. Reviewed our contract to make sure we are scheduled for the following annual inspection on our kitchen hoods and fire suppression systems. This will be completed by our Maintenance Director. This was completed on 10/30/2024.	
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in	K 345		11/28/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245329	A. BUILDING **02 - WARROAD CARE CENTER** B. WING _____	**10/29/2024**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 345	Continued From page 6 accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation, staff interview, and observations, the facility failed to maintain the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, sections 9.6.1.3, 9.6.7.5, and NFPA 72 (2010 edition), National Fire Alarm and Signaling Code, sections 10.12.4, 14.3.1, 14.4.5.3, and 14.6.2.4. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 10/29/2024, between 9:30am and 12:30pm, it was revealed by a review of available documentation that the annual fire alarm inspection report produced by Northland Safety dated 04/03/2024 that the facility could not provide documentation that a sensitivity testing had been conducted. . An interview with Maintenance Director verified these deficient findings at the time of discovery.	K 345	No residents were affected by this deficient practice. All residents had the potential to be affected by this deficient practice. Documentation on the annual fire alarm inspection report didn't provide sensitivity testing. Maintenance Director reached out to Northland Fire Protection for the report and to ask for the sensitivity testing. Northland Fire Protection sent us an email stating the fire alarm control unit at our facility monitors for sensitivity levels and will cause a trouble signal at the control panel if a detector is out of sensitivity range. Maintenance Director or assigned staff will make sure our contracted inspection includes all that is needed to continue to remain in compliance by scheduling our inspections with Northland Fire Protection. This was completed on 10/29/2024.	
K 353 SS=D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection,	K 353		11/28/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245329	A. BUILDING **02 - WARROAD CARE CENTER** B. WING _____	**10/29/2024**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 353	Continued From page 7 Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain the automatic sprinkler system per NFPA 101 (2012 edition), Life Safety Code Section 19.7.6, and 4.6.12, NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 5.1.1.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 10/29/2024, between 9:30am and 12:30pm, it was revealed by a review of available documentation the facility failed to perform quarter sprinkler system testing. An interview with Maintenance Director verified these deficient findings at the time of discovery.	K 353	No residents were affected by this deficient practice. All residents had the potential to be affected by this deficient practice. Our sprinkler system maintenance and testing paperwork couldn't be found by our Maintenance Director. The Maintenance Director reached out to Dakota Fire Protection to see if it was completed and to send him copies of the inspection. Dakota Fire Protection was out to our facility on 8/12/24 and performed the inspection. Copies were put in the survey prep binder. Maintenance Director will make sure the report of inspection and testing will be put in the survey prep binder upon reciept. Maintenance Director will make sure our inspection and testing is scheduled and followed through with paperwork. This will be completed on 11/28/24.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245329	A. BUILDING **02 - WARROAD CARE CENTER** B. WING _____	**10/29/2024**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 363	Continued From page 8	K 363		
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire	K 363		11/28/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245329	A. BUILDING **02 - WARROAD CARE CENTER** B. WING _____	**10/29/2024**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 363	Continued From page 9 protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor doors per NFPA 101 (2012 edition), Life Safety Code, section 19.3.6.3.5. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 10/29/2024, between 9:30am and 12:30pm, it was revealed by observation that the resident room door A106 and B118 did not latch when tested. An interview with Maintenance Director verified these deficient findings at the time of discovery.	K 363	No residents were affected by this deficient practice. All residents had the potential to be affected by this deficient practice. Resident rooms A106 and B118 did not latch properly when tested. Both doors were fixed by the Maintenance Director on 10/29/2024. Maintenance Director or assigned staff will do weekly door checks on an audit form to make sure affected doors latch properly and will be entered in our TELS system. This will be completed on 11/28/2024.	
K 712 SS=D	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct	K 712	No residents were affected by this deficient practice. All residents had the	11/28/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245329	A. BUILDING **02 - WARROAD CARE CENTER** B. WING _____	**10/29/2024**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 712	Continued From page 10 fire drills under varied times and conditions per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.6, 4.7.4, and 4.6.1.1. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 10/29/2024, between 9:30am and 12:30pm, it was revealed by a review of available documentation that fire drills did not meet the standard of varying times and dates: Second Shift - 05/29/2024 @ 1700, 08/31/2024 @ 1800, First Shift - 04/30/2024 @ 1330, 07/30/2024 @ 1406. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 712	potential to be affected by this deficient practice. The Maintenance Director made a spreadsheet (attached) to ensure correct times for fire drills will be conducted according to the varying times and dates. The Maintenance Director or assigned staff will be in charge of reviewing the date for fire drill to make sure it is conducted at the right time for proper varying of drill times. This will be completed on 11/28/24.	

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

January 14, 2025

Administrator
Warroad Care Center
1401 Lake Street Northwest
Warroad, MN 56763

Re: Reinspection Results
Event ID: IXTO12

Dear Administrator:

On January 8, 2025 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on November 6, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 14, 2025

****PLEASE NOTE THAT HEALTH AND LIFE SAFETY CODE SURVEYS ARE BEING PROCESSED IN SEPERATE ENFORCEMENT CYCLES.****

Administrator
Warroad Care Center
1401 Lake Street Northwest
Warroad, MN 56763

RE: CCN: 245329
Cycle Start Date: November 6, 2024

Dear Administrator:

On November 20, 2024, we notified you a remedy was imposed. On January 8, 2025 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of December 20, 2024.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective December 5, 2024 be discontinued as of December 20, 2024. (42 CFR 488.417 (b))

In our letter of November 20, 2024, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from November 6, 2024. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
December 19, 2024

Administrator
Warroad Care Center
1401 Lake Street Northwest
Warroad, MN 56763

RE: CCN: 245329
Cycle Start Date: October 29, 2024

Dear Administrator:

PLEASE NOTE THAT HEALTH AND LIFE SAFETY CODE SURVEYS ARE BEING PROCESSED IN SEPERATE ENFORCEMENT CYCLES.

On December 17, 2024, the Minnesota Department of Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Submitted
November 20, 2024

Administrator
Warroad Care Center
1401 Lake Street Northwest
Warroad, MN 56763

RE: CCN: 245329
Cycle Start Date: November 6, 2024

Dear Administrator:

On November 6, 2024, survey was completed at your facility by the Minnesota Department of Health 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.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On November 5, 2024, the situation of immediate jeopardy to potential health and safety cited at F600 was removed. However, continued non-compliance remains at the lower scope and severity of D.

In addition, on November 5, 2024, the situation of immediate jeopardy to potential health and safety cited at F689 was removed. Continued non-compliance remains at the lower scope and severity of D.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedies listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective December 5, 2024.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective December 5, 2024, (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective December 5, 2024, (42 CFR 488.417 (b)).

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $12,924; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective November 6, 2024. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with with one or more of the following: §483.10, Residents Rights, §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.15, Quality of Life and §483.25, Quality of Care, 483.40 Behavioral Health Services, §483.45 Pharmacy Services, §483.70 Administration, or §483.80 Infection control has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. **If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.**

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Warroad Care Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective November 6, 2024. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

Jen Bahr, RN, Regional Operations Supervisor
Bemidji District Office
Health Regulation Division

Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, Minnesota 56601-2933
Email: Jennifer.bahr@state.mn.us
Office: (218) 308-2104

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. 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 their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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.

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

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 May 6, 2025 (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.

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.

APPEAL RIGHTS DENIAL OF PAYMENT

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services,

Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Steven.Delich@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

Department of Health & Human Services

Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 **and Minnesota Statute 144A.10 subd 15**, 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: **https://forms.web.health.state.mn.us/form/NHDisputeResolution**

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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:
https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 20, 2024

Administrator
Warroad Care Center
1401 Lake Street Northwest
Warroad, MN 56763

Re: State Nursing Home Licensing Orders
Event ID: IXTO11

Dear Administrator:

The above facility was surveyed on October 28, 2024 through November 6, 2024 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

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

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

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

Jen Bahr, RN, Regional Operations Supervisor
Bemidji District Office
Health Regulation Division
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, Minnesota 56601-2933
Email: Jennifer.bahr@state.mn.us
Office: (218) 308-2104

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 feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 20, 2024

Administrator
Warroad Care Center
1401 Lake Street Northwest
Warroad, MN 56763

RE: CCN: 245329
Cycle Start Date: October 29, 2024

Dear Administrator:

PLEASE NOTE THAT HEALTH AND LIFE SAFETY CODE SURVEYS ARE BEING PROCESSED IN SEPERATE ENFORCEMENT CYCLES.

On October 29, 2024, a survey was completed at your facility by the Minnesota Department of 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 constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.

- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. 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, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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.

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 January 29, 2025 (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).

In addition, if substantial compliance with the regulations is not verified by April 29, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 **and Minnesota Statute 144A.10 subd 15**, 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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:

