DEPARTMENT OF HEALTH AND	CENTERS FOR	
	MEDICARE/MEDICAID CERTIFICATI	ON AND TRANSMITTAL
	PART I - TO BE COMPLETED BY THE	STATE SURVEY AGENCY
1. MEDICARE/MEDICAID PROVIDER NO.	3. NAME AND ADDRESS OF FACILITY	
(L1) 245329	(L3) WARROAD CARE CENTER	
2.STATE VENDOR OR MEDICAID NO.	(L4) 1401 LAKE STREET NORTHW	EST

MEDICARE & MEDICAID SERVICES

					AND TRANSMITTAL	ID: VNT4 Facility ID: 00797
1. MEDICARE/MEDICAID PROVIDER NO. (L1) 245329 2.STATE VENDOR OR MEDICAID NO. (L2) 974840700	3. NAME AND AE (L3) WARROAD (L4) 1401 LAKE (L5) WARROAD	DRESS OF FACE CARE CENTE STREET NOR	ility E r	(L6) 56763	4. TYPE OF ACTION: 7 (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other	
5. EFFECTIVE DATE CHANGE OF OWNERSHIP 7. PROVIDER/ (L9) 01 Hospital		7. PROVIDER/SU 01 Hospital	PPLIER CATEGO 05 HHA	ORY 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	8. Full Survey After Complaint
6. DATE OF SURVEY 07/26/2018 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	(L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 09/30
11LTC PERIOD OF CERTIFICATION From (a): To (b):		Complian	nce With Requirements ce Based On:	S:	2. Technical Personnel 3. 24 Hour RN	he Following Requirements: 6. Scope of Services Limit 7. Medical Director
	49 (L18) 49 (L17)	B. Not in Co	Acceptable POC mpliance with Pro and/or Applied W	-	4. 7-Day RN (Rural SN 5. Life Safety Code * Code: A	F) 8. Patient Room Size 9. Beds/Room (L12)
14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 49	19 SNF	ICF	IID		15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)
(L37) (L38) 16. STATE SURVEY AGENCY REMARKS ((L39) IF APPLICABL	(L42) E SHOW LTC CANCI	(L43) ELLATION DATI	Ξ):		
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:
Lisa Carey, HFE - NE II			08/08//2018	(L19)	Joanne Simon, Enf	orcement Specialist 08/08/2018 (L20)
PART	TII - TO BE	E COMPLETED	BY HCFA R	EGIONAI	L OFFICE OR SINGLE ST	TATE AGENCY
 DETERMINATION OF ELIGIBILITY <u>X</u> 1. Facility is Eligible to Particip <u>2</u>. Facility is not Eligible 	ate		MPLIANCE WITH GHTS ACT:	I CIVIL		ncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513) o :
	(L21)					
22. ORIGINAL DATE 23. OF PARTICIPATION 08/01/1986 (L24)	LTC AGREEM BEGINNING (L41)		 LTC AGREEN ENDING DA' (L25) 		26. TERMINATION ACTION: VOLUNTARY 0 01-Merger, Closure 02-Dissatisfaction W/ Reimbursem	05-Fail to Meet Health/Safety
25. LTC EXTENSION DATE: 27. (L27)		VE SANCTIONS a of Admissions: pension Date:	(L44)		03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	n <u>OTHER</u> 07-Provider Status Change 00-Active
			(L45)			
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS	
(L28)	03001		(L31)		
31. RO RECEIPT OF CMS-1539		. DETERMINATION (07/26/2018	OF APPROVAL I	-		
(,	L32)			(L33)	DETERMINATION APPE	ROVAL



Protecting, Maintaining and Improvingthe Health of All Minnesotans

CMS Certification Number (CCN): 245329

August 8, 2018

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

Dear Mr. Bertilrud:

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

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

Effective July 31, 2018 the above facility is recommended for:

49 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 49 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

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

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 8, 2018

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

RE: Project Number H5329008 and S5329027

Dear Mr. Bertilrud:

On June 28, 2018, we informed you that the following enforcement remedies were being imposed:

- State Monitoring effective July 3, 2018. (42 CFR 488.422)
- Discretionary denial of payment for new Medicare and Medicaid admissions effective September 2, 2018. (42 CFR 488.417 (b))

In addition, the Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

• Civil money penalty (42 CFR 488.430 through 488.444)

Also, your were notified in our letter of June 28, 2018, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from June 14, 2018.

This was based on the deficiencies cited by this Department for an extended survey completed on June 14, 2018. The most serious deficiencies at the time of the revisit were found to be widespread deficiencies that constituted immediate jeopardy (Level L) whereby corrections were required.

We were able to verify, on June 13, 2018, that the conditions resulting in our notification of immediate jeopardy had been removed. Therefore, we notified the CMS Region V Office that the recommended remedy of termination of your facility's Medicare and Medicaid provider agreement not be imposed.

On July 26, 2018, the Minnesota Department of Health and Minnesota Department of Health, Office of Health Facility Complaints and on August 1, 2018 the Departement of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies

Warroad Care Center August 7, 2018 Page 2

issued pursuant to a PCR, completed on June 14, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 31, 2018. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on July 26, 2018, as of July 31, 2018. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective July 31, 2018.

In addition, this Department recommended to the CMS Region V Office the following actions related to the remedies outlined in our letter of June 28, 2018. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

• Discretionary denial of payment for new Medicare and Medicaid admissions, effective September 2, 2018, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective September 2, 2018, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective September 2, 2018, is to be rescinded.

In our letter of June 28, 2018, we advised you that, in accordance with 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 June 14, 2018. 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.

In addition, the Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

• Civil money penalty (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding the imposed remedies.

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

Feel free to contact me if you have questions.

Warroad Care Center August 7, 2018 Page 3 Sincerely,

6 >

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

cc: Licensing and Certification File



Protecting, Maintaining and Improvingthe Health of All Minnesotans

Electronically delivered

August 8, 2018

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

Re: Reinspection Results - Project Number S5329027 and H5329008

Dear Mr.. Bertilrud:

On July 26, 2018 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on July 26, 2018, with orders received by you on June 29, 2018. At this time these correction orders were found corrected.

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

Please feel free to call me with any questions.

Sincerely,

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

cc: Licensing and Certification File

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: VNT4

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

	PART I	- TO BE COMP	LETED BY T	THE STAT	TE SURVI	EY AGENCY		Facility ID: 00797
I. MEDICARE/MEDICAID PROVIDER NO. (L1) 245329 2.STATE VENDOR OR MEDICAID NO. (L2) 974840700 974840700	 3. NAME AND ADDRESS OF FACILITY (L3) WARROAD CARE CENTER (L4) 1401 LAKE STREET NORTHWEST (L5) WARROAD, MN (L6) 56763 			(L6) 56763	 TYPE OF ACTIC Initial Termination Validation 	 N: <u>2</u> (L8) 2. Recertification 4. CHOW 6. Complaint 		
5. EFFECTIVE DATE CHANGE OF OWNERS (L9)	SHIP	7. PROVIDER/SU 01 Hospital	,	ORY 09 ESRD	<u>02</u> 13 PTIP	(L7) 22 CLIA	7. On-Site Visit 8. Full Survey After	9. Other
 6. DATE OF SURVEY 06/14/2018 8. ACCREDITATION STATUS: 0 Unaccredited 2 AOA 1 TJC 3 Other 	(L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPI	CE	FISCAL YEAR ENDIN 09/30	NG DATE: (L35)
·	49 (L18) 49 (L17) 19 SNF (L39)	Complian 1	ance With Requirements ce Based On: Acceptable POC	gram	2. 3. 4. 5. * Code: 15. FACII	Approved Waivers Of The Technical Personnel 24 Hour RN 7-Day RN (Rural SNF Life Safety Code B* LITY MEETS (1) or 1861 (j) (1):	E Following Requirements: 6. Scope of S 7. Medical Di 8. Patient Roc 9. Beds/Roon (L12) (L15)	ervices Limit rector om Size
16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE): 17. SURVEYOR SIGNATURE Lisa Carey, HFE NE II 07/12/2018				E): (L19)	18. STATE SURVEY AGENCY APPROVAL Date: Douglas Larson, Enforcement Specialist 07/25/2018			
PART	II - TO BE	COMPLETED	BY HCFA R		(L20) L OFFICE OR SINGLE STATE AGENCY			
19. DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Participa 2. Facility is not Eligible		20. COM	MPLIANCE WITH GHTS ACT:		21.	1. Statement of Finan	cial Solvency (HCFA-257) Interest Disclosure Stmt (
OF PARTICIPATION 08/01/1986 (L24)	A. Suspension	DATE VE SANCTIONS a of Admissions:	4. LTC AGREEN ENDING DAT (L25) (L44)		<u>VOLUNTA</u> 01-Merger, 02-Dissatist 03-Risk of 1		nt 06-Fail to <u>OTHER</u>	Meet Health/Safety Meet Agreement er Status Change
	B. Rescind Sus	pension Date:	(L45)					
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMA	RKS		
()	L28)	03001		(L31)				
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	OF APPROVAL D	DATE				
(I	_32)			(L33)	DETERM	MINATION APPR	OVAL	



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Submitted June 28, 2018

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

RE: Project Number S5329027 and H5329008 Dear Mr. Bertilrud:

On April 24, 2018, an abbreviated standard survey was completed at your facility by the Minnesota Department of Health, Office of Health Facility Complaints 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 isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D). In addition, at the time of the June 14, 2018 abbreviated standard survey the Minnesota Department of Health, Office of Health Facility Complaints completed an investigation of complaint number H5329008.

On June 14, 2018, an extended survey was completed at your facility by the Minnesota Department of Health and on June 12, 2018, 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.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted immediate jeopardy (Level L) as evidence by the electronically attached CMS-2567, whereby corrections are required.

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

<u>Removal of Immediate Jeopardy</u> - date the Minnesota Department of Health verified that the conditions resulting in our notification of immediate jeopardy have been removed;

<u>No Opportunity to Correct</u> - the facility will have remedies imposed immediately after a determination of noncompliance has been made;

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);

<u>Substandard Quality of Care</u> - means one or more deficiencies related to participation requirements under 42 CFR § 483.13, resident behavior and facility practices, 42 CFR § 483.15, quality of life, or 42 CFR § 483.25, quality of care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm;

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

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

Appeal Rights – the facility rights to appeal imposed remedies; and

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

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

REMOVAL OF IMMEDIATE JEOPARDY

We also verified, on June 13, 2018, that the conditions resulting in our notification of immediate jeopardy have been removed. Therefore, we will notify the CMS Region V Office that the recommended remedy of termination of your facility's Medicare and Medicaid provider agreement not be imposed.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F" tag) and emergency preparedness deficiencies (those preceded by an "E" tag), i.e., the plan of correction from the extended survey completed on June 14, 2018 should be directed to:

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

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F" tag), i.e., the plan of correction from the abbreviated standard survey completed on April 24, 2018 should be directed to:

Annette Winters, Supervisor Office of Health Facility Complaints Health Regulation Division Minnesota Department of Health P.O. Box 64970 Saint Paul, Minnesota 55164-0970 Email: annette.m.winters@state.mn.us Phone: (651) 201-4204 Fax: (651) 281-9796

NO OPPORTUNITY TO CORRECT - REMEDIES

CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when immediate jeopardy has been identified. Your facility meets this criterion. Therefore, this Department is imposing the following remedy:

• State Monitoring effective July 3, 2018. (42 CFR 488.422)

The Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition. The CMS Region V Office 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 § 488.41(a), effective September 2, 2018.

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective September 2, 2018. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective September 2, 2018.

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.

Further, Federal law, as specified in the Act at Sections 1819(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 a denial of payment. Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for

two years effective June 14, 2018. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, 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.

In addition, the Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

• Civil money penalty (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding our recommendations and your appeal rights.

APPEAL RIGHTS

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:

Tamika.Brown@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) 565-9462

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 Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at <u>Tamika.Brown@cms.hhs.gov.</u>

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In

order for your allegation of compliance to be acceptable to the Department, the PoC 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 revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. 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 September 2, 2018, the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by October 24, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

> Nursing Home Informal Dispute Process Minnesota Department of Health Health Regulation Division

> P.O. Box 64900 St. Paul, Minnesota 55164-0900

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

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor Health Care Fire Inspections Minnesota Department of Public Safety State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, Minnesota 55101-5145

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

Feel free to contact me if you have questions.

Sincerely,

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

cc: Licensing and Certification File

		AND HUMAN SERVICES & MEDICAID SERVICES				-	APPROVED
STATEMENT OF D AND PLAN OF CO	EFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		E CONSTRUCTION	(X3) DAT	0938-0391 E SURVEY PLETED
		245329	B. WING			06/	14/2018
NAME OF PROV	IDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	-	
WARROAD C	ARE CENTER				401 LAKE STREET NORTHWEST VARROAD, MN 56763		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
E 000 Initi	al Comments		EC	000			
Pre Jun rec con Pre E 009 Loc SS=C CFI [(a) anc tha ann (4) coll Feo to r disa	paredness Requ le 11, 12, 13, & ertification surve npliance with the paredness Requ cal, State, Tribal R(s): 483.73(a)(4 Emergency Pla d maintain an em t must be review hually. The plan in lnclude a process aboration with lo deral emergency naintain an integraster or emerger	Collaboration Process	EC	009			7/8/18
suc par	h officials and, v	when applicable, of its aborative and cooperative					
Inc coll Fec to r disa doc cor par plan the leas of t	lude a process for aboration with lo deral emergency naintain an integ aster or emergen cumentation of the tact such officia ticipation in colla nning efforts. The local emergency st annually to co he dialysis facilit	es only at §494.62(a)(4)]: (4) or cooperation and ocal, tribal, regional, State, and or preparedness officials' efforts grated response during a ney situation, including ne dialysis facility's efforts to ls and, when applicable, of its aborative and cooperative e dialysis facility must contact y preparedness agency at nfirm that the agency is aware y's needs in the event of an	IATUDE		TITLE		(X6) DATE
Electronical		LIVOUFFLILIN NEFREGENTATIVE S SIGI			IIILE		07/08/2018

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 07/13/2018

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	07/13/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED	
		245329	B. WING _		06/1	4/2018
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
WARROA	AD CARE CENTER			1401 LAKE STREET NORTHWEST WARROAD, MN 56763		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
E 009	by: Based on interview facility failed to inclu and collaboration w and federal emerge efforts to maintain a a disaster or emerge documentation of th such officials and, w participation in colla planning efforts in th the potential to affect the facility. Findings include: A facility document, Program Description with its complement various revision dat preparedness plan process for collabor preparedness plan process official during a disaster or including document contact such official participation in colla planning efforts in th During interview on director of nursing a and safety, stated th care coalition, and h	ge 1 NT is not met as evidenced and document review, the ude a process for cooperation ith local, tribal, regional, state, ency preparedness officials' an integrated response during ency situation, including he facility's efforts to contact when applicable, of its aborative and cooperative heir emergency plan. This had ct all 47 current residents in Emergency Management n, revised 10/19/17, together tary policies/procedures with es, as the facility's emergency (EPP) did not identify any ration with tribal, emergency als. There were no efforts n an integrated response emergency situation, ation of the facility's efforts to ls, when applicable, of its aborative and cooperative heir emergency plan. 6/14/18, at 12:15 p.m., the and maintenance of the facility he facility was part of a health had no contact with tribal. s-Volunteers and Staffing	E 00	 Tribal officials were contacted I Director of Maintenance for their awareness and involvement in coordination of our emergency plann procedures. Our emergency plan was updat reference and include the coordination with tribal authority and we will maint an ongoing discussion with them in or routine planning and updating of mat and emergency preparedness procedures. 	hing ted to on tain bur terials	7/13/18
	Policies/Procedures CFR(s): 483.73(b)(6	Ũ	E 02	24		//13/18

If continuation sheet Page 2 of 73

		AND HUMAN SERVICES & MEDICAID SERVICES			FC	ORM A	07/13/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	```			3) DATE	SURVEY PLETED
		245329	B. WING			06/1	4/2018
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
WARRO	AD CARE CENTER				01 LAKE STREET NORTHWEST ARROAD, MN 56763		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE
E 024		ocedures. The [facilities] must	EO	24			
	policies and proceed plan set forth in par assessment at para and the communica this section. The por reviewed and updat	nent emergency preparedness ures, based on the emergency agraph (a) of this section, risk agraph (a)(1) of this section, ation plan at paragraph (c) of blicies and procedures must be ted at least annually. At a es and procedures must ng:]					
	volunteers in an em staffing strategies, i for integration of St) as noted above] The use of hergency or other emergency including the process and role ate and Federally designated ionals to address surge needs cy.					
	procedures. (6) The emergency and oth strategies to addres emergency. This REQUIREMEN by: Based on document facility failed to develop preparedness plan addressing the scree who may be used in	03.748(b):] Policies and e use of volunteers in an er emergency staffing as surge needs during an NT is not met as evidenced nt review and interview, the elop in its emergency (EPP) policies and procedures eening and use of volunteers n emergency staffing the potential to affect all 47 the facility.			Emergency Management Program revisions were completed by the Direct of Nursing and the Director of Maintenance to include consideration f using and screening volunteers who m aide the facility in efforts surrounding a emergency situation. Program guidelin will continue to be reviewed and revise on an ongoing basis to consider opportunities to use volunteers in a sati	for nay an ines ed	
		Emergency Management n, revised 10/19/17, together			and effective manner.		

Facility ID: 00797

If continuation sheet Page 3 of 73

		AND HUMAN SERVICES				FORM	07/13/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í			(X3) DATE	E SURVEY PLETED
		245329	B. WING	i		06/ [,]	14/2018
NAME OF F	PROVIDER OR SUPPLIER			ę	STREET ADDRESS, CITY, STATE, ZIP CODE		
WARRO	AD CARE CENTER				1401 LAKE STREET NORTHWEST WARROAD, MN 56763		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
E 024 E 025 SS=C	with its complement various revision dat facility would screent emergency as part During interview on director of nursing a the facility and safe procedures, did not screening volunteent an emergency situal stated the use of vot an emergency plan Arrangement with O CFR(s): 483.73(b)(1) [(b) Policies and pro- develop and implent policies and proced plan set forth in part assessment at part and the communicat this section. The polici address the followint *[For Hospices at § §441.184,(b) Hospin Facilities at §483.73 (7) [or (5)] The develop patients in the event operations to maint to facility patients. *[For PACE at §460	tary policies/procedures with tes, did not identify how the n and use volunteers in an of the facility's EPP. 6/14/18, at 12:15 p.m., the and maintenance manager of ty stated the policies and include anything about rs who may be helping out in ation. The director of nurses olunteers were not included in Other Facilities 7) ocedures. The [facilities] must nent emergency preparedness lures, based on the emergency ragraph (a) of this section, risk agraph (a)(1) of this section, ation plan at paragraph (c) of olicies and procedures must be ted at least annually. At a ies and procedures must ng:] 418.113(b), PRFTs at tals at §482.15(b), and LTC 3(b):] Policies and procedures. elopment of arrangements with d] other providers to receive at of limitations or cessation of ain the continuity of services	EC				7/3/18

Facility ID: 00797

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	07/13/2018 APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES OF CORRECTION	DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE			E CONSTRUCTION	(X3) DATE	3) DATE SURVEY COMPLETED	
		245329	B. WING			06/1	4/2018	
NAME OF PROVIDER OR SUPPLIER				S	TREET ADDRESS, CITY, STATE, ZIP CODE			
WARRO	AD CARE CENTER				401 LAKE STREET NORTHWEST /ARROAD, MN 56763			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
E 025	§485.920(b) and ES Policies and proced development of arra [facilities] [or] other in the event of limita operations to mainta to facility patients. *[For RNHCIs at §4 procedures. (7) The arrangements with oproviders to receive limitations or cessar the continuity of nor patients. This REQUIREMEN by: Based on interview facility failed to deve agreements, which contracted arranger receive residents in cessation of operation of services to facility potential to affect al facility. Findings include: On 6/14/18, at 12:1. Preparedness Plan director of nurses a The director of nurses have any arrangem receive residents in The director of nurses	SRD Facilities at §494.62(b):] ures. (7) [or (6), (8)] The angements with other providers to receive patients ations or cessation of ain the continuity of services 03.748(b):] Policies and e development of other RNHCIs and other patients in the event of tion of operations to maintain n-medical services to RNHCI NT is not met as evidenced and document review, the elop prearrangements transfer include written agreements or ments with other facilities to the event of limitations or ons to maintain the continuity y residents. This had the I 47 residents residing in the 5 p.m. the facility's Emergency was reviewed with the nd maintenance manager. es indicated the facility did not ents with other facilities to the event of an emergency. es stated the administrator sations with other facilities, but	EC	025	Executive Director contacted LifeC Medical Center upon notification of deficient practice. Director has sec an agreement with LifeCare Medica Center dated 07-03-2018. The agreement includes language for m support in the event of situations re- additional resources for continued s operations. The agreement also sp that transfers and temporary housin be a part of that assistance.	the ured al utual quiring safe becifies		

Facility ID: 00797

If continuation sheet Page 5 of 73

		AND HUMAN SERVICES				FORM	07/13/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´			(X3) DAT	E SURVEY PLETED
		245329	B. WING			06/	14/2018
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
WARRO	AD CARE CENTER				401 LAKE STREET NORTHWEST /ARROAD, MN 56763		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	¢	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 000 F 000	Continued From pa	5	F 0 F 0				
	survey was comple Minnesota Departm your facility was in o of 42 CFR Part 483 Requirements for L	8 & 14, 2018, a standard ted at your facility by the nent of Health to determine if compliance with requirements 8, Subpart B, and ong Term Care Facilities. The an Immediate Jeopardy (IJ) at					
	related to the impro to prevent and/or re illness. The IJ was	F812 on 6/11/18, at 8:26 p.m. oper cooling of foods in order educe the risk of food borne removed on 6/13/18, at 11:08 on of a removal plan.					
	allegation of compli enrolled in the elect (ePOC), a signatur	ion will serve as your facility's iance. Since your facility is tronic Plan of Correction re is not required at the bottom the CMS-2567 form.					
F 565 SS=E	revisit of your facilit that substantial con has been attained in verification. Resident/Family Gr		F 5	65			7/24/18
	and participate in re (i) The facility must group, if one exists reasonable steps, v to make residents a	esident has a right to organize esident groups in the facility. provide a resident or family , with private space; and take with the approval of the group, and family members aware of s in a timely manner.					

Facility ID: 00797

If continuation sheet Page 6 of 73

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	07/13/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE	E SURVEY PLETED
		245329	B. WING			06/*	14/2018
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
WARRO	AD CARE CENTER				01 LAKE STREET NORTHWEST ARROAD, MN 56763		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 565	 (ii) Staff, visitors, or resident group or fathe respective group (iii) The facility musperson who is approgroup and the facility musperson concerning in the facility. (A) The facility musperson and ration (B) This should not facility must impleming request of the resident of the resident of the resident in family §483.10(f)(6) The response and ration (S) This REQUIREMENT is REQUIREMENT by: Based on interview facility failed to addiconcerns related to and quality, during a council meeting with the set of the resident of the resident	 other guests may attend unily group meetings only at p's invitation. t provide a designated staff oved by the resident or family ty and who is responsible for e and responding to written from group meetings. t consider the views of a roup and act promptly upon recommendations of such issues of resident care and life t be able to demonstrate their hale for such response. be construed to mean that the nent as recommended every ent or family group. esident has a right to groups. esident has a right to have r other resident uset in the facility with the representative(s) of other lity. NT is not met as evidenced v and document review, the ress the resident council's food temperature, quantity a survey initiated resident h 8 of 15 residents (R36, R40, , R41 and R8) active members 	F 5	65	 The Dining Service Director spot each resident about their specific concerns and their specific preferer for food temperature and type. The residents will also be a part of follow auditing procedures. The facility established a resident for group and held an initial meeting to discuss the ongoing function of the 	nces ese v up pod	

Event ID: VNT411

Facility ID: 00797

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	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE CONSTRUCTION	OMB NO. (X3) DATE	E SURVEY	
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG	COM	PLETED	
		245329	B. WING		06/*	14/2018	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	IP CODE		
WARRO	AD CARE CENTER			1401 LAKE STREET NORTHWES WARROAD, MN 56763	ST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE	(X5) COMPLETIOI DATE	
F 565	Continued From pa	ge 7	F 5	65			
	On 6/12/18, at 3:55 resident council (R4 survey team to revia resident council me Review of Resident to 6/2018 revealed -8/7/17: Still having warm enough and t menu items was no -9/11/17: Still have warm enough. A sta ordered some parts -10/2/17: Food was crispy (shrimp and have buns heated f might stay warm lor -11/6/17: Food was Requests were mad and for soup to be of alternate choice for -12/4/17: A resident food could be warm -1/8/18: Food could was requested. -2/5/18: Too many r -3/12/18: They were alternative menu ite -4/9/18: Better -5/7/18: Dietary nee cold food, and som hard to chew. There cucumbers, as the There was no toast -6/11/18: There wer temperature of the	 p.m., a co-chair of the 43) gave permission for the ew previous minutes of betings. council minutes from 8/2017 the following: a problem with food not being he quantity of alternative t enough. a problem with food not being aff person came and said they a for the steam tables. cool, cafe choices could be fries). There was a request to or hamburgers so that they nger. cool on the Angle unit. de for more variety in salads offered more often as the the evening meal. from the BB unit said the for the BB unit said the for the menu. e running out of certain ems. 	ΓJ	 and desired outcomes. now met for a second tim on an ongoing basis in a week intervals until it is of the food concerns have I that time frequency may group may be discontinue resident interest. The Co then be reinstated in the the request of the Counce suggestion of manageme dining service satisfactio 2. The facility has create Council policy and a Cou form that will be used to resident concerns and fa These items will become all Council meetings and documented in the meet 07/05/2018 3. The facility Activity Dir with the Council to make concerns are accurately the minutes and via the A She will serve as the liais Council and any departm that needs to respond to either in writing or in pers of follow up and closure. continue to facilitate until satisfactorily resolved. S communicate with the ac necessary to seek assist matters that are either un are recurring in nature. 	he and will meet pproximately 2 letermined that been resolved. At be altered or the ed based on ommittee may future at either cil or the ent based on n. ed a Resident incil Action Plan document incility responses. a regular part of will be ing minutes. rector will work sure that their documented in Action Forms. Son between the hent or individual an Action Plan son as a method She will the matter is she will dministrator as ance with any		

Facility ID: 00797

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DEPARTMENT OF HEALTH A CENTERS FOR MEDICARE &					FORM	07/13/2018 APPROVED 0938-0391		
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED			
	245329	B. WING			06/14/2018			
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE						
WARROAD CARE CENTER				01 LAKE STREET NORTHWEST ARROAD, MN 56763				
PREFIX (EACH DEFICIENCY M	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE		
 never goodthey are There was no eviden concerns listed in the were available for rev On 6/13/18 at 12:30 meeting was held an attended: R36, R40, R8. At the resident cound had concerns about some was not cooke when he has asked f hash browns", the state enough. On 6/13/18, at 1:33 p (AD) stated she take council meetings and the meeting. The AD administrator and ap that are raised and the know what they say. log or written docume concerns raised at th confirmed there was of follow-up to the restated she feels for the was doing the best the concerns, stating for the stated she feels for the meeting there had not been groncerns, stating for the meeting there had not been groncerns, stating for the meeting the meeting the meeting there had not been groncerns, stating for the meeting there had not been groncerns, stating for the meeting there had not been groncerns, stating for the meeting the	enu and the french fries were e cold or soggy. Ince of follow-up to the e minutes. No action forms view. p.m., a resident council to the following residents R26, R6, R34, R38, R41 and cil meeting, R36 stated he the quality of the food, as ed through. R36 also stated for "two eggs over easy and	F 5	65	out each week on resident meal satisfaction under the direction of th Director of Dining Services. They we conducted in a random dining room random meal times as chosen by th Director. Sampling will be reviewed make sure we are covering all dinin rooms and each of the three main of times. Audits will be reported to the Committee and at QAPI meetings of goal of 85% appropriate responses for 2 consecutive months. At that the Committee will change audit freque and number until they are comforta that the problem has been resolved ongoing basis. Food temperatures will be logged of time of service. Weekly audits will conducted by kitchen manager and reports at QAPI meetings.	vill be and at ne d to ng meal e Food until is met me the ency ble I on an aily at be will be art of ence ular			

If continuation sheet Page 9 of 73

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	07/13/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				E SURVEY IPLETED
		245329	B. WING			06/14/2018	
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
WARRO	AD CARE CENTER				1401 LAKE STREET NORTHWEST NARROAD, MN 56763		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 565 F 572 SS=F	kitchen leadership a stated at the May (2 talked about starting would meet more fr resident council me reviewed the minute discussion of a food minutes. The admir are correct with the Review of the Coml Rights revised Nove 5. The resident has participate in reside D. The facility must resident or family gi the grievances and groups concerning in the facility. a. The facility must response and ration Notice of Rights and CFR(s): 483.10(g)(1 §483.10(g)(16) The responsibilities durin facility. §483.10(g)(16) The of rights and service upon admission and (i) The facility must	and staff. The administrator 2018) resident council they g a resident food group that equently, than the monthly eting. The administrator es and confirmed that d group was not evident in the histrator stated the residents ir food concerns. bined Federal and State Bill of ember 2016 included: a right to organize and ant groups in the facility. consider the views of a roup and act promptly upon recommendations of such issues of resident care and life be able to demonstrate their hal for such response. d Rules		565			7/13/18