https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 10/28/24 through 11/6/24, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was not in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 1 identify the date when they will be completed. The following complaints were reviewed during the survey: H53299762C (MN106056). No licensing orders were issued. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 2 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.	2 000		
2 255	MN Rule 4658.0070 Quality Assessment and Assurance Committee A nursing home must maintain a quality assessment and assurance committee consisting of the administrator, the director of nursing services, the medical director or other physician designated by the medical director, and at least three other members of the nursing home's staff, representing disciplines directly involved in resident care. The quality assessment and assurance committee must identify issues with respect to which quality assurance activities are necessary and develop and implement appropriate plans of action to correct identified quality deficiencies. The committee must address, at a minimum, incident and accident reporting, infection control, and medications and pharmacy services. This MN Requirement is not met as evidenced by: Based on interview, and document review, the facility failed to develop and implement appropriate plans of action to correct quality deficiencies identified during the survey that the facility was aware of or should have been aware. This had the potential to adversely affect all 46 residents residing in the facility. Findings include:	2 255	Completed 12/11/2024	12/11/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 255	Continued From page 3 See also F600: The facility failed to ensure 1 of 1 resident (R39) with known sexual behaviors towards others was comprehensively assessed and interventions implemented to mitigate risk to others and prevent ongoing sexual abuse for 2 of 2 residents (R31, R6) who were cognitively impaired and dependent on staff for their care and were sexually abused by R39. See also F689: The facility failed to ensure staff were following care planned interventions when transferring residents with a ceiling lift; and complete therapy/or nursing assessments to determine the appropriate sling sizes per manufacturers guidelines for 3 of 4 residents (R12, R7, R2) to ensure resident and staff safety. These deficient practices resulted in immediate jeopardy for R12, R7 and R2 but had the potential to affect all 12 residents who used ceiling lifts. See also F880: The facility failed to develop and implement an infection control surveillance plan for identifying, tracking, monitoring and/or reporting infections and communicable disease along with a monthly analysis; failed to conduct COVID-19 testing of staff and residents per Centers for Disease Control (CDC) guideline; failed to implement contact precautions and/or enhanced barrier precautions (EBP) for 2 of 2 residents (R7, R30) reviewed with a multi drug resistant organism (MDRO) and chronic wounds; and failed to implement standard precautions while catheterizing 1 of 1 resident (R99) observed to be catheterized. In addition, the facility failed to review and update their infection control policies on an annual bases. These deificient practices had the potential to affect all 46 residents residing in the facility.	2 255		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 255	Continued From page 4 See also 725: The facility failed to provide sufficient staff to transfer residents in lifts according to their care plan for 3 of 4 residents (R12, R7, R2); failed to provide appropriate supervision to mitigate resident-to-resident abuse for 2 of 2 (R31, R6) residents abused by 1 of 1 residents (R39) reviewed for abuse: failed to provide sufficient staff to complete range of motion for 4 of 4 residents (R7, R19, R22, R43) reviewed for restorative therapy. In addition, 4 of 46 residents (R7, R30, R25, R34,) 8 of 8 staff members (RN-B, NA-D, LPN-A, NA-C, NA-A, SWD, RT-A, NA-H); 1 of 3 family members (FM-A) voiced concerns of lack of sufficient staffing in the facility. The lack of sufficient staffing had the potential to affect all 46 residents in the facility. The Facility Assessment 2023 dated 12/18/23, identified the facility had identified the need to develop and implement policies and procedures for the provision of care and the following areas of concern were identified: - Staff turnover rate: YTD as of December 11, 2023 was 22.95%. Turnover had declined from one year ago when it was 24.44%. Staff will continue to work on creating a great culture and sufficient staffing levels in all areas to be able to hire and keep good people on our team. We are impacted by the current labor shortages as well as students both leaving for and returning to school. Our goal was to reduce our number to approach 20%. However, the assessment failed to identify interventions to improve the staff turnover rate nor how to ensure safe resident care was provided. - An Infection Prevention Risk Asscssmenl is completed annually, which guides infection prevention improvements. APIC's Infection	2 255		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 255	Continued From page 5 Preventionists Guide to Long Tenn Care and the Centers for Disease Control are the primary resources that guide our Infection Prevention Program. The facility was registered with NHSN. Covid-19 reporting was being done. However, the facility assessment failed to identify changes in guidance related to Enhanced Barrier Precautions (EBP) and/or staff education needs related to infection prevention. The February QAPI Education Report dated 3/8/24, identified staff education compliance was at 72.8%, however, the facility could not provide evidence actions were taken to increase compliance. The Quality and Safety Meeting (Quarter 1 Data) dated 4/15/24, identified a table of QAPI team reviewed topics: emerging infectious disease, staff influenza vaccination program, emergency preparedness, environmental services, Minnesota Pollution Control Agency (MPCA), skilled nursing safety report (Casper, MDS, QIIP), safe resident handling, consultant pharmacist report, and performance improvment project (PIP) discussion. The data failed to identify goals and measurable actions taken regarding abuse, staffing concerns, accidents and/or infection prevention. The Quality and Safety Meeting (April Data) dated 5/20/24, identified a table of QAPI team reviewed topics: emerging infectious disease, staff influenza vaccination program, emergency preparedness, environmental services, Minnesota Pollution Control Agency (MPCA), skilled nursing safety report (Casper, MDS, QIIP), safe resident handling, consultant pharmacist report, and performance improvment project (PIP) discussion. The data failed to identify goals and	2 255		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 255	Continued From page 6 measurable actions taken regarding abuse, staffing concerns, accidents and/or infection prevention. The Quality and Safety Meeting (May Data) dated 4/15/24, identified a table of QAPI team reviewed topics: emerging infectious disease, staff influenza vaccination program, emergency preparedness, environmental services, Minnesota Pollution Control Agency (MPCA), skilled nursing safety report (Casper, MDS, QIIP), safe resident handling, consultant pharmacist report, and performance improvment project (PIP) discussion. The data failed to identify goals and measurable actions taken regarding abuse, staffing concerns, accidents and/or infection prevention. The Annual Safe Resident Handling Assessment completed on 5/15/24, idendentified poor attendance. NAR meetings would start being held on the 2nd Wed of each month at 1:30 p.m. and 3:00 p.m. and the following Thurs at 7:00 a.m. to accommodate night shift. The meetings were part of the Safe Resident Handling policy. Follow-up from previous meeting: lock-out-tag-out policy was going to be reviewed (r/t Sarah Steady lift had loose hardware). Update: Lock-out/Tag-out policy is primary designed for electrical equipment. Will be reviewing policies including equipment maintenance policies to ensure that protocols were in place for equipment such as the Sarah-Steady lifts. The data failed to identify goals and measurable actions taken for staffing concerns, accidents and/or infection prevention and no further data was provided regarding the NAR meeting attendance. The QAPI Meeting Minutes dated 8/12/24, identified the following:	2 255		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 255	Continued From page 7 - Falls- 26 falls documented in the month of July. PIP written and reviewed on 4/15/24 for fall reduction. PIP was ongoing and continued to be implemented. The fall committee initiated weekly meetings along with the introduction of the Falling star program and policy the week of 8/1/24. 13 less falls identified than the previous 60 days. - Resident Council- held 7/3/24 - All concerns have been communicated and completed. - Grievances - No formal family or resident in the month of July - Resident Quality of Life/Nursing Home report card-addressed with team and will continue in the month of August. The data failed to identify goals and measurable actions taken regarding abuse, staffing concerns, accidents and/or infection prevention. During an interview on 11/06/24 at 1:53 p.m., the administrator stated he was a contracted interim administrator and began his role at the facility on 10/9/24. The facility had undergone several administration changes since the previous survey and the administrator had been told the facility held a QAPI meeting in July or August but he could not find any data that reflected that. The administrator did find an agenda but nothing substantial that reflected how the facility was working towards improvement. The administrator stated he was unsure what happened to the facility files because even common items were missing. The QAPI plan should be reviewed at the end of every QAPI meeting and PIP discussed as well. Does it need to be changed? Is there improvement and, if not, why? The administrator expected staff to report concerns to discuss during QAPI, the minutes to reflect work done and to work towards improvement. The facility Quality Assurance Performance	2 255		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 255	Continued From page 8 Improvement Plan dated 2/24/17, identified the written QAPI plan provided guidance for the overall quality improvement program. Quality assurance and performance improvement principles w drive the decision making within our organization. Decisions will be made to promote excellence in quality of care, quality of life, resident choice, person directed care, and resident transitions. Focus areas will include all systems that affect resident and family satisfaction, quality of care and service provided, and all areas that affect the quality of life for persons living and working in our organization. The executive director will assure that the QAPI plan is reviewed minimally on an annual basis by the QAA committee. Revisions will be made to the plan ongoing, as the need arises, to reflect current practices within our organization. These revisions will be made by the QAA committee. Revisions to the QAPI plan will be communicated as they occur to board members, residents, families, and staff through meetings and newsletters as deemed appropriate by the QAA committee. A project charter will be developed for each PIP at the beginning of the project that clearly establishes the goals, scope, timing, milestones, team roles, and responsibilities. The PIP charter will be developed by the QAA committee and then will be given to the team that will carry out the PIP. For ongoing monitoring of the PIP, we will use the CMS PIP Inventory to include milestones, PDSAs, outcomes, and other lessons learned from the PIP. Information about PIPs will be shared via our quality improvement dashboard, quarterly newsletter provided to all residents, families, and staff, and discussed during the QAPI agenda items on all staff, resident, and family monthly meetings.	2 255		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 255	Continued From page 9 SUGGESTED METHOD OF CORRECTION: The administrator, or designee, could review applicable QA policies and procedures to ensure all lapsed high-risk areas are addressed through the appropriate, comprehensive QA processes to ensure adequate monitoring and resolution(s) are in place. They could then audit to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 255		
2 260	MN Rule 4658.0075 Outside Resources If a nursing home does not employ a qualified professional person to furnish a specific service to be provided by the nursing home, the nursing home must have that service furnished to residents under a written agreement with a person or agency outside the nursing home. The written agreement must specify that the service meets professional standards and principles that apply to professionals providing services in a nursing home, and that the service meets the same standards as required by this chapter. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to provide the facility agreements for contracted services which had the potential to affect all 46 residents residing in the facility reviewed during the extended survey. Findings include: A copy of any agreement the facility had such as dental, hospital transfer, and/or psychiatric	2 260	Completed 12/11/2024	12/11/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 260	Continued From page 10 services was requested. The only agreement received was a Nursing Facility Services Agreement dated 8/26/13, identified the facility had an agreement with LifeCare Medical Center for hospice services. During document review on 11/6/24, at 12:47 p.m. the administrator confirmed he had been unable to locate any current agreements other than the one hospice agreement. No further information was provided. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop/revise and implement policies and procedures related to dental agreements and educate staff on these requirements. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days	2 260		
2 302	MN State Statute 144.6503 Alzheimer's disease or related disorder train ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING: MN St. Statute 144.6503 (a) If a nursing facility serves persons with Alzheimer's disease or related disorders, whether in a segregated or general unit, the facility's direct care staff and their supervisors must be trained in dementia care.	2 302		12/11/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 302	Continued From page 11 (b) Areas of required training include: (1) an explanation of Alzheimer's disease and related disorders; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; and (4) communication skills. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. (d) The facility shall document compliance with this section. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure 3 of 10 staff (DON, RN-E, NA-B) received annual training on behaviors in Alzheimer's disease or related disorders, problem solving with challenging behaviors, and communication skills. Findings include: Review of personnel records identified the following: - Director of nursing (DON) completed no assigned staff education including behavioral health. - Registered nurse (RN)-E last completed behavioral health training 8/3/23. - Nursing assistant (NA)-B completed no assigned staff education including behavioral health in 2024. During an interview on 11/6/24 at 12:42 p.m.,	2 302	Completed 12/11/2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 302	Continued From page 12 human resources (HR)-A stated she used to assigned the annual staff education but registered nurse (RN)-C assigned staff education now. RN-C assigned the annual training for staff and presented some of the general orientation education. The annual training was according to staff hire date: - DON: HR-A stated the DON did not complete any of the new hire trainings. - RN-E: HR-A stated RN-E hire date was 8/29/13 and was "past due" for annual training. RN-C assigned annual trainings at the beginning of the staff's anniversary month and a reminder sheet with their log in was put in their box. However, HR-A stated it did not appear that RN-E had annual trainings assigned to RN-E. - NA-B: HR-A stated NA-B's hire date was 6/28/16 and annual training was assigned to NA-B on 11/9/23. However, NA-B had not completed any training since that time. During an interview on 11/6/24 at 1:09 p.m., RN-C stated she was responsible for staffing training and was aware staff were not compliant with staff education requirements including behavioral health training. During an interview on 11/06/24 at 2:17 p.m., the DON stated she was just informed of the need for staff education. The DON believed she only needed to provide her continuing education transcripts when she started her role and did not have log in information until now to complete the assigned education. The DON stated she was informed of the lack of education/training and staff were expected to complete as directed in the facility policy. During an interview on 11/6/24 at 2:18 p.m., the administrator stated staff were expected to	2 302		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 302	Continued From page 13 complete education as directed by the facility policy. The Facility Assessment 2023 dated 12/18/23, identified staff attend General Orientation upon hire and annually. However, the facility assessment failed to identify the need for staff education/training related to behavioral health. A facility policy related to staff training/education was requested but not provided. SUGGESTED METHOD: The administrator or designee could develop/revise and implement policies and procedures related to the required Alzheimer's training program requirements. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 302		
2 550	MN Rule 4658.0400 Subp. 4 Comprehensive Resident Assessment; Review Subp. 4. Review of assessments. A nursing home must examine each resident at least quarterly and must revise the resident's comprehensive assessment to ensure the continued accuracy of the assessment. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to ensure accurate coding of the Minimum Data Set (MDS) for 1 of 3 residents (R7) reviewed for catheters.	2 550	Completed 12/11/2024	12/11/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 550	Continued From page 14 Findings include: R7's significant change Minimum Data Set (MDS) dated 10/3/24, identified R7 had severely impaired cognition and an indwelling urinary catheter. Diagnoses included multiple sclerosis (MS), type 2 diabetes, and history of urinary tract infection (UTI). The MDS failed to identify R7 had a multi-drug resistant organism (MDRO). R7's care plan revised 8/9/24, identified R7 needed total assistance with toileting needs and catheter management. The care plan failed to identify R7 had an MDRO. R7's Physical Therapy Skilled Nursing Facility Treatment Note dated 9/12/24, identified R7 had an open wound on her right ischial tuberosity and had an increased risk of infection. Precautions/Restrictions: methicillin-resistant staphylococcus aureus (MRSA). During an interview on 10/30/24 at 10:06 a.m., the director of nursing (DON) stated staff were expected the staff to document and submit the MDS timely and accurately to ensure resident care was provided accurately and safely. Additionally, the facility's reimbursement depended on an accurate MDS submission. During an interview on 10/31/24 at 1:10 p.m., registered nurse (RN)-D stated you wouldn't know a resident's history of having an MDRO unless you were digging in their charts. RN-D had just found out the "other day" R7 was colonized for MRSA. During an interview on 11/6/24 at 2:34 a.m., registered nurse (RN)-C stated she did conduct	2 550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 550	Continued From page 15 and submit R7's MDS assessment, however, did not review R7's MDRO status because the MDS was related to R7's COVID-19 diagnosis. RN-C stated she guessed she missed it. RN-C could not say why an accurate MDS could affect a resident's care nor why the accurate MDS was important. "I don't understand what you mean." A facility policy regarding MDS assessments was requested but not received. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could educate the nursing staff on completion of the Minimum Data Set (MDS) in accordance with the Resident Assessment Instrument (RAI) manual. They could then audit to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	2 550		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to develop a comprehensive care plan for 1 of 2 residents (R7, R99); and failed to involve family during the care conference and document the care conference fully for 1 of 2	2 565	Completed 12/11/2024	12/11/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 565	Continued From page 16 residents (R7) reviewed for catheters. Findings include: R7's significant change Minimum Data Set (MDS) dated 10/3/24, identified R7 had severely impaired cognition and an indwelling urinary catheter. Diagnoses included multiple sclerosis (MS), type 2 diabetes, and history of urinary tract infection (UTI). However, the MDS failed to identify R7 had a multi-drug resistant organism (MDRO). R7's care plan revised 8/9/24, identified R7 needed total assistance with toileting needs and catheter management. The care plan failed to identify R7's preferences for family involvement with her care nor to identify R7 had an MDRO. R7's Physical Therapy Skilled Nursing Facility Treatment Note dated 9/12/24, identified R7 had an open wound on her right ischial tuberosity and had an increased risk of infection. Precautions/Restrictions: methicillin-resistant staphylococcus aureus (MRSA). R7's Care Conference Summary New dated 6/26/24, identified a nursing, dietary and activities summary. T The note failed to identify when the care conference was held, who attended and/or who was invited to attend. R7's Care Conference Summary New dated 10/3/24, identified an activities summary. The note failed to identify when the care conference was held, who attended and/or who was invited to attend. R7's Care Conference Summary New dated 10/21/24, identified an activities summary. The	2 565		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 565	Continued From page 17 note failed to identify when the care conference was held, who attended and/or who was invited to attend. During an interview on 10/28/24 at 3:54 p.m., family member (FM)-A stated the facility was supposed to notify R7's daughter by text with the date and time of R7's care conference so R7's daughter could participate. After all the changes in staff, that just did not happen anymore. FM-A stated he did get a letter but preferred R7's daughter be involved too. That's what the plan always was. Why can't they continue to do it that way? If R7's daughter received a text, R7's daughter could show her employer and the employer was good to give R7's daughter the time off to attend the care conference. During an interview on 10/31/24 at 1:10 p.m., registered nurse (RN)-D stated staff were expected to follow the facility's catheter care policy to prevent the spread of infection, however, RN-D did not update R7's care plan to direct staff regarding enhannced barrier precautions during catheter care. During an interview on 11/4/24 at 2:27 p.m., the social worker designee (SWD) stated RN-C did all the MDS assessments, scheduled the care conference meetings, documented the care conference notes and the care coordinator updated the care plan. The care coordinator was out of the building and unavailable during survey. The SWD stated she could not find where R7's history of MRSA was care planned and/or R7's completed care conference notes were completed. During an interview on 11/4/24 at 2:34 p.m., RN-C stated she only scheduled the care conference	2 565		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 565	Continued From page 18 meetings but did not attend them because she wasn't always onsite. Because of this, RN-C did not document the care conference note. RN-C updated the MDS calendar and sent that to the nurses, activities, and the SWD. Who updated the care plan and/or notified R7 or R7's family was between the care coordinator and SWD. During interview on 11/6/24 1:13 p.m. the director of nursing (DON) stated the previous care coordinator was really good about texting and communicating with residents' families regarding changes in condition and/or care conferences. The care coordinator had left the facility prior to the DON taking her role at the facility. "That's just what I've been told." However, the DON stated she was aware that was no longer taking place and communication needed to improve. Resident care plans should be updated timely and accurately, and care conference documentation needed to be complete to ensure the staff knew what to provide to ensure the resident received resident-centered care. A policy regarding resident care conferences and/or care planning was requested but not received. R99's admission MDS dated 10/25/24, identified R99 had moderate cognition and diagnoses including neurogenic bladder, Alzheimer's disease, and dementia. R99 required intermittent catheterization and did not participate in a bladder program. R99's care plan dated 10/22/24, failed to identify a care plan goal and measurable objectives for straight catheterizing R99. R99's Bowel and Bladder Comprehensive	2 565		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 565	Continued From page 19 Assessment dated 10/25/24, identified R99 required intermittent catheterization performed by nursing staff every shift and as needed. On 10/30/24 at 1:55 p.m., stated R99 required staff to use a straight catheter to empty his bladder. Observed while licensed practical nurse (LPN)-A used a straight catheter to empty R99's bladder. LPN-A wore gloves and used sterile technique but failed to wear a gown. LPN-A stated she had failed to wear a gown during R99's catheter cares. LPN-A stated she should have worn a gown to protect herself, other residents and R99 from splashing of urine and the potential spread of bacteria causing an infection. During interview on 11/6/24 1:13 p.m. the DON resident care plans should be updated timely and accurately and to ensure the staff knew what to provide and to ensure the resident received resident-centered care. A facility policy regarding care planning was requested but not received. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) and/or designee could review or revise policies and provide education for staff regarding care plan development and when it should be completed by. The Quality Assessment and Assurance (QAA) committee could do random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 800	Continued From page 20	2 800		
2 800	MN Rule 4658.0510 Subp. 1 Nursing Personnel; Staffing requirements Subpart 1. Staffing requirements. A nursing home must have on duty at all times a sufficient number of qualified nursing personnel, including registered nurses, licensed practical nurses, and nursing assistants to meet the needs of the residents at all nurses' stations, on all floors, and in all buildings if more than one building is involved. This includes relief duty, weekends, and vacation replacements. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide sufficient staff to transfer residents in lifts according to their care plan for 3 of 4 residents (R12, R7, R2); failed to provide appropriate supervision to mitigate resident-to-resident abuse for 2 of 2 (R31, R6) residents abused by 1 of 1 residents (R39) reviewed for abuse: failed to provide sufficient staff to complete range of motion for 4 of 4 residents (R7, R19, R22, R43) reviewed for restorative therapy. In addition, 4 of 46 residents (R7, R30, R25, R34,) 10 of 10 staff members (RN-A RN-B, NA-D, LPN-A, NA-C, NA-A, SWD, RT-A, NA-H, DON); 1 of 3 family members (FM-A) voiced concerns of lack of sufficient staffing in the facility. The lack of sufficient staffing had the potential to affect all 46 residents in the facility. Findings include: Transfer with Lifts: See also F689: Based on observation, interview	2 800	Completed 12/11/2024	12/11/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 800	Continued From page 21 and document review, the facility failed to ensure staff were following care planned interventions when transferring residents with a ceiling lift; and complete therapy/or nursing assessments to determine the appropriate sling sizes per manufacturers guidelines for 3 of 4 residents (R12, R7, R2) reviewed who were transferred via ceiling lifts. R12's quarterly Minimum Data Set (MDS) dated 8/22/24, identified R19 had severe cognitive impairment and R12 was dependent on staff (helper performed all the effort and resident does none of the effort to complete the activity) for toileting and bed to chair transfers. R12's care plan dated 8/9/24, identified R12 was cognitively impaired and required assist of two staff for ceiling lift transfers. R12's care plan did not identify the ceiling lift sling size to be used with the transfer. During an observation on 10/29/24 at 5:50 p.m., NA-E and registered nurse (RN)-B transferred R12 with the ceiling lift into the bathroom using a green (large sling). R12 was holding the sling straps with her shoulders extended 90 degrees with the sling bunched up in her underarms. R12's fingers were grasping the straps tightly and her knees were pointed up towards the ceiling and her bottom hanging from the bottom of the sling. R7's significant change MDS dated 10/3/24, identified R7 had severe cognitive impairment and was dependent for toileting, personal hygiene, and bed to chair transfers. R7's care plan dated 8/9/24, identified R7 was cognitively impaired and required assist of two for ceiling lift transfers and R7 used a size medium ceiling lift sling. R7's Kardex dated 10/29/24, directed staff	2 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 800	Continued From page 22 to provide assist of one with transfers using the ceiling lift. However, the Kardex additionally directed staff to use ceiling lift with total assist of two with a medium Arjo sling. During an observation on 10/29/24 at 12:23 p.m., nursing assistant (NA)-C assisted R7 to the bathroom using a ceiling lift, without another staff person present as care planned. R7 was in the ceiling lift and holding the sling straps with both hands. R7's shoulders were extended 90 degrees and R7's bottom was hanging from the bottom of the sling. R7 had facial grimacing and moaned "ooohh." NA-C asked R7 if she was having pain and R7 stated yes, along her ribcage. NA-C stated this was residual pain due to R7 having just recovered from COVID-19. NA-C stated she would report R7's pain to the nurse. R2's annual MDS dated 6/17/24, identified R2 had severe cognitive impairment and a diagnosis of dementia. R2 had functional limitation with range of motion in both lower extremities and was dependent on staff for bed mobility, toileting, and transfers. R2 had one fall with injury (including skin tears, abrasions, lacerations, superficial bruises, hematomas, and sprains) during assessment dates. R2's care plan dated 6/28/22, identified R2 required assist of two staff to move between surfaces using the ceiling lift. The ceiling lift sling size was not identified on the plan. During an interview on 10/29/24 at 6:55 p.m., registered nurse (RN)-B stated R7 and R12 were care planned for assist of two with ceiling lift transfers but with the way staffing was going, staff usually transferred using assist of one. Nursing helped as much as they could but there just wasn't enough staff.	2 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 800	Continued From page 23 On 10/30/24 at 8:22 a.m., nursing assistant (NA)-D was standing in R2's room. R2 was fully dressed in their wheelchair. The ceiling lift sheet, size unidentified, was underneath with the straps crossed between the resident's legs. NA-E proceeded to use the ceiling lift to transfer R2 from the bed to the toilet, without a second staff member present as care planned. NA-E stated when R2 was calm like today she would transfer the resident by herself using the ceiling lift. When R2 was resistive NA-D would ask for other staff assistance. The care plan provided direction that two staff were required for ceiling lift transfers. On 10/30/24 at 8:22 a.m., NA-D stated she had no time to check the care plan so was unaware what the care plan directed. During an interview on 10/30/24 at 9:20 a.m., licensed practical nurse (LPN)-A stated she was very concerned regarding resident and staff safety. The facility did not have enough staff to provide assist of 2 with ceiling lift transfers. . Residents were being left alone in the lifts in the bathrooms, staff were transferring resident by assist of one with the ceiling lifts, and not answering call lights timely. During an interview on 10/30/24 at 9:44 a.m., NA-C stated the facility was "always" short staffed. The A-wing was just too heavy of care for one nursing assistant. There was supposed to be a float nursing assistant that would go between the different units but that rarely happened and especially when the nurse had to "bounce" between units as well. Abuse: See also F600: Based on observation, interview	2 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 800	Continued From page 24 and document review, the facility failed to ensure 1 of 1 resident (R39) with a known history of sexual behaviors towards others was comprehensively assessed and interventions implemented to mitigate risk to prevent ongoing sexual abuse for 2 of 2 residents (R31, R6) who were cognitively impaired, dependent on staff for their care, and were sexually abused by R39. R31's quarterly Minimum Data Set (MDS) dated 7/31/24, identified R31 had severe cognitive impairment and exhibited physical behaviors of grabbing, hitting, scratching, or abusing others sexually one to three days per week, and verbal behaviors toward others one to three days per week. R31 required substantial assistance to dress and was independent with transfer and ambulation. Diagnoses included Alzheimer's disease, anxiety, mood disorder, dementia, restlessness, and agitation. R6's quarterly MDS dated 7/31/24, identified R6 had moderate cognitive impairment and exhibited delusions, physical behaviors of grabbing, hitting, scratching, or abusing others sexually one to three days per week, verbal behaviors toward others four to six days per week and other behaviors not directed toward others four to six days per week. R6 required substantial assistance to dress and partial assistance with transfers. R6 was independent with ambulation once standing. Diagnoses included depression, anxiety, dementia, and sever mood disturbance. R39's quarterly MDS dated 8/30/24, identified R39 had severe cognitive impairment with physical behaviors of grabbing, hitting, scratching, or abusing others sexually one to three days per week. R39 was able to transfer and ambulate independently. R39 diagnoses included dementia,	2 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 800	Continued From page 25 psychotic disturbance, mood disturbance and anxiety. R39's progress notes identified the following: - 8/23/24, R39 was observed to take R31 by her hands and lead R31 to his room and close the door. When staff entered the room, R39 was lying on his side in bed and R31 was just seated on R39's bed. Staff directed R31 out of room and reminded R39 they were not allowed alone in room with door shut. - 9/6/24, licensed practical nurse (LPN)-A documented R39 had approached a female resident [identified as R31 from interview] from behind and gave the resident what appeared to be a "bear hug" [identified in interview to be reaching from behind and grabbing breast] which staff observed from behind. The social service designee (SWD) was notified. - 9/18/24, R39 made attempts to enter an unidentified female resident's room when she was sleeping in bed with lights off. Staff redirected R39 out of the room several times. - 9/25/24, R39 was observed fondling R31's breast. Staff intervened and separated the two residents. - 10/11/24, R39 was walking back to his room when R39 approached a female resident [identified as R31 through interview] to grab her breast area. R39 was redirected away and reminded it was inappropriate to touch anyone without permission. The DON was notified. - 10/15/24, R6 was found in R39's room with the door closed. R6 was seated in her wheelchair	2 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 800	Continued From page 26 beside R39's bed and R39 was fondling R6's breast. R6 was removed from area and R39 was reminded the behavior was not appropriate. R6 stated the incident made her uncomfortable and R39 had been squeezing her breast pretty hard. The DON and SWD were notified. R39's medical record lacked evidence R39's inappropriate sexual behaviors toward other residents had been comprehensively assessed and interventions implemented to mitigate potential abuse toward other residents, despite R39 being independently mobile and displaying ongoing inappropriate sexual behaviors. R31's medical record lacked any assessment to ensure her psychosocial needs were met and interventions implemented. R6's medical record lacked any assessment to ensure her psychosocial needs were met and interventions implemented. On 10/29/24 at 11:00 a.m., NA-A stated R39 could get grabby and try to grab staff breasts, you just needed to watch for it and remind him the behavior was not appropriate. NA-A was not aware R39 had inappropriate sexual behaviors toward other residents. The facility usually staffed the locked unit with one nursing assistant and a nurse would come on the unit on and off to pass medications. Once in a while they would have a float nursing assistant that would come on the unit occasionally to see if help was needed, but that did not happen very often. When interviewed on 10/29/24, at 1:30 p.m. SWD stated she was notified of some incidents with R39's behavior toward residents. SWD received calls regarding incidents of R39 inappropriately	2 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 800	Continued From page 27 touching other residents on 10/14/24 and 10/15/24. SWD discussed the incidents regarding R31's behavior with the DON and it was determined there were no non-consensual type of feelings. The residents had not seemed upset, so SWD and the DON determined it would be ok to just document the incidents when they occurred. The MDS coordinator was going through all the resident care plans and trying to get them all updated and they were all just trying to catch up and survive. Range of Motion: See also F688: Based on observation, interview and document review, the facility failed to provide range of motion (ROM) services for 4 of 4 residents (R7, R19, R22 ,R43) reviewed for range of motion. R7's significant change Minimum Data Set (MDS) dated 10/3/24, identified R7 had severe cognitive impairment. Diagnoses included multiple sclerosis (MS) (a potentially disabling disease of the brain and spinal cord that affects nerve fibers and causes communication problems), type 2 diabetes and peripheral vascular disease (PVD) (reduced blood flow to the arms and legs). R7 had a restorative nursing program (RNP) but R7 did not participate during the look back period. R7's care plan revised 8/9/24, directed staff to provide: RT- UBC x15 mins (tension 90). Pulleys at level 2 (reps of 5 as tolerated). Red squeeze ball (30 second reps). Green level 3 Thera putty. 3# free weight bicep curls. AROM with green Thera Bands. Lower AROM (AAROM - marching, knee extensions, hip adductions and abductions, ankle pumps). 5 times a week or as tolerated.	2 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 800	Continued From page 28 R7's Range of Motion task documentation dated 10/7/24 through 11/1/24, identified R7 received RNP services 3 times, was unavailable 2 times, R7 refused 2 times and was not applicable for 5 times. During the time-period, R7 should have been offered RNP services a total of 17 times. R19's quarterly MDS dated 8/7/24, identified R19 had moderately impaired cognition and diagnoses included Alzheimer's disease, anxiety and heart failure. R19 had a restorative nursing program (RNP) but R19 did not participate during the look back period. R19's care plan revised 8/1/24, directed staff to provide seated general lower and upper extremity exercises to be completed 3 times a week. R19's Range of Motion task documentation dated 10/7/24 through 11/1/24, identified R19 received RNP services 3 times, was unavailable 1 time and not applicable 7 times. During the time period, R19 should have been offered RNP services a total of 11 times. R22's significant change MDS dated 9/9/24, identified severe cognitive impairment. R22 had no impairment in range of motion and required substantial to maximal (helper does more than half the effort) with bed mobility, transferring and toileting. R22's diagnoses included arthritis, Alzheimer's disease, and lumbago with sciatica (pain radiating from back to legs and feet which can be eased with range of motion/stretching). R22 did not have a restorative nursing program. R22's provider's order dated 10/2/24, identified R22 was to receive functional maintenance program (FMP) by restorative therapy (RT). The order directed staff to complete active ROM (AROM) (resident helping with range of motion) to	2 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 800	Continued From page 29 both arms and legs in all ranges and planes (normal range of motion) for all joints and to walk as tolerated with transfers five times a week. R22's restorative therapy documentation from 10/4/24 through 11/3/24, identified 21 opportunities for R22 to receive AROM. There was one documented occurrence of AROM being done, one documented resident not available, and 19 marked not applicable. R43's quarterly MDS dated 9/11/24, identified R43 had moderate cognitive impairment. R43 required supervision to touch assistance with transfers, toileting, and walking. R43 had a diagnosis of Parkinson's disease. R43 had one fall without injury since last assessment. R43 was not part of a restorative nursing program. R43's provider order dated 7/25/24, identified RT program-seated or standing general lower extremity exercises as tolerated. Nustep level 2-5 up to 15 minutes 3 times a week. R43's care plan dated 7/30/24, identified R43 was to receive RT seated or standing general lower extremity exercises as tolerated. Nustep (a low impact exercise machine) level 2-5 up to 15 minutes 3 times a week. R43's restorative therapy documentation from 10/4/24 through 11/3/24, identified 13 opportunities for R43 to receive RT. There were three documented occurrences of RT being done, one refusal, and 9 times were marked not applicable. During an interview on 11/4/24 at 11:51 a.m., restorative therapy (RT)-A stated RNP services were supposed to be offered Monday through Saturday every week and RT-A scheduled each resident according to their RNP on the calendar.	2 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 800	Continued From page 30 RT-A stated the RT department had staffing problems and RT-A was the most consistent staff member. Currently, there was another staff member trained and passed competency, but that person had not been at the facility often. RT-A worked at the facility Mondays, Wednesdays, and Fridays. The other days were not consistently staffed and no RNP was offered on those days unless a resident was independent enough to do the exercises on their own without staff assistance. "I just can't complete it." RT-A stated she did inform administration that she was not able to complete tasks but there were no other staff available. During an interview on 11/5/24 at 3:30 p.m., the director of nursing (DON) stated she was aware the facility's restorative aide was at the facility only three days a week even though there were residents requiring RNP 5 days a week. However, a plan to address the issue had not been implemented. Staff were expected to provide RNP to maintain a resident's abilities and/or to prevent contractures. General Resident/Staff and Family Staffing Concerns: During an interview on 10/28/24 at 12:43 p.m., R7 stated a lot of the time you wait at least a half hour for someone to come when you turn on your call light. R7 had times when she was incontinent of bowel because she didn't make it to the bathroom on time. "That makes me [R7] feel embarrassed. Dumb." R7 was weepy and wiped away tears. During an observation on 10/30/24 at 7:27 a.m., R7 was lying in bed with her lights off. R7's door was partially open and R7 was screaming "help"	2 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 800	Continued From page 31 over 10 times. - At 7:28 a.m., R7 screamed "help" 8 times. R7 can be clearly heard at each each of the unit. - At 7:29 a.m., R7 was again screaming "help". R27 came out of her room and asked if R7 was alright. No staff were in the area. - At 7:31 a.m., R7 continued to scream "help" repeatedly, however, there were no staff to assist R7. - At 7:32 a.m., R27 came out of her room and stood in her doorway rubbing at her eyes and stated she was worried for R7. "Is she ok?" - At 7:33 a.m., R7 screamed "help" 5 times in a row. R27 walked to R7's doorway and peeked in stating "What's going on?" R27 was barefoot on the right foot and a gripper sock on the left. No staff were in the area and R27 turned back to her room. - At 7:39 a.m., R7 screamed "help" and nursing assistant (NA)-B entered R7's room and asked R7 if she had a bad dream. Provided a blanket for R7 and told R7 she could go back to sleep. - At 7:42 a.m., NA-B stated she was the float nursing aide that day. NA-C was the nursing aide assigned to R7's wing and had a phone that NA-C carried that alerted her to the call lights. The float nursing aide used to have a phone but didn't anymore. NA-B did not know why. NA-B stated when she's in a room she was able to hear the call light box that announced call lights at the nurses' station. That's how she knew she needed to check on R7 because R27's bed alarm went off, or that's how NA-B heard R7 screams for help. When in a room, staff could turn on the call light if they needed help. There was no walkie system or any other way to request help unless staff left the room. On 10/28/24 at 3:27 p.m., NA-H stated there was usually one staff on either side and a float that	2 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 800	Continued From page 32 went back/forth between the two units. If there wasn't a float staff, then she would have to run over to the other side or find the medication nurse will help with two person