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	OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION		0938-039 SURVEY	
ND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G	СОМ	PLETED	
		245329	B. WING _		06/14/2018		
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00.		
WARRO	AD CARE CENTER			1401 LAKE STREET NORTHWEST WARROAD, MN 56763			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 572	Continued From pa	ae 10	F 57	2			
	understands of his regulations governi responsibilities duri (ii) The facility must the State-developer obligations, if any. (iii) Receipt of such amendments to it, r writing; This REQUIREMEN by: Based on interview facility failed to give resident rights to ac the potential to affer the facility. Findings include: Review of the facilit to new admissions of resident rights da current Bill of Rights On 6/14/18, at 8:44 designee (SSD) co the Bill of Rights we admission. The SSD indicated Combined Federal Rights dated 11/28/ resident at one time update. This rights available at the info	or her rights and all rules and ng resident conduct and ng the stay in the facility. t also provide the resident with d notice of Medicaid rights and information, and any must be acknowledged in NT is not met as evidenced and document review, the the correct version of dmitting residents. This had ct all 47 residents residing in ty's Resident Handbook given revealed it contained a version ated 7/1/07 and not the most		 Facility, through the Social Ser Designee identified all residents th not received updated Bill of Rights information. Updated Bill of Rights documents are being provided to a discussed with all residents admitt the distribution of the updated righ booklets and acknowledgements v recorded. This will be completed I 07/13/18. The Resident Handbook and th admission packet have been upda include the most current version o of Rights. 06/14/2018. This updat material will be shared with all new admissions and acknowledgemen same will be kept with resident records. A Residents Rights policy has the updated/created and will serve as guide in sharing, distributing and communicating this information or ongoing basis. 06/27/2018 	at had and ed after ts vill be by e ted to f the Bill ed y t of the ords. been the		
	However, the SSD not provided to resi	confirmed the booklets were dents on admission. Rather, sion are getting the rights		 The Social Service Designee s maintain records and acknowledge of proper distribution of Residents 	ement		

Facility ID: 00797

		(X1) PROVIDER/SUPPLIER/CLIA		PLE CONSTRUCTION		0938-039 E SURVEY
ND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	<u> </u>		IFLEIEU
		245329	B. WING		06/	14/2018
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
WARRO	AD CARE CENTER			1401 LAKE STREET NORTHWEST WARROAD, MN 56763		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETIC DATE
F 572	Continued From pa	ige 11	F 572	2		
	dated 2007.	0		upon admission. In addition she	e will	
		a.m., the administrator s were getting an old version of ssion.		assure proper postings in the but that education will be provided to Resident Council annually and documented in the minutes of the	o the	
	residents received	that indicated the date the new rights booklet was eceived from the facility.		meetings. Designee will also me ongoing compliance and report facility QAPI Committee on an o basis. Reports will be for a mini months and will then be adjusted	to the ngoing mum of 3	
F 623	requested but not r	n of resident rights was eceived from the facility. Its Before Transfer/Discharge	F 623	frequency based on compliance		7/13/18
SS=D	CFR(s): 483.15(c)(3)-(6)(8)				
	resident, the facility (i) Notify the resider representative(s) of the reasons for the language and many facility must send a representative of th Long-Term Care Or (ii) Record the reas discharge in the res accordance with pa and	nsfers or discharges a must- nt and the resident's f the transfer or discharge and move in writing and in a mer they understand. The copy of the notice to a the Office of the State mbudsman. tons for the transfer or sident's medical record in aragraph (c)(2) of this section;				
	paragraph (c)(5) of §483.15(c)(4) Timir (i) Except as specif (c)(8) of this section discharge required	ng of the notice. ied in paragraphs (c)(4)(ii) and n, the notice of transfer or under this section must be at least 30 days before the				

		AND HUMAN SERVICES				FORM	07/13/2018 APPROVED 0938-0391		
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED		
		245329	B. WING			06/1	14/2018		
NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE				
WARRO	AD CARE CENTER		1401 LAKE STREET NORTHWEST WARROAD, MN 56763						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE		
F 623	 (ii) Notice must be r before transfer or d (A) The safety of in- be endangered und this section; (B) The health of in- be endangered, und this section; (C) The resident's h allow a more immed under paragraph (c (D) An immediate tr required by the resi- under paragraph (c (E) An immediate tr required by the resi- under paragraph (c (E) A resident has r days. §483.15(c)(5) Conte- notice specified in p- must include the fol- (i) The reason for t (ii) The effective dar (iii) The location to transferred or disch (iv) A statement of t including the name, and telephone num receives such reque to obtain an appeal completing the form hearing request; (v) The name, addr telephone number of Long-Term Care Or (vi) For nursing faci and developmental disabilities, the mail 	made as soon as practicable ischarge when- dividuals in the facility would der paragraph (c)(1)(i)(C) of dividuals in the facility would der paragraph (c)(1)(i)(D) of nealth improves sufficiently to diate transfer or discharge, ()(1)(i)(B) of this section; ransfer or discharge is dent's urgent medical needs, ()(1)(i)(A) of this section; or not resided in the facility for 30 ents of the notice. The written baragraph (c)(3) of this section llowing: transfer or discharge; te of transfer or discharge; which the resident is narged; the resident's appeal rights, , address (mailing and email), ber of the entity which ests; and information on how form and assistance in n and submitting the appeal ress (mailing and email) and of the Office of the State	F	523	3				

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	07/13/2018 APPROVED 0938-0391		
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í			(X3) DATE	E SURVEY PLETED		
		245329	B. WING	i		06/1	4/2018		
NAME OF	PROVIDER OR SUPPLIER		1	S	TREET ADDRESS, CITY, STATE, ZIP CODE				
WARRO	AD CARE CENTER			1401 LAKE STREET NORTHWEST WARROAD, MN 56763					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE		
F 623	the protection and a developmental disa C of the Developmental and Bill of Rights Ac codified at 42 U.S.C (vii) For nursing fac disorder or related email address and agency responsible advocacy of individ established under t for Mentally III Indiv §483.15(c)(6) Char If the information in effecting the transfer must update the red as practicable once becomes available. §483.15(c)(8) Notic In the case of facilit the administrator of written notification p to the State Survey State Long-Term C the facility, and the well as the plan for relocation of the res 483.70(I). This REQUIREMEN by: Based on interview facility failed to notification of	advocacy of individuals with bilities established under Part ental Disabilities Assistance ct of 2000 (Pub. L. 106-402, C. 15001 et seq.); and ility residents with a mental disabilities, the mailing and telephone number of the for the protection and uals with a mental disorder he Protection and Advocacy iduals Act. ges to the notice. the notice changes prior to er or discharge, the facility cipients of the notice as soon the updated information e in advance of facility closure y closure, the individual who is the facility must provide prior to the impending closure Agency, the Office of the are Ombudsman, residents of resident representatives, as the transfer and adequate sidents, as required at § NT is not met as evidenced and document review, the fy the ombudsman of a 2 of 2 residents (R20, R31)	F	623	 Facility has notified the ombuds the missing hospital transfers for R2 R31. 07/11/2018. Facility has created an updated of Discharge Policy, 06/25/2018 to it the use of a monthly tracking sheet 	20 and Notice include			

Event ID: VNT411

Facility ID: 00797

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		AND HUMAN SERVICES				FORM	07/13/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	```			(X3) DATE SURVEY COMPLETED	
		245329	B. WING			06/14/2018	
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
WARRO	AD CARE CENTER				401 LAKE STREET NORTHWEST VARROAD, MN 56763		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 623	R20's Admission Reindicated R20 had of Alzheimer's disease of the digestive track (C-Diff, an infection failure, functional up and gout. R20's progress note had 5 large loose si confused than usua R20's condition and received to transfer family member was R20's Census List of hospital leave from R20's Physician Dis 5/17/18, indicated F worsening generalized dehydration. R20 had was receiving of R20's progress note returned to the facil Review of R20's redombudsman was metransfer. R31's progress note for the physician gave a te physician gave a te for the p	ecord, dated 6/13/18, diagnoses that included e, enterocolitis (inflammation et) due to clostridium difficile of the colon), acute kidney rinary incontinence, diabetes, e dated 5/13/18, indicated R20 tools, was lethargic and more al; the physician was notified of d a telephone order was r R20 to the hospital. R20's e notified of the hospitalization. dated 6/14/18, indicated a 5/13/18 to 5/17/18. scharge Summary dated R20 was hospitalized due to zed weakness and ad been diagnosed with C-Diff oral antibiotics. e dated 5/17/18, indicated he ity at 2:10 p.m. cord does not reflect the otified of the facility-initiated es dated 5/12/18, indicated eeling well and was short of notified of R31's change of ated R31 should go to the Progress note then indicated notified of R31's condition; the lephone order to transfer R31 urther evaluation. R31 was	F	523	record all required notices to the Ombudsman. Social Service Design will complete the log and send it to th Ombudsman as required and not lat than monthly as a summary of the required notice. 3. Social Service Designee will audi records not less than monthly to ass the appropriate distribution and acknowledgement of discharge notice 4. Social Service Designee will mon compliance and report monthly resul the facility QAPI Committee. Social Service Designee will also coordinat other departments in the event of fai to comply with required notices and frames to develop an system change that are necessary to meet complian expectations. Monitoring will continu- the Social Service Designee until the are 3 successive months of complian and will be reevaluated at that time.	he ter it sure ces. hitor lts to te with ilure time es nce ue by ere ince	

					FORM	07/13/2018 APPROVED 0938-0391
OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	245329	B. WING			06/	14/2018
PROVIDER OR SUPPLIER						
AD CARE CENTER						
(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	ID PREFIZ TAG	x	(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION DATE
Continued From page	ge 15	F 6	623			
(SSD) stated notific not been completed transferred to the he	ations to the ombudsman had for residents whom were ospital and had not been					
Documentation date discharge forms muthe the State Ombudsm not specifically addr related to emergence Notice of Bed Hold	ed 4/1/17, included: 4) All ust be faxed to the Office of nan for review. The policy did ress Ombudsman notification cy hospitalization transfers. Policy Before/Upon Trnsfr	F 6	625			7/13/18
§483.15(d) Notice c	of bed-hold policy and return-					
nursing facility trans the resident goes of nursing facility must the resident or resid specifies- (i) The duration of th any, during which the return and resume to facility; (ii) The reserve bed plan, under § 447.4	sfers a resident to a hospital or n therapeutic leave, the t provide written information to dent representative that he state bed-hold policy, if he resident is permitted to residence in the nursing d payment policy in the state 0 of this chapter, if any;					
	RS FOR MEDICARE OF DEFICIENCIES F CORRECTION PROVIDER OR SUPPLIER AD CARE CENTER SUMMARY STA (EACH DEFICIENCY REGULATORY OR LS Continued From pa R31's progress note had returned to the p.m. R31's record does r was notified of the f On 6/12/18, at 4:13 (SSD) stated notific not been completed transferred to the he aware of the required Facility policy Trans Documentation date discharge forms mut the State Ombudsm not specifically addur related to emergend Notice of Bed Hold CFR(s): 483.15(d)(1) Notice nursing facility trans the resident or resident specifies- (i) The duration of the any, during which the return and resume facility; (ii) The reserve bed plan, under § 447.4	IDENTIFICATION NUMBER: 245329 PROVIDER OR SUPPLIER AD CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 15 R31's progress note dated 5/14/18, indicated R31 had returned to the facility at approximately 3:10 p.m. R31's record does not reflect the ombudsman was notified of the facility-initiated transfer. On 6/12/18, at 4:13 p.m. social services designee (SSD) stated notifications to the ombudsman had not been completed for residents whom were transferred to the hospital and had not been aware of the requirement. Facility policy Transfer or Discharge Documentation dated 4/1/17, included: 4) All discharge forms must be faxed to the Office of the State Ombudsman for review. The policy did not specifically address Ombudsman notification related to emergency hospitalization transfers. Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing	RS FOR MEDICARE & MEDICAID SERVICES IOF DEFICIENCIES FORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MUL A. BUILD 245329 B. WING PROVIDER OR SUPPLIER 245329 AD CARE CENTER ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID Continued From page 15 F 6 R31's progress note dated 5/14/18, indicated R31 had returned to the facility at approximately 3:10 p.m. F 6 R31's record does not reflect the ombudsman was notified of the facility-initiated transfer. On 6/12/18, at 4:13 p.m. social services designee (SSD) stated notifications to the ombudsman had not been completed for residents whom were transferred to the hospital and had not been aware of the requirement. F 60 Facility policy Transfer or Discharge Documentation dated 4/1/17, included: 4) All discharge forms must be faxed to the Office of the State Ombudsman for review. The policy did not specifically address Ombudsman notification related to emergency hospitalization transfers. F 60 Vitex of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) F 60 §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing fac	RS FOR MEDICARE & MEDICAID SERVICES OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPL A. BUILDING. 245329 B. WING	IMENT OF HEALTH AND HUMAN SERVICES OI SFOR MEDICARE & MEDICAID SERVICES OI OP DEFICIENCIES (X1) PROVIDERSUPPLERICLIA DENTIFICATION NUMBER (X2) MULTIPLE CONSTRUCTION A BUILDING AD CARE CENTER 245329 B. WING ND CARE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE MOLARE OPENDERY MAY STATEMENT OF DEFICIENCIES (EACH DERIVENCY OR LSC IDENTIFING INFORMATION) ID PROVIDER SPLAN OF CORRECTION (EACH DERIVENCY ON LSC IDENTIFING INFORMATION) SUMMARY STATEMENT OF DEFICIENCIES ID (EACH CORRECTIVE ACTION SHOULD (EACH DERIVENCY AND THE PRECEDED BY FULL REGULATORY OR LSC IDENTIFING INFORMATION) ID PREFIX TAG PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD (CROSS-REFERENCED TO THE APPROPH DEFICIENCY) Continued From page 15 F 623 F 623 R31's progress note dated 5/14/18, indicated R31 had returned to the facility-initiated transfer. F 623 Continued From page 15 F 623 R31's record does not reflect the ombudsman was notified of the facility-initiated transfer. F 625 Colly State of the Propicitation transfers. F 625 Documentation dated 4/1/17, included: 4) All discharge forms must be faxed to the Office of the State Ombudsman for review. The policy did not specifically address Ombudsman notification related to emergency hospitalization transfers. F 625 §483.15(d) (Notice of bed-hold policy and re	MENT OF HEALTH AND HUMAN SERVICES PORM SF ORM EDUCARE & MEDICAID SERVICES OMB NO. OBS FOR MEDICARE & MEDICAID SERVICES OMB NO. OF OFFICIENCIES (X1) PROVIDERINUPLIER (X3) DAT AD CARE CENTER 245329 B. WING 06/ PROVIDER OR SUPPLER AD CARE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 140 LAKE STREET NORTHWEST MARROAD, MN S6763 FORWMARY STATEMENT OF DEFICIENCIES ID PREFX CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES ID PREFX CARE CENTER ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFX CARE CENTER ID Continued From page 15 F 623 F 623 F 623 F 623 R31's progress note dated 5/14/18, indicated R31 had returned to the facility at approximately 3:10 p.m. F 623 F 623 R31's record does not reflect the ombudsman was notified of the facility-initiated transfer. F 625 F 625 On 6/12/18, at 4:13 p.m. social services designee (SSD) stated notification ransfers. F 625 F 625 CFR(s): 483.15(d) (1)(2) S4602 LAND RY Correster LAND RY CORRECTOR TO SUPPLIER F 625 VARE OLD ADD RY CORRECTOR DISTRUCTION RY CORRECTOR DISTRUC

Facility ID: 00797

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		AND HUMAN SERVICES & MEDICAID SERVICES			FOR	D: 07/13/2018 MAPPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		E CONSTRUCTION (X3) D/	TE SURVEY
		245329	B. WING		0	6/14/2018
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	
WARRO/	AD CARE CENTER					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 625	paragraph (e)(1) of resident to return; a (iv) The information of this section. §483.15(d)(2) Bed- the time of transfer hospitalization or th facility must provide resident representa specifies the duration described in paragr This REQUIREMEN by: Based on interview facility failed to prov hold policy for 2 of 2 were transferred to Findings include: R20's Admission Re indicated R20 had of Alzheimer's disease of the digestive trace (C-Diff, an infection failure, functional un and gout. R20's quarterly Min assessment, dated severe cognitive im extensive assistance and toileting. R20's progress note had 5 large loose st	which must be consistent with this section, permitting a and specified in paragraph (e)(1) hold notice upon transfer. At of a resident for erapeutic leave, a nursing to the resident and the tive written notice which on of the bed-hold policy aph (d)(1) of this section. NT is not met as evidenced and document review, the vide a written copy of the bed 2 residents (R20, R31) who	F 6	;25	 Bed hold agreements for R20 & R31 were completed and added to the resider record. The facility revised the Bed Hold Agreement Policy 07/06/2018 to include the proper notification, acknowledgemen and the distribution and filing of bed hold notices. Business Office shall be provided a copy of the notice for filing an accuracy checking. Ongoing tracking and monitoring of th notice requirements will be logged by the Social Service Designee via an updated and ongoing log of activity. 06-27-2018 This log will be reviewed after each potential bed hold situation and will be compiled and analyzed monthly for timely compliance. Results of the logging activity will be reported to the facility QAPI Committee b the Social Service Designee at their 	t d e

Facility ID: 00797

		AND HUMAN SERVICES				FORM	07/13/2018 APPROVED 0938-0391		
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		245329	B. WING			06/ [,]	14/2018		
NAME OF F	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE						
WARRO	AD CARE CENTER			1401 LAKE STREET NORTHWEST WARROAD, MN 56763					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE		
F 625	R20's condition and received to transfer family member was R20's Census List of hospital leave from R20's Physician Dis 5/17/18, indicated F worsening generaliz dehydration. R20 ha and was receiving of Review of R20's red documentation that been provided prior or R20's responsibl On 6/14/18, at 8:43 designee (SSD) ind if a bed hold had be evidence that one v to 5/17/18 hospitaliz R31's quarterly Min assessment dated cognitively intact. R31's progress note indicated R31 had r short of breath; fam change of condition to the hospital if ne indicated the physic condition; the physic transfer R31 to the R31's progress note	d a telephone order was R20 to the hospital. R20's a notified of the hospitalization. dated 6/14/18, indicated a 5/13/18 to 5/17/18. scharge Summary dated R20 was hospitalized due to zed weakness and ad been diagnosed with C-Diff oral antibiotics. cord identified no a bed hold notification had to being hospitalized to R20 le party. a.m., the social services dicated she had looked to see een given to R20 and found no was completed for his 5/13/18 zation. imum Data Set (MDS) an 5/11/18, identified R31 was es dated 5/12/18, at 9:56 p.m. not been feeling well and was hily was notified of R31's a and indicated R31 should go eded. Progress note then cian gave a telephone order to hospital for further evaluation. e dated 5/13/18, at 4:31 a.m.	F	625	regular meetings and will have appropriate follow up action based monitoring results. Results will be presented by the Social Service De until there is compliance for a 6 mo period and at that time will be reeva to determine if ongoing monitoring necessary. Regardless of monthly monitoring, agreements will be disc and filed in a timely manner in resic records by the Social Service Desig	esignee onth aluated is cussed dent			
	indicated the facility	e dated 5/13/18, at 4:31 a.m. / received a status update that itted to the hospital.							

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	07/13/2018 APPROVED 0938-0391	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		E SURVEY PLETED	
		245329	B. WING _			06/14/2018		
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE	•		
WARROA	AD CARE CENTER				01 LAKE STREET NORTHWEST ARROAD, MN 56763			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 625	Continued From pa	ge 18	F 62	25				
		ed hold notification had been R31's responsible party before						
	verified lack of evid had been provided	a.m. registered nurse (RN)-B ence a bed hold notification to R31 or responsible party. notification should have been insfer.						
	(DON) stated bed h provided prior to the of the transfer is urg resident's responsit	8 a.m. director of nursing old notifications were to be e transfer unless the situation gent and resident or the ole party is not in a position to hen notification should be racticable.						
	the policy of Warroa the bed of a current hospitalized or goes resident/responsible concerning the bed the policy as eviden properly notified pri- service. 3) In cases will attempt to provi and will notify the re and policy within 24	ed Hold Policy, included: It is ad Senior Living Center to hold t resident if he/she needs to be s on therapeutic leave. The e party must be notified hold policy of WSLC and sign nee that they have been or to being charged by any of emergency transfer, staff de the resident with a copy esponsible party of the transfer hours. Staff will follow up with fy any questions concerning ext business day.						
F 641 SS=D	Accuracy of Assess	-	F 64	11			7/18/18	
	§483.20(g) Accurac	cy of Assessments.						

ATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245329		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		B. WING		06/	06/14/2018			
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP COL	DE			
WARROAD CARE CENTER				1401 LAKE STREET NORTHWEST WARROAD, MN 56763				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE		
F 641	Continued From pa	qe 19	F 64	1				
	The assessment must accurately reflect the resident's status.							
	This REQUIREMENT is not met as evidenced by:							
	Based on observat review, the facility fa status lacked evide Set (MDS) an asse	tion, interview and document ailed to ensure oral/dental nce a quarterly Minimum Data ssment was accurately 1 resident (R12) in the sample		1) The affected resident has assessed here at WSLC by C Dross-Sandy, DDS, with reco for referral to oral surgeon to remaining teeth. Family has	indy mmendation remove			
		for dental status and service		surgery and an appointment h made for July 30, 2018. Resid	nas been			
	Findings include:			started on Augmentin for facia and fever on June 29, 2018.				
		ecord dated 6/14/18, included imer's disease and dementia urbance.		monitoring had already been charting board, but has also a e-Mar as of July 6, 2018, and obtained for prn Tramadol in a	added to an order			
	had severe cognitiv speech. The MDS i	dated 10/1/17, indicated R12 re impairment and had unclear ndicated R12 did not have any		scheduled Tramadol and Tyle event of pain observed. MDS modify 10/1/17, 1/1/18, and 4	nol in the S nurse will			
		luring the assessment period. Care Area Assessment		assessments by 7/15/2018 to reflect dental issues resident				
	times, such as facia brow and could not	pained facial expression at al grimaces and furrowing of be determined if non-verbal		experiencing. Quarterly MDS 7/4/2018 has been completed an additional dental assessm	l, along with ent			
	history of back pain oral pain from prior	related. However, R12 had a and was having presumed dental surgery in which 14 racted on 7/25/17, according to		completed on 7/3/2018, both reviewed by DON as accurate dental issues.				
	an oral surgeon's le	etter dated 7/31/17.		2) DON will conduct a review recent MDS assessments for	all residents			
	of a physical oral/de	d evidence of documentation ental examination and een completed for coding of		that have their own teeth with conditions by 7/15/2018 for a related to dental conditions as with progress over the quarte	ccuracy compared			
		S dated, 1/1/18, indicated R12		Inaccuracies will be corrected and followed up on in terms of	by MDS RN			

Facility ID: 00797

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245329		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 06/14/2018	
WARROAD CARE CENTER						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE
F 641	facial pain or difficul R12's record lacked of a physical oral/da assessment had be the quarterly MDS. R12's quarterly MDS R12's quarterly MD had severe cognitive unclear speech. The have any facial pain chewing. The MDS days as noted by fat body movements. R12's record lacked of a physical oral/da assessment had be the quarterly MDS. R12's record reflect concerns that were the annual or quart -A facility referral for nursing observation more and grinding Physician's recomm family member (FM dental appointment control but I do not teeth which if prese -Nursing health sta included when physician	Ilty/discomfort when chewing. d evidence of documentation ental examination and een completed for coding of S dated 4/3/18, indicated R12 ve impairment, and had he MDS indicated R12 did not n or difficulty/discomfort when identified R12 had pain 1-2 acial expressions or protective d evidence of documentation ental examination and een completed for coding of ted ongoing evidence of dental not captured or assessed on	F 641	 Dental assessments will be by RN in conjunction with quarter assessments, and a field added Care Conference form to trigger discussion with resident/family redental needs. A reminder was pall nursing staff to report any evitoral pain to charge nurse in nurse newsletter on June 24, and this be included in the July 12 nursin agenda. MDS coordinator/Unit coordinator(s) will conduct quarter assessments for all residents at "Dental assessment complete" radded to the Quarterly Care Cord Summary that guides discussion residents/families. MDS coordinator/Unit Coord will bring a list of MDS assessments for completion of quarter assessments, an additional threat assessments, an additional threat if we have not achieved 100%. of High Risk Meeting discussion trending will be presented to the QAPI Committee for their review similar time frame as listed above. 	rly MDS to WSLC a elated to rovided to dence of ing will also g meeting erly dental WSLC. has been ofference as with dinator(s) ents sk ree rly dental e months Results and facility as well in	

		AND HUMAN SERVICES				FORM	07/13/2018 APPROVED 0938-0391		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
		245329	B. WING	i		06/	14/2018		
NAME OF F	PROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, STATE, ZIP CODE	<u>.</u>			
WARROAD CARE CENTER			1401 LAKE STREET NORTHWEST WARROAD, MN 56763						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE		
F 641	AD CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 21 -Nurse health status note dated 4/12/18, only nine days after the quarterly MDS dated 4/3/18, was completed included R12 had lost one of her molar teeth that looked like it had rotted out. On 6/11/18, at 5:40 p.m. R12 had been observed in the dining room being fed by an unidentified nursing assistant (NA). R12 was observed to be making facial grimaces, clenching fists, and pushing self away from table while being fed and given liquids. R12 was also observed to have several missing teeth. On 6/14/18, at 12:59 p.m. registered nurse (RN)-A stated the oral cavity is assessed annually with dental assessments. RN-A confirmed that the individual's oral cavity is assessed by her when doing R12's annual assessment. When R12's assessment was done in October it was coded as no problems noted; therefor a Care Area Assessment was not triggered for further assessment and care planning. RN-A could not recall if an actual inspections of R12's oral cavity were completed for the completion of the MDS's. RN-A confirmed the MDSs had not identified any oral health concerns. RN-A confirmed that the assessment indicated no teeth, swelling, lesions, broken teeth, pain or difficulty with chewing were identified. RN-A indicated that she felt there were no dental issues and was unclear if pain was related to dental or something else. The MDS 3.0 RAI (Resident Assessment Instrument) Manual last updated 10/1/17, directed users to complete the following steps for assessment for coding purposes: "Steps for Assessment 1. Ask the resident about the presence of		F	641					

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	07/13/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245329	B. WING			06/ [,]	14/2018
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
WARROA	AD CARE CENTER				1401 LAKE STREET NORTHWEST WARROAD, MN 56763		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 641	whether the resider or partials. (If resider partials, but they do ask for a reason.) 3. If the resident ha examine for loose f and examine for cho cracks, and cleanlin and/or partials is ne assessment. 4. Conduct exam of cavity with dentures applicable. Use a lig visualize the back of and feel all oral surf tongue, palate, mou Check for abnorma teeth, or inflamed of assessor should us adequately feel for 5. If the resident is to observe him or her partials, if indicated problems or mouth 6. Oral examination uncooperative and oral exam may resu- missed. Referral for considered for thes who exhibits dental Dental Services pro- indicated oral health the data collection a	family, or significant other it has or recently had dentures ent or family/significant other dent recently had dentures or not have them at the facility, s dentures or partials, it. Ask him or her to remove, ips, ness. Removal of dentures ecessary for adequate f the resident 's lips and oral or partials removed, if ght source that is adequate to of the mouth. Visually observe faces including lips, gums, ith floor, and cheek lining. I mouth tissue, abnormal r bleeding gums. The e his or her gloved fingers to masses or loose teeth. unable to self-report, then while eating with dentures or , to determine if chewing pain are present. of residents who are do not allow for a thorough alt in medical conditions being r dental evaluation should be e residents and any resident or oral issues."		641			
F 680	Qualifications of Ac		F6	680			7/16/18