transfers. STAFF INTERVIEWS: On 10/28/24 at 3:27 p.m., NA-H stated there was usually one staff on either side and a float that went back/forth between the two units. If there wasn't a float staff, then she would have to run over to the other side or find the medication nurse will help with two person transfers. During an interview on 10/28/24 at 4:07 p.m., family member (FM)-A stated R7 had wounds and a physical therapist changed the dressings at 1:00 p.m. Because of that, there was a lot of days R7 didn't get out of bed until after that because there wasn't enough staff. During interview on 10/30/24 at 8:22 a.m. NA-D stated she was uncertain if R2 needed assist of one or two for ceiling transfers. NA-D stated she had not reviewed the care plan prior to transferring R2 because she did not have time. On 10/30/24 at 9:58 a.m., a resident council meeting was held and R34, R25 and R20 expressed concerns regarding staffing. - R34 stated she had to wait a long time for her food at meals. R34 was unable or unwilling to share specific date/times of incidents, although stated it happened frequently. R34's significant change MDS dated 8/26/24, identified R34 had intact cognition and was dependent on staff for toileting; partial/moderate assistance with bathing; and substantial/maximal assistance for	2 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 800	Continued From page 33 dressing. - R25 stated more times than not there were not enough staff. R25 was unable or unwilling to share specific date/times of incidents, although stated it happened frequently. R25's quarterly MDS dated 9/10/24, identified R25 had intact cognition and needed substantial/ maximal assistance with for toileting, bathing, and dressing. - R20 stated the wait time of call lights at times was too long. R20 was unable or unwilling to share specific date/times of incidents, although stated it happened frequently. R20's annual MDS dated 10/9/24, identified R20 had intact cognition and was dependent on staff for toileting, bathing; and substantial to dependent on staff for dressing. During interview on 10/31/24 at 10:14 a.m. RN-A stated she was trying to do the DON position and work the floor. Staffing took up so much time and there was only so much a person could do and they were trying to get done what they could. The Payroll Based Journal (PBJ) Staffing Data Report for the third quarter of 2024, identified excessively low weekend staffing. The daily staffing/working schedules from 8/1/24 thru 10/28/24 were reviewed. The facility was unable to provide a working schedule for 8/3/24, 8/4/24, 8/10/24, and 8/11/24. The Facility Assessment dated 2023, identified a need for a ratio of nurse (RN/LPN) to resident was 1:16 to 1:24 for day shift and evening shift and 1:24-1:48 for overnight shift. The assessment also identified a ratio of NA's to residents	2 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 800	Continued From page 34 including: 1:12 -1:13 during each shift (day, evening, overnight) and each shift would consist of a minimum of 4 NA's. The facility daily staffing/working schedules dated 8/17/24 and 8/25/24 identified only 2 NA's were scheduled for the overnight shift; and the nurse staff posting observed on 10/29/24 at 4:53 p.m. identified there was one nurse for A-wing (Pine Island, and The Angle), one for B-wing (Birch-Lake of the Woods) during day and evening. B-wing also had a TMA for day. Each wing had three nursing assistants a.m. and two nursing assistants for B-wing and 2.5 nursing assistants for A-Wing in evening. There was 1 nurse and three nursing assistants combined for the A and B wings. During an interview on 10/30/24 at 9:58 a.m., the DON stated when the DON first started at the facility, she approached the former administrator because they were using 70% agency staff and had lost many experienced staff. To determine resident to staff ratios, they looked at resident acuity and the number of residents requiring lifts. The previous administrator insisted all lifts required assist of 2 staff to complete. However, it took one aide away from a wing entirely to help the other side if the nurse was busy. "It's a mess." The DON stated she went to the administrator and requested to add two nursing assistants to A-wing as "That's what I needed." The DON needed two staff on another unit as well. That was the goal. "I'll be honest with you, it's difficult." Sometimes, there was a float but it hadn't come to fruition yet and hasn't been consistent. The DON also went to the board and explained staff couldn't be retained and/or incentivized, especially when the facility was losing agency staff as well, when the facility's wages were $5 lower than all the other facilities around. The facility finally approved a pay increase but it was	2 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 800	Continued From page 35 "on pause" due to the start of survey. The DON stated she was excited because the former administrator just would not let that happen. The DON stated she also needed a care coordinator for a unit. Ultimately, the DON's plan was to incentivize to get staff to come and get agency staff out of the facility. Some agency staff were great and most worked evenings. A policy on staffing was requested but none were received. SUGGESTED METHOD OF CORRECTION: The administrator and DON and/or designee could review current and ongoing staffing patterns to evaluate if addition or relocation of staff is needed to ensure all resident cares needs are met. Review the plan with QA committee and then audit to ensure there is enough staff to meet resident needs. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 800		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed.	2 830		12/11/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 36 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure staff were following care planned interventions of 2 staff assist when transferring residents with a ceiling lift; and failed to complete therapy/or nursing assessments to determine the appropriate sling sizes per manufacturers guidelines for 3 of 4 residents (R12, R7, R2) reviewed who were transferred via ceiling lifts. Findings include: The Maxi Sky 440 Instruction for Use revised 3/2020, identified the lift was designed to assist caregiver in hospitals, long-term care, nursing homes and home care environments, including private homes and patients with reduced mobility. Patient transfers must be done under the supervision of appropriately trained caregivers in accordance the instructions. Constant attention to the patient was required from caregiver during the whole transfer. In the unlikely event of a failure of the device, the caregiver must be ready to react. The Maxi Sky 440 Portable Lift and Charger Station Product Description undated, identified ceiling lifts enabled a single caregiver to transfer patients or residents smoothly without any manual lifting. All slings are color coded for size by having a different colored edge binding or attachment strap coloring: - Grey or Teal -Extra Extra Small -XXS [weight range 0-55 pounds (lbs)] - White or Brown -Extra Small -XS [weight range 55-77 pounds (lbs)]	2 830	Completed 12/11/2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 37 - Red -Small -S [weight range 77-132 pounds (lbs)] - Yellow -Medium -M [weight range 121-165 pounds (lbs)] - Green -Large -L [weight range 154-264 pounds (lbs)] - Blue -Extra Large -XL [weight range 308-440pounds (lbs)] - Terracotta -Extra Extra Large -XXL [weight range 440-500 pounds (lbs)] The option of a headrest for many slings was available if it is considered necessary for a particular patient. A range of special purpose slings were available as accessories. R12: R12's quarterly Minimum Data Set (MDS) dated 8/22/24, identified R12 had severe cognitive impairment and R12 was dependent on staff (helper performed all the effort and resident does none of the effort to complete the activity) for toileting and bed to chair transfers. R12's care plan dated 8/9/24, identified R12 was cognitively impaired and required assist of two staff for ceiling lift transfers. R12's care plan did not identify the ceiling lift sling size to be used with the transfer. R12's Rehabilitation Services Physical Therapy Out-Patient Treatment Note dated 5/10/23, identified a mechanical lift was used with assistance x 2 to transfer. The note failed to identify what ceiling lift sling size staff should use for R12. R12's medical record identified R12 weighed 167.1 lb.	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 38 During an interview on 10/28/24 at 2:38 p.m., R12 stated, last week a nursing assistant left R12 in the bathroom in the ceiling lift alone. R12 was unable to say a name or date but R12 was crying and stated R12 waited at least 20 minutes. R12 was in the bathroom already in the lift, up in the air, and R12's feet were dangling and "going numb." R12 stated staff usually left R12 in the ceiling lift, hanging over the toilet, but usually not for that long. R12 stated she urinated almost immediately when she got to the toilet and could have gone back to bed. R12 did report the incident to facility staff and was told by facility staff it always felt longer when you're in the lift, but it wasn't that long. R12 was crying and stated she felt "neglected." "I don't like to complain and get people in trouble, but I can't put up with this either. I just can't." R12 was grasping her bed linens in her hands and stated she was told there were many other people to help take care of. During an observation on 10/29/24 at 5:50 p.m., NA-E and registered nurse (RN)-B transferred R12 with the ceiling lift into the bathroom using a green (large sling). R12 was holding the sling straps with her shoulders extended 90 degrees with the sling bunched up in her underarms. R12's fingers were grasping the straps tightly and her knees were pointed up towards the ceiling and her bottom hanging from the bottom of the sling. During an observation on 10/30/24 at 5:20 p.m., R12 had a green (large) sling laying in her bathroom. R7: R7's significant change MDS dated 10/3/24, identified R7 had severe cognitive impairment	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 39 and was dependent for toileting, personal hygiene, and bed to chair transfers. R7's care plan dated 8/9/24, identified R7 was cognitively impaired and required assist of two for ceiling lift transfers and R7 used a size medium ceiling lift sling. R7's Kardex dated 10/29/24, directed staff to provide assist of one with transfers using the ceiling lift. However, the Kardex additionally directed staff to use ceiling lift with total assist of two with a medium Arjo sling. R7's medical record failed to identify a physical therapy or nursing evaluation was completed to determine safe transferring of R7 or what ceiling lift size should be used. R7's medical record identified R7 weighed 130.1 lb. During an observation on 10/29/24 at 12:23 p.m., nursing assistant (NA)-C assisted R7 to the bathroom using a ceiling lift, without another staff person present as care planned. R7 was in the ceiling lift and holding the sling straps with both hands. R7's shoulders were extended 90 degrees and R7's bottom was hanging from the bottom of the sling. R7 had facial grimacing and moaned "ooohh." NA-C asked R7 if she was having pain and R7 stated yes, along her ribcage. NA-C stated this was residual pain due to R7 having just recovered from COVID-19. NA-C stated she would report R7's pain to the nurse. During an interview on 10/29/24 at 12:45 p.m., NA-C stated R7 had been an assist of one with the ceiling lift since NA-C started working at the facility two years ago. NA-C stated R7's care plan	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 40 contradicted itself and NA-C wasn't even sure what R7's care planned need for transfer was. NA-C never asked anyone what R7 needed because she felt safe transferring R7 in the ceiling lift by herself. NA-C stated she used the sling in her room. Laundry replaced the sling if it was soiled, and NA-C didn't have to get a new one. NA-C stated she didn't even know how to tell what size the sling was. During an interview on 10/29/24 at 6:46 p.m., NA-E stated R12 was never to be left alone while in the ceiling lift. Staff routinely transferred R12 using the ceiling lift with assist of one, but NA-E wasn't comfortable with this because "you saw. She [R12] has chicken wings sticking out." NA-E didn't trust R12 not to fall. R7 was the same way. NA-E wouldn't transfer R7 alone either. NA-E stated she always just asked the nurse to help her because if R7 or R12 raised their arms due to the pressure of the sling they would slip right out and fall. NA-E stated staff transferred residents with assist of one because they can't find anyone to help. During an interview on 10/29/24 at 6:55 p.m., RN-B stated R7 and R12 were care planned for assist of two with ceiling lift transfers but with the way staffing was going, staff usually transferred using assist of one. Nursing helped as much as they could but there just wasn't enough staff. If the nurse couldn't help with transfers, the nursing assistants had been doing assist of one. R12 had lost a lot of muscle tone and just kind of "hung" in the sling like that. Hanging in the sling like that could potentially lead to a shoulder dislocation or a rotator cuff injury. If that happened, R12 could slip out of the sling and fall, however, RN-B had never heard of that happening. RN-B never reported any safety concerns for R7 or R12	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 41 during ceiling lift transfers to the unit coordinator nor had requested a physical/occupational therapy evaluation to determine if they were safe to transfer. "I'm just a floor nurse so I'm not the one to ask about that." R2: R2's annual MDS dated 6/17/24, identified R2 had severe cognitive impairment and a diagnosis of dementia. R2 had functional limitation with range of motion in both lower extremities and was dependent on staff for bed mobility, toileting, and transfers. R2 had one fall with injury (including skin tears, abrasions, lacerations, superficial bruises, hematoma's, and sprains) during assessment dates. R2's care plan dated 6/28/22, identified R2 required assist of two staff to move between surfaces using the ceiling lift. The ceiling lift sling size was not identified on the plan. R2's therapy orders dated 8/1/24, recommended staff use the ceiling lift or total mechanical lift to transfer the resident. The orders failed to identify how many staff were required for transfers and what size sling to use. R2's medical record lacked any other assessment to identify how many staff were needed to transfer and what size lift sling to use. R2's medical record identified R2 weighed 166 lbs. On 10/30/24 at 8:22 a.m., nursing assistant (NA)-D was standing in R2's room. R2 was fully dressed in their wheelchair. The ceiling lift sheet, size unidentified, was underneath with the straps	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 42 crossed between the resident's legs. NA-E proceeded to use the ceiling lift to transfer R2 from the bed to the toilet, without a second staff member present as care planned. NA-E stated when R2 was calm like today she would transfer the resident by herself using the ceiling lift. When R2 was resistive NA-D would ask for other staff assistance. The care plan provided direction that two staff were required for ceiling lift transfers. NA-E stated she did not have any problems and the transfer went as it usually did when R2 was calm. NA-E stated she had not looked at the care plan and was uncertain how many staff were required to safely transfer R2 with the ceiling lift. On 10/30/24 at 8:22 a.m., NA-D stated she had no time to check the care plan so was unaware what the care plan directed. On 10/30/24 at 9:17 a.m., the director of nursing (DON) stated all staff were aware all mechanical lifts, including the ceiling lifts, required two staff to safely transfer a resident. During an observation on 10/30/24 at 5:20 p.m. R7 had a yellow (medium) sling folded in a chair in her room. During an interview on 10/30/24 at 9:20 a.m., licensed practical nurse (LPN)-A stated she was very concerned regarding resident and staff safety. The facility did not have enough staff to provide assist of 2 with ceiling lift transfers. Residents were being left alone in the lifts in the bathrooms, staff were transferring resident by assist of 1 with the ceiling lifts, and not answering call lights timely. LPN-A stated she knew of an incident on 10/25/24, between R12 and NA-D where R12 was left alone in the bathroom hanging from the ceiling lift. LPN-A did not report	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 43 this to anyone but stated R12 was not safe to be left unattended in the ceiling lift in the bathroom. R12 did not have the ability to sit up and could have fallen. LPN-A further stated there were five residents who required assist of two for ceiling lift transfers and staff routinely transferred using assist of one. Staff were supposed to ask for assistance, but who were they going to ask? By the time a staff person was found to help, the resident only waited even longer. Plus, with call lights, bed alarms and chair alarms going off, what were staff supposed to do? That's what happened when R12 was left in the bathroom, NA-D was answering call lights. During an interview on 10/30/24 at 9:44 a.m., NA-C stated the facility was "always" short staffed. The A-wing was just too heavy of care for one nursing assistant. There was supposed to be a float nursing assistant that would go between the different units but that rarely happened and especially when the nurse had to "bounce" between units as well. Again, NA-C stated she got confused by the "rules" for ceiling lift transfers. One day, staff are told it's ok to use assist of one then they're told only use assist of two. NA-C just did her thing and, besides, NA-C couldn't magically pick up a staff member to help. When directed to use assist of two for ceiling lift transfers, NA-C stated she told administration that the workload was too heavy to do that. NA-C stated she felt it was safe to transfer using assist of one and/or to leave a resident in the bathroom while in the ceiling lift. NA-C routinely transferred R12 and R7 in the ceiling lift by herself without assistance of another staff person. NA-C stated she had heard about an incident on 10/25/24, where R12 was left alone in the bathroom because staff were answering call lights because there wasn't enough staff. NA-C stated she felt	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 44 R12 was safe to be in the bathroom alone and had left R12 alone as well to answer call lights. There were residents who were at risk for falling and staff had to check on them. Who else would do it? During an interview on 10/30/24 at 9:58 a.m., the DON stated staff were expected to follow care planned interventions for ceiling lift transfers for the resident and staff safety. "That's so unsafe." During an interview on 10/30/24 at 10:34 a.m., NA-D stated she had worked at the facility a little over a month as an agency nursing assistant. NA-D was trained by another traveler and wasn't told where they could find care plans or "cheat sheets." NA-D had to go to the interim DON and ask where to find it. NA-D was not going to transfer someone until NA-D knew how it was supposed to be done. NA-D stated she was told to look at the kardex, but with twelve residents to care for it was hard to be read through each one. NA-D stated she asked for a little sheet for like teeth, diet, transfers and was told there was a sheet but it was not up to date. There were residents that the sheet said were sit-to-stands but because things happened and they became weaker, they can't do it. The sheet needed to be updated. NA-D would have liked better training. Agency nursing assistants knew what their job consisted of but haven't cared for these residents before. NA-D told the interim DON that the facility needed staff who were employees of the facility to train agency nursing assistants. When NA-D asked the nurse or the float nursing assistant to help with assist of two transfers. NA-D was told the ceiling lifts required assist of two, then it changed to assist of one, and now it was assist of two again. NA-D needed a definite answer for this because NA-D didn't want to lose her certificate	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 45 for something that was out of her control. Regarding the 10/25/24, incident with R12, NA-D wouldn't call it an incident. R12 wanted to sit on the toilet because she was smearing bowel movement (BM). NA-A transferred R12 to the toilet via the ceiling lift but had never worked with R12 before. NA-D didn't know R12 got anxiety in the bathroom if left alone. NA-D left R12 in the ceiling lift sling and left her in the bathroom alone and answered other call lights. NA-D went back into R12 and R12 was like "what took you so long." NA-D stated she told R12 NA-D tried to get to R12 as fast as NA-D could. The float nursing assistant couldn't use the lift because she was 17 years old. It was probably 10 minutes. NA-D did someone's cares and went back and did "my thing." The next day NA-D reported the bathroom thing.The staff were shorthanded. NA-D did the best she could. R12 should have been assist of two and staff should have stayed with R12 while she was in the bathroom. NA-D did not know why they didn't stay because it was dangerous to leave R12. R12's feet were literally up in the air, not resting on the floor, because R12 was unstable. R12 was unstable and flailing and moving all the time so R12 needed assist of two with ceiling lift transfers. Staff have said if R12 was calm he could be assist of one. On 10/30/24, R12 was calm so NA-D transferred him in the ceiling lift by herself. "No, I shouldn't have." NA-D stated she had no idea where it said there were times R12 could be assist of one because NA-D had never been able to read all the care plans. During an interview on 10/30/24 at 1:25 p.m., NA-B stated R12 reported the 10/25/24, bathroom incident to her and NA-B reported it to the nurse. After that, NA-B didn't know what happened.	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 46 During a telephone interview on 10/30/24 at 2:36 p.m., the medical director stated staff were expected to follow a resident's care plan to ensure safety. During an interview on 10/30/24 at 2:39 p.m., the social worker designee (SWD) stated she was informed of R12's bathroom incident and staff were expected to not leave residents unattended in the bathroom while in the ceiling lift and were expected to follow the resident's care plan during ceiling lift transfers to ensure safety. On 10/30/24 at 5:09 p.m., RN-A stated the nursing assistants were trained to size slings for residents. The slings were color coded for size. However, RN-A stated she did not know if the size was documented in the resident's care plan or not. She would have to ask. During an interview on 10/30/24 at 5:24 p.m., NA-E stated she "just knew" what size a resident needed. For example, a reddish pink color was an extra small, a yellow was a small and a green was a medium. For R12, she used a green and it was kind of big and NA-E had considered getting a different size for her to try. Staff just went in the "cage" and got one. NA-E stated she didn't know if there was a size listed for the residents anywhere, even the care plan or Kardex. NA-E stated that was a good question, but NA-E just went by her "gut". For example, another resident in the facility had a pink sling in his room. NA-E knew that was way too small, so NA-E just grabbed a bigger sized sling to be safe. "I go by my gut," During an interview on 10/30/24 at 5:26 p.m., NA-F stated staff were usually assigned to a certain wing all the time and staff just "knew"	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 47 what sling a resident used. Like R12, used a green sling and, if it was dirty, staff just went to the "cage" and got a new one. If staff were floated to a different wing and they didn't know what sling to use, they would just ask the nurse or another aide which sling to use. NA-F didn't know if sling size was "written down" anywhere. NA-F knew the nurses did check the slings and would put different ones in the rooms sometimes, but NA-F stated she didn't know if they put that anywhere either. "You just know." During an interview on 10/30/24 at 6:14 p.m., the DON stated R12 and R2 did not have a ceiling lift sling size care planned. R7's care plan directed staff to use a size medium sling, however, R7 had lost weight since admission and her size may be incorrect. It was important to have a resident's sling size care planned so all staff were able to easily determine the correct size to ensure safe transferring of the resident. Unsafe ceiling lift transfers could result in resident injury or a fall. Any nurse could request a physical therapy (PT) evaluation for sizing, and it was important for sling size to be care planned for safety for everyone to see. Further, no unlicensed staff member should attempt to size a ceiling lift sling for a resident. During an interview on 10/30/24 at 6:21 p.m., the administrator stated staff were expected to report concerns with sling size and to request a PT evaluation to ensure resident safety. The facilities Safe Resident Handling Program dated 5/14/24, identified it was the policy of the facility that when residents required assistance to move, the assistance would be provided in a manner that was safe for both the resident and employee.	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 48 A facility policy regarding ceiling lift slings and transfers was requested but the facility did not have one to provide. The IJ was removed on 11/6/24 at 9:09 p.m., when it could be verified through observation, interview and document review the facility implemented the following immediate interventions of: assessing R12, R7 and R2 for correct amount of staff to ensure safe transfers, assessed for the appropriate sling size per manufacturers recommendation's, educated nursing staff and created a policy for ceiling lift assessments and ensured there were enough staff to transfer residents according to their care plans. SUGGESTED METHOD OF CORRECTION: The DON, or designee, could review and revise applicable policies and procedures pertaining to comprehensive transfer assessments; then assess all resident that use lifts to ensure they are fitted with the correct sling and the appropriate number of staff were identified to ensure a safe transfer. Then educate staff and on ensuring timely completion of such assessments; then audit staff to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 890	MN Rule 4658.0525 Subp. 2 A Rehab - Range of Motion Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the	2 890		12/11/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 890	Continued From page 49 comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without a limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide range of motion (ROM) services for 4 of 4 residents (R7, R19, R22 ,R43) reviewed for range of motion. Findings include: R7's significant change Minimum Data Set (MDS) dated 10/3/24, identified R7 had severe cognitive impairment. Diagnoses included multiple sclerosis (MS) (a potentially disabling disease of the brain and spinal cord that affects nerve fibers and causes communication problems), type 2 diabetes and peripheral vascular disease (PVD) (reduced blood flow to the arms and legs). R7 had a restorative nursing program (RNP) but R7 did not participate during the look back period. R7's care plan revised 8/9/24, identified R7 had a RNP. Restorative Therapy nursing assistant would monitor R7's progress and tolerance daily and document. RT staff were to report concerns to nursing and/or physical therapy/occupational therapy for assessment and recommendations. Staff were directed to provide: RT- UBC x15 mins	2 890	Completed 12/11/2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 890	Continued From page 50 (tension 90). Pulleys at level 2 (reps of 5 as tolerated). Red squeeze ball (30 second reps). Green level 3 Thera putty. 3# free weight bicep curls. AROM with green Thera Bands. Lower AROM (AAROM - marching, knee extensions, hip adductions and abductions, ankle pumps). 5 times a week or as tolerated. R7's Range of Motion task documentation dated 10/7/24 through 11/1/24, identified R7 received RNP services 3 times, was unavailable 2 times, R7 refused 2 times and was not applicable for 5 times. During the time-period, R7 should have been offered RNP services a total of 17 times. During an observation on 10/29/24 at 12:30 p.m., R7 did not have visible contractures and was able to lift/extend arms during a ceiling lift transfer. R19's quarterly Minimum Data Set (MDS) dated 8/7/24, identified R19 had moderately impaired cognition and diagnoses included Alzheimer's disease, anxiety and heart failure. R19 had a restorative nursing program (RNP) but R19 did not participate during the look back period. R19's care plan revised 8/1/24, directed staff to provide seated general lower and upper extremity exercises to be completed 3 times a week. R19's Range of Motion task documentation dated 10/7/24 through 11/1/24, identified R19 received RNP services 3 times, was unavailable 1 time and not applicable 7 times. During the time period, R19 should have been offered RNP services a total of 11 times. During an observation on 10/29/24 at 1:22 p.m., NA-C and licensed practical nurse (LPN)-A transferred R19 to the toilet using the ceiling lift.	2 890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 890	Continued From page 51 R19 had no visible contractures and was able to extend her upper and lower extremities. R22's significant change MDS dated 9/9/24, identified severe cognitive impairment. R22 had no impairment in range of motion and required substantial to maximal (helper does more than half the effort) with bed mobility, transferring and toileting. R22's diagnoses included arthritis, Alzheimer's disease, and lumbago with sciatica (pain radiating from back to legs and feet which can be eased with range of motion/stretching). R22 did not have a restorative nursing program. R22's care plan dated 6/23/23, identified R22 had chronic pain related to arthritis and lumbago with sciatica. Staff were to monitor and report any decrease in range of motion (ROM). R22's provider's order dated 10/2/24, identified R22 was to receive functional maintenance program (FMP) by restorative therapy (RT). The order directed staff to complete active ROM (AROM) (resident helping with range of motion) to both arms and legs in all ranges and planes (normal range of motion) for all joints and to walk as tolerated with transfers five times a week. R22's restorative therapy documentation from 10/4/24 through 11/3/24, identified 21 opportunities for R22 to receive AROM. There was one documented occurrence of AROM being done, one documented resident not available, and 19 marked not applicable. During observation on 11/4/24 at 1:58 p.m., R22 was sitting in her wheelchair and there we no visible contractures. R22 was able to move hands and feet without restriction.	2 890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 890	Continued From page 52 R43's quarterly MDS dated 9/11/24, identified R43 had moderate cognitive impairment. R43 required supervision to touch assistance with transfers, toileting, and walking. R43 had a diagnosis of Parkinson's disease. R43 had one fall without injury since last assessment. R43 was not part of a restorative nursing program. R43's provider order dated 7/25/24, identified RT program-seated or standing general lower extremity exercises as tolerated. Nustep level 2-5 up to 15 minutes 3 times a week. R43's care plan dated 7/30/24, identified R43 was to receive RT seated or standing general lower extremity exercises as tolerated. Nustep (a low impact exercise machine) level 2-5 up to 15 minutes 3 times a week. R43's restorative therapy documentation from 10/4/24 through 11/3/24, identified 13 opportunities for R43 to receive RT. There were three documented occurrences of RT being done, one refusal, and 9 times were marked not applicable. During observation on 11/4/24 at 1:54 p.m., R43 was sitting in her recliner in her room scrolling through her phone. R43 had no visible contractures. During an interview on 11/4/24 at 11:51 a.m., restorative therapy (RT)-A stated "not applicable" in the Range of Motion task documentation meant a resident was not offered RNP services. RT-A stated when a resident was admitted to the facility, they're asked if they wanted to participate in exercise. If so, the physical therapist did an evaluation and entered the orders in the	2 890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 890	Continued From page 53 resident's chart. RT-A followed those orders during RNP services. RNP services were supposed to be offered Monday through Saturday every week and RT-A scheduled each resident according to their RNP on the calendar. RT-A stated the RT department had staffing problems and RT-A was the most consistent staff member. Currently, there was another staff member trained and passed competency, but that person had not been at the facility often. RT-A worked at the facility Mondays, Wednesdays, and Fridays. The other days were not consistently staffed and no RNP was offered on those days unless a resident was independent enough to do the exercises on their own without staff assistance. - The residents were welcome to come down to the RT department and get on the machines and do exercises. The door was always open, and the residents had access if they wanted. Because of limited time, RT-A started with residents who had contractures to prevent worsening and ambulatory residents. RT-A stated there were 37 residents who had an RNP program ordered, and RT-A was getting to 18-20 per day. "I just can't complete it." RT-A stated she had not reported any refusals and/or inability to complete RNP services so the residents were re-evaluated and/or RNP orders changed. RT-A stated she did inform administration that she was not able to complete tasks but there were no other staff available. During an interview on 11/5/24 at 3:30 p.m., the director of nursing (DON) stated she was aware the facility's restorative aide was at the facility only three days a week even though there were residents requiring RNP 5 days a week. However, a plan to address the issue had not been implemented. Staff were expected to provide RNP to maintain a resident's abilities and/or to	2 890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 890	Continued From page 54 prevent contractures. A policy regarding restorative therapy was requested but not received. SUGGESTED METHOD OF CORRECTION: The DON or designee could audit all residents to ensure ordered exercises were being implemented. The DON or designee could review the process for implementing ordered exercises and how that is communicated, then educate the staff on the process. The DON or designee could perform audits to ensure the exercises were completed as ordered. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 890		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.	2 910		12/11/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 910	Continued From page 55 This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to follow provider's orders for intermittent catheterization for 1 of 1 resident (R99); and failed to ensure catheter care was provided in a manner to prevent potential urinary tract infection (UTI) for 1 of 3 residents (R7) reviewed for catheters. Findings include: R99's admission Minimum Data Set (MDS) dated 10/25/24, identified R99 had moderate cognition. R99 required intermittent catheterization and did not participate in a bladder program. Diagnoses included neurogenic bladder, Alzheimer's disease and dementia. R99's interagency transfer orders signed 10/24/24, identified orders for staff to perform scheduled straight catheterizations 4 times a day; If staff were consistently draining >500 mL per catheterization, then add a scheduled catheterization. R99's Bowel and Bladder Comprehensive Assessment dated 10/25/24 identified R99 required intermittent catheterization every shift and as needed, requires extensive assist from staff with transfers on/off the toilet and peri cares. Intermittent catheterization performed by nursing every shift and as needed. R99's care plan 10/22/24, failed to identify R99's catheterization. R99's October electronic treatment administration record (TAR), directed staff to straight catheterize R99 every shift or as requested by resident,	2 910	Completed 12/11/2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 910	Continued From page 56 related to neuromuscular dysfunction of bladder, with a start date 10/24/24 at 3:00 p.m., signed by care coordinator (CC)-G. CC-G was out of the office and unable to be interviewed during the survey dates. On 10/29/24 at 10:17 a.m., R99 was seated in a wheelchair in his room. R99 stated he used a catheter to empty his bladder due to being unable to urinate on his own. There were individually wrapped sterile straight catheters and sterile glove kits on the bathroom counter. On 10/30/24 at 7:04 a.m., licensed practical nurse (LPN)-A stated staff assisted resident with straight catheterization every shift because R99 was not able to complete it himself. On 10/30/24 at 4:48 p.m., LPN-B stated R99 was unable to urinate on the toilet and staff were using a straight catheter to empty R99's bladder three times per day; although, the original orders dated 10/24/24, were as follows: straight catheterizations 4 times a day; If staff are consistently draining >500 mL per catheterization, then add a scheduled catheterization. LPN-B stated the orders entered into the computer system on 10/24/24, for intermittent catheterization every shift and as needed were incorrect and not as originally ordered. On 10/30/24 at 5:18 p.m., the director of nursing (DON) stated R99 had been using a straight catheter to empty his bladder since before admission. The DON reviewed the original order and the order that was entered by the nursing staff and stated the orders entered by the staff were incorrect and staff should have assisted R99 with catheterization 4 times per day and as ordered by the doctor on 10/24/24. The risk of	2 910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 910	Continued From page 57 incorrectly completing the orders as directed were a high risk for infection. On 10/30/24 at 6:03 p.m., the medical doctor stated he was not notified that staff were only assisting R99 with catheterization once per shift and not four times daily as originally ordered. R99's medical record did not identify any pain or hospitalizations related to not providing catheterization four times a day as ordered. R7's significant change MDS dated 10/3/24, identified R7 had severe cognitive impairment with diagnoses of multiple sclerosis (MS), type 2 diabetes, history of UTI, and peripheral vascular disease. R7 had two stage 3 pressure ulcers and had a suprapubic indwelling urinary catheter (a tube that drains from your bladder through a small incision in your abdomen). The MDS failed to identify R7 had an MDRO. R7's care plan revised 8/9/24, identified R7 had an activities of daily living self-care performance deficit due to weakness related to MS. The care plan directed staff to provide assist of 1-2 for repositioning, dressing, grooming, and toileting/catheter care. During an observation on 10/29/24 at 10:17 a.m., nursing assistant (NA)-B was providing morning cares for R7. R7's catheter bag was uncovered and lying on the floor. During an interview on 10/29/24 at 10:34 a.m., NA-B stated yea, the catheter bag was on the floor, but NA-B had just wiped it down with	2 910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 910	Continued From page 58 alcohol. NA-B stated she "guessed" there could be residual urine on the catheter bag that could soil the floor. NA-B also "guessed" there was dirt on the floor and there could be "germs" in the "dirt" that could potentially cause a UTI. "It doesn't make sense but there's so many by-the-book rules in nursing homes. The bag touching the floor was overkill. To tell you the truth, in a nursing home, care was never going to be perfect and just too much was expected." During an interview on 10/29/24 at 10:39 a.m., LPN-A stated a catheter bag should never touch the floor due to infection control because it can lead to an infection. During an interview on 10/31/24 at 1:10 p.m., registered nurse (RN)-A stated staff were expected to follow the facility's catheter care policy. During an interview on 10/31/24 at 2:18 p.m., DON stated staff were expected to provide catheter care per facility policy and to demonstrate understanding of infection control to prevent the spread of microorganisms in the facility to prevent possible infections. The facility policy Suprapubic Catheter Placement dated 3/1/17, identified the purpose of this procedure was to relieve the retention of urine in the bladder in a resident who required a permanent or long-term catheter. However, the policy/procedure failed to address catheter care after placement. SUGGESTED METHOD OF CORRECTION: The DON could review/revise bowel and bladder assessment policies and procedures, educate staff, and then audit to ensure compliance. In	2 910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 910	Continued From page 59 addition the DON could review/revise catheter protocols, educate staff and then audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 910		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop and implement an infection control surveillance plan for identifying, tracking, monitoring and/or reporting infections and communicable disease along with a monthly analysis; failed to conduct COVID-19 testing of staff and residents per Centers for Disease Control (CDC) guideline; failed to implement contact precautions and/or enhanced barrier precautions (EBP) for 2 of 2 residents (R7, R30) reviewed with a multi drug resistant organism (MDRO) and chronic wounds; and failed to implement standard precautions while catheterizing 1 of 1 resident (R99) observed to be catheterized. In addition, the facility failed to review and update their infection control policies on an annual bases. These deificient practices had the potential to affect all 46 residents residing in the facility. Findings include:	21375	Completed 12/11/2024	12/11/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 60 Surveillance: The Monthly Infection Control Log (Line List) September 2024, for Unit A, identified resident name, date of onset, body site, and type of infection, antibiotic start date and type, date resolved and type of isolation. The log identified one resident (R7) with skin infection which was treated with antibiotic. The isolation type initiated and date the infection was resolved was not documented. The log further identified two residents (R7, R5) both who had tested postive for COVID-19 and placed on contact precautions. There were no listed infections or resident infection symptoms which were not treated with antibiotics (i.e. common cold symptoms, viral infections). The facility did not provide an analysis of the infections to include patterns or what interventions were implemented to reduce incidences of further infection. The Monthly Infection Control Log (Line List) September 2024, for Unit B, identified resident name, date of onset, body site, and type of infection, antibiotic start date and type, date resolved and type of isolation. The log failed to identify any resident not treated with an antimicrobial. The log identified three residents (R30, R32, R40,) with skin infections requiring antibiotics, Organisms or culture results were not identified for the wounds. The residents were placed on barrier precautions and date resolved was listed as ongoing. The log further identified one resident (R10) with respiratory infection requiring antibiotic treatment. The resident was placed on precautions and resolved date was recorded. There were no listed infections or resident infection symptoms which were not treated with antibiotics (i.e. common cold	21375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 61 symptoms, viral infections). The facility did not provide an analysis of the infections to include patterns or what interventions were implemented to reduce incidences of further infection. The Monthly Infection Control Log (Line List) October 2024, for Unit A, identified resident name, date of onset, body site, and type of infection, antibiotic start date and type, date resolved and type of isolation. The log failed to identify any resident not treated with an antimicrobial. The log identified three residents (R19, R7, R99) with urinary tract infections, one with colonized Methicillin-resistant Staphylococcus Aureus (MRSA), all three requiring antibiotics. Barrier isolation was identified and the infections were listed as ongoing. There were no listed infections or resident infection symptoms which were not treated with antibiotics (i.e. common cold symptoms, viral infections). The facility did not provide an analysis of the infections to include patterns or what interventions were implemented to reduce incidences of further infection. The log failed to identify R7 and R19 signs and symptoms of potential infection (identified below). The Monthly Infection Control Log (Line List) October 2024, for Unit B, identified resident name, date of onset, body site, and type of infection, antibiotic start date and type, date resolved and type of isolation. The log failed to identify any resident not treated with an antimicrobial. The log identified two residents (R32, R43,) with urinary tract infections, with the same organism, requiring antibiotics. Isolation and date resolved was not docuemented. The log further identified one resident (R30) with a wound infection and organism identified as MRSA requiring antibiotic treatment. The log identified a	21375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 62 date of resolved infection and that isolation was required, however, did not list type of isolation implemented. There were no listed infections or resident infection symptoms which were not treated with antibiotics (i.e. common cold symptoms, viral infections). The facility did not provide an analysis of the infections to include patterns or what interventions were implemented to reduce incidences of further infection. R7's significant change Minimum Data Set (MDS) dated 10/3/24, identified R7 was 73 years of age. Diagnoses included multiple sclerosis, peripheral vascular disease, pulmonary edema and diabetes. R7's nursing progress note dated 10/27/24, identified R7 