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		AND HUMAN SERVICES & MEDICAID SERVICES			F	FORM	07/13/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í			K3) DATE	SURVEY PLETED
		245329	B. WING			06/1	4/2018
NAME OF F	PROVIDER OR SUPPLIER		1	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
WARRO	AD CARE CENTER				401 LAKE STREET NORTHWEST /ARROAD, MN 56763		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	directed by a qualifi qualified therapeutia activities profession (i) Is licensed or reg State in which pract (ii) Is: (A) Eligible for certri recreation specialis professional by a re- or after October 1, (B) Has 2 years of recreational program of which was full-tim program; or (C) Is a qualified oc- occupational therap (D) Has completed the State. This REQUIREMEN by: Based on interview facility failed to ensi- (AD) was in charge	2)(i)(ii)(A)-(D) activities program must be ed professional who is a c recreation specialist or an hal who- gistered, if applicable, by the ticing; and fication as a therapeutic t or as an activities ecognized accrediting body on 1990; or experience in a social or m within the last 5 years, one ne in a therapeutic activities ecoupational therapist or	F	\$80	1. Executive Director has contacted LifeCare Medical Center for assistand providing program support with a fully qualified director. LifeCare has the services of a qualified COTA who will agree to serve in a capacity to provid qualified leadership to the department Contract negotiations are underway to	ce in y l le nt. to	
	started in her positi and starting taking shortly after. On 6/13/18, at 2:15 they advertised for	p.m., the AD stated she on during the summer of 2017 an activity director course p.m., the administrator stated a qualified activity director but			 outline the agreement and implement change necessary to become complia Contract will be in place not later than 07/16/2018 2. Executive Director will monitor and continue to follow the contract 	t the iant. n d	
	did not find someor	ne who met the qualifications.			arrangement until our Director compl	etes	

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	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	LE CONSTRUCTION		E SURVEY
ND PLAN C	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	·	СОМ	PLETED
		245329	B. WING		06/	14/2018
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
WARRO	AD CARE CENTER			I401 LAKE STREET NORTHWEST WARROAD, MN 56763		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETIC DATE
F 680	Continued From pa	ge 24	F 680			
	The administrator s worked previously i she met the require experience. In addi	tated the current AD had n activities, and he thought ments based on previous tion, they enrolled the AD in an s immediately upon hiring her.		her educational training and is full qualified. At that time the agreem LifeCare will be terminated or alte reflect the current needs of the department.	ent with	
	confirmed the AD's 7/2012, through 9/2	a.m., the administrator previous experience from 2017, only adds up to 14.5 xperience in the last 5 years; It was 2 years.		3. Executive Director has created on the qualifications of an activity professional in the facility and will that the program meets these requirements and qualifications. 06/16/2018.		
	professional was re	the qualifications of an activity quested but not provided.				
F 686 SS=D	Treatment/Svcs to CFR(s): 483.25(b)(Prevent/Heal Pressure Ulcer 1)(i)(ii)	F 686			7/24/18
	resident, the facility (i) A resident receiv professional standa pressure ulcers and ulcers unless the in demonstrates that t (ii) A resident with p necessary treatmen with professional st promote healing, pr new ulcers from de This REQUIREMEN by:	sure ulcers. The provide the system of a must ensure that- tes care, consistent with ands of practice, to prevent d does not develop pressure dividual's clinical condition they were unavoidable; and pressure ulcers receives and a services, consistent andards of practice, to revent infection and prevent veloping. NT is not met as evidenced				
	Based on observat review, the facility fa assess a facility acc provide consistent	tion, interview and document ailed to comprehensively quired pressure ulcer, and monitoring to promote healing R20) reviewed for pressure		 Resident has bolstered air man place with repositioning every hour prn. Tegaderm foam has been app coccyx, to be changed with nurse assessment every three days. We 	r and olied to	

Facility ID: 00797

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	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MULTI	PLE	CONSTRUCTION		SURVEY	
ND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G _		COM	PLETED	
		245329	B. WING			06/1	4/2018	
NAME OF F	PROVIDER OR SUPPLIER			STI	REET ADDRESS, CITY, STATE, ZIP CODE	DDE		
WARRO	AD CARE CENTER			1401 LAKE STREET NORTHWEST WARROAD, MN 56763				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETIC DATE	
F 686	Continued From pa	age 25	F 68	6				
	ulcers.	0			skin rounds by PT wound specialist	will be		
	Findings include:				conducted until the wound is resolve Resident's wound has improved.			
					2) Body audits will be performed or			
		ecord, dated 6/13/18, diagnoses that included			residents that need extensive assis with repositioning to identify other	tance		
		e, enterocolitis (inflammation			residents with possible undetected	and		
	of the digestive trac	ct) due to clostridium difficile			untreated pressure ulcers by July 1	5,		
		n of the colon, often causes			2018.			
	incontinence, diabe	Iney failure, functional urinary			 Skin incident form changed on 6/23/2018 to include "Notify DON or 	r unit		
					coordinator immediately of any pres			
		imum Data Set (MDS) an			ulcer or skin problem on a pressure	•		
		4/15/18, identified R20 had			point". This change was included in			
		pairment and required ce for transfers, bed mobility			nursing newsletter on June 24, and detection with skin incident form wil			
		IDS identified R20 as			included at nursing staff meeting ag			
	frequently incontine	ent of urine and always			on July 12. Licensed nurses will be			
		The MDS further indicated			assigned an EduCare Module on pr			
		develop pressure ulcers, and sure ulcer on the previous			ulcers to be completed by July 24, 2 Pressure ulcers have been added a			
		ent. Finally, the MDS indicated			agenda item on weekly High Risk M			
		ng and repositioning program			Agenda to improve communication			
	and had lotion or oi	intment applied to his skin.			care planning, and follow through u			
		are Area Assessment (CAA)			resolution.			
	related to skin or pl	ressure ulcer prevention.			 Pressure ulcers will be tracked t skin incident forms/body audits and 			
	R20's Care Plan, d	ated 10/21/15, indicated R20			reported to QAPI. DON will monitor			
	was at risk for skin	breakdown related to the need			Risk Committee oversight of press	ure		
		tance with bed mobility and			ulcers or potential pressure ulcers t	•		
		nad occasional incontinence. tified the goal was for R20 to			resolution and report to QAPI Comr quarterly. Reporting will be for a mi			
		ee of redness, blisters or			of 6 months and will continue based			
	discoloration. Interv	ventions included to turn or			the recommendation of the Commit			
		every two hours; R20 had an			that time.			
		cushion (pressure preventing)						
		help maintain skin integrity. hot identify the stage II						
	pressure ulcer which							

	-	AND HUMAN SERVICES				FORM	APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245329	B. WING			06/ [,]	14/2018
NAME OF F	PROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZIP CODE			
WARRO	AD CARE CENTER			1	1401 LAKE STREET NORTHWEST		
					WARROAD, MN 56763		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 686	Continued From pa 5/20/18.	ge 26	F 6	86			
	 R20's Physician Dis 5/17/18 after a four R20 was hospitalized generalized weakned been diagnosed wit oral antibiotics. The dated 5/17/18, indic redness, intact skin and right buttocks. The cavilon cream (barr R20's progress note returned to the facil no skin issues to not A 5/18/18, progress area was slightly rea was applied. The first identification perineal area was efficient of perineal area was efficient (cm) open area note intragluteal fold (befind waking that morning appeared to be from loose stools that sh and Lantiseptic barr note indicated the in on for staff to contin was to be turned or back when in bed to R20's health status a.m. indicated R20 hours while in bed, 	on of an open area on R20's evident in a 5/20/18, 12:43 that identified a 0.7 centimeter red to the top of R20's evident the buttocks) upon g. The note indicated the area m moisture, as R20 had 2 wift. The area was cleansed rier cream was applied. The nformation would be passed nue to apply cream and R20 n each side rather than on his o help aid in healing.					
	perineal area was e p.m. progress note (cm) open area note intragluteal fold (bet waking that morning appeared to be from loose stools that sh and Lantiseptic barn note indicated the ir on for staff to contin was to be turned or back when in bed to R20's health status a.m. indicated R20 hours while in bed,	evident in a 5/20/18, 12:43 that identified a 0.7 centimeter ed to the top of R20's tween the buttocks) upon g. The note indicated the area m moisture, as R20 had 2 nift. The area was cleansed rier cream was applied. The nformation would be passed nue to apply cream and R20 n each side rather than on his o help aid in healing.					

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		AND HUMAN SERVICES				FORM	07/13/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245329	B. WING	i		06/	14/2018
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
WARRO	AD CARE CENTER				1401 LAKE STREET NORTHWEST WARROAD, MN 56763		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 686	his coccyx was cov dressing with water R20's skin/wound m p.m. indicated an of The area was clear with a duoderm. A progress note dat an open area to the fold that was previo but this was not stic nurse removed the (barrier cream) was protection. Progress notes date Lantiseptic cream v top of the intraglute described as red ar A progress note dat physician was notifi stools. The note lac physician was notifi fold, pressure ulcer A skin/wound note of was an open area t area was covered v A skin/wound note of complete descriptio area on R20's perin Stage II pressure ul borders. The wound	ered with duoderm (a wound resistant outer layer). note dated 5/21/18, at 12:29 pen area to the right buttock. nsed with saline and covered ted 5/22/18, indicated R20 had a buttock near the intragluteal ously covered with a duoderm, cking. The note indicated the duoderm and Lantiseptic applied to the area for ed 5/23/18, indicated vas applied to an open area on al fold. The area was nd had a small open area. ted 5/25/18, indicated a led regarding R20's loose cked indication that the led of a coccyx, or intragluteal con 5/28/18, indicated there o the left buttock and that the	F	586			

Facility ID: 00797

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		AND HUMAN SERVICES				FORM	07/13/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245329	B. WING			06/*	14/2018
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
WARRO	AD CARE CENTER				401 LAKE STREET NORTHWEST VARROAD, MN 56763		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 686	Medihoney (helps v tegaderm foam (tra dressing) were app the dressing would needed if the dress off. The note furthe bed, Roho cushion being repositioned On 5/31/18, a treate completed for tegad sacral/coccyx regio and tegaderm foam healed; one time a Review of R20's me documentation of o administration reco ulcer prior to 5/31/1 Review of R20's me tissue tolerance tes were completed on diagnosis and hosp A 6/11/18, progress cm circular healing A 6/11/18, High Ris indicated R20 had a was allowing staff to 2 hours. The note of Stage II pressure u Review of R20's me of provider notificat plan updates regard	with wound healing) and insparent, breathable lied. The note indicated that be changed daily and as ing got soiled or was falling r indicated R20 had an air to his wheelchair and was every 2 hours and as needed. ment administration was derm foam to ulcer on in; cleanse, apply skin prep in daily and as needed until day for ulcer. edical record lacks orders or treatment rd to coccyx area pressure 8. edical record revealed the last st and skin observation tools 4/13/18, prior to his C. Diff bitalization. a note indicated R20 had a 1.0 open area on his coccyx. k Committee progress note a new bolstered air bed and o turn and reposition him every did not identify R20 as having a	Fθ	886			

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					FORM	07/13/2018 APPROVED 0938-0391
T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l`´´		E CONSTRUCTION	(X3) DATI	E SURVEY PLETED
	245329	B. WING			06/	14/2018
PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
AD CARE CENTER						
(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	x	(EACH CORRECTIVE ACTION SHOULE	BE	(X5) COMPLETION DATE
Continued From pa	ıge 29	F 6	86			
-						
was observed in be pressure mattress. (NA)-A and NA-B re his care plan, remo	ed on an alternating air At 8:32 a.m., nursing assistant epositioned R20 according to oving a pillow from his right					
(RN)-D and RN-BB dressing to R20's c wound was describ measured at 0.9 cm wound bed describe with 10% granulation	8, were observed changing the coccyx pressure ulcer. The bed as "almost gone"; m x 0.5 cm x 0.1 cm; and the ed as 90% white/yellow slough on tissues surrounding slough.					
rounds were done e of wound rounds, a formal assessment are to be charting o RN-BB confirmed F assessed until 5/30 first noted). RN-BB incident report or a her to assess a wou returned from the h intact area on his co confirmed it was a f ulcer; and while the 5/20/18 and 5/21/18 knowing about it be	every two weeks, she was part and these were considered a t. RN-BB also indicated staff on wounds on bath days. R20's wound was not fully 0/18 (which was ten days after stated she usually gets an note from staff that triggers und. RN-BB confirmed R20 nospital with a reddened but soccyx. RN-BB further facility acquired pressure e initial notes on it were from 8, she does not remember efore 5/30/18.					
	RS FOR MEDICARE OF DEFICIENCIES OF CORRECTION PROVIDER OR SUPPLIER AD CARE CENTER SUMMARY STA (EACH DEFICIENCY REGULATORY OR LA Continued From pa On 6/12/18, at 9:49 bed on an alternatin On 6/13/18, from 7: was observed in be pressure mattress. (NA)-A and NA-B re his care plan, remo side and repositioni left side. On 6/13/18, at 10:4 (RN)-D and RN-BB dressing to R20's c wound was describ measured at 0.9 cm wound bed describon with 10% granulation The periwound was On 6/13/18, at 11:11 rounds were done of of wound rounds, at formal assessment are to be charting of RN-BB confirmed F assessed until 5/300 first noted). RN-BB incident report or a her to assess a wour returned from the h intact area on his con confirmed it was a function pressing about it be	DF CORRECTION IDENTIFICATION NUMBER: 245329 PROVIDER OR SUPPLIER AD CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 29 On 6/12/18, at 9:49 a.m., R20 was observed in bed on an alternating air pressure mattress. On 6/13/18, from 7:05 a.m. until 8:32 a.m., R20 was observed in bed on an alternating air pressure mattress. At 8:32 a.m., nursing assistant (NA)-A and NA-B repositioned R20 according to his care plan, removing a pillow from his right side and repositioning R20 with a pillow under his	RS FOR MEDICARE & MEDICAID SERVICES FOF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MUL A. BUILD PROVIDER OR SUPPLIER 245329 B. WING AD CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFU REGULATORY OR LSC IDENTIFYING INFORMATION) PREFU TAG Continued From page 29 F 6 On 6/12/18, at 9:49 a.m., R20 was observed in bed on an alternating air pressure mattress. F 6 On 6/13/18, from 7:05 a.m. until 8:32 a.m., R20 was observed in bed on an alternating air pressure mattress. At 8:32 a.m., nursing assistant (NA)-A and NA-B repositioned R20 according to his care plan, removing a pillow from his right side and repositioning R20 with a pillow under his left side. On 6/13/18, at 10:48 a.m., registered nurse (RN)-D and RN-BB, were observed changing the dressing to R20's coccyx pressure ulcer. The wound was described as "almost gone"; measured at 0.9 cm x 0.5 cm x 0.1 cm; and the wound bed described as 90% white/yellow slough with 10% granulation tissues surrounding slough. The periwound was described as pink and intact. On 6/13/18, at 11:17 a.m., RN-BB stated wound rounds were done every two weeks, she was part of wound rounds, and these were considered a formal assessment. RN-BB also indicated staff are to be charting on wounds on bath days. RN-BB confirmed R20's wound was not fully assessed until 5/30/18 (which was ten days after first noted). RN-BB stated she usually gets an incident report or a note from staff that triggers her to assess a wound. RN-BB confirmed R20 returned from	RS FOR MEDICARE & MEDICAID SERVICES COF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPL A. BUILDING. 245329 B. WING PROVIDER OR SUPPLIER 245329 B. WING AD CARE CENTER 14 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG Continued From page 29 F 686 On 6/12/18, at 9:49 a.m., R20 was observed in bed on an alternating air pressure mattress. F 686 On 6/13/18, from 7:05 a.m. until 8:32 a.m., R20 was observed in bed on an alternating air pressure mattress. At 8:32 a.m., nursing assistant (NA)-A and NA-B repositioned R20 according to his care plan, removing a pillow from his right side and repositioning R20 with a pillow under his left side. On 6/13/18, at 10:48 a.m., registered nurse (RN)-D and RN-BB, were observed changing the dressing to R20's coccyx pressure ulcer. The wound was described as "almost gone"; measured at 0.9 cm x 0.5 cm x 0.1 cm; and the wound bed described as 90% white/yellow slough. The periwound was described as pink and intact. On 6/13/18, at 11:17 a.m., RN-BB stated wound rounds, and these were considered a formal assessment. RN-BB also indicated staff are to be charting on wounds on bath days. RN-BB confirmed R20's wound was not fully assessed until 5/30/18 (which was ten days after first noted). RN-BB stated she usually gets an incident report or a note from staff that triggers her to assess a wound. RN-BB confirmed R20 returned from the hospital with a reddened but intact area on his coccyx. RN-BB	IMENT OF HEALTH AND HUMAN SERVICES O RS FOR MEDICARE & MEDICAID SERVICES O FOR FORLENCES (X) PROVIDER/SUPPLERICIA PROVIDER OR SUPPLIER ABULIDING AD CARE CENTER US B WING 1401 LAKE STREET ADDRESS, CITY, STATE, ZIP CODE 1401 LAKE STREET NORTHWEST DEPROVIDER OR SUPPLIER AD CARE CENTER 1401 LAKE STREET NORTHWEST WARROAD, MN 56763 DEPROVED STATE PROVIDENT OF DEFICIENCIES (EACH DEFICIENCY WIST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX Continued From page 29 F 686 On 6/13/18, at 9:49 a.m., R20 was observed in bed on an alternating air pressure mattress. At 8:32 a.m., nursing assistant (NA)-A and NA-B repositioned R20 according to his care plan, removing a pillow from his right side and repositioned R20 according to his care plan, removing a pillow from his right side and Popolitioning R20 with a pillow under his left side. On 6/13/18, at 10:48 a.m., registered nurse (RN)-D and RN-BB, were observed changing the dressing to 29 coccyx pressue ulcer. The wound was described as Similary Pollow Slough with 10% granulation tissues surrounding slough. The periwounds, and these were considered a formal assessment. RN-BB stated wound rounds, were done every two weeks, she was part of wound rounds, and these were considered a formal assessment mill 8:301 (1) (1) (1) (1) (1) (1) (1) (1) (1) (1	IMENT OF HEALTH AND HUMAN SERVICES FORM SF OR MEDICARE & MEDICAID SERVICES OMB NO. FOR DEFICIENCIES (X1) PROVDERSUPPLEXCLA (X2) MULTIPLE CONSTRUCTION (X3) DAT A BULDING 245329 B. WING (X3) CM PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, 2IP CODE 1401 LAKE STREET NORTHWEST MARROAD, MN STATEMENT OF DEFICIENCIES IN PROVIDER NUMBER 06/ AD CARE CENTER IN PROVIDER NUMBER IN CARE CORRECTIVE ACTION NUMBER 06/ SUMMARY STATEMENT OF DEFICIENCIES IN PROVIDER NUMS' BE PRECEDED BY FULL REGULATORY OR USC DENTFRYING INFORMATION) PREFX PROVIDERS PLAN OF CORRECTION Continued From page 29 F 686 IN PREFX PROVIDERS CITY & ATTOR NUMBER DEFICIENCY) Continued From page 29 F 686 On 6/13/18, from 7:05 a.m. until 8:32 a.m., R20 F 686 IN PREFX On 6/13/18, from 7:05 a.m. until 8:32 a.m., R20 according to his care plan, removing a plilow from his right side and repositioned R20 according to his care plan, removing a plilow from his right side and repositioned R20 according to his care plan, removing a plilow from his right side and repositioned R20 according to his care plan. RM-BB setted wound rounds, and these were considered a find the direction staff that triggers here tasses a vound. RN-BB scaff with a the direction staff that triggers here tasses a wound. RN-BB scaff was an tfully assessed until 5/3018 (which was ten

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		AND HUMAN SERVICES				FORM	07/13/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245329	B. WING	i		06/ [,]	14/2018
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
WARRO	AD CARE CENTER				401 LAKE STREET NORTHWEST VARROAD, MN 56763		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 686	(LPN)-A confirmed skin/wound note as indicated this was n wound, as she rema and replacing it. LP who put the original wound first opened. following suit with th the wound. On 6/13/18, at 1:54 stated they are imp report that will hope and monitoring pro- weren't clear on the current report form. was a certified wou The facility's Prever policy, dated 6/11/1 have a system/pro- are timely and appr condition are recog to the practitioner, p addressed. The po routinely assess an the resident's skin t Integrity Form for an irritation or breakdo staff to report any s ulcer to a nurse sup The facility's Pressu dated 7/29/15, indic completed on all re- weekly and as need established pressur	she wrote R20's 5/21/18, that was his bath day. LPN-A not the first identification of the embers removing a duoderm N-A indicated she didn't know I duoderm on, or when the . LPN-A stated she was just he treatment she had found on p.m. the director of nursing lementing a new skin incident efully improve the reporting cess. The DON stated staff e right thing to do with the . The DON indicated RN-BB	F	586			

		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	07/13/2018 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í			(X3) DATE	E SURVEY IPLETED
		245329	B. WING	i		06/	14/2018
NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
WARRO	AD CARE CENTER				1401 LAKE STREET NORTHWEST NARROAD, MN 56763		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 686	 -Observe, measure ulcers weekly on the Documentation Floy If deteriorating or noted, update the p Implement any net obtained. Complete docume staging. Update the care p new wound treatment discontinuation of a when a wound was Pressure Ulcer stage Pressure Ulcer stage Pressure trademate stage Pressure trademate stage Pressure trademate stage Pressure trademate st	re, and document pressure he Weekly Pressure Ulcer w Sheet. non-healing wounds are ohysician. w wound treatment orders entation to include location and olan to include addition of any ent or nursing interventions or any established interventions a healed. ges defined by the National <i>v</i> isory Panel (NPUAP): njury: Non-blanchable skin ocalized area of non-blanchable ay appear differently in darkly esence of blanchable es in sensation, temperature, ecede visual changes. Color dude purple or maroon e may indicate deep tissue	F	586			

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	07/13/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i í			(X3) DATE	E SURVEY PLETED
		245329	B. WING			06/ [,]	14/2018
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
WARRO	AD CARE CENTER				01 LAKE STREET NORTHWEST ARROAD, MN 56763		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
	should not be used associated skin dar incontinence associ intertriginous derma related skin injury (f (skin tears, burns, a Nutrition/Hydration) CFR(s): 483.25(g)(f §483.25(g) Assisted (Includes naso-gast both percutaneous percutaneous endo enteral fluids). Bas comprehensive ass ensure that a reside §483.25(g)(1) Maint of nutritional status, desirable body weig balance, unless the demonstrates that t preferences indicate §483.25(g)(2) Is offi- maintain proper hyd §483.25(g)(3) Is offi- there is a nutritional provider orders a th This REQUIREMEN by: Based on observat review, the facility fa- comprehensive nutrievaluation based a	to describe moisture nage (MASD) including iated dermatitis (IAD), atitis (ITD), medical adhesive MARSI), or traumatic wounds abrasions). Status Maintenance 1)-(3) d nutrition and hydration. tric and gastrostomy tubes, endoscopic gastrostomy and scopic jejunostomy, and ed on a resident's essment, the facility must ent- tains acceptable parameters such as usual body weight or yht range and electrolyte resident's clinical condition his is not possible or resident e otherwise; ered sufficient fluid intake to dration and health; ered a therapeutic diet when I problem and the health care erapeutic diet. NT is not met as evidenced ion, interview and document	F 6		1. On June 13th 2018 a nutrition assessment was completed for resi R27 by consultant dietitian, Linda B Additional interventions have been implemented to increase calorie inta including providing resident with add	ump. ake	7/16/18

Facility ID: 00797

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		AND HUMAN SERVICES & MEDICAID SERVICES	1			FORM	07/13/2018 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD				E SURVEY PLETED
		245329	B. WING			06/1	4/2018
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
WARROA	AD CARE CENTER				01 LAKE STREET NORTHWEST ARROAD, MN 56763		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 692	Continued From pa Findings include: R27's Admission Re indicated R27 was a diagnoses that inclu hypokalemia, hyper failure, chronic obst and chronic kidney R27's admission Mi assessment dated was 157 pounds. R27's quarterly MD weighed 140 pound weight loss over five a physician prescrite MDS indicated this the last month or a 6 months. R27's Care Plan da diabetes and an inte dietary consult for n ongoing monitoring supplement twice d R27's care plan also prescribed a diabeti was 140 pounds wit weight within 5% of at least 50% of at least	ge 33 ecord, dated 6/13/18, admitted on 1/22/18, had uded atrial fibrillation, diabetes, tension, congestive heart tructive pulmonary disease disease. inimum Data Set (MDS) an 1/19/18, indicated his weight S dated 5/1/18, indicated R27 Is which was a 17 pound e months. R27 and was not on bed weight loss program. The was a loss of 5% or more in loss of 10% or more in the last ted 5/2/18, indicated R27 had ervention was to request a nutritional regimen and and to provide a glucerna aily related to weight loss. o indicated R27 was ic diet and his current weight th the goal of maintaining 140 pounds, and consuming east 2 meals daily. An a registered dietician to diet change	F			S at had will be by any be d for all r llow up eetings on will etitian. eetings upletion s months sk any ly ons, ditional vill be ied at	
	2018 dated 5/1/18,	dministration record for May indicated an order for Lasix 40 t he received once daily. The			consecutive months is met.		