had nausea and vomiting after supper. R7's medical record failed to identify if any further follow up was completed or if R7 had been placed in isolation. R19's quarterly MDS dated 8/7/24, identified R19 was 84 years of age. Diagnoses included diabetes, hypertension, atrial fibrillation and dementia. R19's nursing progress note dated 10/21/24, identified R19 complianed of not feeling good. R19 was flushed and having difficulty staying awake. Afebrile and tested negative for COVID antigen test. R19's medical record failed to identify in any further follow up was completed or if R19 had a confirmatory COVID-19 test or if R19 had been placed in isolation. There was no documented, provided evidence which demonstrated the facility had a system for tracking non-antibiotic treated infections (i.e. viral infections); nor any evidence demonstrating a comprehensive analysis of the identified infections was completed despite have two UTI	21375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 63 with the same causative organism. Further, there was no provided evidence the facility had reviewed or investigated the developed infections for potential causes and addressed any subsequent action needed to reduce the risk of recurrence to the same and/or other resident(s). When interviewed on 10/31/24, at 3:00 p.m. registered nurse (RN)-A stated she had not been tracking or trending resident or staff illness/symptoms. The nurse responsible for infection control quit in September and RN-A had not taken the program over until about two weeks ago. RN-A was trying to get resident antibiotic use logged and tracked and had not started on tracking resident or employee symptoms of illness or infection. RN-A told the director of nursing (DON) the facility should be tracking when a resident had diarrhea or a fever, but RN-A had not been able to get tracking of infections implemented. The facility was using an infection control program called Peerlytics, but RN-A was unable to access that program. The facility was working on getting RN-A access to the computerized infection control program. - RN-A was not tracking employee illness and only recorded when staff called in with positive COVID-19. The facility did not require confirmation of test results when employees reported symptom of illness. RN-A stated it would be important to track other illness in both staff and residents to determine the source of illness and track if it could spread. RN-A just did not have the time and had only recently taken the infection preventionist role. The facility did not isolate residents for symptoms of illness. Residents were only isolated if they tested positive for COVID-19. RN-A felt the residents all had a private room and so were kind of isolated	21375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 64 anyway. If a resident exhibited symptoms such as a cough, fever, or diarrhea the facility did not isolate them and did not require staff to wear personal protective equipment (PPE) when providing care to symptomatic residents. RN-A supposed some of the symptom's residents exhibited should require some PPE, but the facility did not direct staff to wear PPE when residents exhibited symptoms of illness. Staff should wear PPE when caring for residents with potentially contagious symptoms. Staffing took up so much of RN-A's time, there was only so much a person could do. RN-A was just trying to get what she could done. At this time, the surveillance and analysis of the facility's infection prevention and control program was requested. During interview on 10/31/24, at 2:40 p.m. the DON stated tracking and trending of resident and employee illness should be done and it was not currently being completed. The tracking and trending of illness was important so the facility could quickly recognize when they had a problem. The facility should be isolating and implementing PPE with any resident that was noted with infectious type of symptoms such as cough, fever, or diarrhea. The facility's policy Infection Control Surveillance with revision date 4/4/24, identified infection prevention began with ongoing surveillance to identify infections that were causing or have the potential to cause an outbreak. The facility would establish routine, ongoing and systematic collection, analysis, interpretation, and dissemination of surveillance data to identify infections, infection risks, communicable disease outbreaks, and to maintain or improve resident health status. The facility nurses would identify residents with symptoms or identified infections	21375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 65 and complete a wait and watch in Peerlytics and in the residents' medical record, documenting the signs and symptoms the resident was exhibiting. The infection preventionist would be alerted to identify any necessary interventions and add to Peerlytics for follow up and data collection. The infection preventionist would utilize the information to monitor infection sit, type, pathogen if known, signs and symptoms and resident location to identify trends or clusters for action. COVID-19 Testing: Centers for Disease Control (CDC) website Infection Control Guidance: SARS-CoV-2 (COVID-19) dated 6/24/24, identified a single new case of COVID-19 infection in any health care provider (HCP) or resident should be evaluated to determine if others in the facility could have been exposed. Perform testing for all residents and HCP identified as close contacts or on the affected unit. Testing was recommended at day 1, day 3 and day 5, where day of exposure is day 0. If additional cases were identified, testing should continue on affected units or facility-wide every 3 to 7 days until there were no new cases for 14 days. A facility Employee COVID Line List Spread Sheet for months of September and October 2024 identified employee name, age, sex, onset date, positive testing collection date, day one isolation, day 7 test result, day 10 test result and date return to work. The spread sheet identified eight employees with onset positive dates which included: maintenance (maint)-A on 9/22/24, housekeeper (HSK)-A on 9/25/24, cook (CK)-A on 9/26/24, the director of nursing (DON) on 9/26/24, nursing assistant (NA)-F on 9/26/24,	21375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 66 registered nurse (RN)-D on 9/27/24, NA-B 10/14/24 and care coordinator (CC)-G on 10/27/24. A facility Resident COVID Line List Spread Sheet for the month of September 2024 identified resident name, age, sex, onset date, positive testing collection date, day one isolation, day 7 test result, day 10 test result and date out of isolation. The spread sheet identified two resident names with positive test results; R5 on 9/24/24 and R7 on 9/25/24. A facility October calendar listed resident testing dates for all units on 10/2/24, 10/4/24, 10/7/24, 10/9/24, 10/11/24. Residents who resided on unit A were tested on 10/15/24 due to an exposure with NA-B on 10/14/24, however, the facility failed to continue COVID-19 testing day 3 and day 5 to determine if there were any additional positive cases as required. Unit A residents were tested again on 10/28/24 due to an exposure with CC-G on 10/27/24, however, the facility failed to continue COVID-19 testing day 3 and day 5 to determine if there were any additional positive cases as required. On the bottom of the calendar it was indicated any other resident testing would be done randomly with any resident that exhibited symptoms and not every three to seven days until no further new cases were identified as required. The facility documented when testing occured on resident units, the facility failed to track which residents were tested and results of individual tests. The facility documented positive employees COVID-19 test results when the tests results were reported by the employee. The facility failed to produce evidence of any employee testing. The	21375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 67 facility failed to track and document which employees tested, when and how the employees tested as well as employee COVID-19 test results. Furthermore, the facility failed to track and document if employees tested and/or results of COVID-19 testing prior to working their scheduled shifts . The testing of residents was not completed on day 1, day 3 and day 5, after a known exposure from a positive staff members 10/14/24 and 10/28/24, as required. Nor did testing occur every three to seven days until no further additional staff or residents tested positive for COVID-19. During interview on 10/29/24, at 9:30 a.m. RN-A stated she did not have documentation of residents testing or testing results other than individual entries in each resident's chart that were tested. RN-A was unable to identify exactly which residents had tested without going into each individual resident medical record and was unable to identify if any residents had refused or were absent when COVID-19 testing was conducted. RN-A stated she thought the facility was in outbreak when three employees all tested positive on 9/26/24, despite having been notified an employee (maintenace (maint)-A) had tested positive on 9/22/24, after working the day prior. RN-A instructed all employees to test when the facility was in outbreak, however did not track or record which employees tested or their results. The facility continued testing all residents and employees were reminded to test for COVID-19 until 10/12/24. RN-A felt, because the facility had not had any further positive COVID-19 test results since 9/27/24, the facility completed outbreak testing and were out of outbreak status on 10/12/24. On 10/14/24, NA-B reported fatigue,	21375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 68 sore throat and a positive COVID-19 test. NA-B had worked the weekend (10/12/24 & 10/13/24) prior to positive test result on 10/14/24. RN-A did not conduct or record any formal contact tracing, other than review of where NA-B had been scheduled. RN-A felt only residents on unit A had been exposed to NA-B, because that was the unit NA-B was scheduled, so RN-A tested all residents on unit A on 10/15/24. RN-A had instructed staff to test if they knew they had exposure to NA-B, however, did not track or document which staff had contact with NA-B and/or tested. RN-A felt staff would know if they had an exposure and test accordingly. RN-A did not do formal contact tracing of who NA-B had contact with when she worked on 10/13/24 and 10/14/24, prior to having symptoms of fatigue and sore throat on 10/14/24, and positive test result. All residents on unit A tested negative for COVID-19 on 10/15/24, and no further testing was conducted. RN-A did not know why testing exposed residents was not completed on day 3 and day 5 of exposure as required. RN-A did not conduct contact tracing on employees who may have been exposed to NA-B and did not know which employees had tested when NA-B had reported positive on 10/14/24. RN-A stated CC-G reported nausea, vomiting, headache and positive COVID-19 test result on 10/27/24. RN-A did not conduct or record any formal contact tracing, other than review of where CC-G had been scheduled. RN-A felt only residents on unit A had been exposed to CC-G, so RN-A tested all residents on that unit on 10/28/24. All residents on unit A tested negative for COVID-19 on 10/28/24, and no further testing was conducted. RN-A did not know why testing exposed residents was not completed on day 3 and day 5 of exposure as required. RN-A did not conduct contact tracing on employees who may have	21375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 69 been exposed to CC-G and did not know which employees had tested when CC-G had reported positive on 10/28/24. RN-A felt staff would know if they had an exposure and test accordingly. RN-A could not say if all staff were tested prior to starting their shift, even during the outbreak. RN-A had given all staff instructions via communication email, to test prior to their shift and so all staff were aware they needed to test. Tracking or documentation of staff testing had not been completed to ensure testing had been completed, other than documentation of the positive tests that were reported to RN-A. Employees were not required to provide proof of testing When interviewed on 10/31/24, at 2:30 p.m. the DON stated staff testing should have been tracked to keep the transmission of COVID-19 to a minimum and to keep residents safe. All testing for COVID-19 should have been documented. The facility's Long Term Care and Assisted Living Response Plan for COVID-19 Testing, approved 9/1/20, identified an outbreak and testing trigger as one or more residents confirmed to have COVID-19, a direct care staff member who tested positive for COVID-19 and worked in the facility while ill or 48 hours prior to development of symptoms or a symptomatic resident who has tested negative. MDH and CDC would be consulted for current recommendations for the particular disease epistemology at the time that testing was considered. The infection preventionist would ensure that records were maintained regarding the testing process, resident and staff consent for testing and test results.	21375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 70 Contact/Enhanced Barrier Precautions: R7's significant change MDS dated 10/3/24, identified R7 had severe cognitive imairment R7 had two stage 3 pressure ulcers and had a suprapubic indwelling urinary catheter (a tube that drains from your bladder through a small incision in your abdomen). The MDS failed to identify R7 had an MDRO. Diagnoses included multiple sclerosis (MS), type 2 diabetes, history of UTI, and peripheral vascular disease. R7's care plan revised 8/9/24, identified R7 had an activities of daily living self-care performance deficit due to weakness related to MS. The care plan directed staff to provide assist of 1-2 for repositioning, dressing, grooming, and toileting/catheter care. However, the care plan failed to address R7's need for contact precautions or enhanced barrier precautions (EBP). R7's Physical Therapy Skilled Nursing Facility Treatment Note dated 9/12/24, identified R7 had an open wound on her right ischial tuberosity and had an increased risk of infection. Precautions/Restrictions: methicillin-resistant staphylococcus aureus (MRSA). During an observation on 10/29/24 at 10:17 a.m., nursing assistant (NA)-B was providing morning cares for R7. There was a 3-drawer plastic bin outside of R7's door containing gowns, gloves, facemasks and face shields. No signage was on R7's door directing staff what personal protective equipment (PPE) was required or when it was required. R7's catheter bag was uncovered and lying on the floor. NA-B did not apply a gown or gloves and stated the only time she needed to do	21375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 71 so was if she was emptying R7's urinary catheter bag because "pee could get on me." Wearing gowns and gloves for catheters was something new, but NA-B could not remember what "it" was called. No one had ever explained why sometimes staff needed to wear personal protective equipment (PPE) and it was something staff never did before. "It's just something to be 'extra'". "It doesn't make sense but there's so many by-the-book rules in nursing homes." The bag touching the floor was overkill. To tell you the truth, in a nursing home, care was never going to be perfect and just too much was expected. NA-B could not explain what an MDRO was and/or if R7 was known to have a history of MRSA. During an observation on 10/29/24 at 12:23 p.m., NA-C assisted R7 to the toilet using the ceiling lift. NA-C did not don a gown and gloves. - At 12:28 p.m., NA-C put on gloves and pulled down R7's pants, then lowered R7 onto the toilet. NA-C then hung R7's catheter bag from the toilet handrail. - At 12:29 p.m., R7's catheter bag fell onto the floor. NA-C picked up the bag and again hung it from the toilet handrail. "I don't know if it will hang there or not." NA-C did not clean R7's catheter bag. NA-C did not remove her soiled gloves and was touching scrubs and high touch areas in the bathroom. - At 12:33 p.m., NA-C straightened R7's pillows and bed linens. NA-C continued to wear the same soiled gloves. - At 12:35 p.m., NA-C raised R7 off the toilet and pulled up R7's pants. NA-C stated R7 didn't have a bowel movement so did not need wiping. NA-C continued to wear the same gloves. NA-C transferred R7 to bed using the ceiling lift and continued touching high touch areas with the same soiled gloves.	21375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 72 During an interview on 10/29/24 at 12:23 p.m., NA-C stated you only need to wear a gown when you empty R7's catheter. That's it. NA-C stated she wore gloves, but the 3-drawer bin outside R7's room was left over from when R7 had COVID-19 in previous weeks. Someone just forgot to take it away. NA-C stated she was unaware if R7 had a history of a MRSA or any type of infection. NA-C stated she had never been told why sometimes staff wore PPE and other times they didn't need to. During an interview on 10/29/24 at 10:39 a.m., licensed practical nurse (LPN)-A could not recall what EBP was called or when it was required but only staff needed to wear a gown when doing anything with the catheter. "I don't know why but that's what we were told." It started about a year ago, when staff needed to wear a gown when doing anything with a wound and/or a catheter. Staff were given a bunch of papers to review. LPN-A stated she asked for a simple explanation and not a stack of papers because it was just too much to understand, but LPN-A was told "it's just the rules". That was just it. Staff should be wearing a gown and gloves every time they're in R7's room because "we're supposed to." That's just what staff were told. During an observation on 10/30/24 at 7:42 a.m., NA-B did not gown or glove and entered R7's room to answer R7's yell for help. NA-B stated she did not gown or glove because she was told she only needed to do that if she was doing catheter care, but "now that's changed." "I don't know what I'm supposed to do now." NA-B pointed to R7's 3 drawer plastic bin that contained PPE and stated, "I really don't know what that's about." NA-B stated she had not received any	21375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 73 education regarding infection prevention precautions. "You're my education." During an interview on 10/30/24 at 9:14 a.m., LPN-A stated anytime staff go into R7's room and provide care, staff were supposed to wear a gown. "We need to work on that." LPN-A stated R7 had MRSA in her (R7) wounds. LPN-A could not explain the different types of precautions: standard, contact, droplet, and/or EBP. LPN-A became tearful and stated staff did not receive education. It started at the top and never trickled down to staff on the floor. "We're not safe." During an interview on 10/31/24 at 1:10 p.m., registered nurse (RN)-A stated she took over the role of facility infection preventionist two weeks prior for the duration of her contract. "I inherited this." Staff needed education regarding precautions. Any resident with a catheter or a wound (because there could also be an unknown organism) needed Enhanced Barrier Precautions (EBP). However, RN-A did not have a listing of residents with a known MDRO, a wound or a catheter. RN-A went room to room to look for a catheter. "I just know." For MDRO, staff wouldn't know that unless they went digging in the charts. RN-A had just found out the other day R7 was colonized with MRSA and should be on Contact Precautions. "Well, I guess staff did need to dig in charts." "You know you are asking me for information. I find it hard to I know I'm accountable for speaking for the previous IP nurse." Staff were expected to follow Centers for Disease Control and Prevention (CDC) guidance to prevent the spread of infection. During an interview on 10/31/24 at 2:18 p.m., the director of nursing (DON) stated staff were expected to follow CDC precautions guidance for	21375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 74 donning/doffing PPE per facility policy and to demonstrate understanding of infection control to prevent the spread of microorganisms in the facility to prevent possible infections. R30's admission MDS dated 9/27/24, identified R30 was cognitively intact and had a stage 3 pressure ulcer with a multi-drug resistant organism (MDRO). R30's care plan dated 10/1/24, identified Methicillin-resistant Staphylococcus aureus (MRSA) (an infection which is caused by a type of staph bacteria that's become resistant to many of the antibiotics used to treat ordinary staph infections. A type of MDRO) Intervention included contact isolation(precautions): wear gown, gloves and mask when providing any cares. Mask or face shield to be worn during procedures. The care plan did not address EBP for having a chronic wound. R30's provider's order dated 9/26/24, identified dressing change to right residual limb (the limb with stage 3 pressure ulcer and MRSA): cleanse with wound cleaner, Aquacel ribbon (a wound dressing that absorbs wound fluid and creates a moist environment to help wounds heal) lightly packed into wound bed and cover with a large Tegaderm foam (a highly absorbent, breathable wound dressing). During observation on 10/29/24 at 10:19 a.m., there was a sign on R30's door identifying resident was on contact precautions. An isolation cart was located outside her door and held gowns, gloves, face masks, and eye protection. During an interview on 10/29/24 at 12:40 p.m., nursing assistant (NA)-A stated R30 was on	21375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 75 contact precautions and whenever NA-A would go into the room to assist the resident with cares, bed mobility, transfers, toileting or changing linens NA-A would wear a gown and gloves to help. During observations on 10/30/24 at 8:43 a.m., physical therapy assistant (PTA)-A approached R30's room and took gloves from the isolation cart outside of the door. PTA-A then entered the room without putting on gloves. PTA-A gathered the supplied for the dressing change and prepared them for the dressing change. With the ungloved hands, PTA-A removed the ace bandage, lymph wrap (a wrap for legs to offer management of swelling and surgical areas) and stump sock (a compression stocking placed on a recently amputated limb). PTA-A then sanitized her hands and put gloves on and removed the final dressing over the wound. The bandage had some red drainage on it and the surgical site wound had a pencil eraser size hole with a small amount of purulent (pus) drainage. Wearing the same gloves, she cleaned the wound with saline spray and a 4 x 4 gauze dressing. PTA-A then removed the gloves and sanitized her hands. PTA-A took a cell phone from her pocket and took a picture of the wound for R30's chart and then placed the cell phone directly on R30's bed. PTA-A then sanitized her hand and placed clean gloves on. PTA-A then placed iodoform gauze (an antiseptic), then covered with an Aquacel dressing (a dressing to help contain drainage) and then placed foam dressing over the wound. PTA-A then removed the dirty gloves and sanitized her hands and gathered the remaining supplies and put them away in R30's room and placed the cell phone in her bag and then sanitized her hands.	21375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 76 - At 9:00 a.m., PTA-A was finished with the dressing change and proceeded to work on exercises with R30 without wearing gloves. Exercises included marching in place while sitting on the edge of the bed by lifting her knees. Then asked resident to kick out with amputated limb and was placing ungloved hand on the dressing she just changed. PTA-A then rubbed her hands together and placed them on the outside of each knee and had R30 push against her hands. PTA-A then moved to the inside of the knees and did the same. A gait belt was then placed on R30 and with a walker PTA-A assisted R30 to stand while she held the gait belt and walker with her ungloved hands. R30 then proceeded to exercise her amputated limb. PTA-A was standing by R30 with on ungloved hand on the gait belt and one on the walker and did that exercise twice. R30 was then seated on the edge of her bed and repeated the initial exercises done with ungloved hands, which included placing the ungloved hands on the dressing which was just changed. When finished with the exercises PTA-A with her ungloved hands rolled up the Ace bandage which was originally wrapped around the amputated limb at the beginning of the observation. PTA-A then sanitized her hands and left the room. PTA-A did not wear a gown at any time during the encounter. During an interview on 10/30/24 at 7:56 a.m., PTA-A stated she seen the sign on door indicating contact precautions and knew it was for an infection in the wound. Since it had been mostly contained, she had been only wearing gloves during the dressing changes and was unsure of why a gown would be needed. PTA-A stated nobody reviewed contact precautions, and the only times a gown was worn is if wounds were worse than R30's, if the resident had a catheter	21375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 77 or covid. R30 was on contact precautions, and she should probably have been wearing a gown and gloves. During and interview on 10/31/24 at 12:50 a.m., RN-A stated residents who were colonized with MDRO in urine and had a catheter or had an MDRO in a wound would be expected to be on contact precautions. Meaning any staff doing close contact cares, bed mobility, or dressing changes with a resident on contact precautions would be wearing a gown and gloves. The importance of contact precautions is to protect the resident on any infections that staff my unknowing bring into the room, and to protect the staff and other resident after contact with infected resident. R30 was on contact precautions for a MDRO in a wound on her leg and would expect all staff to follow contact precautions. During an interview on 10/31 24 at 1:07 p.m., the DON stated it was the expectation that all staff would follow infection control policies, and this included contact precautions. This was to protect the resident on contact precautions and all the other residents in the building. The facility's Transmission Based Precautions policy dated 4/4/24 identified contact precautions were intended to prevent transmission of infections and require the use of gown and gloves upon entering the room. The facility's Multidrug Resistant Organisms (MDROs) policy dated copyright 2009 identified contact precautions shall be considered for residents infected or colonized with a MDRO. Standard Precautions:	21375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 78 R99's admission MDS dated 10/25/24, identified R99 had moderate cognition and required intermittent catheterization. Diagnoses included neurogenic bladder, Alzheimer's disease, and dementia. R99's physician notes dated 10/17/24, identified R99 performed catheterization by himself as needed to empty his bladder. R99's care plan dated 10/22/24, failed to identify R99's catheterization plan and goals including what personal protective equipment was needed. R99's medication administration report (MAR) dated 10/1/24 through 10/31/24, identified staff were required to perform catheterization for R99 every shift or as requested by the resident due to the resident's neuromuscular dysfunction of the bladder. On 10/29/24 at 10:17 a.m., R99 was seated in a wheelchair in his room. R99 stated he used a catheter to empty his bladder due to being unable to urinate on his own. Staff used gloves but did not wear gowns when catheterizing him. On 10/30/24 at 1:30 p.m., registered nurse (RN)-A stated when providing direct cares for R99, including being straight cathed, staff were required to wear a gown and gloves. On 10/30/24 at 1:55 p.m., licensed practical nurse (LPN)-A stated R99 required staff to use a straight catheter to empty his bladder. LPN-A used a straight catheter to empty R99's bladder. LPN-A wore gloves and used sterile technique but failed to wear a gown. LPN-A stated she had failed to wear a gown during catheterization and should of to protect herself, other resident. As	21375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 79 splashing of urine could potentially spread bacteria causing aninfection. On 10/31/24 at 2:18 p.m., the DON stated staff were expected to follow the Center for Disease Control (CDC) precautions guidance for personal protective equipment during catheter care. Further, the DON stated the facility policy directed staff to demonstrate understanding of infection control to prevent the spread of microorganisms in the facility to prevent possible infections. The Standard Precautions policy revision 2009 identified all resident blood, body fluids, excretions, and secretions other than sweat were considered potentially infections and standard precautions would be used for all residents. The policy further identified gowns/aprons (fluid resistant) should be worn when there was a potential for soiling clothing with blood/body fluids. The facility policy Standard and Transmission Based Precautions revised 4/4/24, identified Transmission-based precautions must be used when a resident developed signs and symptoms of a transmissible infection, arrived with symptoms of an infection (pending laboratory confirmation), or has a laboratory confirmed infection and was at risk of transmitting the infection to other residents. The diagnosis of many infections is based on clinical signs and symptoms, but often required laboratory confirmation. However, since laboratory tests {especially those that depend on culture techniques) may require two or more days to complete, transmission-based precautions may be implemented while test results were pending, based on the clinical presentation and the likely category of pathogens. Nurses would identify the	21375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 80 type (i.e., contact, droplet, airborne) and duration of the transmission-based precautions required, depending upon the infectious agent or organism involved. Contact Precautions Contact precautions are intended to prevent transmission of infections that were spread by direct (e.g., person-to-person) or indirect contact with the resident or environment, and required the use of appropriate PPE, including a gown and gloves upon entering the room. Prior to leaving the resident's room, the PPE was removed, and hand hygiene was performed. Contact precautions were indicated for gastrointestinal illnesses such as C. difficile or norovirus, infected draining wounds, or secretions. Policies: A review of the facility infection control policies identified the following policies were not reviewed or updated in the past year: The Standard Precautions policy revision 2009, Multidrug Resistant Organisms (MDROs) policy dated 2009, Infectious Disease Outbreak Policy last revised 10/23/20, Infection Preventionist Responsibilities revised 7/25/17, Infection Control Plan revision date 3/10/20, C. Difficile policy dated 8/17/18, Antimicrobial Stewardship Program dated 12/4/18, Hand Hygiene dated 3/10/20, Personal Protective Equipment-using gloves dated 7/25/17, Personal Protective Equipment- using protective eyewear dated 7/25/17, Personal Protective Equipment- using face masks dated 7/25/17, Influenza, Prevention and Control of Seasonal Influenza dated 7/25/17, Infection Control Education dated 7/25/17,	21375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 81 Pneumococcal Vaccination dated 4/14/17, and Long Term Care and Assisted Living Response Plan for Supporting COVID-19 Testing dated 9/1/20. The facility lacked documentation their infection control policies had been reviewed annually as required. When interviewed on 10/31/24, at 10:15 a.m. RN-A stated she had never updated any of the facility policies or procedures as she had just taken over her position a few weeks prior. There was only so much a person could do and RN-A was just trying to complete what she could. During interview on 10/31/24, at 2:40 p.m. the DON stated infection control policies should be updated annually. Updating infection control policies should have been completed by the DON or infection preventionist. It was important to update infection control policies because things changed so much within the infection control program. The facility's Infection Prevention Plan Policy, dated 3/10/20, identified an annual review would be conducted to review the Infection Prevention and Control Program and the program would be updated as necessary, including necessary updates as national standards changed. SUGGESTED METHOD OF CORRECTION: The DON or designee could review applicable policies and procedures to ensure the comprehensive infection control (IC) program contains on-going analysis of collected data to prevent potential spread of illness and that policies are appropriately implemented; along with contact, transmission based, standard and	21375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 82 enhanced barrier precautions. The DON could inservice staff regarding proper infection control measures are implemented. The DON or designee could implement audits to ensure ongoing compliance and report those results to the quality assurance group. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21375		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the	21426	Completed 12/11/2024	12/11/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21426	Continued From page 83 facility failed to ensure a tuberculosis (TB) symptom screening was completed upon admission for 4 of 5 residents (R8, R15, R43, R99); and accurately record the results of a tuberculin skin test (TST) for 1 of 5 residents (R43); and failed to administer a 2nd step Mantoux for 1 of 5 residents (R43). In addition, the facility failed to ensure TB symptom screening was completed on hire for 3 of 5 employees (DA-A, DON, AA-B); and ensure a tuberculin skin test (TST) was administered to 2 of 5 employees (DA-A, AA-B) prior to working with residents of the facility. Findings include: Residents: R8 was admitted 1/25/24. R8's medical record indicated her TST test that was given 1/26/24 and 2/9/24, was documented as negative. R8's medical record lacked evidence that an assessment for risk factors and physical screening for active symptoms of TB had been completed. R30 was admitted 9/24/24. R30's medical record indicated her TST test that was given 9/24/24 and 10/9/24, was documented as negative. R30's medical record lacked evidence that an assessment for risk factors and physical screening for active symptoms of TB had been completed. R43 was admitted 6/5/24. R43's medical record indicated her TST test that was given 6/19/24 did not have results of the TST documented. R43's medical record lacked documentation her second TST had been completed as required. Further, R43's medical record lacked evidence that an	21426		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21426	Continued From page 84 assessment for risk factors and physical screening for active symptoms of TB had been completed. R99 was admitted 10/15/24. R99's medical record indicated his TST test that was given 10/15/24 and 10/29/24, was documented as negative. R99's medical record lacked evidence that an assessment for risk factors and physical screening for active symptoms of TB had been completed. Employees: Dietary aide (DA)-A's hire date was 1/11/24. DA-A's employee file identified DA-A had a T spot TB test on 6/24/24, which was negative. DA-A's employee file lacked evidence that an assessment for risk factors and physical screening for active symptoms of TB had been completed or that a tuberculin test had been completed prior to working with residents. Director of nursing's (DON) hire date was 8/12/24. DON's employee file identified DON had a Quantiferon TB test on 4/4/24, prior to hire. The DON's employee file lacked evidence that an assessment for risk factors and physical screening for active symptoms of TB had been completed. Activity aide (AA)-B's hire date was 1/3/24. AA-B's employee file identified AA-B had a T spot TB test on 6/26/24, which was negative. AA-B's employee file lacked evidence that an assessment for risk factors and physical screening for active symptoms of TB had been completed or that a tuberculin test had been completed prior to working with residents.	21426		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21426	Continued From page 85 When interviewed on 10/29/24, at 4:12 p.m. registered nurse (RN)-A stated the facility had to go through all the employee records in June 2024, because someone had mistakenly destroyed a bunch of employee files. The facility had redone some of the employee TB testing to be sure to have everyone recorded. She was unsure of why there was no documentation for resident screening and R43's testing must have just gotten missed. RN-A was unable to find any of the missing documentation and stated most had occurred prior to RN-A taking her position. RN-A stated it would be important to complete TB testing and monitoring to remain in compliance with regulations. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) and/or designee could review current CDC guidelines for tuberculosis control within health care facilities, audit resident and staff for requirements, update/complete any steps missing and complete ongoing monitoring of new admissions and new hires to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced	21805		12/11/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21805	Continued From page 86 by: Based on interview and document review, the facility failed to provide toileting cares in a dignified manner for 1 of 1 resident (R12) reviewed for dignity. Findings include: R12's quarterly Minimum Data Set (MDS) dated 8/22/24, identified R19 was severely cognitively impaired and R12 was dependent (helper performed all the effort and resident does none of the effort to complete the activity) for toileting and bed to chair transfers. R12 required substantial/maximal assistance (helper does more than half the effort) for personal hygiene. R12's care plan dated 8/9/24, identified R12 was cognitively impaired and required assist of two staff for ceiling lift transfers. During an interview on 10/28/24 at 2:38 p.m., R12 stated, last week, a nursing assistant left R12 in the bathroom in the ceiling lift alone. R12 was unable to say a name or date but R12 was crying and stated R12 waited at least 20 minutes. R12 was in the bathroom already in the lift, up in the air, and R12's feet were dangling and "going numb". Staff usually left R12 in the ceiling lift, hanging over the toilet, but usually not for that long. R12 stated she urinated almost immediately when she got to the toilet and could have gone back to bed. R12 did report the incident to facility staff and stated she was told by facility staff it always felt longer when you're in the lift, but it wasn't that long. R12 was crying and stated she felt "neglected. "I don't like to complain and get people in trouble, but I can't put up with this either. I just can't." R12 was grasping her bed linens in her hands and stated she was told there	21805	Completed 12/11/2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21805	Continued From page 87 were many other people to help take care of. During an interview on 10/30/24 at 9:20 a.m., licensed practical nurse (LPN)-A stated she was very concerned regarding resident and staff safety. The facility did not have enough staff to provide assist of two with ceiling lift transfers. Residents were being left alone in the lifts in the bathrooms and not answering call lights timely. LPN-A stated she knew of an incident on 10/25/24 between R12 and NA-D, where R12 was left alone in the bathroom hanging from the ceiling lift. LPN-A did not report this to anyone but stated R12 was not safe to be left unattended in the ceiling lift in the bathroom nor was it dignified.R12 had a history of depression as well. During an interview on 10/30/24 at 9:44 a.m., NA-C stated the facility was "always" short staffed. NA-C stated she had heard about an incident where R12 was left alone in the bathroom because staff were answering call lights because there wasn't enough staff. During an interview on 10/30/24 at 1:25 p.m., NA-B stated R12 reported the bathroom incident to her, and NA-B reported it to the nurse. After that, NA-B didn't know what happened. During an interview on 10/30/24 at 2:39 p.m., the social worker designee (SWD)-A stated she was informed of R12's bathroom incident and staff were expected to not leave residents unattended in the bathroom to ensure resident's safety and to provide comfort to the resident. However, there was no documented grievance for R12's concerns or follow up. During an interview on 10/30/24 at 6:21 p.m., the administrator stated staff were expected to	21805		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21805	Continued From page 88 provide cares in a dignified manner to maintain the resident's individuality and to provide comfort. A facility policy regarding dignity was requested but not received. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) could inservice staff about ensuring cares are initiated and complete timely for each resident, then complete audits of care to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21805		
21880	MN St. Statute 144.651 Subd. 20 Patients & Residents of HC Fac.Bill of Rights Subd. 20. Grievances. Patients and residents shall be encouraged and assisted, throughout their stay in a facility or their course of treatment, to understand and exercise their rights as patients, residents, and citizens. Patients and residents may voice grievances and recommend changes in policies and services to facility staff and others of their choice, free from restraint, interference, coercion, discrimination, or reprisal, including threat of discharge. Notice of the grievance procedure of the facility or program, as well as addresses and telephone numbers for the Office of Health Facility Complaints and the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12) shall be posted in a conspicuous place. Every acute care inpatient facility, every residential program as defined in section 253C.01, every nonacute care facility, and every facility employing more than two people that	21880		12/11/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21880	Continued From page 89 provides outpatient mental health services shall have a written internal grievance procedure that, at a minimum, sets forth the process to be followed; specifies time limits, including time limits for facility response; provides for the patient or resident to have the assistance of an advocate; requires a written response to written grievances; and provides for a timely decision by an impartial decision maker if the grievance is not otherwise resolved. Compliance by hospitals, residential programs as defined in section 253C.01 which are hospital-based primary treatment programs, and outpatient surgery centers with section 144.691 and compliance by health maintenance organizations with section 62D.11 is deemed to be compliance with the requirement for a written internal grievance procedure. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed ensure a voiced grievance was acted upon; and provide a written policy for how the facility would handle grievances for 1 of 1 resident (R20) reviewed for missing property Findings include: R20's quarterly Minimum Data Set (MDS) dated 7/19/24, identified R20 was cognitively intact and demonstrated no delusional behavior and/or thinking. The facility 8/7/24, resident council minutes identified R20 was missing a long white, lacy nightgown that had been gone for an	21880	Completed 12/11/2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21880	Continued From page 90 undetermined length of time. On 10/30/24 at 9:58 a.m., during a resident council discussion R20 stated she reported a missing night gown a few months ago at a resident council meeting. R20 stated she asked staff about the gown a couple weeks ago but had not received any follow up. An interview was completed on 10/30/24 at 2:45 PM, with environmental services manager (EVS) and laundry aide (LA)-A. LA-A stated in August 2024, the facility changed the laundry process, and all personal and facility laundry was done in the large laundry room and not on the units as previously done. Staff and/or family were instructed to label all the residents clothing and any unlabeled and/or unclaimed items were folded/hung on the cart and brought to the units for the nurses, residents, and family to look through and identify. EVS stated residents/families/staff notified the laundry staff of missing items. Residents also voiced concerns of missing items during resident council and laundry staff were notified to watch for the item/s. After an undetermined amount of time, the concern would be discussed with administration to make a decision regarding compensation. During interview on 11/4/24 2:32 p.m., nursing assistant (NA)-E stated staff would search for any missing items and notify the nurse and laundry staff. NA-E was unaware that R20 was missing a night gown and was uncertain if there was a form to fill out for missing items. During interview on 11/4/24 at 1:52 P.M., the activities director (AD) stated when missing items were brought to resident council meetings she would make a note in the minutes, highlights the	21880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21880	Continued From page 91 concern, and placed a copy of the minutes in the appropriate manager's mailbox as well as the director of nursing (DON)'s for follow up. If the concern came up again at future resident council meeting would make another note in the minutes and place a highlighted copy in the administrator's mailbox. The AD stated once the copies were placed in the appropriate mailbox, the AD would not follow up any further. Missing items were discussed at the interdisciplinary meeting but did not recall that R20's missing night gown had been discussed. On 11/4/24 at 2:16 p.m., EVS stated she was unaware of R20 having any missing clothing items and if it had been prior to 8/24, the nursing staff would have tracked and followed through with the item. A facility grievance policy was requested but not received. SUGGESTED METHOD OF CORRECTION: The DON and/or designee could review and revise policies pertaining to handling resident grievances, educate staff on these policies and perform audits to ensure each resident grievance has been addressed by the facility. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245329	A. BUILDING **02 - WARROAD CARE CENTER** B. WING _____	**10/29/2024**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 10/29/2024. At the time of this survey, Warroad Care Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