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		AND HUMAN SERVICES				FORM	: 07/13/2018 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		LE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245329	B. WING	i		06/	14/2018
NAME OF F	PROVIDER OR SUPPLIER	•		S	STREET ADDRESS, CITY, STATE, ZIP CODE		
WARRO	AD CARE CENTER				1401 LAKE STREET NORTHWEST WARROAD, MN 56763		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 692	administration reco Glucerna suppleme R27's physician ord change in dose of L once daily. On 6/12/18, at 9:20 alone in his room w him: R27 had eater biscuit, drank part of On 6/13/18, at 8:50 brought to R27 in h A 5/1/18, nursing pr diagnosis of diabete a 7 pound weight lo physician ordered a Review of R27's pro- dietary assessment provided when requ On 6/13/18, at 11:5 (RN)-BB stated R27 RN-BB confirmed a been done for R27. started on a supple had been newly dia stated she does nor was when R27's phy which made it "hard eat as much as he appetite. RN-BB st supper with R27 in know if R27's wife v	 and also indicated R27 received ent twice daily for weight loss. ders dated 6/13/18, indicated a _asix (a diuretic) for 20 mg a.m., R27 was observed with a breakfast plate in front of a about 25% of his gravy and of his milk, juice and coffee. a.m., a breakfast tray was alone. a.m., a breakfast tray was alone. a.m., a breakfast tray was alone. rogress note identified a new es and physician notification of bas in the last month. The a glucerna supplement. ogress notes does not reveal a t or progress note nor was one uested. 4 a.m., registered nurse 7 had been slowly failing. a dietary assessment had not . RN-BB also stated R27 ment on 5/4/18, and that he agnosed as a diabetic. RN-BB t work on Tuesdays and that hysician came to the facility, d." RN-BB stated R27 doesn't didn't have much of an tated R27's wife came and ate his room, but RN-BB did not was able to make it as much 	F	592			
	as previously. RN-E	BB didn't think the high risk terdisciplinary team had talked					

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		AND HUMAN SERVICES				FORM	07/13/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		PLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245329	B. WING	i		06/	14/2018
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	. <u>.</u>	
WARRO	AD CARE CENTER				1401 LAKE STREET NORTHWEST WARROAD, MN 56763		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 692	(DON) stated the hi every week, but the carry-through to en- were resolved. The committee discusse fall and weight loss follow up in subseq indicated there had department, that it H time in regards to n DON indicated a dia left for medical con- awaiting her return. dietician consultant did not know how m with individual resid also stated she did done for R27, other On 6/13/18, at 2:50 (CD) stated she had help with the lack o the dietary departm manager position h the last two years a done by the last man new dietician hired on resident satisfac meals on the table address systems w January 2018, she nutritional assessm getting nutritional as each resident in the completed this work	a in eating recently. 7 p.m., the director of nursing igh risk committee meets are had not been a method for sure that areas of concern DON stated the high risk ed R27 on 5/14/18 regarding a , but she did not see any uent meetings. The DON also been issues with the dietary hadn't been strong for a long outritional assessments. The etician had been hired, then cern and they were eagerly The DON stated there was a hired by the facility, but she nuch the consultant had done lent assessments. The DON n't know what else could be than the current supplement. I p.m., the consultant dietician d been hired by the facility to f leadership and experience in then. The CD stated the dietary ad changed several times in and assessments were not anager. The CD stated that the this spring has had to focus ction issues and just getting and had not had time to ork. The CD stated that in began by developing a good tent for facility use, and then ssessments completed for a facility. The CD stated she k in January and February	F	692			
		when the new dietician was					

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	07/13/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE	E SURVEY PLETED
		245329	B. WING			06/1	14/2018
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
WARRO	AD CARE CENTER				401 LAKE STREET NORTHWEST /ARROAD, MN 56763		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 692 F 697 SS=G	hired. The CD verifi assessment done for should have been d must have slipped t also stated there has representative at ca year, no formal syst and indicated the nu because the previou been doing a forma The facility policy tit Referrals to the Reg dated 2017, indicate individuals for nutrit regular intervals, or condition warrants, screening tool and a further directed staff screening form upo Pain Management CFR(s): 483.25(k) §483.25(k) Pain Ma The facility must en provided to resident consistent with profi the comprehensive and the residents' g This REQUIREMEN by: Based on observat review, the facility fa assessed in order to interventions and/or	ed there was no nutritional or R27, that an assessment lone on R27, and that R27 through the cracks. The CD ad been no dietary are conferences for almost a tem to monitor weight changes urses were "carrying the ball" us dietary manager had not I nutritional assessment. led Nutrition screening for gistered Dietitian Nutritionist ed facility staff would screen ion risk on admission, at whenever a change in using a validated nutrition approved process. The policy f to complete a validated n admission, and quarterly. magement. sure that pain management is ts who require such services, essional standards of practice, person-centered care plan, ioals and preferences. NT is not met as evidenced ion, interview and document ailed to ensure pain had been o identify appropriate r medical attention for 1 of 1 awed for dental pain. This	F 6		1) The affected resident has been assessed here at WSLC by Cindy Dross-Sandy, DDS, with recommen for referral to oral surgeon to remov remaining teeth. Family has agreed surgery and an appointment has bee made for July 30, 2018. Resident wa	dation re I to en	7/16/18

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	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MI II T			MB NO.	SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:					PLETED	
		245329	B. WING			06/1	4/2018	
NAME OF I	PROVIDER OR SUPPLIER			SI	TREET ADDRESS, CITY, STATE, ZIP CODE			
WARRO	AD CARE CENTER				401 LAKE STREET NORTHWEST /ARROAD, MN 56763			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIO DATE	
F 697	Continued From pa	ige 37	F 69	97				
	Findings include: R12 was observed dining room being f assistant (NA). R1 facial grimaces, cle away from table wh R12 was observed R12's Admission R diagnoses of Alzhe behavioral disturba shoulder. R12's annual Minim 10/1/17, indicated to impairment and wa self understood or required extensive oral cares. The MI indicators of pain (f winces, wrinkled fo clenched teeth or ja received scheduled dental was coded a present" related to likely cavities, inflar	on 6/11/18, at 5:40 p.m. in the fed by an unidentified nursing 2 was observed to be making enching fists, and pushing self hile being fed and given liquids. to have several missing teeth. ecord dated 6/14/18, included imer's disease, dementia with nce, and pain in unspecified hum Data Set (MDS) dated hat R12 had severe cognitive is rarely/never able to make understand others. R12 assistance with eating and DS indicated R12 had facial expressions - grimaces, rehead, furrowed brow, aw) one to two days and d pain medication. Section L for as "none of the above were broken teeth, missing teeth, med/bleeding gums, mouth or er, the MDS was coded			 started on Augmentin for facial flus and fever on June 29, 2018. Pain monitoring had already been on nu charting board, but has also added e-Mar as of July 6, 2018, and an or obtained for prn Tramadol in addition scheduled Tramadol and Tylenol in event of pain observed. 2) An oral inspection with pain assessment will be completed by a on all WSLC residents with their ow teeth in poor condition by July 10, 2 and dental examination appointment be made if appropriate. A dental con has been established with Cindy Dross-Sandy, DDS, who performs examinations at WSLC if needed. 3) Dental assessments will be corr by RN in conjunction with quarterly assessments, and a field added to Care Conference form to trigger a discussion with resident/family relation dental needs. A reminder was provider oral pain to charge nurse in nursing newsletter on June 24, and this will 	rse to der on to the n RN vn 2018, nts will ontract dental mpleted MDS WSLC ted to vided to nce of		
	extract 14 teeth on R12's pain Care Ar 10/1/17, indicated F expression at times brow, etc It is not due to R12's difficu and is mostly not po	2 underwent oral surgery to 7/25/17. ea Assessment (CAA) dated R12 does have pained facial s, such as grimacing, furrow clear that this is pain-related It time with communication ossible to have a conversation a history of back pain and			 be included in the July 12 nursing r agenda. "Unmanaged Pain" has be added to high risk flow sheet and standard agenda as an additional to point to ensure pain is addressed. 4) WSLC Director of Nursing or designee will monitor dental assess completed quarterly with appropriat follow up and report findings to the QAPI Committee. Reports will be 	een rigger sments te		

Facility ID: 00797

			()(0) 1 11 11 -		OMB NO.	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·	IPLE CONSTRUCTION		E SURVEY PLETED
		245329	B. WING _			14/2018
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODI	<u> </u>	
WARRO	AD CARE CENTER			1401 LAKE STREET NORTHWEST WARROAD, MN 56763		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 697	••••••	-	F 69	97 provided for a minimum of six	months and	
	was having presumed oral pain prior to dental surgery. Care plan will include interventions to monitor for and keep pain controlled. R12's quarterly MDS dated 4/3/18, indicated no			until such time the Committee there is no longer a need base satisfactory performance and documentation.	determines	
	notations in the ora days as noted by fa body movements. I	Il care section and pain 1-2 acial expressions or protective However, the MDS was coded 2 underwent oral surgery to				
	to two staff member hygiene which inclu- care plan indicated did not identify R12 plan did not specify care and did not ine goals to maintain d directed staff to ad monitor/record pair nurse any signs or and notify physician unsuccessful or if of significant change	ovided on 6/14/18, directed one ers to provide personnel uded oral care. The hygiene R12 had her own teeth and thad missing teeth. The care y how or when to provide oral clude and/or identification of ental health. The care plan minister medications, n characteristics, report to symptoms of non-verbal pain, n if interventions are current complaints were a from past experience of pain. I not include dental pain.	ersonnel The hygiene wn teeth and eth. The care o provide oral entification of the care plan tions, a, report to on-verbal pain, a are tis were a ience of pain.			
	assessment compl score a one on a 0	Dementia (PAINAD) eted 4/3/18, indicated R12 to to 10 scale (0="no pain" to The pain assessment did not of the pain.				
	acetaminophen 16 (milliliter) give 15 m back pain; acetami ml one time per da	for pain relief include 0 mg (milligrams)/5 ml 1 every 6 hours as needed for nophen 160 mg/5 ml, give 15 y for back pain; Tramadol 50 wice daily for pain in shoulder.				

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		AND HUMAN SERVICES				FORM	07/13/2018 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		LE CONSTRUCTION	(X3) DATI	E SURVEY IPLETED
		245329	B. WING	i		06/	14/2018
NAME OF I	PROVIDER OR SUPPLIER	•		S	STREET ADDRESS, CITY, STATE, ZIP CODE		
WARRO	AD CARE CENTER				1401 LAKE STREET NORTHWEST NARROAD, MN 56763		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 697	Continued From pa	ıge 39	Fŧ	697			
	 9/30/16, indicated F staff attempt to brue will often clench more giving R12 a preparation and verbally promp uncooperative. Will cares and scheduler No further dental of completed. Review of R12's real worsening of oral p dental treatment an -on 7/25/17, oral su (per letter from oral -on 11/28/17, (refer that R12 had been teeth. Possible too recommendation w wants a dental app pain control but did of teeth which if preserves a dental app pain control but did of teeth which	argery for extraction of 14 teeth I surgeon dated 7/31/18). rral form) nursing observation yelling more and grinding her th pain. Physician's vas to talk with son to see if he ointment. The other option is not know if there is infection esent could get worse. d evidence of an oral empts of, the record further monitoring for signs and ion, and also lacked evidence ber (FM)-A was contacted in al appointment for further th status note) when physician ober, R12 was showing signs bain again and talked about g remaining teeth extracted. asked if it looks like there is an					

DEPARTMENT OF HEALTH CENTERS FOR MEDICAR					FORM	07/13/2018 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
	245329	B. WING			06/ [,]	14/2018
NAME OF PROVIDER OR SUPPLIER		·	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
WARROAD CARE CENTER				401 LAKE STREET NORTHWEST VARROAD, MN 56763		
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
teeth? FM-B resp keep her comforta R12's record conti examinations and for oral pain and o infection. From 12 had no mention ar dental/oral health. Review of nursing interdisciplinary te through present da observations of R ² discomfort. - 4/12/18, PN, R12 that looked like it H - 5/16/18, IDT, ind tooth pain. -5/25/18, PN, R12 taking medication -5/26/18, PN, R12 shift, when drinkin and get upset. R1 teeth hurt and at o R12 will not open teeth. -5/27/18, PN, R12 taking a drink thro drinking. -5/30/18, IDT, indi "yes" " Call Dentis -5/31/2018, PN, w	made to extract remaining onded "yes, if it would help ible." nued to lack evidence of oral documentation of monitoring r signs and symptoms of /15/17 to 4/12/18, the record and did not address or evaluate progress notes (PN) and am (IDT) notes from 4/12/18, ay reflected an increase in staff 12 demonstrating oral 2 lost one of her molar teeth had rotten out. dicated grinding more - monitor did not like the cold juice when s. 2 had been grinding teeth this g cold liquid would pull back 2 was asked multiple times if ine point R12 did say "yes." mouth to allow you to look at was noted to be grinding her is shift, cold liquids irritate her y. did pull her head back while ugh a straw and then stopped cated teeth? "my teeth twitter" t." hen attempting to look in mouth dition of teeth R12 clamped lips	F6	97			

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245329	B. WING			06/ [,]	14/2018
NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
WARRO	AD CARE CENTER				401 LAKE STREET NORTHWEST WARROAD, MN 56763		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 697	-6/1/18, PN, R12 willing the table. -6/5/18, PN, R12 willing to tooth decay. appointments as net- 6/8/18, PN, R12 willing the supper pajamas, and gettin- 6/9/18, PN, R12 willing the supper pajamas, and gettin- 6/9/18, PN, R12 willing too -6/11/18, PN, R12 willing too -6/11/18, PN, R12 willing too -6/11/18, PN, R12 willing too -6/11/18, PN, R12 willing too -6/13/18, PN, Include Despite documenter pain, an examination cavity or attempts of identification of poss infection was not coo ongoing monitoring possible oral infection notified of the notate since 5/26/18, and and symptoms of a 6/5/18. In addition, the family was notifing had demonstrated at the signs and symp further lacked evide and/or a referral ma by a family member R12's physician pro- address oral/dental	as grinding her teeth at the as noted to have reddened w and upper right jaw, possibly Will notify family and make eeded. as grinding her teeth this shift table, while changing into og ready for bed. Illed her head back and would roo when trying to give food. vas noted to be grinding teeth g medications in milk. vas grinding teeth this evening <i>A</i> medications. Ided "teeth? in pain" ed concerns with teeth/oral on/assessment of R12's oral of assessment even after sible signs and symptoms of ompleted. There was no of signs and symptoms of a on. The physician was not ions of increased oral pain was not notified of the signs n oral infection that began on the record lacked evidence ied R12 had lost a tooth, R12 an increase in oral pain, and toms of infection. The record ence a dentist was contacted ade as directed on 12/15/17, r.	F	597			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	07/13/2018 APPROVED 0938-0391
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		PLE CONSTRUCTION	(X3) DATI	E SURVEY PLETED
		245329	B. WING	i		06/	14/2018
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
WARROA	D CARE CENTER				1401 LAKE STREET NORTHWEST WARROAD, MN 56763		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
	registered nurse (R observed making fa supplement from a facial grimaces indi- although could not o sucking through stra- At 12:04 p.m. RN-E son after referral or hold off with dental RN-E stated at this her pain and signs daily. RN-E stated family wishes were. no documentation of -At 12:36 p.m. RN-E progress note 6/5/1 would be notified ar needed. RN-E stated and FM-B, left mess heard back, and did the record. RN-E stated and FM-B, left mess heard back, and did the record. RN-E co noted while drinking could have been fro -At 12:45 p.m. NA-C increase in mouth p month and a half. N use a straw all the t grimacing. -At 12:51 p.m. conta who is the primary of stated R12 had 13 f stated there had no from the nursing ho oral discomfort and contacted with that -At 2:33 p.m. director her expectation was	hursing assistant (NA)-C and N)-E was observing. R12 was icial grimaces when drinking straw. NA-C stated that the cated that R12 was in pain determine if it was related to aw or the liquids being cold. E stated she had spoken to a 11/28/17, and son wanted to referrals for awhile longer. time they were just monitoring or symptoms of infection monitoring was what R12's RN-E verbalized there was of conversations with family. E was interviewed regarding 8, which indicated family appointments made as ed she tried to contact FM-A sages with them, had not I not document the attempt in onfirmed R12's discomfort of from a straw at lunch today of dental discomfort. C stated R12 was showing an bain for the last month to IA-C indicated R12 used to ime and now could not without acted family member (FM)-A contact by telephone. FM-A teeth pulled last year. FM-A t been any recent contact me regarding recent signs of FM-A would expect to be	F	697			

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		AND HUMAN SERVICES				FORM	07/13/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´			(X3) DATI	E SURVEY IPLETED
		245329	B. WING			06/	14/2018
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
WARROA	AD CARE CENTER				401 LAKE STREET NORTHWEST		
				V	WARROAD, MN 56763		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 697	Continued From pa	ige 43	Fe	697			
	signs of discomfort.	. The RN should not be					
		om family as we already have					
		hem dated 12/15/17, to have					
	teeth extracted if re	esident was experiencing pain.					
	On 6/14/18 at 7:22	2 a.m. NA-A stated R12 made					
		time, and it is common with					
		added R12 grinds teeth. NA-A					
	stated R12 was in p	pain, grinded her teeth all the					
		ind asleep. NA-A stated the					
		orted to the RN. NA-A					
		has had decreased appetitive					
		r, could not recall for how long. stated R12 was choosing not					
		it was related to pain. NA-C					
		nced with the cold liquids and					
		R12 pulled back and					
	5	rther stated, R12 would also					
		o at times and at times it					
		s teeth bothered her. NA-C veek, the left lower side of					
		/red and was reported to					
		ndicated, R12 grinded her					
		nd would not let staff use a					
		use a diluted mouthwash and					
		R12 resisted everyday by					
		ck. NA-C then stated R12 had					
		h odor, and there were days much and on other days she					
		g, and could not tell if it was					
		th or dementia. NA-A indicated					
	that she lets bevera						
		offering and R12 takes them					
	better.						
		A entered room with breakfast					
		atmeal and carnation instant					
		ot lips clamped shut, turned balized "no." NA-A would					
		h spoon and straw to attempt					

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	07/13/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		PLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245329	B. WING			06/ [,]	14/2018
NAME OF F	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
WARROA	D CARE CENTER				1401 LAKE STREET NORTHWEST WARROAD, MN 56763		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 697	R12's face appeare gets really warm. F drink milk, no grima swallowing. -At 8:36 a.m. NA-A breakfast. NA-A ma with a pink swab an opened mouth once opened mouth agai pink swab on left sig forward motion. R1 out of mouth. NA-A three times with R1 tightly closed. -At 9:49 a.m. conta R12 was never see dentist visited R12 c concluding there we extraction. FM-A do needed to be remov place. Dentist state consults regarding a contract with the r -At 10:30 a.m. activ R12 had been grind usually assists R12 week and had not r drinks, just noticed some sweating. No During the last 2 we puckering/tightening indicated pain could -At 11:00 a.m. licen stated she had not when drinking altho when administering swelling in the jaw a	mouth. NA-A indicated that d pink in color, but added R12 t12 began to take bites and cing noted or difficulty stated R12 consumed entire ade an attempt to do oral care d diluted mouthwash. R12 e and sucked on swab then n at which time NA-A placed de of mouth in a back and 2 yelled out and pushed swab a tempted to cleanse mouth 2 holding mouth clamped oted dentist by telephone. n in the dentist office but on 6/21/17, at nursing home, ere many teeth in need of ecided only the bad teeth ved and left the molars in ad there have been no further R12 and dentist does not have nursing home. ities aides (AA)-C indicated ling teeth. AA-C stated she with eating three times a oticed any problems with cold tightness of her mouth and o swelling of checks noted. eeks AA-C stated g of mouth increased and	F	697			

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		PLE CONSTRUCTION	(X3) DATI	E SURVEY PLETED
		245329	B. WING	i		06/	14/2018
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
WARRO	AD CARE CENTER				1401 LAKE STREET NORTHWEST WARROAD, MN 56763		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 697	require hospitalizati sepsis (a life-threat when the body's res- injury to its own tiss and possible death pretty good that cou LPN-B examined R filled teeth and som indicated R12 has g -At 12:14 p.m. RN-I dental concerns sof poor teeth and not a completed. The pla extracted although requested only infe- believes R12 has th stated R12 had rec- but unsure if it is de accident. RN-E ind examine R12's oral conversations with although not docum monitoring. RN-E s was just slight and RN-E was not able sepsis. RN-E stated completes the oral charting is not com When asked expect RN-E she indicated which she stated sh document attempt a -At 12:59 p.m. RN-/ dental assessment MDS. RN-A indicated annual MDS Octob noted on the assest	ge 45 on, intravenous medications, ening condition that arises sponse to infection causes sues and organs) could occur . LPN-B stated chances are uld happen with R12. When 12's oral cavity she noted he of them were black. LPN-B grinded teeth for a long time. E stated R12 began having metime last summer noting allowing oral cares to be an was to have all teeth family member intervened and cted teeth be removed. RN-E nere remaining teeth. RN-E ently been experiencing pain ental or back issues from past licated it was difficult to cavity. RN-E stated telephone family have occurred, nented, indicating to just keep tated redness noted on 6/5/18, was not reported to physician. to speak regarding risks of d the MDS coordinator assessments. RN-E indicated pleted regarding oral cares. tation if staff reported pain to a she would do an assessment, he attempted although did not and did not notify physician. A stated an oral exam and is completed with annual red when completing R12's er 2017, no problems were sment although she could not into R12's oral cavity. RN-A	F	697			

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STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		LE CONSTRUCTION		(X3) DATE	E SURVEY PLETED
		245329	B. WING	i			06/	14/2018
NAME OF F	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP (CODE		
WARRO/	AD CARE CENTER				1401 LAKE STREET NORTHWEST WARROAD, MN 56763			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD	BE	(X5) COMPLETION DATE
F 697	stated R12 had pain dental or something -At 2:20 p.m. direct dentist should have DON confirmed a s for emergency serv the family should has should have been d conversations with that risk and benefit discussed with famil Attempts to contact Dental Services pro- indicated oral health the data collection a promptly referred to Pain policy dated 3/ directed physician a who have pain or w related to oral or de nursing staff will as new pain or worsen nursing staff to asse approach and a sta instrument nursing staff will ob movement) for evid the staff and physic is affecting mood, a and the resident's of complication such a appetitive. the physician will he example by examin	n at the time but was unclear if g else. tor of nursing (DON) stated a e been contacted for R12. signed contract with a dentist vices did not exist. DON stated ave been contacted and there documentation regarding any family. It would be expected its should have been ily. t FM-B were unsuccessful. ocedure dated 3/9/17, h review will be completed with annually. Residents will be o a dentist. /1/17: and staff to identify individuals /ho are at risk for having pain ental pathology. sess when there is onset of ning of existing pain. ess pain using a consistent andardized pain assessment oserve resident (during rest and	F	697				

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	07/13/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		245329	B. WING			06/	14/2018
NAME OF F	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
WARROA	AD CARE CENTER				401 LAKE STREET NORTHWEST VARROAD, MN 56763		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
	and related conseq least each shift for i Pain Assessment a dated 3/1/17: pain management i potential for pain, e presence of pain, ic pain, addressing the developing and imp management, ident strategies for different monitoring for the e modifying approach comprehensive pain there is onset of ne existing pain, assess consequences of pain. report the following significant changes pain, adverse effect prolonged, unrelieve interventions. Pharmacy Srvcs/Prr CFR(s): 483.45(a)(I §483.45 Pharmacy The facility must pro- drugs and biologicat them under an agre §483.70(g). The fa personnel to admin permits, but only un a licensed nurse.	assess the individual's pain uences at regular intervals; at newly identified pain. Ind Management procedure includes: assessing the ffectively recognizing the lentifying the characteristics of e underlying causes of pain, ilementing approaches to pain ifying and using specific ent levels and sources of pain, ffectiveness of interventions, ues as necessary, conduct a in assessment quarterly, when w pain or worsening of as the resident's pain and ain at least each shift for acute information to physician: in the level of the resident's ts from pains medications, ed pain despite care plan ocedures/Pharmacist/Records o)(1)-(3) Services ovide routine and emergency ls to its residents, or obtain	F 6				7/12/18

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		AND HUMAN SERVICES & MEDICAID SERVICES			FOI	ED: 07/13/2018 RM APPROVED IO. 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (X3) [OMPLETED
		245329	B. WING	i		6/14/2018
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	
WARRO	AD CARE CENTER				401 LAKE STREET NORTHWEST VARROAD, MN 56763	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	pharmaceutical ser that assure the acc dispensing, and adu biologicals) to meet §483.45(b) Service must employ or obt pharmacist who- §483.45(b)(1) Provi aspects of the prov the facility. §483.45(b)(2) Estat receipt and disposit sufficient detail to e reconciliation; and §483.45(b)(3) Dete order and that an adu is maintained and p This REQUIREMEN by: Based on observat failed to ensure a co (lorazepam) that has reconciled to ensure diversion for 1 of 2 facility. This had th who were prescribe emergency basis. Findings include On 6/13/18, at 1:27 room was toured wi During the tour a bo which contained lor	vices (including procedures urate acquiring, receiving, ministering of all drugs and the needs of each resident. Consultation. The facility ain the services of a licensed des consultation on all ision of pharmacy services in olishes a system of records of ion of all controlled drugs in nable an accurate rmines that drug records are in ccount of all controlled drugs eriodically reconciled. NT is not met as evidenced ion and interview, the facility ontrolled medication is potential for abuse was e rapid detection of potential storage rooms toured at the e potential to affect residents	F	755	 Lock boxes were purchased for A at B wing medication room refrigerators ar Lorazepam was placed under double lo on June 14 with reconciliation process established for emergency kit controlled medication requiring refrigeration. Reconciliation has been accomplished every shift since June 14 at shift change with two nurses signing. Intervention above will resolve this deficient practice for all residents at WSLC. Medication Storage Policy has been established, approved by consulting pharmacist, and will be discussed with nurses during July 12 nursing staff 	d xk

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		AND HUMAN SERVICES				FORM	07/13/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·			(X3) DATE	E SURVEY PLETED
		245329	B. WING _			06/ [,]	14/2018
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
WARRO/	AD CARE CENTER				01 LAKE STREET NORTHWEST ARROAD, MN 56763		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
	labeled E-kit (emerg medication was par refrigeration. RN-D controlled medication abuse and required nurses every shift) indicated the facility medication and it w if doses were missin On 6/13/18, at 2:29 (DON) verified loration controlled medication and required recome DON confirmed this the facility and the f place for the recome controlled medication The facility Policy a Controlled Medication to provided by the Routine/Emergency CFR(s): 483.55(a)(1) §483.55(a)(1) Must outside resource, in §483.70(g) of this p	gency kit). RN-D stated the t of the E-Kit which required indicated lorazepam was a on that had a potential for reconciliation (counted by two to avoid diversion. RN-D y was not counting this rould not be easily identifiable ng. p.m. the director of nursing zepam was considered a on that had potential for abuse ciliation by nurses every shift. s practice was not occurring at facility did not have a system in ciliation of refrigerated E-Kit ons. nd Procedure for Storage of ons was requested although facility. y Dental Srvcs in SNFs 1)-(5) vices. sist residents in obtaining remergency dental care.	F 75		meeting. 4) DON receives e-kit controlled medication requiring refrigeration reconciliation sheets monthly and w monitor compliance and report discrepancies or areas of concern to QAPI Committee. A field was addeed consulting pharmacist monthly audit to include checking proper storage reconciliation of refrigerated control medications.	to d to it sheet and	7/12/18

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM /	07/13/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE	SURVEY PLETED
		245329	B. WING			06/1	4/2018
NAME OF F	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
WARRO	AD CARE CENTER				401 LAKE STREET NORTHWEST /ARROAD, MN 56763		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 790	additional amount fe dental services; §483.55(a)(3) Must circumstances whe dentures is the facil charge a resident fo dentures determine policy to be the faci §483.55(a)(4) Must assist the resident; (i) In making appoin (ii) By arranging for dental services loca §483.55(a)(5) Must residents with lost of dental services. If a 3 days, the facility n what they did to ens and drink adequate services and the ex led to the delay. This REQUIREMEN by: Based on observat review, the facility fa for 1 of 1 resident (I In addition, the facil agreement to obtain which could affect a Findings include: R12 had been observed p.m. located in the	charge a Medicare resident an or routine and emergency have a policy identifying those n the loss or damage of ity's responsibility and may not or the loss or damage of d in accordance with facility lity's responsibility; if necessary or if requested, ntments; and transportation to and from the	F 7	.90	1) The affected resident has been assessed here at WSLC by Cindy Dross-Sandy, DDS, with recommend for referral to oral surgeon to remove remaining teeth. Family has agreed surgery and an appointment has been made for July 30, 2018. Resident was started on Augmentin for facial flush and fever on June 29, 2018. Pain monitoring had already been on nurs charting board, but has also added t e-Mar as of July 6, 2018, and an ord	e I to en as ing se so	

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE CONSTRUCTION	(X3) DATE	
ID PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG	COMP	LETED
		245329	B. WING		06/1/	4/2018
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE	, ZIP CODE	
VARRO	AD CARE CENTER			1401 LAKE STREET NORTHW WARROAD, MN 56763	/EST	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETIC DATE
F 790	Continued From pa	ge 51	F 7	90		
	observed to be mak fists, and pushing s	king facial grimaces, clenching self away from table while n liquids. R12 was observed to		obtained for prn Trama scheduled Tramadol a event of pain observed 2) An oral inspection	nd Tylenol in the I.	
	assessment dated severe cognitive im able to make self up others. R12 require eating and oral care had indicators of pa grimaces, winces, w	num Data Set (MDS) an 10/1/17, indicated R12 had pairment and was rarely/never nderstood or understand ed extensive assistance with es. The MDS indicated R12 ain (facial expressions - wrinkled forehead, furrowed th or jaw) one to two days and		assessment will be cor on all WSLC residents teeth in poor condition and dental examination be made if appropriate has been established v Dross-Sandy, DDS, wh examinations at WSLC	mpleted by an RN with their own by July 10, 2018, n appointments will . A dental contract with Cindy no performs dental	
	received scheduled Review of R12's no -on 7/25/17 oral sur (per letter from oral -on 11/28/17, (refer that R12 had been teeth. Possible too recommendation w (FM)-A to see if R12 The other option is if there is infection of get worse.	I pain medication. tes: rgery for extraction of 14 teeth surgeon dated 7/31/18) ral form) nursing observation yelling more and grinding her th pain. Physician's as to talk with family member 2 needs a dental appointment. pain control but I do not know of teeth which if present could		 3) Dental assessment by RN in conjunction wassessments, and a file Care Conference form discussion with resider dental needs. A remin all nursing staff to report oral pain to charge nur newsletter on June 24, be included in the July agenda. 4) WSLC Director of design and the state of t	vith quarterly MDS eld added to WSLC to trigger a nt/family related to der was provided to ort any evidence of se in nursing and this will also 12 nursing meeting f Nursing or	
	was here in Novem of possible mouth p possibility of having FM-B notified and a increase in pain or arrangements be m	nade to extract remaining nded "yes, if it would help		designee will monitor of completed quarterly wi follow up and report fir QAPI Committee. Rep provided for a minimur until such time the Cor there is no longer a ne satisfactory performan documentation.	th appropriate adings to the facility ports will be n of six months and nmittee determines ed based on	

	-	AND HUMAN SERVICES				FORM	07/13/2018 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245329	B. WING			06/	14/2018
NAME OF	PROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
WARRO	AD CARE CENTER				401 LAKE STREET NORTHWEST VARROAD, MN 56763		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 790	oral discomfort: -on 4/12/18, R12 lo looked like it had ro - on 5/25/2018, R12 when taking medic -on 5/26/2018, R12 shift, when drinking and get upset. R12 teeth hurt and at on R12 will not open m teeth. - on 5/27/18, R12 w teeth on and off this and she pulls away - on 5/30/18, R12 d taking a drink throu drinking. - on 5/31/18, when see current condition together and would - on 6/1/18, R12 wa lunch table. - on 6/5/18, R12 wa area to lower left jar due to tooth decay. appointments as ne - on 6/8/18, R12 wa while at the supper pajamas, and gettir - on 6/9/18, R12 pu shake her upper tor - on 6/11/18, R12 wa while taking mornin - on 6/11/18, R12 wa while getting her PM Review of Interdisco reports:	est one of her molar teeth that often out. 2 did not like the cold juice cations. 2 had been grinding teeth this g cold liquid would pull back 2 was asked multiple times if he point R12 did say "yes". nouth to allow you to look at was noted to be grinding her s shift, cold liquids irritate her f. lid pull her head back while ugh a straw and then stopped a attempting to look in mouth to on of teeth R12 clamped lips not open mouth. as grinding her teeth at the as noted to have reddened w and upper right jaw, possibly Will notify family and make eeded. as grinding her teeth this shift table, while changing into ng ready for bed. Illed her head back and would rso when trying to give food. vas noted to be grinding teeth ng medications in milk. as grinding teeth this evening	F 7	790			