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

Electronically Signed | 11/26/2024

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245329	A. BUILDING **02 - WARROAD CARE CENTER** B. WING _____	**10/29/2024**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Warroad Care Center is a 1-story building without a basement that was built in 2009 and was determined to be built of Type V(111) construction. The facility is divided into four separate smoke compartments by smoke barrier walls. The facility is fully protected throughout by an automatic fire sprinkler system and has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility also has smoke detection	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245329	A. BUILDING **02 - WARROAD CARE CENTER** B. WING _____	**10/29/2024**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 in the resident rooms that is tied into the nurse call system. The facility has a capacity of 49 beds and had a census of 42 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K 000		
K 293 SS=D	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain and/or install proper exit signage under NFPA 101 (2012 edition), Life Safety Code sections 19.2.10.1, 7.10.1.2.2, 7.10.83, 7.10.8.31 and 7.10.8.3.2. These deficient findings could have an isolated impact on the residents within the facility. Findings include: On 10/29/2024, between 9:30am and 12:30pm, it was revealed by observation that the door leading to the Courtyard outside the employee break room was missing a "NO EXIT" sign.	K 293	No residents were affected by this deficient practice. All residents had the potential to be affected by this deficient practice. In the employee breakroom there was no 'No Exit' sign on the door to the patio. Maintenance Director put a 'No Exit' sign up on the employee breakroom door on 10/30/2024. The Maintenance Director or assigned personnel will check doors for 'No Exit' signs immediately, then once every 6 months a routine check will be completed. The Maintenance Director will monitor for compliance. This will be completed on 11/28/2024	11/28/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245329	A. BUILDING **02 - WARROAD CARE CENTER** B. WING _____	**10/29/2024**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 293	Continued From page 3 An interview with Maintenance Director verified these deficient findings at the time of discovery.	K 293		
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain their smoke barrier per	K 321	No residents were affected by this deficient practice. All residents had the	11/28/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245329	A. BUILDING **02 - WARROAD CARE CENTER** B. WING _____	**10/29/2024**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 321	Continued From page 4 NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.3, 8.5.6.5 and 8.5.6.2. These deficient findings could have an isolated impact on the residents within the facility. Findings include: On 10/29/2024, between 9:30am and 12:30pm, it was revealed by observation that there was a penetration running from one smoke compartment to another above doors leading to Pine Island. An interview with Maintenance Director verified these deficient findings at the time of discovery.	K 321	potential to be affected by this deficient practice. Hazardous areas-enclosures we had a smoke penetration from 1 smoke compartment to another smoke compartment above the doors leading to our Pine Island Unit. The smoke penetration was fixed by our Maintenance Director with fire caulk on 10/29/2024. Maintenance Director or assigned staff will check all 6 fire doors immediately and then audit the 6 fire doors 1 time a year for smoke penetrations. The completion date is 11/28/2024.	
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor.	K 324		11/28/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245329	A. BUILDING **02 - WARROAD CARE CENTER** B. WING _____	**10/29/2024**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 324	Continued From page 5 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on documentation review and staff interview, the facility failed to test and inspect the kitchen hood ventilation and fire suppression system per NFPA 101 (2012 edition), Life Safety Code, section 9.2.3 and NFPA 96 (2011 edition), Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, section 11.2.1. This deficient finding could have an isolated impact on the residents within the facility. Findings Include: On 10/29/2024, between 9:30am and 12:30pm, it was revealed by a review of available documentation that inspection documentation for the kitchen hood ventilation and fire suppression system was not available. The facility could not provide completed test/inspection documentation for both of the semi-annual kitchen hood suppression system inspections for the last 12 months. An interview with Maintenance Director verified these deficient findings at the time of discovery.	K 324	No residents were affected by this deficient practice. All residents had the potential to be affected by this deficient practice. The kitchen hood ventilation and fire suppression inspection documentation of the semi-annual reports was completed and the information was sent to Maintenance Director on 10/30/2024. We contract with Northland Fire Protection and both our hoods were inspected on 1/12/24 and again on 08/13/24. Reviewed our contract to make sure we are scheduled for the following annual inspection on our kitchen hoods and fire suppression systems. This will be completed by our Maintenance Director. This was completed on 10/30/2024.	
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in	K 345		11/28/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245329	A. BUILDING **02 - WARROAD CARE CENTER** B. WING _____	**10/29/2024**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 345	Continued From page 6 accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation, staff interview, and observations, the facility failed to maintain the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, sections 9.6.1.3, 9.6.7.5, and NFPA 72 (2010 edition), National Fire Alarm and Signaling Code, sections 10.12.4, 14.3.1, 14.4.5.3, and 14.6.2.4. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 10/29/2024, between 9:30am and 12:30pm, it was revealed by a review of available documentation that the annual fire alarm inspection report produced by Northland Safety dated 04/03/2024 that the facility could not provide documentation that a sensitivity testing had been conducted. . An interview with Maintenance Director verified these deficient findings at the time of discovery.	K 345	No residents were affected by this deficient practice. All residents had the potential to be affected by this deficient practice. Documentation on the annual fire alarm inspection report didn't provide sensitivity testing. Maintenance Director reached out to Northland Fire Protection for the report and to ask for the sensitivity testing. Northland Fire Protection sent us an email stating the fire alarm control unit at our facility monitors for sensitivity levels and will cause a trouble signal at the control panel if a detector is out of sensitivity range. Maintenance Director or assigned staff will make sure our contracted inspection includes all that is needed to continue to remain in compliance by scheduling our inspections with Northland Fire Protection. This was completed on 10/29/2024.	
K 353 SS=D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection,	K 353		11/28/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245329	A. BUILDING **02 - WARROAD CARE CENTER** B. WING _____	**10/29/2024**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 353	Continued From page 7 Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain the automatic sprinkler system per NFPA 101 (2012 edition), Life Safety Code Section 19.7.6, and 4.6.12, NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 5.1.1.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 10/29/2024, between 9:30am and 12:30pm, it was revealed by a review of available documentation the facility failed to perform quarter sprinkler system testing. An interview with Maintenance Director verified these deficient findings at the time of discovery.	K 353	No residents were affected by this deficient practice. All residents had the potential to be affected by this deficient practice. Our sprinkler system maintenance and testing paperwork couldn't be found by our Maintenance Director. The Maintenance Director reached out to Dakota Fire Protection to see if it was completed and to send him copies of the inspection. Dakota Fire Protection was out to our facility on 8/12/24 and performed the inspection. Copies were put in the survey prep binder. Maintenance Director will make sure the report of inspection and testing will be put in the survey prep binder upon reciept. Maintenance Director will make sure our inspection and testing is scheduled and followed through with paperwork. This will be completed on 11/28/24.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245329	A. BUILDING **02 - WARROAD CARE CENTER** B. WING _____	**10/29/2024**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 363	Continued From page 8	K 363		
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire	K 363		11/28/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245329	A. BUILDING **02 - WARROAD CARE CENTER** B. WING _____	**10/29/2024**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 363	Continued From page 9 protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor doors per NFPA 101 (2012 edition), Life Safety Code, section 19.3.6.3.5. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 10/29/2024, between 9:30am and 12:30pm, it was revealed by observation that the resident room door A106 and B118 did not latch when tested. An interview with Maintenance Director verified these deficient findings at the time of discovery.	K 363	No residents were affected by this deficient practice. All residents had the potential to be affected by this deficient practice. Resident rooms A106 and B118 did not latch properly when tested. Both doors were fixed by the Maintenance Director on 10/29/2024. Maintenance Director or assigned staff will do weekly door checks on an audit form to make sure affected doors latch properly and will be entered in our TELS system. This will be completed on 11/28/2024.	
K 712 SS=D	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct	K 712	No residents were affected by this deficient practice. All residents had the	11/28/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245329	A. BUILDING **02 - WARROAD CARE CENTER** B. WING _____	**10/29/2024**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 712	Continued From page 10 fire drills under varied times and conditions per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.6, 4.7.4, and 4.6.1.1. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 10/29/2024, between 9:30am and 12:30pm, it was revealed by a review of available documentation that fire drills did not meet the standard of varying times and dates: Second Shift - 05/29/2024 @ 1700, 08/31/2024 @ 1800, First Shift - 04/30/2024 @ 1330, 07/30/2024 @ 1406. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 712	potential to be affected by this deficient practice. The Maintenance Director made a spreadsheet (attached) to ensure correct times for fire drills will be conducted according to the varying times and dates. The Maintenance Director or assigned staff will be in charge of reviewing the date for fire drill to make sure it is conducted at the right time for proper varying of drill times. This will be completed on 11/28/24.	