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		AND HUMAN SERVICES				FORM	APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /			(X3) DATI	E SURVEY IPLETED
		245329	B. WING _			06/	14/2018
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	·	
WARROA	AD CARE CENTER				01 LAKE STREET NORTHWEST ARROAD, MN 56763		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 790	tooth pain - on 5/30/18, indica "yes" Call Dentist - on 6/13/18, indica There had been no appointment was se evident oral pain wi month. On 6/14/18 at 2:20 stated absolutely a contacted for R12. Lack of dental agre On 6/14/18, at 8:54 written statement in copy of dental contr survey there was no provided by the faci	ted teeth? "my teeth twitter" ted teeth? in pain indication that a dental et up for R12 even with ith eating/drinking over past p.m. director of nursing (DON) dentist should have been eement: a.m. Administrator provided a ndicating still looking for signed ract with a dentist. By end of o signed dental agreement	F 75	90	DEFICIENCY)		
	with dental services						
F 804 SS=E	directed physician a who have pain or w related to oral or de Nutritive Value/App	and staff to identify individuals /ho are at risk for having pain ental pathology. ear, Palatable/Prefer Temp	F 80	04			7/24/18
	§483.60(d) Food ar Each resident recei	nd drink ives and the facility provides-					

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PRINTED: 07/13/2018

	OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CONSTRUCTION		0938-039 SURVEY
ND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING	COM	PLETED
		245329	B. WING		06/14/2018	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
WARRO	AD CARE CENTER			1401 LAKE STREET NORTHWEST WARROAD, MN 56763		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		D BE	(X5) COMPLETION DATE
F 804	Continued From pa	qe 54	F 8	04		
	§483.60(d)(1) Food	l prepared by methods that value, flavor, and appearance;				
	attractive, and at a temperature.	l and drink that is palatable, safe and appetizing NT is not met as evidenced				
	by: Based on observat	tion, interview and document		The facility will maintain acceptab		
	temperatures were	ailed to ensure food of resident preference for 1 of 1 resident (R13) alatability.		parameters for food and drink that palatable, attractive and at a safe appetizing temperature.	and	
	Findings include:			 Resident comments from findings were reviewed in addition comments from Resident Council 		
	R13 had diagnosis	ecord dated 6/14/18, indicated that included diabetes, y, and vascular dementia disturbance.		minutes. 2. RD, or Kitchen Manager will a Resident Counsel meetings upon invitation to address any concerns to food service activities.		
	assessment, dated	inimum Data Set (MDS) an 4/4/18, indicated he could others, had no behaviors and		 Follow up of any concerns from Resident Counsel or daily meal set will take place in a timely manner be reported at Resident Counsel r on a regular basis. 	rvice and will	
	was able to feed his plan also indicated	tted 3/29/18, indicated R13 mself after set up. R13's care he was able to make simple make himself understood.		As of 7/6/18 all staff have been ed on safe food holding and service, as educating staff on taking tempe prior to service. Policy and Procedures for holding	as well eratures	
	be improved as gre	p.m., R13 stated food could en beans are served often, no ed them, and breakfast foods t.		will be revised by 7/12/18. Staff w be educated on customer service pertaining to resident satisfaction meals by 7/24/18.	erature ill also skills	
	were warm and like	a.m., R13 stated his eggs d them hot. R13's table mate tion and agreed the food was		 4. Food temperatures will be log daily at time of service. Weekly a be conducted by kitchen manager 	udits will	

	OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE	0938-039 SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	<u> </u>	СОМ	PLETED
		245329	B. WING		06/	14/2018
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
WARRO	AD CARE CENTER			1401 LAKE STREET NORTHWEST WARROAD, MN 56763		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 804	Continued From pa	ige 55	F 804	1		
	warm and not hot a	is they liked.		be reported at QAPI meetings. Au		
	On 6/14/18 at 8·14	a.m., R13 was observed		be performed for 3 days out each resident meal satisfaction either b		
		When asked about breakfast,		Director of Dining Service or unde		
		good today." When asked if it		direction. They will be conducted		
		13 replied, "Well, it's never could write down we don't get		random dining room and at randor times as chosen by the Director.	n meal	
	hot food.	Source with the down we don't get		Sampling will be reviewed to make	e sure	
	0.04440.400			we are covering all dining rooms a		
		a.m., a breakfast test plate n dietary aide (DA)-A. DA-A		of the three main meal times. Auc be reported by the Director at Res		
	used a thermometer	er to test the oatmeal, which		Food & Council meetings and QA	PI	
		s Fahrenheit (F); the egg bake,		meetings until goal 85% appropria responses is met for 2 consecutive		
		, and the sausage which was A-A stated she had put the food		months. At that time the Committee		
	in the steam tables	at the station at approximately		change audit frequency and numb		
		sted, the oatmeal tasted hot, he sausage luke warm.		they are comfortable that the prob been resolved on an ongoing basi		
		g resident council having a rving foods hot for several esolution.				
	2017, indicated all to appropriate inter served at a temper	emperatures policy, dated hot food items must be cooked nal temperatures, held and ature of at least 135F. Review sked direction on palatability of				
	· ·	Store/Prepare/Serve-Sanitary)(2)	F 812	2		7/24/18
	§483.60(i) Food sa The facility must -	fety requirements.				
		cure food from sources ered satisfactory by federal, rities.				

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	: 07/13/2018 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		E CONSTRUCTION (X3) DA	TE SURVEY MPLETED
		245329	B. WING		06	/14/2018
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	
WARRO	AD CARE CENTER				401 LAKE STREET NORTHWEST /ARROAD, MN 56763	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	from local producer and local laws or re (ii) This provision de facilities from using gardens, subject to safe growing and fo (iii) This provision de from consuming food §483.60(i)(2) - Store serve food in accor- standards for food a This REQUIREMEN by: Based on observat review, the facility fave vegetable beef sour and/or minimize the This deficient pract jeopardy (IJ) due to illness for all 47 res facility and received The immediate IJ w it was determined the not cooled to the ap the required timefra growth of infectious borne illnesses. The director of nursing (on 6/11/18, at 8:26 6/13/18, but non-co- lower scope and se	e food items obtained directly s, subject to applicable State gulations. Des not prohibit or prevent produce grown in facility compliance with applicable ood-handling practices. Des not preclude residents ods not procured by the facility. e, prepare, distribute and dance with professional service safety. NT is not met as evidenced ion, interview and document ailed to appropriately cool p in a manner that prevented e risk for food borne illness. ice resulted in an immediate the potential risk of serious sidents who resided in the d meals from the kitchen. vas identified on 6/11/18, when he vegetable beef soup had opropriate temperature within the in order to prevent the forganisms which cause food e administrator and the (DON) were informed of the IJ p.m. The IJ was removed on impliance remained at the verity of an F, widespread, no tential for more than minimal	F	312	 on 06/12/2018 the facility provided a Plan of Correction for the Immediate Jeopardy situation that included the following: Monday 06-11-18 Upon notification of the problem by the survey team the Chef Manager was notified by phone and we initiated alternate menu planning for the next day. Approximately 8:50 p.m. Items in the cooler were specifically identified with the Chef manager over the phone, removed and disposed. Approximately 9:00 p.m. Chef Manager returned to the kitchen to inspect for any similar concerns in the cooler or other food storage areas. Approximately 9:15 p.m. Communicated the situation with the Dining Services Director/ Registered Dietitian who is currently on maternity leave. She indicated the ability to come to 	

Event ID: VNT411

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	OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	. ,	G	COMPLETED
		245329	B. WING _		06/14/2018
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE
WARRO	AD CARE CENTER			1401 LAKE STREET NORTHWEST WARROAD, MN 56763	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLÉTIO
F 812	Continued From pa	ge 57	F 81	2	
		chen tour on 6/11/18, at 3:14		the facility in the morning to	assist with
		A, the following was observed		Plan of Correction and follo	
	sitting on the count			Approximately 9:45 p.m.	
		re plastic container with		Tuesday 06-12-18	
		inch congealed surface. The		E Mot with morning Cook	[Com/o Cofo
	container was com -A two gallon stock			5. Met with morning Cook Certified] and discussed up	
		inch thick, crust like,		and looked for any issues the	
		The pot was $\frac{1}{2}$ full.		concern for similar food har	
	g			related issues. Approximat	
	At the time of the o	bservation, C-A stated she had		6. Contacted Consultant E	3
		getable beef soup at 2:00		seek assistance with trainin	
		in the above containers and		and suggestions for immed	
		ool. C-A stated at that time the		for training. Approximately	
		he containers, it measured 207 d the soup was for the next		7. Dining Services Directo	
		C-A stated it would take about		site to begin plan for immed team members. Approxima	
		to cool down to the appropriate		a.m.	
		oup had not been stirred since			
		ter. At the request of the		Following pages further indi	cate our plans
	surveyor, C-A chec	ked the temperature of both		to correct the deficient prac	tice and obtain
		evealed both measured 120		compliance.	
		d the soup was getting closer			
		put in the refrigerator and		1. Dining Services Direct the policy manual that has been serviced as the policy manual that has the policy manual that has the policy manual that has the	
	had cooled down so	e soup in the cooler once it		review and development to	
		one more.		existing policies. [Becky Do	
	-At 5:15 p.m. the di	etary manager (DM)		policies were reviewed and	
		ngs and stated for now, they		out to staff onsite starting 0	
		the coolers. The DM stated		[General Food Preparation	
		food should be less than two		General HACCP Guidelines	
		o stated within two hours, the		Handling.]Staff members no	
		cooling food should have been		today will be trained prior to	
		one (period when bacteria of 41 degrees. The DM also		scheduled shift. All training be maintained.	
		roperly cool food, it should			
		smaller divided containers and		In addition the facility throug	the Director
		ler. The DM stated he had		will purchase online training	

TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		E SURVEY	
	FORRECTION	IDENTIFICATION NUMBER.	A. BUILDING	3		FLETED	
		245329	B. WING		06/	14/2018	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
WARRO	AD CARE CENTER			1401 LAKE STREET NORTHWEST WARROAD, MN 56763			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	ILD BE	(X5) COMPLETIO DATE	
F 812	Continued From pa	ge 58	F 81:	2			
	worked at the facilit was previously Serv had not kept up the DM stated there was member that was c -At 6:03 p.m. both c observed on the bo DM stated he was u actually placed in th "log." The DM state documentation on t 100 degrees at 4:30 in the cooler, howev was for both contain verified there was n soup's temperature taken/monitored as the DM obtained the containers. The pla degrees and the me DM stated he was u protocols for all foo purchasing cooling/ cooling of foods but ordered any, yet. -At 6:38 p.m. the DI have been cooled s again confirmed the for cooling time to p therefore should ha smaller divided con properly in order to	y for about two months and VSafe certified, however, he certification. In addition, the is only one kitchen staff urrently ServSafe certified. containers of soup were ttom shelf of the cooler. The unsure what time the soup was be cooler and referred to a d according to the he "log," the soup measured 0 p.m. just prior to it being put ver, he did not know if that hers, or just one. The DM to further documentation of the s having been it was cooling. At this time, e temperature of both stic container's soup was 130 etal pot was 90 degrees. The uncertain of the cooling ds and was in the process of fice sticks to aid in the rapid t confirmed he had not M confirmed the soup should cooner and faster. The DM e soup had less than two hours prevent bacterial growth, ve been placed in a cooler in tainers in order to cool prevent food borne illness. soup was going to be		 supplement policy implementatic Training will begin on 06/13/2018 be completed by /06/20/2018 [B Dorner Food Safety Made Easy In-service.] Additional online trai [ServSafe Food Handler Online] completed with all departmental June 30, 2018. To monitor compliance with polic online training the following mon be initiated immediately and will until compliance is satisfactory. will be reviewed daily by the Che Manager and/or department dire Trended results will be shared w Committee and reviewed at their scheduled meetings. [Critical Co Point Documentation Form] Additional information to include previous POC: Staff members completed review related policies prior to their next shift. All completed review by 6/1 Staff members were educated of food handling including cooling procedures using Becky Dorner Safety Made Easy on 6/20/2018. post tests were given and compl time of completion. All staff members will complete S Food Handler Certificate online to 7/10/18. Any new hires will complete train safe food handling during orientat to start date using Becky Dorner 	and will ecky ning will be staff by y and toring will continue All results f ctor. th QAPI regularly ntrol with y of schedule 6/18. n proper Food Pre and eted at ServSafe raining by ing on ttion prior		

Facility ID: 00797

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STATEMEN	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	(X3) DAT	<u>. 0938-039</u> E SURVEY		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G	CON	IPLETED		
		245329	B. WING			14/2018		
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE			
WARRO	AD CARE CENTER		1401 LAKE STREET NORTHWEST WARROAD, MN 56763					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE		
F 812	soup was not coole The RD stated edu the staff. On 6/14/18, at 12:2 consultant stated th her of the IJ and ag cooled which could illness if consumed The facility's undate Guidelines for Food bullet #5, titled, Ess staff to cool food fro in two hours and fro in four hours, not to not cooled to 41 de to 65 degrees for a hours) and discard This included mech temperatures freque methods of cooling directed staff to: -divide food into se containers that per Place pans in an in cool, then refrigerat more ice than wate storage refrigerator the total temperatu level). -Place cooling item refrigerator or freez	emoval of the IJ, confirmed the ed properly and was discarded. cation would be provided to 21 p.m. the on call dietary he administrator had informed greed the soup was improperly have caused food borne	F 81	2 tests. All training records will be m Cooling logs for CCP foods used and records will be ma year. Audits of temperature performed weekly by Kitche and monthly by RD. New menu □s including reci CCP □s have been ordered implemented by 7/23/18. A kitchen staff will be trained to mandatory use of new recip sign every menu and diet sp highlighting foods of concer CCP □s. New small wares appropria will be purchased including by 7/23/18.	are being aintained for 1 log will be n Manager pes with and will be ppropriate o the es. RD will oread n relating to			

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 07/13/2018 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245329	B. WING			06/	14/2018
NAME OF	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
WARRO	AD CARE CENTER				01 LAKE STREET NORTHWEST ARROAD, MN 56763		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU) CROSS-REFERENCED TO THE APPRC DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 812	Continued From pa	ge 60	F 8	312			
F 865 SS=F	notified that the IJ h following facility inter- discarded the sour initiated an alternate -inspected the kitch the coolers and oth -notified the RD wh come to the facility and education. -reviewed the upcor concerns related to -contacted the cons assistance with train suggestions. -reviewed and/or re related to the prope -online education (S related to food safe training for all dining would begin on 6/13 by 6/20/18. -revised/updated cu- educated all kitche policies and proced safe and proper coo QAPI Prgm/Plan, D CFR(s): 483.75(a)(2) §483.75(a)(2) Prese	vised policies and procedures or cooling of foods. ServSafe Food Handler) ty was purchased and the g service team members 3/18, and would be completed urrent policies and procedures. n staff on the revised/updated ures specifically related to the bling of foods. isclosure/Good Faith Attmpt 2)(h)(i) assurance and performance I) program. ent its QAPI plan to the State ater than 1 year after the	F٤	365			7/24/18

Facility ID: 00797

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	RS FOR MEDICARE				OMB NO.		
	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	· · ·	E SURVEY IPLETED	
		245329	B. WING _		06/	14/2018	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (CODE	•	
NARRO	AD CARE CENTER			1401 LAKE STREET NORTHWEST WARROAD, MN 56763			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETIC DATE	
F 865	§483.75(h) Disclosi A State or the Secret disclosure of the re- except in so far as a the compliance of s requirements of this §483.75(i) Sanction Good faith attempts and correct quality a basis for sanction This REQUIREMEN by: Based on interview facility failed to com- assessment (QA) a develop and implem action to correct qu during the survey the should have been a to adversely affect a facility. Findings include: On 6/14/18, at 1:30 (DON) stated the fai include policies and and correct its own development stage implemented. DON projects had been i and infection control existing quality assi- timelines with corre- with timelines had r	ure of information. etary may not require cords of such committee such disclosure is related to such committee with the s section. as. s by the committee to identify deficiencies will not be used as	F 86		en addressed s specifically ce under other ficiency. sidents with the specific n addressed ell. hensive facility ed and will be nd approval at g scheduled for dized QAPI a has been sident council equirements, itored in follow		

Facility ID: 00797

		AND HUMAN SERVICES				FORM	07/13/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	```		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245329	B. WING			06/ [,]	14/2018
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
WARRO	AD CARE CENTER				401 LAKE STREET NORTHWEST VARROAD, MN 56763		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 865	quality assurance (i the lack of leadersh department; goals a situation had not be QA committee had committee identified council grievances the lack of required hour annual nurse a The following areas identified during the not identified for pe initiatives and/or wa monitoring systems areas in need of im committee: See F812: Based of document review th cooling methods of manner that would risk for food-borne to effect all 47 resion This deficient pract jeopardy that was id See F697: Based of document review, th had been assessed appropriate interven for 1 of 1 residents pain. This deficient See F565: Based of review, the facility for council's concerns quantity and quality	QA) committee was aware of hip and training in the dietary and action plans to resolve the een developed. In addition, the not been apprised nor had the d the continued resident pertaining to food quality and d dementia care training and 12 aide training. s of deficient practices were e course of survey that were rformance improvement as there evidence of QA is to assist in ascertaining provement by the QA on observation, interview, and he facility failed to use the safe soup for future use in a minimize and/or prevent the illness. This had the potential dents resident in the facility. ice resulted in an immediate dentified on 6/11/18. on observation, interview and he facility failed to ensure pain	F 8	365	maintained in the meeting minutes		

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		AND HUMAN SERVICES				FORM	07/13/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245329	B. WING			06/ [,]	14/2018
NAME OF F	PROVIDER OR SUPPLIER	-		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
WARROA	AD CARE CENTER				401 LAKE STREET NORTHWEST VARROAD, MN 56763		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 865	active members of See F947: Based o review, the facility fa annual in-service tr 4 nursing assistants whose personnel re addition, the facility dementia training w nursing assistants (personnel records v The following areas identified during the were identified in th provided by the dire lacked overall quali to maintain complia deficient practices. evidence of identific plans that included frames for completi evidence interventio analyzed, reevaluat to ensure successfue See F692: Based o review, the facility fa comprehensive nut prevent, assess, an significant weight lo reviewed for nutrition See F804: Based of document review th foods were served a	5, R34, R38, R41 and R8) the facility resident council. n interview, and document ailed to ensure 12 hours of aining was completed by 4 of s (NA-G, NA-H, NA-I, NA-J) ecords were reviewed. In failed to ensure required vas completed by 4 of 4 (NA-D, NA-E, NA-F) whose were reviewed. s of deficient practices were e course of the survey that e QA committee minutes ector of nursing; however, ty assurance activities in order ince with identified areas of The minutes further lacked cation of comprehensive action specific goals, and time ion. The minutes also lacked, ons were implemented, ted and revised as necessary ul completion. n interview and document ailed to complete a ritional assessment and ad monitor subsequent bas for 1 of 5 residents (R27) on.	F	365			
	Minutes dated 7/12	/17, identified multiple					

		AND HUMAN SERVICES				FORM	07/13/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE	E SURVEY PLETED
		245329	B. WING			06/ [,]	14/2018
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
WARRO	AD CARE CENTER				401 LAKE STREET NORTHWEST VARROAD, MN 56763		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 865	quality, however, di resident council. M resident with excess and indicated a teat working on identifyi loss. However, the goals with timeliness plans with timeliness improvement. Minutes dated 10/1 number of residents excessive/unexplained Mad gained weight a reflect unexplained Minutes further refle low resident satisfa dining services; the negotiations for cor hired dining service reflect identification pertaining to food q developed goals wi corresponding action Minutes dated 1/3/1 resident council grid quality and indicate the 4th quarter. The progress on the exc The minutes indicate satisfaction scores implement a two ye project. Minutes lact timelines and correct timelines for improve	 March, pertaining to food d not reflect concerns from the linutes also reflected one sive/unexplained weight loss m was established and ng residents at risk for weight minutes lacked developed and corresponding action for sustainability or 0/17, identified an increase in s (2) with ned weight loss, however, one and was not expected to weight loss next quarter. ected, ongoing concerns with ctions and grievances for minutes reflected nsulting dietician and newly s director. The minutes did not of resident council concerns uality. The minutes lacked th timelines and on plans for improvement. 18, lacked identification of the evances pertaining to food d no grievances were made in e minutes also did not address cessive/unplanned weight loss. ted a goal to improve resident for dining with a plan to ear performance improvement cked identification of goals with sponding action plans with 	Fξ	365			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	07/13/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245329	B. WING			06/	14/2018
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
WARROA	AD CARE CENTER				1401 LAKE STREET NORTHWEST NARROAD, MN 56763		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 865 F 880 SS=F	residents with excer The minutes reflect date was delayed re- leadership. Minutes with timelines and co- with timelines for im The facility did not procedure for qualit Infection Prevention CFR(s): 483.80(a)(1) §483.80 Infection C The facility must es infection prevention designed to provide comfortable environ development and tr diseases and infect §483.80(a) Infection program. The facility must es and control program a minimum, the follo §483.80(a)(1) A sys reporting, investigat and communicable staff, volunteers, vis providing services u arrangement based conducted accordin accepted national s	evances and did not address ssive/unexplained weight loss. ed the dietary project start elated to department a lacked identification of goals corresponding action plans provement. provide a policy and cy assurance activities. n & Control 1)(2)(4)(e)(f) control tablish and maintain an and control program a safe, sanitary and ment and to help prevent the ansmission of communicable ions. n prevention and control tablish an infection prevention n (IPCP) that must include, at owing elements: etem for preventing, identifying, ting, and controlling infections diseases for all residents, sitors, and other individuals under a contractual upon the facility assessment og to §483.70(e) and following tandards;		380			7/12/18
	§483.80(a)(2) Writte	en standards, policies, and program, which must include,					

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		AND HUMAN SERVICES				FORM	07/13/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245329	B. WING			06/	14/2018
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
WARRO	AD CARE CENTER				1401 LAKE STREET NORTHWEST WARROAD, MN 56763		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	but are not limited t (i) A system of surve possible communic infections before the persons in the facili (ii) When and to wh communicable dise reported; (iii) Standard and tra- to be followed to pro- (iv)When and how i resident; including the (A) The type and du depending upon the involved, and (B) A requirement the least restrictive pos- circumstances. (v) The circumstance must prohibit emplo- disease or infected contact with resider contact will transmit (vi)The hand hygier by staff involved in or §483.80(a)(4) A sys- identified under the corrective actions ta §483.80(e) Linens. Personnel must han transport linens so a infection. §483.80(f) Annual r The facility will cond	o: eillance designed to identify sable diseases or ey can spread to other ity; nom possible incidents of ease or infections should be ansmission-based precautions event spread of infections; isolation should be used for a but not limited to: uration of the isolation, e infectious agent or organism that the isolation should be the esible for the resident under the ces under which the facility by ees with a communicable skin lesions from direct t the disease; and ne procedures to be followed direct resident contact. estem for recording incidents facility's IPCP and the aken by the facility. ndle, store, process, and as to prevent the spread of	F8	380			

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	OF DEFICIENCIES	<u>& MEDICAID SERVICES</u> (X1) PROVIDER/SUPPLIER/CLIA	(X2) MI II TII	PLE CONSTRUCTION	OMB NO.	E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:		G		PLETED
		245329	B. WING		06/	14/2018
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
WARRO	AD CARE CENTER			1401 LAKE STREET NORTHWEST WARROAD, MN 56763		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE
F 880	Continued From pa	qe 67	F 88	0		
		NT is not met as evidenced	1 00			
	review, the facility f for 1 of 1 resident (In addition, the facili agreement to obtain which could affect a Findings include: R12 had been obset p.m. located in the unidentified nursing observed to be mail fists, and pushing s being fed and giver have several missin R12's annual Minim assessment dated severe cognitive im able to make self u others. R12 require eating and oral care had indicators of pa grimaces, winces, y brow, clenched tee received scheduled Review of R12's no	num Data Set (MDS) an 10/1/17, indicated R12 had pairment and was rarely/never nderstood or understand ed extensive assistance with es. The MDS indicated R12 ain (facial expressions - wrinkled forehead, furrowed th or jaw) one to two days and I pain medication.		 The affected resident has be assessed here at WSLC by Cind Dross-Sandy, DDS, with recomm for referral to oral surgeon to rem remaining teeth. Family has agu surgery and an appointment has made for July 30, 2018. Resider started on Augmentin for facial f and fever on June 29, 2018. Pai monitoring had already been on charting board, but has also add e-Mar as of July 6, 2018, and ar obtained for prn Tramadol in add scheduled Tramadol and Tyleno event of pain observed. An oral inspection with pain assessment will be completed b on all WSLC residents with their teeth in poor condition by July 10 and dental examination appointr be made if appropriate. A denta has been established with Cindy Dross-Sandy, DDS, who perform examinations at WSLC if neede Dental assessments will be by RN in conjunction with quarter assessments, and a field added Care Conference form to trigger 	dy nendation nove reed to been at was lushing n nurse ed to order dition to l in the y an RN own 0, 2018, nents will l contract ns dental d. completed rly MDS to WSLC	
	that R12 had been teeth. Possible too recommendation w (FM)-A to see if R1.	ral form) nursing observation yelling more and grinding her th pain. Physician's as to talk with family member 2 needs a dental appointment. pain control but I do not know		dental needs. A reminder was p all nursing staff to report any evi oral pain to charge nurse in nurs newsletter on June 24, and this be included in the July 12 nursin agenda.	dence of sing will also	

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					OMB NO.		
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		E SURVEY PLETED	
		245329	B. WING		06/	14/2018	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
WARRO	AD CARE CENTER			1401 LAKE STREET NORTHWEST WARROAD, MN 56763			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE	
F 880	Continued From pa	ige 68	F 88	0			
	get worse. -on 12/15/17, (heal was here in Novem of possible mouth p possibility of having FM-B notified and a increase in pain or arrangements be m teeth? FM-B respond keep her comfortat Review of nursing p increase in observatorial oral discomfort: -on 4/12/18, R12 lo looked like it had ro - on 5/25/2018, R12 when taking medic - on 5/26/2018, R12 shift, when drinking and get upset. R12 teeth hurt and at or R12 will not open m teeth. - on 5/27/18, R12 w teeth on and off this and she pulls away - on 5/30/18, R12 d taking a drink throut drinking.	hade to extract remaining onded "yes, if it would help ole." brogress notes showed an ations of R12 demonstrating st one of her molar teeth that otten out. 2 did not like the cold juice cations. 2 had been grinding teeth this 1 cold liquid would pull back 2 was asked multiple times if he point R12 did say "yes". houth to allow you to look at was noted to be grinding her s shift, cold liquids irritate her		4) WSLC Director of Nursing designee will monitor dental as completed quarterly with approp follow up and report findings to QAPI Committee. Reports will provided for a minimum of six r until such time the Committee of there is no longer a need based satisfactory performance and documentation.	sessments briate the facility be nonths and letermines		
	together and would - on 6/1/18, R12 wa lunch table. - on 6/5/18, R12 wa area to lower left ja	on of teeth R12 clamped lips not open mouth. as grinding her teeth at the as noted to have reddened w and upper right jaw, possibly Will notify family and make					

		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	07/13/2018 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION	(X3) DATI	E SURVEY IPLETED
		245329	B. WING			06/14/2018	
NAME OF	PROVIDER OR SUPPLIER		<u> </u>	S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
WARRO	AD CARE CENTER				401 LAKE STREET NORTHWEST VARROAD, MN 56763		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 880	appointments as ne - on 6/8/18, R12 wa while at the supper pajamas, and gettir - on 6/9/18, R12 pu shake her upper tor - on 6/11/18, R12 wa while taking mornin - on 6/11/18, R12 wa while getting her PN Review of Interdisc reports: - on 5/16/18 indicat tooth pain - on 5/30/18, indica "yes" Call Dentist - on 6/13/18, indica There had been no appointment was se evident oral pain wi month. On 6/14/18 at 2:20 stated absolutely a contacted for R12. Lack of dental agre On 6/14/18, at 8:54 written statement in copy of dental conta survey there was no provided by the fac Dental Services pro- indicated facility offi- residents. The faci	eeded. as grinding her teeth this shift table, while changing into ng ready for bed. Illed her head back and would rso when trying to give food. vas noted to be grinding teeth ng medications in milk. as grinding teeth this evening M medications. Eiplinary Team daily handwritten ted grinding more - monitor ted teeth? "my teeth twitter" ated teeth? in pain indication that a dental et up for R12 even with ith eating/drinking over past p.m. director of nursing (DON) dentist should have been eement: a.m. Administrator provided a ndicating still looking for signed ract with a dental agreement	F8	680			

ATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION (X3) DATE SI	URVEY
	F CORRECTION	IDENTIFICATION NUMBER:		G	COMPLE	
		245329	B. WING		06/14/2018	
IAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
VARROA	AD CARE CENTER			1401 LAKE STREET NORTHWEST WARROAD, MN 56763		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) OMPLETIO DATE
F 880	Continued From pa Oral health review v collection annually.	ge 70 will be completed with the data	F 88	0		
	who have pain or w related to oral or de	and staff to identify individuals ho are at risk for having pain ental pathology. e Training for Nurse Aides	F 94	7	7/2	23/18
	§483.95(g) Require aides. In-service training r	d in-service training for nurse nust-				
		ufficient to ensure the ence of nurse aides, but must hours per year.				
		de dementia management nt abuse prevention training.				
	determined in nurse and facility assessm	ess areas of weakness as e aides' performance reviews nent at § 483.70(e) and may I needs of residents as facility staff.				
	to individuals with c address the care of This REQUIREMEN by: Based on interview	nurse aides providing services cognitive impairments, also the cognitively impaired. NT is not met as evidenced w, and document review, the ure 12 hours of annual		1) Staff found to be deficient in educ are included in facility-wide plan requ		
	in-service training w nursing assistants (vas completed by 4 of 4 (NA-G, NA-H, NA-I, NA-J) ecords were reviewed. In		2) WSLC staff education spreadshee		

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	OF DEFICIENCIES	KMEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATI	0938-039 E SURVEY PLETED	
		IDENTIFICATION NONDER.	A. BUILDING	3			
		245329	B. WING		06/	14/2018	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
WARRO	AD CARE CENTER		1401 LAKE STREET NORTHWEST WARROAD, MN 56763				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE	
F 947	Continued From pa	ige 71	F 947	7			
	nursing assistants	vas completed by 3 of 4 (NA-D, NA-E, NA-F) whose		staff dementia training and ann education hours, and calculate	how many		
	personnel records	were reviewed.		hours each employee needed f compliance. On 6/15/2018, a so	chedule		
	Findings include Required 12 hours	of training:		was developed based on the nu classes each employee had to with deadlines to get all employ	complete,		
	NA-G was hired on record indicated sh	6/21/16, NA-G's employee e had completed 6 hours of ning hours from 6/21/16 to		through the required EduCare r July 20,2018. Employees were the appropriate EduCare modu received a list of their required Employees were informed that unable to work after their educa	nodules by enrolled in es, and nodules. they will be		
	record indicated sh the 12 required trai 6/11/18.	6/28/16. NA-H's employee e had completed 10.7 hours of ning hours from 6/28/16 to		deadline until education has be completed. On 6/28/2018 eight care staff members participated Educare dementia modules, an 7/20/2018, non-direct care staff	en non-direct I in group d by		
	record indicated sh	6/27/16. NA-H's employee e had completed 8.7 hours of ning hours from 6/27/16 to		 caught up. 3) WSLC will no longer allow er to start working until required of dementia education is complete 	nboarding		
	record indicated sh	6/5/14. NA-J's employee e had completed 10.4 hours of ning hours from 6/5/14 to		employees will be required to a General Orientation education i or on Educare within the first m hire. If an employee is unable to General Orientation within the f	itend n person onth of o attend		
	Dementia care trair	ning:		of hire, they will not be allowed working until EduCare General			
	record indicated sh	1/12/18. NA-D's employee e had completed 4 of the 5 care training modules since		requirements are complete. HR will oversee staff education req and provide updates to departm managers. Department manage review staff education status du	uirements, ient ers will		
	record indicated sh	12/19/17. NA-E's employee e had completed zero of the 5 odules since hire date.		employee evaluations to ensure education requirements are bei	e that		

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CENTERS FOR MEDICARE & MEDICAID SERVICES		. 0938-0391
		TE SURVEY IPLETED
245329 B. WI	NG 06	/14/2018
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
WARROAD CARE CENTER	1401 LAKE STREET NORTHWEST WARROAD, MN 56763	
PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PR	D PROVIDER'S PLAN OF CORRECTION EFIX (EACH CORRECTIVE ACTION SHOULD BE AG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
 F 947 Continued From page 72 NA-F was hired on 4/4/18. NA-F's employee record indicated at the start of the survey on 6/11/18, had not completed any dementia training, however, all the required training was completed on 6/12/18. On 6/13/18, at 11:37 a.m. director of nursing (DON) confirmed nursing assistants were behind on fulfillment of required annual 12 hour training. DON stated the plan was to wait until the NAs anniversary date and assign on-line learning modules accordingly. DON indicated dementia training was required upon hire, and then annually. DON stated facility had moved away from the on-line dementia training modules and implemented a curriculum entitled Buddies Forever Dementia Communication Coaching with a focus on communication that used more of an in-person hands on approach to learning. DON indicated "Buddie System" was part of new hire orientation and was taught/completed over 25 minutes, however, a video was available that last approximately 2 hours. DON indicated the facility had just started going back to the assigning the online modules in order to meet dementia training criteria and competency. On 6/13/18, at 12:20 p.m. human resources manager (HRM) verified the lack of education requirements for dementia care and required 12 hour annual nurse aide training requirements. HRM stated the facility was working on getting staff caught up and assigning education at there annual performance review evaluations. 	 947 4) Staff education compliance related to dementia and 12 hours of annual CNA education compliance will be reported to QAPI Committee by Human Resources Manager on a regular basis and for a minimum of 9 months. At that time, based on reported results the Committee will evaluate the need for ongoing reporting. 	

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		TIPLE CONSTRUCTION NG 02 - WARROAD CARE CENTER		TE SURVEY
		245329	B. WING _		06	/12/2018
AME OF F	PROVIDER OR SUPPLIER		T	STREET ADDRESS, CITY, STATE, ZIP COI		
	D CARE CENTER			1401 LAKE STREET NORTHWEST		
				WARROAD, MN 56763		(26)
(X4) ID PREFIX T A G	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETH DATE
K 000	INITIAL COMMENT	ſS	K 0	00		
	FIRE SAFETY					
	ALLEGATION OF O DEPARTMENT'S A SIGNATURE AT TH PAGE OF THE CM	OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR IE BOTTOM OF THE FIRST S-2567 FORM WILL BE ATION OF COMPLIANCE.				
:	ONSITE REVISIT O CONDUCTED TO SUBSTANTIAL CO REGULATIONS HA	F AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION.				
	conducted by the M Public Safety, State June 12, 2018. At Warroad Care Cen compliance with the in Medicare/Medica 483.70(a), Life Safe edition of National (NFPA) Standard 1 Chapter 19 Existing	ety Code survey was linnesota Department of e Fire Marshal Division on the time of this survey, ter was found not in e requirements for participation aid at 42 CFR, Subpart ety from Fire, and the 2012 Fire Protection Association 01, Life Safety Code (LSC), g Health Care and the 2012 the Health Care Facilities		EPO	C	
	copy of the plan of	ne E-POC process, a paper correction is not required."				
	PLEASE RETURN CORRECTION FO DEFICIENCIES (K	R THE FIRE SAFETY				

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 DERIGENCIES (X) PROVIDERSUPPLEALING (X) PROVIDERS (X) PROVIDERSUPPLEALING (X) PROVIDER OF SUPPLEALING (X) PROVIDERSUPPLEALING (X) PROVIDER OF SUPPLEALING (X) PROVID	- · ·		AND HUMAN SERVICES				FORM	07/10/2018 APPROVED 0938-0391
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS. CITY. STATE. JPC CODE MARROAD CARE CENTER 101 LAKE STREET NORTHWEST WARROAD MARVAY STATEMENT OF DEFICIENCES PARROAD, MI SFG 3 MARROAD, MI SFG 3 SUMMARVAY STATEMENT OF DEFICIENCES MARROAD, MI SFG 3 PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDE BY FULL RECAL DEFICIENCY MUST BE PRECED BY FULL RECAL DEFICIENCY MUST BE PRECEDED BY FULL RECAL DEFICIENCY MUST BE PRECEDED BY FULL RECAL DEFICIENCY MUST BY FULL BY ALL DEFIC RECAL DEFICIENCY MUST BE PRECEDED BY FULL RECAL DEFICIENCY MUST BE PRECEDED BY FULL RECAL DEFICIENCY MUST BY FULL BY THE BY FULL BY ALL DEFICIENCY RECENT BY FULL BY THE BY FULL BY THE BY FULL	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA					
WARROAD CARE CENTER 1401 LAKE STREET NORTHWEST WARROAD, MN 56763 (Y0) 0 PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL FREQUENCY OR LS DEMTIFYING INFORMATION) PAC PROVIDER'S FLAM OF CORRECTION (EACH CORRECTIVE ACTION SHOLD BE DEFICIENCY) COUNTY AND D PREFIX PROVIDER'S FLAM OF CORRECTION (EACH CORRECTIVE ACTION SHOLD BE DEFICIENCY) COUNTY AND COUNTY AND </th <th></th> <th></th> <th>245329</th> <th>B. WING</th> <th></th> <th></th> <th>06/1</th> <th>2/2018</th>			245329	B. WING			06/1	2/2018
WARROAD CARE CENTER WARROAD, MN 5573 (X4) [0] PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (RECH DEFICIENCY WIST BE PRECEDED BY FULL (RECH ORFICIENCY ON LISC IDENTIFYING INFORMATION) D PREFIX TAG D PROVINCE ACTION STOULD BY (EACH ORFICENCY ACTION STOULD BY (EACH ORFICENCY ON LISC IDENTIFYING INFORMATION) D PREFIX TAG D PREFIX (EACH ORFICENCY ON STOULD BY (EACH ORFICENCY ACTION STOULD BY (EACH ORFICENCY ACTION STOULD BY (EACH ORFICENCY) COUNTRY (EACH ORFICENCY) K 000 Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota SL, Suite 145 St. Paul, MN 55101-5145, OR By email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us K 000 THE PLAN OF CORRECTION FOR EACH DEFICIENCY 1. A description of what has been, or will be, done to correct the deficiency. I I. A description of what has been, or will be, done to correct the deficiency. Warroad Care Center is a 1-story building without a basement that was built n 2009 and was determined to built of Type V(111) construction. The facility is fully protected throughout by an automatic fire eprinkler system and has a fire alarm system with smoke detection in the coridors and space open to the coridors that is monitored for automatic fire department notification. The facility also has smoke detection in the resident rooms that is the din to the nurse call system. The requirement at 42 CFR, Subpart 483.70(a) is	NAME OF	PROVIDER OR SUPPLIER						
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREAX TAG CRACH CORRECTVE ACTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE COMPLETION DOTE K 000 Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota SL, Suite 145 St. Paul, MN 55101-5145, OR By email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us K 000 THE PLAN OF CORRECTION FOR EACH DEFICIENCY DEFICIENCY Fire Marshall Division 445 Minnesota SL, Suite 146 St. Paul, MN 55101-5145, OR By email to: Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: I. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Warroad Care Center is a 1-story building without a basement that was built in 2009 and was determined to be built of Type V(111) construction. The facility is fully protected throughout by an automatic fire department notification. The facility also has smoke detection in the resident rooms that is tied into the nurse call system. The facility has a capacity of 49 beds and had a census of 46 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is The double of the survey.	WARRO	AD CARE CENTER			L			
Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St, Suite 145 St. Paul, MN 55101-5145, OR By email to: Marian. Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLIDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Warroad Care Center is a 1-story building without a basement that was built in 2009 and was determined to be built of Type V(111) construction. The facility is fully protected throughout by an automatic fire sprinkler system and has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility also has smoke detection in the resident rooms that is tied into the nurse call system. The facility has a capacity of 49 beds and had a census of 46 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	DBE	COMPLETION
	К 000	Healthcare Fire Ins State Fire Marshal 445 Minnesota St., St. Paul, MN 5510 By email to: Marian.Whitney@s Angela.Kappenma THE PLAN OF CO DEFICIENCY MUS FOLLOWING INFO 1. A description of to correct the defice 2. The actual, or pr 3. The name and/or responsible for cor prevent a reoccurre Warroad Care Cer a basement that w determined to be b construction. The f throughout by an a and has a fire alarn in the corridors and that is monitored for notification. The fa in the resident root call system. The facility has a co census of 46 at time	spections Division Suite 145 1-5145, OR state.mn.us and m@state.mn.us RRECTION FOR EACH STINCLUDE ALL OF THE DRMATION: what has been, or will be, done iency. roposed, completion date. or title of the person rection and monitoring to ence of the deficiency. neter is a 1-story building without as built in 2009 and was built of Type V(111) facility is fully protected butomatic fire sprinkler system m system with smoke detection d spaces open to the corridors or automatic fire department cility also has smoke detection ms that is tied into the nurse spacity of 49 beds and had a ne of the survey.		000			
					-	neilite ID: 00707 If contin	union shee	t Page 2 of 1

	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MULTE		OMB NO.	E SURVEY	
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:		3 02 - WARROAD CARE CENTER		PLETED	
		245329	B. WING		06/12/2018		
AME OF I	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE			
VARRO	AD CARE CENTER			1401 LAKE STREET NORTHWEST WARROAD, MN 56763			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIO DATE	
K 000	Continued From pa	age 2	K 000	D			
	NOT MET as evide	•				7/04/40	
	Multiple Occupanc CFR(s): NFPA 101	ies	K 13 [.]	1		7/31/18	
	Facilities Sections of health	ies - Sections of Health Care care facilities classified as meet all of the following:					
	inpatients for purpo customary access. o They are separa occupancies by construction ha resistance rating in accordance with o The entire build an approved, supe	ated from areas of health care ving a minimum two hour fire n Chapter 8. ing is protected throughout by					
	required to be clas Care Occupancy re patients served. 19.1.3.3, 42 CFR 4	surgical departments are sified as an Ambulatory Health egardless of the number of 82.41, 42 CFR 485.623 NT is not met as evidenced					
	Based on observa facility failed to ma resistive ratings for the Life Safety Coo section 19.1.3.3. T allow for the transf	tion and staff interview the intain the proper 2 hour fire r occupancies as described in de (NFPA 101) 2012 edition his deficient practice could er of smoke or fire from r and affect an undetermined d visitors.		Since the date of the survey Tom Thompson, Director of Maintenan been in contact with the original who supplied the doors during construction. We have research to see if the doors are mislabeled fact the wrong doors. Research shown that verification and retag would be time consuming and the	nce, has vendor ed testing d or are in has ging		

Facility ID: 00797

If continuation sheet Page 3 of 11

		& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(YO) MILLET	TIPLE CONSTRUCTION	(X3) DATE	SURVEY
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		NG 02 - WARROAD CARE CENTER		PLETED
		245329	B. WING		06/*	2/2018
NAME OF	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
WARRO	AD CARE CENTER			1401 LAKE STREET NORTHWEST WARROAD, MN 56763		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT ((EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
K 321	on 06/12/2018 obse hour fire barrier sep cross corridor door only, they should be several one inch co the cross corridor do fire stopped. Observations revea separating the C bl cross corridor door they should be 90 r conduit by environr ceiling that was not This deficient cond facility Maintenance Hazardous Areas - CFR(s): NFPA 101 Hazardous Areas a having 1-hour fire r fire rated doors) or system in accordar When the approved	between 7:30 am to 12:00 pm ervations revealed on the 2 barating the B & C bldg. , the s were rated for 20 minutes e 90 minute and there were onduits above the ceiling line at loors that were not properly aled at the 2 hour fire barrier dg and the assisted living has s rated for 20 minutes only, minute and there is a one inch nental services above the c properly fire stopped. ition was confirmed by the e Director. Enclosure	К 13	 expedient way to fix will be to represent the doors with new units meeting concerning quote and doors will be ordered as that quote is available. Install depend on vendor order fulfillme be expedited as much as possible time it is anticipated to be the en 2018. All fire wall penetrations without fire stopping were corrected on 06-13-2018 by Tony Thompson. 	le ng a final as soon ation will nt and will e, at this d of July	6/25/18
	partitions and doors Doors shall be self- and permitted to ha protective plates th from the bottom of Describe the floor a	er spaces by smoke resisting s in accordance with 8.4. -closing or automatic-closing ave nonrated or field-applied at do not exceed 48 inches the door. and zone locations of hat are deficient in REMARKS.				

If continuation sheet Page 4 of 11

	OF DEFICIENCIES	KEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE		
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A BUILDING	02 - WARROAD CARE CENTER	COMF	PLETED	
	3	245329	B. WING		06/1	12/2018	
NAME OF I	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE			
WARRO	AD CARE CENTER			401 LAKE STREET NORTHWEST VARROAD, MN 56763			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETIC DATE	
K 321	Continued From pa	age 4	K 321				
	 b. Laundries (large c. Repair, Mainten d. Soiled Linen Ro e. Trash Collection (exceeding 64 gall f. Combustible Sto (over 50 square fe g. Laboratories (if Hazard - see K322 This REQUIREME by: Based on observa facility failed to ma room in accordanc Code (NFPA 101) deficient condition enter the corridor r the quick and effic undetermined amo Findings include: On the facility tour on 06/12/2018 obs room, also used fo over 100 sq feet an door. 	Fired Heater Rooms Fired Heater Rooms Fired Heater Rooms For than 100 square feet) ance, and Paint Shops oms (exceeding 64 gallons) Rooms ons) rage Rooms/Spaces et) classified as Severe This not met as evidenced attion and staff interview the intain one hazardous storage re with the 2012 Life Safety section 19.3.2.1.3. This could allow smoke or fire to naking it untenable and affect ient exiting for an ount of staff and visitors. between 7:30 am to 12:00 pm servations revealed a data or combustible storage was and did not have a self closing dition was confirmed by the e Director. Seiling Finish	K 331	All combustible material was remo from the storage room under the di of Tony Thompson, Director of Maintenance. Alternate locations v found for ongoing storage.	irection	6/19/18	

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	07/10/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION DING 02 - WARROAD CARE CENTER		E SURVEY PLETED
		245329	B. WING		06/	12/2018
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
WARRO	AD CARE CENTER			1401 LAKE STREET NORTHWEST WARROAD, MN 56763		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG		D BE	(X5) COMPLETION DATE
K 346 SS=F	exposed interior su fixed or movable w have a flame sprea The reduction in cla sprinkler system as permitted. 10.2, 19.3.3.1, 19.3 Indicate flame sprea This REQUIREME by: Based on observa record review the fa proper documentat finish class of the v combustible materi Code, NFPA 101 2 This deficient pract fuel load in a fire co spread more quick of all residents staf Findings include: On the facility tour on 06/12/2018 doc there was no recor of the wood panels This deficient cond facility Maintenance Fire Alarm System CFR(s): NFPA 101	iling finishes, including rfaces of buildings such as alls, partitions, columns, and d rating of Class A or Class B. ass of interior finish for a s prescribed in 10.2.8.1 is 3.3.2 ad rating(s). NT is not met as evidenced tions, staff interview and acility failed to provide the ion to identify the interior valls in building C, with als as stated in the Life Safety 012 edition section 19.3.3.2. ice could create an additional ondition and cause a fire to by which could affect the exiting f and visitors in that section.		Paperwork indicating proper flam spread ratings was provided to the inspector by Tony Thompson, Die Maintenance. Documentation with and maintained in facility records	ne rector of II be filed	6/18/18 at Page 6 of 11

				E CONSTRUCTION	(X3) DATE	SURVEY	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		02 - WARROAD CARE CENTER		PLETED	
		245329	B. WING		06/1	12/2018	
AME OF F	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE			
VARRO	AD CARE CENTER			401 LAKE STREET NORTHWEST VARROAD, MN 56763			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIC DATE	
K 346	period, the authorit notified, and the but approved fire watch parties left unprote fire alarm system h 9.6.1.6 This REQUIREME by: Based on a record facility has failed to acceptable written be followed in the e system has to be p more hours in a 24 practice could affeer response and notifi affect the safety of	age 6 han 4 hours in a 24-hour y having jurisdiction shall be hilding shall be evacuated or an in shall be provided for all cted by the shutdown until the has been returned to service. NT is not met as evidenced review and staff interview, the provide a complete and policy containing procedures to event that the Fire Alarm laced out-of-service for four or hour period. This deficient ct the facility's ability for early ication of a fire and would of all 49 residents as well as umber of staff, and visitors to	K 346	Policy was updated/created to clea indicate fire alarm system out proc Tony Thompson, Director of Mainte was responsible for development a implementation of the new/revised This plan will be filed with other emergency planning documentatio implemented in appropriate situation required.	edures. enance and plan. on and		
	on 06/12/2018 doc there was no recor service policy. This deficient cond facility Maintenance Sprinkler System - CFR(s): NFPA 101 Sprinkler System - Where the sprinkle	Out of Service	K 354			6/18/18	

Facility ID: 00797

ATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLI		TE SURVEY		
ID PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A BUILDING	02 - WARROAD CARE CENTER	COMPLETED		
		245329	B. WING		6/12/2018		
IAME OF F	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE			
VARROA	D CARE CENTER		1401 LAKE STREET NORTHWEST WARROAD, MN 56763				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIC DATE		
K 354	Continued From pa	age 7	K 354				
	inspected and risks	•					
		are submitted to management					
		esentative, and the fire her authorities having					
	jurisdiction have be	een notified. Where the					
		out of service for more than 10 period, the building or portion					
	of the building affe	cted are evacuated or an					
	approved fire watch system has been re	h is provided until the sprinkler					
		9.7.5, 15.5.2 (NFPA 25)					
	This REQUIREME	NT is not met as evidenced					
	by: Based on a record	d review and staff interview, the		Policy was updated/created to clearly			
1	facility has failed to	provide a complete and		indicate sprinkler system out procedures			
		policy containing procedures to event that the automatic fire		Tony Thompson, Director of Maintenance was responsible for development and	e		
	sprinkler system ha	as to be placed out-of-service		implementation of the new/revised plan.			
		urs in a 24 hour period. This ould affect the facility's ability		This plan will be filed with other emergency planning documentation and			
		and notification of a fire and		implemented in appropriate situations as			
		fety of all 49 residents as well		required.			
	as an undetermine to the facility .	d number of staff, and visitors					
	Findings include:						
	on 06/12/2018 doc there was no recor	between 7:30 am to 12:00 pm sumentation review revealed of a fire sprinkler system out					
	of service policy.		11				
	This deficient cond facility Maintenance	lition was confirmed by the					
K 372		ding Spaces - Smoke Barrie	K 372		6/13/18		

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DA	TE SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:	. ,	02 - WARROAD CARE CENTER) ´COI	MPLETED
		245329	B. WING		06/12/2018	
AME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
VARROA	D CARE CENTER			1401 LAKE STREET NORTHWEST WARROAD, MN 56763		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
K 372	Continued From pa	ge 8 ling Spaces - Smoke Barrier	K 372			
	Construction 2012 EXISTING Smoke barriers sha fire resistance ratin be permitted to terr Smoke dampers ar penetrations in fully an approved sprink smoke compartment barrier. 19.3.7.3, 8.6.7.1(1) Describe any mech in REMARKS. This REQUIREMENT by: Based on observation facility failed to mai barriers as required (NFPA 101) section deficient practice con from one smoke con affecting the exiting an undetermined and Findings include: On the facility tour I on 06/12/2018 observe penetrations in the 1. B-wing across fr inch above the ceili 2. B-wing above the fountains a 8" x 10"	all be constructed to a 1/2-hour g per 8.5. Smoke barriers shall ninate at an atrium wall. e not required in duct ducted HVAC systems where ler system is installed for ints adjacent to the smoke anical smoke control system NT is not met as evidenced tion and staff interview the ntain one of two smoke d by the 2012 Life Safety Code 19.3.7.3, 8.8.7.1 (1). This build allow smoke to transfer impartment to another of 25 of the 49 residents and mount of staff and visitors.		All noted observations were rep meet code requirements by Ton Thompson, Director of Maintena	ıу	

Facility ID: 00797

If continuation sheet Page 9 of 11

		& MEDICAID SERVICES			TE SURVEY
	OF CORRECTION OF CORRECTION NUMBER:			MPLETED	
		245329	B. WING		6/12/2018
AME OF F	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	
ARRO/	AD CARE CENTER			401 LAKE STREET NORTHWEST /ARROAD, MN 56763	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIC DATE
K 372	Continued From pa	•	K 372		
	facility Maintenanc	e Director.			7/5/40
	HVAC CFR(s): NFPA 101		K 521		7/5/18
	by: Based on docume the facility did not r ventilation, and air with the 2012 LSC NFPA 90A. This de 49 residents.	NT is not met as evidenced nt review and staff interview, naintain the heating, conditioning in accordance NFPA 101 9.2, 19.5.2.1 and ficient practice could effect all		Upon completion of the inspection Tony Thompson, Director of Maintenance, contacted our vendor for fire/smoke damper testing. That testing was scheduled and completed on 07-05-2018 Records of the inspection results will be maintained by the Director.	5.
	on 06/12/2018 doc there was no recor	between 7:30 am to 12:00 pm umentation review revealed d of the last inspection of the s in the last four years.			
	This deficient cond facility Maintenanc	ition was confirmed by the e Director.			
	Evacuation and Re CFR(s): NFPA 101		K 711		7/16/18
		elocation Plan plan for the protection of all eir evacuation in the event of			

Facility ID: 00797

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		AND HUMAN SERVICES			FORM	07/10/2018 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION G 02 - WARROAD CARE CENTER		E SURVEY PLETED
		245329	B. WING		06/1	2/2018
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
WARRO	AD CARE CENTER			1401 LAKE STREET NORTHWEST WARROAD, MN 56763		
(X4) ID PREFIX T A G	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
К 711	informed with their copy of the plan is in operator or with see basic response req and provides for all components per 18 18.7.1.1 through 18 18.7.2.3, 19.7.1.1 th 19.7.2.2, 19.7.2.3 This REQUIREMEN by: Based on record ref facility failed to main required in NFPA 11 edition section 19.7 could cause confus affect all 49 resider amount of staff and Findings include: On the facility tour for on 06/12/2018 door the fire safety plan for evacuation of the preparation of floor	iodically instructed and kept duties under the plan, and a readily available with telephone curity. The plan addresses the uired of staff per 18/19.7.2.1.2 of the fire safety plan 8/19.2.2. 8.7.1.3, 18.7.2.1.2, 18.7.2.2, hrough 19.7.1.3, 19.7.2.1.2, NT is not met as evidenced eview and staff interview the ntain a Fire Safety Plan as 01 Life Safety Code, 2012 7.2.2. This deficient practice sion in an emergency and nts and an undetermined I visitors.	κ 71	1 Plan was updated to include desc for evacuation of the smoke comp and preparation of floors and build evacuation by Tony Thompson, Di Maintenance. Plan changes will b incorporated into orientation and t for new and existing staff member well as all scheduled fire emergen training exercises.	artment ling for rector of e raining s as	

Facility ID: 00797

If continuation sheet Page 11 of 11



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered June 28, 2018

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

Re: State Nursing Home Licensing Orders - Project Number S5329027

Dear Mr. Bertilrud:

The above facility was surveyed on June 11, 2018 through June 14, 2018 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the 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 <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>. 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

Warroad Care Center June 28, 2018 Page 2 the Suggested Method of Correction and the Time Period For Correction.

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

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

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

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

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

Please feel free to call me with any questions.

Sincerely,

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

cc: Licensing and Certification File

Minnesc	ta Department of He	alth				
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				
		00797	B. WING		06/1	4/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
WARRO	AD CARE CENTER					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL	D BE	(X5) COMPLETE DATE
2 000	Initial Comments	(X1) PROVIDERSUPPLIERCLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A BUILDING: (X3) DATE SURVEY COMPLETED 00797 B. WING 06/14/2018 R STREET ADDRESS, CITY, STATE, ZIP CODE 1401 LAKE STREET NORTHWEST VARROAD, MN 56783 PROVIDER'S PLAN OF CORRECTION AND DE CONSTRUCTION OF CONSTRUCTION OF CORRECTION AND DE CONSTRUCT AND OF CORRECTIVE ACTION STOLD DE CROSS-REFERENCED TO THE APPROPRIATE CM31 CM31 CM31 CM31 CM31 CM31 CM31 CM31				
	****ATTE	NTION*****			COMPLETED 06/14/2018 DE T DUDER'S PLAN OF CORRECTION COMPLETE DEFICIENCY) DUDER'S PLAN OF CORRECTION COMPLETE DATE	
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defic herein are not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	ction order has been issued y. If, upon reinspection, it is iency or deficiencies cited ected, a fine for each violation be assessed in accordance ines promulgated by rule of artment of Health. The ther a violation has been compliance with all rule provided at the tag ile number indicated below. Ins several items, failure to the items will be considered Lack of compliance upon ny item of multi-part rule will ment of a fine even if the item				
	that may result from orders provided tha the Department with	n non-compliance with these t a written request is made to hin 15 days of receipt of a				
	receipt of State lice the Minnesota Depa Informational Bullet http://www.health.st obul.htm The State	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are				
ABORATOR	epartment of Health Y DIRECTOR'S OR PROVID ically Signed	ER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE 07/08/18

Electronically Signed

If continuation sheet 1 of 55

		ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00797	B. WING		06/	14/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
WARRO	AD CARE CENTER		KE STREET NO AD, MN 56763			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
2 000	Department of Hea you electronically. is necessary for Sta enter the word "cor text. You must then State licensure pro- completion date, th corrected prior to e Minnesota Departm On June 11, 12, 13 Department's staff the following correct Please indicate in y correction that you and identify the dat Minnesota Departm the State Licensing federal software. Ta assigned to Minnes Nursing Homes. The assigned tag n column entitled "ID statute/rule out of co "Summary Statemen and replaces the "T correction order. Th findings which are in after the statement evidence by." Follow are the Suggested Time period for Con	Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be lectronically submitting to the nent of Health. & 14, 2018, surveyors of this visited the above provider and ction orders are issued. Your electronic plan of have reviewed these orders, e when they will be completed nent of Health is documenting Correction Orders using ag numbers have been sota state statutes/rules for umber appears in the far left of Deficiencies" column to Comply" portion of the nis column also includes the n violation of the state statute , "This Rule is not met as wing the surveyors findings Method of Correction and				
	FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE S COMPL	
		00797	B. WING		06/	14/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
VARROA	AD CARE CENTER		-	IORTHWEST		
			AD, MN 5676			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLET DATE
2 000	Continued From pa	ge 2	2 000			
	PLAN OF CORREC	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.				
2 255	MN Rule 4658.0070 Assurance Commit) Quality Assessment and tee	2 255			7/27/18
	assessment and as of the administrator services, the medic designated by the n three other member representing discipl resident care. The assurance committer respect to which qui necessary and dever appropriate plans o quality deficiencies. address, at a minim	f action to correct identified The committee must num, incident and accident control, and medications and				
	by: Based on interview, facility failed to con- assessment (QA) a develop and implen action to correct qu during the survey the should have been a	ent is not met as evidenced , and document review, the duct ongoing quality nd assurance activities and nent appropriate plans of ality deficiencies identified nat the facility was aware of or aware of that had the potential all 47 residents residing in the		Corrected		
	Findings include					

STATEMEN	It a Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00797	B. WING		06/	14/2018
AME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
VARRO	AD CARE CENTER		KE STREET NO AD, MN 56763	-		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLE DATE
2 255	On 6/14/18, at 1:30 (DON) stated the fainclude policies and and correct its own development stage implemented. DON projects had been and infection contre- existing quality assi- timelines with corre- with timelines had indicated there was identify other areas improvement. DON quality assurance (the lack of leaders! department; goals situation had not be QA committee identifie council grievances the lack of required hour annual nurse The following areas identified during the not identified for pe- initiatives and/or was monitoring systems areas in need of im committee: See F812: Based of document review th cooling methods of manner that would risk for food-borne to effect all 47 residential content of the state	 p.m. director of nursing acility's QAPI plan that would d protocols that would identify quality deficiencies was in and had not yet been I stated quality assurance identified by the Casper report ol logs. DON indicated that for urance projects goals with esponding written action plans not been established . DON s not a good system in place to a for needed quality I further stated, although the QA) committee was aware of hip and training in the dietary and action plans to resolve the een developed. In addition, the not been apprised nor had the d the continued resident pertaining to food quality and I dementia care training and 12 	2			

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00797	B. WING		06/	14/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
NARRO	AD CARE CENTER		KE STREET NO AD, MN 56763			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 255	Continued From pa	ge 4	2 255			
	document review, th had been assessed appropriate interver for 1 of 1 residents pain. This deficient See F565: Based o review, the facility fa council's concerns quantity and quality resident council me (R36, R40, R26, R6 active members of See F947: Based o review, the facility fa annual in-service tra 4 nursing assistants whose personnel re addition, the facility dementia training w nursing assistants (personnel records of The following areas identified during the were identified in th provided by the dire	ntions and/or medical attention (R12) reviewed for dental practice resulted in harm. n interview and document ailed to address the resident related to food temperature, during a survey initiated betting with 8 of 15 residents 6, R34, R38, R41 and R8) the facility resident council. n interview, and document ailed to ensure 12 hours of aining was completed by 4 of s (NA-G, NA-H, NA-I, NA-J) ecords were reviewed. In failed to ensure required vas completed by 4 of 4 (NA-D, NA-E, NA-F) whose				
	deficient practices. evidence of identific plans that included frames for completi evidence interventio	Ince with identified areas of The minutes further lacked cation of comprehensive action specific goals, and time ion. The minutes also lacked, ons were implemented, ted and revised as necessary ul completion.				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00797	B. WING		06/	14/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
WARRO	AD CARE CENTER		KE STREET NO AD, MN 56763			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 255	Continued From pa	age 5	2 255			
	review, the facility f comprehensive nut prevent, assess, ar significant weight lo reviewed for nutrition See F804: Based document review th foods were served Minutes dated 7/12 grievances made in quality, however, d resident council. M resident with excess and indicated a tea working on identify loss. However, the goals with timelines	on interview and document failed to complete a tritional assessment and nd monitor subsequent bass for 1 of 5 residents (R27) on. on observation, interview, and ne facility failed to ensure hot at a palatable temp. 2/17, identified multiple in March, pertaining to food id not reflect concerns from the linutes also reflected one asive/unexplained weight loss im was established and ing residents at risk for weight minutes lacked developed is and corresponding action is for sustainability or	9			
	number of resident excessive/unexplain had gained weight reflect unexplained Minutes further refl low resident satisfat dining services; the negotiations for con- hired dining services reflect identification pertaining to food of developed goals with	ned weight loss, however, one and was not expected to weight loss next quarter. ected, ongoing concerns with actions and grievances for e minutes reflected nsulting dietician and newly es director. The minutes did no n of resident council concerns quality. The minutes lacked				
		18, lacked identification of the evances pertaining to food				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00707	B. WING			4.4/00.4.0
	PROVIDER OR SUPPLIER	00797	DDRESS, CITY, ST		06/	14/2018
			KE STREET NO			
	AD CARE CENTER	WARRO	AD, MN 56763			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
2 255	Continued From pa	age 6	2 255			
	the 4th quarter. The progress on the ex- The minutes indicas satisfaction scores implement a two yes project. Minutes lace timelines and correc- timelines for impro- Minutes dated 4/4/ resident council gri- residents with exce The minutes reflec- date was delayed r leadership. Minutes with timelines and with timelines for in-	18, lacked identification of the ievances and did not address essive/unexplained weight loss ted the dietary project start related to department s lacked identification of goals corresponding action plans nprovement.	1			
	SUGGESTED ME The adminstrator of interdisciplinary tea having a quality as identifies residented determine if interve outcome of the ide appoint a person to TIME PERIOD FO	ity assurance activities. THOD OF CORRECTION: could in-service the entire am on the requirements for sessment program that related concerns and entions are improving the ntified concerns. Also to o monitor for compliance. R CORRECTION: Twenty-one				
2 302	(21) days. MN State Statute 1 or related disorder	44.6503 Alzheimer's disease train	2 302			7/27/18
	ALZHEIMER'S DIS DISORDER TRAIN	SEASE OR RELATED				

		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
	00797		B. WING		06/14/2018	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
NARRO	AD CARE CENTER		E STREET N D, MN 5676	NORTHWEST 3		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 302	MN St. Statute 144 (a) If a nursing facil Alzheimer's disease or related or segregated or gene care staff and their superviso care. (b) Areas of require (1) an explanation or related disorders; (2) assistance with (3) problem solving and (4) communication (c) The facility shall written or electronic training program, th trained, the frequent topics covered.	6503 ity serves persons with disorders, whether in a eral unit, the facility's direct rs must be trained in dementia d training include: of Alzheimer's disease and activities of daily living; with challenging behaviors;	2 302			
	by: Based on interview facility failed to prov training for 3 of 3 no NA-E, NA-F) review services. In addition consumers with wri Alzheimer's training potential to affect re	ent is not met as evidenced and document review, the vide the required Alzheimer's ursing assistants (NA-D, ved who provided direct care h, the facility failed to provide tten information regarding the program. This had the esidents with Alzheimer d disorders in the facility and		Corrected.		

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
		00797	B. WING		06/14/2018	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
NARRO	AD CARE CENTER		KE STREET N AD, MN 56763			
(X4) ID	SUMMARY STA			PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	COMPLET DATE
2 302	Continued From pa	age 8	2 302			
	Findings include					
	record indicated sh	1/12/18. NA-D's employee had completed 4 of the 5 care training modules since				
	record indicated sh	12/19/17. NA-E's employee le had completed zero of the 5 odules since hire date.				
	record indicated at 6/11/18, had not co training, however, a	4/4/18. NA-F's employee the start of the survey on impleted any dementia all the required training was /18 after bring this concern to				
	(DON) confirmed n on fulfillment of the training. DON indic was completed dur then annually. DON away from the on-li and implemented a Forever Dementia a focus on commun in-person hands on indicated "Buddie S orientation and was minutes, however, lasted approximate facility had just star assigning the online	7 a.m. director of nursing jursing assistants were behind e required dementia care ated dementia care training ing new hire orientation and N stated the facility had moved ine dementia training modules a curriculum entitled Buddies Communication Coaching with nication that used more of an a approach to learning. DON System" was part of new hire is taught/completed over 25 a video was available that by 2 hours. DON indicated the ted going back to the e modules in order to meet criteria and competency.				
	Coaching curriculu	er Dementia Communication m was reviewed for the nts of dementia training. The				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00797	B. WING		06/14/2018	
AME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST			
VARRO/	AD CARE CENTER		KE STREET NO AD, MN 56763			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 302	Continued From pa	ge 9	2 302			
	curriculum lacked education and training components for assistance with activities of daily living and problem solving with challenging behaviors. The curriculum indicated the approximate length of the training was 2 hours. The facilities General Orientation syllabus dedicated 25 minutes for Buddies Forever, Communication Strategies for People with Dementia.					
	provided with a des program, the categories frequency of trainin	ked evidence consumers were cription of the training ories of employees trained, the g, and the basic topics ritten or electronic form.				
	The administrator, of designee could reverse procedures related training is provided residents and famili request it, describin related training it pr categories of emplois training, and the base administrator, direct could develop a syst develop a monitorin compliance as direct care. The facility con quality assurance pr	THOD OF CORRECTION: director of nursing (DON) or iew and revise policies and to ensuring the Alzheimer's in written or electronic form, to ies or other persons who ng the training program and the ovides, including the overes trained, the frequency of sic topics covered. The tor of nursing, or designee stem to educate staff and ng system to ensure cted by the written plan of ould report those findings to the erformance improvement for further recommendations to mpliance.	9			
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED 06/14/2018			
		00797	B. WING					
NAME OF F	PROVIDER OR SUPPLIER	STREET A	r Address, City, State, Zip Code					
WARRO	AD CARE CENTER		KE STREET I AD, MN 5676	NORTHWEST 33				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLET DATE		
2 830	Continued From pa	age 10	2 830					
2 830	MN Rule 4658.052 Proper Nursing Ca	0 Subp. 1 Adequate and re; General	2 830			7/16/18		
	individual needs an the comprehensive plan of care as de 4658.0405. A nurs of bed as much as written order from t	I supervision based on ad preferences as identified in e resident assessment and scribed in parts 4658.0400 and ing home resident must be out possible unless there is a the attending physician that the ain in bed or the resident n bed.	I					
	by: Based on observat review, the facility f assessed in order t interventions and/o	ent is not met as evidenced ion, interview and document failed to ensure pain had been to identify appropriate or medical attention for 1 of 1 iewed for dental pain.		Corrected.				
	Findings include:							
	dining room being t assistant (NA). R1 facial grimaces, cle away from table wh	on 6/11/18, at 5:40 p.m. in the fed by an unidentified nursing 2 was observed to be making enching fists, and pushing self hile being fed and given liquids. to have several missing teeth.						
	diagnoses of Alzhe	ecord dated 6/14/18, included imer's disease, dementia with ince, and pain in unspecified						

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	- 06/14/2018	
		00797	B. WING			
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
WARRO	AD CARE CENTER		KE STREET NO AD, MN 56763			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 830	10/1/17, indicated t impairment and wa self understood or required extensive oral cares. The ME indicators of pain (f winces, wrinkled fo clenched teeth or ja received scheduled dental was coded a present" related to likely cavities, inflar facial pain. Howeve	hum Data Set (MDS) dated hat R12 had severe cognitive is rarely/never able to make understand others. R12 assistance with eating and DS indicated R12 had facial expressions - grimaces, rehead, furrowed brow, aw) one to two days and d pain medication. Section L for as "none of the above were broken teeth, missing teeth, med/bleeding gums, mouth or er, the MDS was coded 2 underwent oral surgery to	2 830 r			
	10/1/17, indicated F expression at times brow, etc It is not due to R12's difficu and is mostly not p with. R12 did have was having presum	ea Assessment (CAA) dated R12 does have pained facial s, such as grimacing, furrow clear that this is pain-related It time with communication ossible to have a conversation a history of back pain and ned oral pain prior to dental will include interventions to ep pain controlled.				
	notations in the ora days as noted by fa body movements. I	S dated 4/3/18, indicated no Il care section and pain 1-2 acial expressions or protective However, the MDS was coded 2 underwent oral surgery to 7/25/17.				
	to two staff membe hygiene which inclu	ovided on 6/14/18, directed one ers to provide personnel ided oral care. The hygiene R12 had her own teeth and				

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED 06/14/2018	
		00797	B. WING			
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
VARRO	AD CARE CENTER		KE STREET NO AD, MN 56763			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETI DATE
2 830	did not identify R12 plan did not specify care and did not ino goals to maintain de directed staff to adr monitor/record pain nurse any signs or and notify physiciar unsuccessful or if c significant change f R12's care plan did Pain in Advanced D assessment comple score a one on a 0 10="severe pain"). identity the location Physician's orders f acetaminophen 160 (milliliter) give 15 m back pain; acetamin ml one time per day mg give 0.5 tablet f The last Dental Obs 9/30/16, indicated F staff attempt to brus will often clench mo giving R12 a prepai and verbally promp uncooperative. Wil cares and schedule No further dental of completed. Review of R12's reference	had missing teeth. The care how or when to provide oral clude and/or identification of ental health. The care plan minister medications, or characteristics, report to symptoms of non-verbal pain, or if interventions are current complaints were a from past experience of pain. not include dental pain. Dementia (PAINAD) eted 4/3/18, indicated R12 to to 10 scale (0="no pain" to The pain assessment did not of the pain. For pain relief include 0 mg (milligrams)/5 ml of every 6 hours as needed for nophen 160 mg/5 ml, give 15 y for back pain; Tramadol 50 wice daily for pain in shoulder. Servation completed on R12 was resistive to oral cares sh teeth twice daily, but R12 buth shut. Staff have tried red toothbrush with toothpaste t to brush but R12 is I continue attempting oral e dental exams as necessary. Deservations/assessments were cord revealed ongoing and ain and oral health without	,	DEFICIENC	T)	

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00797	B. WING		06/	06/14/2018	
NAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, ST	ATE, ZIP CODE			
WARRO	AD CARE CENTER		KE STREET NO AD, MN 56763	DRTHWEST			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 830	Continued From pa	ge 13	2 830				
	-on 11/28/17, (refer that R12 had been teeth. Possible too recommendation w wants a dental app pain control but did of teeth which if pre R12's record lacked assessment or atte lacked evidence of symptoms of infecti R12's family memb	surgeon dated 7/31/18). ral form) nursing observation yelling more and grinding her th pain. Physician's as to talk with son to see if he pintment. The other option is not know if there is infection esent could get worse. d evidence of an oral mpts of, the record further monitoring for signs and on, and also lacked evidence er (FM)-A was contacted in al appointment for further					
	was here in Novem of possible mouth p possibility of having FM-B notified and a increase in pain or arrangements be m	ade to extract remaining nded "yes, if it would help					
	examinations and of for oral pain and or infection. From 12/	ued to lack evidence of oral locumentation of monitoring signs and symptoms of 15/17 to 4/12/18, the record d did not address or evaluate					
	interdisciplinary tea through present day observations of R12 discomfort.	progress notes (PN) and m (IDT) notes from 4/12/18, y reflected an increase in staff 2 demonstrating oral lost one of her molar teeth					

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00797	B. WING	B. WING		14/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
VARRO	AD CARE CENTER		KE STREET NO AD, MN 56763			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	ge 14	2 830			
	tooth pain. -5/25/18, PN, R12 of taking medications -5/26/18, PN, R12 shift, when drinking and get upset. R12 teeth hurt and at or R12 will not open m teeth. -5/27/18, PN, R12 of teeth on and off this and she pulls away -5/30/18, PN, R12 of taking a drink throu drinking. -5/30/18, IDT, indic "yes" " Call Dentist. -5/31/2018, PN, R12 of together and would -6/1/18, PN, R12 w lunch table. -6/5/18, PN, R12 w area to lower left ja due to tooth decay. appointments as ne -6/8/18, PN, R12 w while at the supper pajamas, and gettir -6/9/18, PN, R12 w while taking mornin	cated grinding more - monitor did not like the cold juice when a. had been grinding teeth this cold liquid would pull back 2 was asked multiple times if ne point R12 did say "yes." nouth to allow you to look at was noted to be grinding her s shift, cold liquids irritate her did pull her head back while gh a straw and then stopped ated teeth? "my teeth twitter" " en attempting to look in mouth lition of teeth R12 clamped lips not open mouth. as grinding her teeth at the as noted to have reddened w and upper right jaw, possibly Will notify family and make beded. as grinding her teeth this shift table, while changing into ng ready for bed. Jlled her head back and would rso when trying to give food. was noted to be grinding teeth tig medications in milk. was grinding teeth this evening M medications.				

Minnesota Department of H	ealth				IAPPROVEI
TATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
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NAME OF PROVIDER OR SUPPLIER		DDRESS, CITY, ST KE STREET NO			
WARROAD CARE CENTER		AD, MN 56763			
	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	THE APPROPRIATE	COMPLETE DATE
2 830 Continued From p	age 15	2 830			
cavity or attempts identification of po- infection was not of ongoing monitoring possible oral infec- notified of the nota since 5/26/18, and and symptoms of a 6/5/18. In addition, the family was not had demonstrated the signs and sym further lacked evid and/or a referral m by a family member R12's physician pr address oral/denta On 6/13/18, at 11:3 the dining room by registered nurse (I observed making a supplement from a facial grimaces ind although could not sucking through st -At 12:04 p.m. RN son after referral of hold off with denta RN-E stated at this her pain and sign daily. RN-E stated family wishes were no documentation	ogress notes reviewed did not				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00797	B. WING	B. WING		14/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
WARRO	AD CARE CENTER		KE STREET NO AD, MN 56763			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
2 830	Continued From page 16 and FM-B, left messages with them, had not heard back, and did not document the attempt in the record. RN-E confirmed R12's discomfort noted while drinking from a straw at lunch today		2 830			
	could have been from den -At 12:45 p.m. NA-C state increase in mouth pain for month and a half. NA-C in	om dental discomfort. C stated R12 was showing an				
	grimacing. -At 12:51 p.m. cont who is the primary stated R12 had 13 stated there had no from the nursing ho	acted family member (FM)-A contact by telephone. FM-A teeth pulled last year. FM-A of been any recent contact ome regarding recent signs of FM-A would expect to be				
	contacted with that -At 2:33 p.m. direct her expectation was been made for R12 signs of discomfort awaiting contact from	•				
	teeth extracted if re On 6/14/18, at 7:22 weird noises all the	sident was experiencing pain. 2 a.m. NA-A stated R12 made time, and it is common with				
	stated R12 was in p time when awake a pain had been repo indicated that R12 I	added R12 grinds teeth. NA-A pain, grinded her teeth all the and asleep. NA-A stated the orted to the RN. NA-A has had decreased appetitive				
	-At 7:49 a.m. NA-C to eat and guessed also stated R12 wir	r, could not recall for how long. stated R12 was choosing not it was related to pain. NA-C need with the cold liquids and R12 pulled back and				
	grimaced. NA-C fu do that with food to	rther stated, R12 would also o at times and at times it s teeth bothered her. NA-C				

STATEME	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
		00797	B. WING		06/14/2018	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
WARRO	AD CARE CENTER		KE STREET NO AD, MN 56763			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 17	2 830			
	mouth was swollen, nurse. NA-C also in teeth most days, an toothbrush but they a pink swab which in pulling her body bar a little bit of a mouth R12 would not eat in would eat everythin because of her teet that she lets bevera temperature before better. -At 8:09 a.m. NA-A tray consisting of or breakfast. R12 kep head away and veri touch R12's lips with to get R12 to open R12's face appeare gets really warm. F drink milk, no grima swallowing. -At 8:36 a.m. NA-A breakfast. NA-A m with a pink swab ar opened mouth once opened mouth agai pink swab on left si forward motion. R1 out of mouth. NA-A three times with R1 tightly closed. -At 9:49 a.m. conta R12 was never see dentist visited R12 concluding there we extraction. FM-A d	offering and R12 takes them entered room with breakfast atmeal and carnation instant of lips clamped shut, turned balized "no." NA-A would h spoon and straw to attempt mouth. NA-A indicated that ed pink in color, but added R12 R12 began to take bites and acing noted or difficulty				

STATEME	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:			E SURVEY PLETED
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NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
WARRO	AD CARE CENTER		KE STREET NO AD, MN 56763			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	age 18	2 830			
nnesota D	consults regarding a contract with the -At 10:30 a.m. activ R12 had been grind usually assists R12 week and had not r drinks, just noticed some sweating. No During the last 2 we puckering/tightenin indicated pain could -At 11:00 a.m. licen stated she had not when drinking althout when administering swelling in the jaw a tooth issue, which require hospitalizat sepsis (a life-threat when the body's re- injury to its own tiss and possible death pretty good that could LPN-B examined R filled teeth and som indicated R12 has g -At 12:14 p.m. RN- dental concerns so poor teeth and not completed. The pla extracted although requested only infe believes R12 has th stated R12 had rec but unsure if it is de accident. RN-E ind examine R12's oral conversations with	vities aides (AA)-C indicated ding teeth. AA-C stated she with eating three times a noticed any problems with cold tightness of her mouth and o swelling of checks noted. eeks AA-C stated g of mouth increased and				

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		00707	B. WING		000	06/14/2019	
	PROVIDER OR SUPPLIER	00797	DRESS, CITY, S		06/	06/14/2018	
	-ROVIDER OR SUPPLIER		E STREET N				
VARRO	AD CARE CENTER		D, MN 56763				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
2 830	Continued From pa	age 19	2 830				
2 830	was just slight and RN-E was not able sepsis. RN-E state completes the oral charting is not com When asked expect RN-E she indicated which she stated sl document attempt -At 12:59 p.m. RN- dental assessment MDS. RN-A indica annual MDS Octob noted on the asses recall if she looked	etated redness noted on 6/5/18, was not reported to physician. to speak regarding risks of d the MDS coordinator assessments. RN-E indicated pleted regarding oral cares. ctation if staff reported pain to d she would do an assessment, he attempted although did not and did not notify physician. A stated an oral exam and tis completed with annual ted when completing R12's per 2017, no problems were assment although she could not into R12's oral cavity. RN-A in at the time but was unclear if g else.					
	dentist should have DON confirmed a s for emergency serv the family should h should have been of conversations with	etor of nursing (DON) stated a been contacted for R12. signed contract with a dentist vices did not exist. DON stated ave been contacted and there documentation regarding any family. It would be expected its should have been hily.					
	Attempts to contac	t FM-B were unsuccessful.					
	indicated oral healt	ocedure dated 3/9/17, h review will be completed with annually. Residents will be o a dentist.					
		/1/17: and staff to identify individuals /ho are at risk for having pain					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _			E SURVEY PLETED
		00797	B. WING		06/14/2018	
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
WARRO	AD CARE CENTER		KE STREET NO AD, MN 56763			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 20	2 830		• /	
	new pain or worser nursing staff to ass approach and a sta instrument nursing staff will ob movement) for evid the staff and physic is affecting mood, a and the resident's of complication such a appetitive. the physician will he example by examin reviewing history, a nursing staff will rea and related conseq least each shift for	sess when there is onset of ning of existing pain. ess pain using a consistent indardized pain assessment serve resident (during rest and				
	dated 3/1/17: pain management in potential for pain, e presence of pain, ic pain, addressing th developing and imp management, ident strategies for different monitoring for the e modifying approach comprehensive pain there is onset of ne existing pain, assess	includes: assessing the ffectively recognizing the dentifying the characteristics of e underlying causes of pain, blementing approaches to pain tifying and using specific ent levels and sources of pain, effectiveness of interventions, nes as necessary, conduct a n assessment quarterly, when w pain or worsening of as the resident's pain and				
nnesota D	consequences of p pain. report the following significant changes pain, adverse effec	ain at least each shift for acute information to physician: in the level of the resident's ts from pains medications, red pain despite care plan	3			

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _		(X3) DATE SURVEY COMPLETED	
		00797	B. WING		06/	14/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
WARRO	AD CARE CENTER		KE STREET NO AD, MN 56763			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
2 830	interventions.	ge 21 HOD OF CORRECTION:	2 830			
	review policies and care, pain assessm DON or designee c staff on reporting or conditions, and the follow-up and/or do designee could read potential residents a then develop individ plans. Then the DC system for quality a	sing (DON) or designee could procedures for oral/dental nents, and monitoring. The ould then provide education to ral/dental change of n providing any necessary cumentation. The DON or ssess residents to identify any at risk for oral/dental problems dual comprehensive care ON could develop an auditing issurance and provide results ance committee in order to ce.				
	days.	R CORRECTION: Seven (7)				
2 900	Ulcers Subp. 3. Pressure comprehensive res of nursing services development of a n provides that: A. a resident wh without pressure so pressure sores unle condition demonstr	5 Subp. 3 Rehab - Pressure sores. Based on the ident assessment, the director must coordinate the ursing care plan which o enters the nursing home ores does not develop ess the individual's clinical ates, and a physician they were unavoidable; and	2 900			8/1/18
	receives necessary	ho has pressure sores y treatment and services to revent infection, and prevent				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		00707	B. WING		00/44/0040	
	ROVIDER OR SUPPLIER	00797		STATE, ZIP CODE	06/14/2018	
				NORTHWEST		
VARROA	D CARE CENTER	WARROA	D, MN 5676	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLET	
2 900	Continued From pa	ge 22	2 900			
	new sores from dev	veloping.				
	This MN Requirem	ent is not met as evidenced				
	Based on observati review, the facility f assess a facility ac provide consistent	on, interview and document ailed to comprehensively quired pressure ulcer, and monitoring to promote healing R20) reviewed for pressure		Corrected.		
	Findings include:					
	indicated R20 had of Alzheimer's disease of the digestive trac (C. Diff, an infection	ecord, dated 6/13/18, diagnoses that included e, enterocolitis (inflammation ct) due to clostridium difficile n of the colon, often causes ney failure, functional urinary ites, and gout.				
	assessment, dated severe cognitive im extensive assistant and toileting. The M frequently incontine continent of bowel. R20 was at risk to o had not had a press quarterly assessme R20 was on a turnin and had lotion or oi There was not a Ca	imum Data Set (MDS) an 4/15/18, identified R20 had pairment and required se for transfers, bed mobility IDS identified R20 as ent of urine and always The MDS further indicated develop pressure ulcers, and sure ulcer on the previous ent. Finally, the MDS indicated ng and repositioning program ntment applied to his skin. are Area Assessment (CAA) ressure ulcer prevention.				
	was at risk for skin	ated 10/21/15, indicated R20 breakdown related to the need ance with bed mobility and				

STATEME	<u>ota Department of He</u> NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00797	B. WING		06/	06/14/2018	
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	ATE, ZIP CODE			
WARRO	AD CARE CENTER		KE STREET NO AD, MN 56763				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLETI DATE	
2 900	repositioning, and h The care plan ident have intact skin, fred discoloration. Interv reposition at least e air bed and ROHO in his wheelchair to The care plan did n pressure ulcer whice 5/20/18. R20's Physician Dis 5/17/18 after a four R20 was hospitalize generalized weakne been diagnosed with oral antibiotics. The dated 5/17/18, indic redness, intact skin and right buttocks. cavilon cream (barr R20's progress note returned to the facil no skin issues to no A 5/18/18, progress area was slightly re was applied. The first identification perineal area was e p.m. progress note (cm) open area not intragluteal fold (be waking that morning appeared to be from loose stools that sh	ad occasional incontinence. ified the goal was for R20 to be of redness, blisters or ventions included to turn or every two hours; R20 had an cushion (pressure preventing) help maintain skin integrity. not identify the stage II the was first identified on scharge Summary dated day hospitalization, indicated ed due to worsening ess and dehydration. R20 had th C. Diff and was receiving a hospital discharge notes, cated R20 had blanchable o on his coccyx, sacrum, left Treatment was to apply rier) and provide repositioning. e dated 5/17/18, indicated he lity at 2:10 p.m. and there were	r				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00797	B. WING		06/	14/2018
IAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
VARRO	AD CARE CENTER		E STREET NO D, MN 56763			
()())		TEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF C	ORRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	E APPROPRIATE	COMPLET DATE
2 900	Continued From pa	ge 24	2 900			
	was to be turned or	nue to apply cream and R20 n each side rather than on his o help aid in healing.				
	R20's health status notes dated 5/21/18, at 3:31 a.m. indicated R20 was repositioned every 2 hours while in bed, was incontinent of bladder, had no bowel movements and the open area to his coccyx was covered with duoderm (a wound dressing with water resistant outer layer).					
	p.m. indicated an o	ote dated 5/21/18, at 12:29 pen area to the right buttock. nsed with saline and covered				
	an open area to the fold that was previo but this was not stic nurse removed the	ted 5/22/18, indicated R20 had buttock near the intragluteal busly covered with a duoderm, cking. The note indicated the duoderm and Lantiseptic s applied to the area for				
	Lantiseptic cream v top of the intraglute	ed 5/23/18, indicated vas applied to an open area on al fold. The area was nd had a small open area.				
	physician was notifi stools. The note lac	ted 5/25/18, indicated a ed regarding R20's loose ked indication that the ed of a coccyx, or intragluteal				
		on 5/28/18, indicated there o the left buttock and that the vith Lantiseptic.				
	A skin/wound note	dated 6/1/18, provided the first				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00797	B. WING		06/	14/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
WARRO	AD CARE CENTER		E STREET NO D, MN 56763	-		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLETI DATE
2 900	Continued From pa	ge 25	2 900			
	area on R20's perin Stage II pressure ui measured 2.4 cm b described as red wi borders. The wound (prepares skin for a Medihoney (helps v tegaderm foam (tra dressing) were app the dressing would needed if the dress off. The note furthe bed, Roho cushion being repositioned of On 5/31/18, a treath completed for tegad sacral/coccyx regio and tegaderm foam healed; one time a	-				
	Review of R20's me documentation of o administration reco ulcer prior to 5/31/1	rders or treatment rd to coccyx area pressure				
	tissue tolerance tes	edical record revealed the last and skin observation tools 4/13/18, prior to his C. Diff italization.				
		note indicated R20 had a 1.0 open area on his coccyx.				
	indicated R20 had a was allowing staff to	k Committee progress note a new bolstered air bed and o turn and reposition him every lid not identify R20 as having a				

STATE FORM

VNT411

If continuation sheet 26 of 55

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	or connection	IDENTIFICATION NOMBER.	A. BUILDING:			
		00797	B. WING		06/′	14/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
WARRO	AD CARE CENTER		KE STREET N AD, MN 56763			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC)	WUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	COMPLET DATE
2 900	Continued From pa	ge 26	2 900			
	of provider notificat plan updates regare	edical record lacks indication ion, family notification, or care ding the Stage II pressure cyx which was first identified				
		a.m., R20 was observed in ng air pressure mattress.				
	was observed in be pressure mattress. (NA)-A and NA-B re his care plan, remo	05 a.m. until 8:32 a.m., R20 d on an alternating air At 8:32 a.m., nursing assistan epositioned R20 according to ving a pillow from his right ing R20 with a pillow under his				
	(RN)-D and RN-BB dressing to R20's c wound was describ measured at 0.9 cn wound bed describ- with 10% granulation	8 a.m., registered nurse , were observed changing the occyx pressure ulcer. The ed as "almost gone"; n x 0.5 cm x 0.1 cm; and the ed as 90% white/yellow slough on tissues surrounding slough. a described as pink and intact.				
	rounds were done e of wound rounds, a formal assessment are to be charting o RN-BB confirmed F assessed until 5/30 first noted). RN-BB incident report or a her to assess a wou returned from the h	7 a.m., RN-BB stated wound every two weeks, she was part nd these were considered a . RN-BB also indicated staff on wounds on bath days. R20's wound was not fully /18 (which was ten days after stated she usually gets an note from staff that triggers und. RN-BB confirmed R20 ospital with a reddened but				
necota D		occyx. RN-BB further facility acquired pressure				

TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 2 900 Continued From page 27 2 900 ulcer; and while the initial notes on it were from 5/20/18 and 5/21/18, she does not remember knowing about it before 5/30/18. 2 900 On 6/13/18, at 1:33 p.m. licensed practical nurse (LPN)-A confirmed she wrote R20's 5/2/118, skin/wound note as that was his bath day. LPN-A indicated this was not the first identification of the wound, as she remembers removing a duoderm and replacing it. LPN-A indicated she didn't know who put the original duoderm on, or when the wound first opendu. LPN-A stated she was just following suit with the treatment she had found on the wound. On 6/13/18, at 1:54 p.m. the director of nursing stated they are implementing a new skin incident report that will hopefully improve the reporting and monitoring process. The DON stated staff weren't clear on the right thing to do with the current report form. The DON indicated RN-BB was a certified wound specialist. The facility's Prevention of Pressure Ulcers policy, dated 6/11/15, indicated the facility should have a system/procedure to assure assessments are timely and appropriate and changes in condition are recognized, evaluated, and reported to the practitioner, physician and family, and addressed. The policy further directed staff to routinely assess and document the condition of the resident's skin through use of a Weekly Skin Integrily Form for any signs and symptoms of irritation or breakdown. The policy also directed		NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AWE OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE MARROAD CARE CENTER 1401 LAKE STREET NORTHWEST WARROAD, MN 56763 PROVIDER'S PLAN OF CORRECTION (EACH DEPICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFX Yadi D. Charles and the initial notes on it were from S/201/8 and S/2118, she does not remember knowing about it before 5/30/18. 2 900 On 6/13/18, at 1:13 p.m. licensed practical nurse (LPN)-A confirmed she wrote R20's 5/21/18, skin/wound note as that was his bath day. LPN-A indicated this was not the first identification of the wound, as she remembers removing a duoderm and replacing it. LPN-A indicated she didn't know who put the original duoderm on, or when the wound. On 6/13/18, at 1:54 p.m. the director of nursing stated they are implementing a new skin incident report that will hopefully improve the reporting and monitoring process. The DON staded staff weren't clear on the right thing to do with the current report form. The DON indicated RN-BB was a cettified wound specialist. The facility's Prevention of Pressure Ulcers policy, dated 6/11/1/5, indicated the facility should have a system/procedure to assure assessments are timely and appropriate and changes in condition are recognized, evaluated, and reported to the practitioner, physician and family, and addressed. The policy further directed staff to routiney assess and document the condition of the resident's skin through use of a Weekly Skin Integrity Form for any signs and symptoms of irritation or breakdown. The policy also directed			00707				
MARCAD CARE CENTER MarcAD, MN 56763 PROVIDER'S PLAN OF CORRECTION (#CACH DEPICIENCY MUST BE PRECEDED BY FULL PRETIX PROVIDER'S PLAN OF CORRECTION (#CACH CORRECTIVE ACTION OR LSC IDENTIFYING INFORMATION) Preter Comparison of the Correction of (#CACH CORRECTIVE ACTION OR LSC IDENTIFYING INFORMATION) Preter Comparison of the Correction of (#CACH CORRECTIVE ACTION OR LSC IDENTIFYING INFORMATION) 2 900 Continued From page 27 2 900 2 900 Continued From page 27 2 900 2 000 Continued From page 27 2 900 Continued From page 27 2 900 0 continued From page 27 Loss on the members knowing about it before 5/30/18. 2 900 Continued State						00/	14/2010
WARROAD, INN 56763 OPERTY TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D PREFIX TAG PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE CROSS.REFERENCED TO THE APPROPRIATE DEFICIENCY) 2 900 Continued From page 27 Ucer; and while the initial notes on it were from S/20/18 and 5/21/18, she does not remember knowing about it before 5/30/18. 2 900 Continued From page 27 Ucer; and while the initial notes on it were from S/20/18 and 5/21/18, she does not remember knowing about it before 5/30/18. Cn 6/13/18, at 1:13 p.m. licensed practical nurse (LPN)-A confirmed she wrote R20'S 5/21/18, skin/wound note as that was his bath day. LPN-A indicated this was not the first identification of the wound, as she remembers removing a duoderm and replacing it. LPN-A stated she was just following suit with the treatment she had found on the wound. On 6/13/18, at 1:54 p.m. the director of nursing stated they are implementing a new skin incident report that will hopfully improve the reporting and monitoring process. The DON stated staff werent clear on the right thing to do with the current report from. The DON indicated RN-BB was a certified wound specialist. The facility's Prevention of Pressure Ulcers policy, dated 6/11/15, indicated the facility should have a system/procedure to assure assessments are timely and appropriate and changes in condition are recognized, evaluated, and reported to the practitioner, physician and family, and addressed. The policy further directed staff to routinely assess and document the condition of the resident's skin through use of a Weekly Skin Integrily Form for any signs and symptoms of irritation or breakdown. The policy also directed <							
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5/20/18 and 5/21/18, she does not remember knowing about it before 5/30/18. On 6/13/18, at 1:13 p.m. licensed practical nurse (LFN)-A confirmed she wrote R20's 5/21/18, skin/wound note as that was his bath day. LPN-A indicated this was not the first identification of the wound, as she remembers removing a duoderm and replacing it. LPN-A indicated she didn't know who put the original duoderm on, or when the wound first opened. LPN-A stated she was just following suit with the treatment she had found on the wound. On 6/13/18, at 1:54 p.m. the director of nursing stated they are implementing a new skin incident report that will hopefully improve the reporting and monitoring process. The DON stated staff weren't clear on the right thing to do with the current report form. The DON indicated RN-BB was a certified wound specialist. The facility's Prevention of Pressure Ulcers policy, dated 6/11/15, indicated the facility should have a system/procedure to assure assessments are timely and appropriate and changes in condition are recognized, evaluated, and reported to the practitioner, physician and family, and addressed. The policy further directed staff to routinely assess and document the condition of the resident's skin through use of a Weekly Skin Integrity Form for any signs and symptoms of irritation or breakdown. The policy also directed	2 900	Continued From pa	age 27	2 900			
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policy, dated 6/11/15, indicated the facility should have a system/procedure to assure assessments are timely and appropriate and changes in condition are recognized, evaluated, and reported to the practitioner, physician and family, and addressed. The policy further directed staff to routinely assess and document the condition of the resident's skin through use of a Weekly Skin Integrity Form for any signs and symptoms of irritation or breakdown. The policy also directed		stated they are imp report that will hope and monitoring pro weren't clear on the current report form	Dementing a new skin incident efully improve the reporting cess. The DON stated staff e right thing to do with the . The DON indicated RN-BB				
ulcer to a nurse supervisor and physician.		policy, dated 6/11/1 have a system/prod are timely and appriced condition are recogno to the practitioner, addressed. The por routinely assess are the resident's skin Integrity Form for a irritation or breakdo staff to report any s	15, indicated the facility should cedure to assure assessments ropriate and changes in gnized, evaluated, and reported physician and family, and blicy further directed staff to ad document the condition of through use of a Weekly Skin any signs and symptoms of own. The policy also directed signs of a developing pressure				
The facility's Pressure Ulcer Guidelines policy, dated 7/29/15, indicated wound rounds would be completed on all residents with pressure ulcers		dated 7/29/15, indi	cated wound rounds would be				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00797	B. WING		06/	14/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
WARRO	AD CARE CENTER		KE STREET N AD, MN 56763			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 900	established pressur specified the follow basis: Observe, measur- ulcers weekly on th Documentation Flo If deteriorating or noted, update the p Implement any ne obtained. Complete docume staging. Update the care p new wound treatme discontinuation of a when a wound was Pressure Ulcer stag Pressure Ulcer Adv	ded by the RN for all new and re ulcers. The policy further ing be completed on a weekly e, and document pressure e Weekly Pressure Ulcer w Sheet. non-healing wounds are bysician. w wound treatment orders entation to include location and plan to include addition of any ent or nursing interventions or iny established interventions healed. ges defined by the National risory Panel (NPUAP): njury: Non-blanchable	2 900			
	Intact skin with a lo erythema, which ma pigmented skin. Pro erythema or change or firmness may pro changes do not inc discoloration; these pressure injury. Stage 2 Pressure In	calized area of non-blanchable ay appear differently in darkly esence of blanchable es in sensation, temperature, ecede visual changes. Color lude purple or maroon e may indicate deep tissue				
	dermis. The wound moist, and may also ruptured serum-fille visible and deeper	dermis ss of skin with exposed bed is viable, pink or red, o present as an intact or ed blister. Adipose (fat) is not tissues are not visible. slough and eschar are not				

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
		00797	B. WING		06/	14/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
WARRO	AD CARE CENTER		KE STREET N AD, MN 56763			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 900	adverse microclima the pelvis and shea should not be used associated skin dar incontinence assoc intertriginous derma related skin injury (I (skin tears, burns, a SUGGESTED MET The director of nurs all residents at risk they are receiving the treatment/services from developing an pressure ulcers. The designee, could con delivery of care; to services are implem pressure ulcer developed	ries commonly result from the and shear in the skin over ir in the heel. This stage to describe moisture mage (MASD) including iated dermatitis (IAD), atitis (ITD), medical adhesive MARSI), or traumatic wounds abrasions). THOD OF CORRECTION: sing or designee, could review for pressure ulcers to assure he necessary to prevent pressure ulcers d to promote healing of ne director of nursing or nduct random audits of the ensure appropriate care and nented; to reduce the risk for	2 900			
2 960	Food Quality Subpart 1. Food qu) Subp. 1 Dietary Service - uality. Food must have taste, ance that encourages resident d.	2 960			7/16/18
	by: Based on observati review, the facility f temperatures were	ent is not met as evidenced on, interview and document ailed to ensure food of resident preference for 1 of 1 resident (R13)		Corrected.		

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED 06/14/2018	
		00797	B. WING			
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
WARRO	AD CARE CENTER		KE STREET NO AD, MN 56763			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLETI DATE
2 960	Continued From pa	ige 30	2 960			
	reviewed for food p	alatability.				
	Findings include:					
	R13 had diagnosis	ecord dated 6/14/18, indicated that included diabetes, sy, and vascular dementia disturbance.				
	assessment, dated	inimum Data Set (MDS) an 4/4/18, indicated he could others, had no behaviors and				
	was able to feed hi plan also indicated	ated 3/29/18, indicated R13 mself after set up. R13's care he was able to make simple make himself understood.				
	be improved as gre	p.m., R13 stated food could een beans are served often, no ed them, and breakfast foods t.				
	were warm and like	a.m., R13 stated his eggs ad them hot. R13's table mate ation and agreed the food was as they liked.				
	finishing breakfast. R13 stated, "it was was hot enough, R	a.m., R13 was observed When asked about breakfast, good today." When asked if it 13 replied, "Well, it's never could write down we don't get				
	was requested from used a thermometer	a.m., a breakfast test plate n dietary aide (DA)-A. DA-A er to test the oatmeal, which s Fahrenheit (F); the egg bake	,			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
		00797	B. WING		06/	14/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
WARRO	AD CARE CENTER		KE STREET NO AD, MN 56763			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLETE DATE
2 960	which was at 138 F temped at 85 F. DA	F, and the sausage which was A-A stated she had put the food				
	7:15 a.m. When tag the egg bake and t	at the station at approximately sted, the oatmeal tasted hot, he sausage luke warm.	/			
		ng resident council having a prving foods hot for several esolution.				
	2017, indicated all to appropriate inter served at a temper	emperatures policy, dated hot food items must be cooked nal temperatures, held and ature of at least 135 F. Review cked direction on palatability of	,			
	certified dietary ma could identify and c dining experience a staff education rega included temperatu	THOD OF CORRECTION: The inager (CDM) and/or designee levelop a more palatable and could provide appropriate arding food preparation, ires. The Quality Assessment (A) committee could do insure compliance.				
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one				
21025	MN Rule 4658.061	5 Food Temperatures	21025			7/16/18
	40 degrees Fahren or below, or 150 de centigrade) or abov food" means any fo and temperature co	us food must be maintained at heit (four degrees centigrade) egrees Fahrenheit (66 degrees /e. "Potentially hazardous bod subject to continuous time ontrols in order to prevent the ive growth of infectious or anisms.				

STATE FORM

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		00797	B. WING		06/	14/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
WARRO	AD CARE CENTER		E STREET N D, MN 5676	NORTHWEST 3		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	, ID	PROVIDER'S PLAN OF CO	RRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	EAPPROPRIATE	COMPLET DATE
21025	Continued From pa	ge 32	21025			
	by: Based on observati review, the facility fa vegetable beef sou and/or minimize the	ent is not met as evidenced on, interview and document ailed to appropriately cool p in a manner that prevented e risk for food borne illness. I residents in the facility who itchen.		Corrected.		
	Findings include:					
		chen tour on 6/11/18, at 3:14 A, the following was observed er, uncovered:				
	approximately a ¼ container was com -A two gallon stock	pot type kettle with inch thick, crust like,				
	finished making veg p.m and placed it on the counter to co soup was put into th degrees. C-A stated day's lunch meal. C an hour and a half t temperature. The s placed on the count surveyor, C-A check containers which re degrees. C-A stated to being able to be	bservation, C-A stated she had getable beef soup at 2:00 in the above containers and bol. C-A stated at that time the ne containers, it measured 207 d the soup was for the next C-A stated it would take about to cool down to the appropriate oup had not been stirred since ter. At the request of the ked the temperature of both evealed both measured 120 d the soup was getting closer put in the refrigerator and e soup in the cooler once it ome more.				

STATEMEN	ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00797	B. WING		06/	14/2018
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
WARRO	AD CARE CENTER		KE STREET NO AD, MN 56763			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
21025	Continued From pa	ge 33	21025			
	confirmed the findir had put the soup in the cooling time for hours. The DM also temperature of the below the danger z grow most rapidly) stated in order to put have been put into directly into the coo worked at the facilit was previously Ser had not kept up the DM stated there was member that was c -At 6:03 p.m. both c observed on the bo DM stated he was u actually placed in th "log." The DM stated documentation on t 100 degrees at 4:30 in the cooler, howev was for both contain verified there was n soup's temperature taken/monitored as the DM obtained the containers. The pla degrees and the mo DM stated he was u protocols for all foo purchasing cooling/	the "log," the soup measured D p.m. just prior to it being put ver, he did not know if that ners, or just one. The DM no further documentation of the	5			
		M confirmed the soup should sooner and faster. The DM				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00797	B. WING		06/	14/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
WARRO	AD CARE CENTER		E STREET NO D, MN 56763			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21025	Continued From pa	ige 34	21025		, 	
	for cooling time to p therefore should ha smaller divided con properly in order to	e soup had less than two hours prevent bacterial growth, ave been placed in a cooler in tainers in order to cool prevent food borne illness. soup was going to be				
	(RD) who was on le to assist with the re soup was not coole	7 a.m. the registered dietician eave had arrived at the facility moval of the IJ, confirmed the ed properly and was discarded. cation would be provided to				
	consultant stated th her of the IJ and ag	1 p.m. the on call dietary ne administrator had informed greed the soup was improperly have caused food borne				
	Guidelines for Food bullet #5, titled, Ess staff to cool food fro in two hours and fro in four hours, not to not cooled to 41 de to 65 degrees for a hours) and discard This included mech temperatures frequ	ed, General HACCP d Safety policy and procedure sentials of Cooling, directed the om 135 degrees to 70 degrees on 70 degrees to 41 degrees o exceed six hours. If food was grees within six hours, reheat t least 15 seconds (within two if not served immediately. nanically altered foods. Take ently to determine if altered are needed. The policy also				
	containers that peri Place in smaller pre -Place pans in an ic	veral smaller batches, and in mitted the food to cool rapidly. e-chilled stainless steel pans. ce bath and stir foods as they te (ice bath should contain				

STATEME	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
		00797	B. WING		06/	14/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
WARRO	AD CARE CENTER		E STREET NO D, MN 56763			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETE DATE
21025	more ice than water storage refrigerator the total temperatur level). -Place cooling items refrigerator or freez covered in two inch 15 to 60 minutes. -Allow air to circulat SUGGESTED MET The dietary director training for all dietar food safely in order food borne illness. assurance committa audits to ensure committa	r). Avoid cooling foods in s or freezers. (This can bring re of the unit to an unsafe s on the top shelf of the er uncovered or loosely shallow pans and stir every the around the food. THOD OF CORRECTION: or designee, could provide ry staff staff related to cooling to prevent and/or minimize The quality assessment and ee could perform random	21025			
21335	Routine & Emerger Subp. 3. Emergen A. A nursing ho from an outside res services to meet the Emergency dental s needed to treat: an teeth, gums, or pala damaged teeth; or a cavity, appropriately requires immediate B. When emergen nursing home mus hours, describe the	cy dental services. me must provide, or obtain ource, emergency dental e needs of each resident. services include services episode of acute pain in ate; broken or otherwise any other problem of the oral y treated by a dentist, that	21335			7/16/18

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION		E SURVEY PLETED
		00797	B. WING		06/	14/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY,	STATE, ZIP CODE		
WARRO	AD CARE CENTER		KE STREET I AD, MN 5676	NORTHWEST 33		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETI DATE
21335	Continued From pa	ge 36	21335			
	orders.					
	by: Based on observati review, the facility f	ent is not met as evidenced ion, interview and document ailed to obtain dental services R12) reviewed for dental care.		Corrected.		
	Findings include:					
	p.m. located in the unidentified nursing observed to be mal fists, and pushing s	erved on 06/11/18, at 5:40 dining room being fed by an assistant (NA). R12 was king facial grimaces, clenching self away from table while h liquids. R12 was observed to ng teeth.				
	assessment dated severe cognitive im able to make self u others. R12 require eating and oral care had indicators of pa grimaces, winces, v	num Data Set (MDS) an 10/1/17, indicated R12 had pairment and was rarely/never nderstood or understand ed extensive assistance with es. The MDS indicated R12 ain (facial expressions - wrinkled forehead, furrowed th or jaw) one to two days and I pain medication.				
	(per letter from oral on 11/28/17, (refer that R12 had been teeth. Possible too recommendation w (FM)-A to see if R12 The other option is	tes: rgery for extraction of 14 teeth surgeon dated 7/31/18) ral form) nursing observation yelling more and grinding her th pain. Physician's as to talk with family member 2 needs a dental appointment. pain control but I do not know of teeth which if present could				

ODE 06/14/2018 ODE 05/14/2018 ST COVIDER'S PLAN OF CORRECTION (X5) H CORRECTIVE ACTION SHOULD BE COMPLET FREFERENCED TO THE APPROPRIATE DATE DEFICIENCY) DATE
DDE ST ROVIDER'S PLAN OF CORRECTION (X5) H CORRECTIVE ACTION SHOULD BE REFERENCED TO THE APPROPRIATE DATE
OVIDER'S PLAN OF CORRECTION (X5) H CORRECTIVE ACTION SHOULD BE REFERENCED TO THE APPROPRIATE DATE
OVIDER'S PLAN OF CORRECTION (X5) H CORRECTIVE ACTION SHOULD BE COMPLE -REFERENCED TO THE APPROPRIATE DATE
H CORRECTIVE ACTION SHOULD BE COMPLE REFERENCED TO THE APPROPRIATE DATE
-REFERENCED TO THE APPROPRIATE DATE
,

STATE FORM

	NT OF DEFICIENCIES	alth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00797	B. WING		06/	14/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	ATE, ZIP CODE		
WARRO	AD CARE CENTER		KE STREET NO AD, MN 56763			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
21335	 while at the supper pajamas, and gettin - on 6/9/18, R12 pu shake her upper tor - on 6/11/18, R12 w while taking mornin - on 6/11/18 R12 wa while getting her PM Review of Interdisci reports: on 5/16/18 indicate tooth pain - on 5/30/18, indicate tooth pain - on 5/30/18, indicate tooth pain - on 5/30/18, indicate There had been no appointment was seevident oral pain witmonth. On 6/14/18 at 2:20 stated absolutely a contacted for R12. Pain policy dated 3/ directed physician a who have pain or w related to oral or de SUGGESTED MET The administrator a secure an agreeme services. The directed per care. The DON or of the pain or w related to oral or de secure an agreeme services of the pain or w related to oral or de secure an agreeme services. The directed per care. The DON or of the pain or w related to oral or de secure per care. The DON or of the pain or w related to oral or de secure per care. The DON or of the pain or w related to oral or de secure per care. The DON or of the pain or w related to oral or de the pain or w related to oral or de the pain policy date per care. The DON or of the pain or w related to oral or de the pain	table, while changing into g ready for bed. lled her head back and would so when trying to give food. as noted to be grinding teeth g medications in milk. as grinding teeth this evening <i>A</i> medications. plinary Team daily handwritter ed grinding more - monitor ted teeth? "my teeth twitter" ted teeth? in pain indication that a dental et up for R12 even with th eating/drinking over past p.m. director of nursing (DON) dentist should have been 1/17: and staff to identify individuals ho are at risk for having pain				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION (X:	3) DATE SURVEY COMPLETED
		00797	B. WING		06/14/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	
WARRO	AD CARE CENTER		E STREET I D, MN 5676	NORTHWEST 3	
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PRÉFIX TAG		YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
21335	Continued From pa	ge 39	21335		
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one			
21350	MN Rule 4658.0730 Requirements;Writt) Subp. 2 A-C NH Dental ten Agreement	21350		7/16/18
	must maintain a wri agreement with at le the Board of Dentis A. routine and e nursing home's res B. consultation health policies and	on the nursing home's oral			
	by: Based on observati review, the facility fa	ent is not met as evidenced on, interview and document ailed to obtain an agreement by dental services which could its at the facility.		Corrected.	
	Findings include:				
	written statement in for signed copy of d	a.m. Administrator provided a adicating he was still looking lental contract with a dentist. ere was no signed dental d by the facility.			
	The administrator a obtain an agreemer licensed by the Boa agree to provide rou	THOD OF CORRECTION: and/or governing board could nt with at least one dentist ard of Dentistry that would utine and emergency dental is residents, consultation on			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00797	B. WING		06/	14/2018
AME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
ARRO	AD CARE CENTER		E STREET NO D, MN 56763			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO		(X5)
PRÉFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	EAPPROPRIATE	COMPLET DATE
21350	Continued From pa	ge 40	21350			
		and procedures, and provide for nursing home staff.				
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one				
21390	MN Rule 4658.0800	0 Subp. 4 A-I Infection Control	21390			7/16/18
	control program mu procedures which p A. surveillance collection to identify residents; B. a system for control of outbreaks C. isolation and reduce risk of trans D. in-service en prevention and con E. a resident he immunization progr defined in part 465 procedures of resid the prevention and F. the develop employee health po practices, including defined in part 4658 G. a system for H. a system for products which affe disinfectants, antise incontinence produ I. methods for	ealth program including an am, a tuberculosis program as 8.0810, and policies and lent care practices to assist in treatment of infections; ment and implementation of olicies and infection control a tuberculosis program as 8.0815; r reviewing antibiotic use; r review and evaluation of ect infection control, such as eptics, gloves, and				
	This MN Requirem	ent is not met as evidenced				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION		E SURVEY PLETED
		00797	B. WING		06/	14/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY,	STATE, ZIP CODE		
WARRO	AD CARE CENTER		KE STREET I AD, MN 5676	NORTHWEST		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO		(X5) COMPLETE
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	E APPROPRIATE	DATE
21390	Continued From pa	ige 41	21390			
	review, the facility f for 1 of 1 resident (In addition, the faci agreement to obtain which could affect a Findings include: R12 had been obse p.m. located in the unidentified nursing observed to be mal fists, and pushing s	ion, interview and document ailed to obtain dental services R12) reviewed for dental care. lity failed to obtain an n emergency dental services all 47 residents at the facility. erved on 06/11/18, at 5:40 dining room being fed by an g assistant (NA). R12 was king facial grimaces, clenching self away from table while n liquids. R12 was observed to		Corrected.		
	assessment dated severe cognitive im able to make self u others. R12 require eating and oral care had indicators of pa grimaces, winces, v	num Data Set (MDS) an 10/1/17, indicated R12 had pairment and was rarely/never nderstood or understand ed extensive assistance with es. The MDS indicated R12 ain (facial expressions - wrinkled forehead, furrowed th or jaw) one to two days and	-			
	Review of R12's no -on 7/25/17 oral sur (per letter from oral -on 11/28/17, (refer that R12 had been teeth. Possible too recommendation w (FM)-A to see if R1. The other option is					

Minnesota Department or STATE FORM

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00797	B. WING		06/	14/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
WARRO	AD CARE CENTER		CE STREET NO D, MN 56763			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC ¹	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
	was here in Novem of possible mouth p possibility of having FM-B notified and a increase in pain or arrangements be m teeth? FM-B respo keep her comfortab Review of nursing p increase in observa oral discomfort: -on 4/12/18, R12 lo looked like it had ro - on 5/25/2018, R12 when taking medic	hade to extract remaining onded "yes, if it would help ole." brogress notes showed an ations of R12 demonstrating st one of her molar teeth that otten out. 2 did not like the cold juice				
	shift, when drinking and get upset. R12 teeth hurt and at or R12 will not open m teeth. - on 5/27/18, R12 w teeth on and off this and she pulls away - on 5/30/18, R12 d	cold liquid would pull back was asked multiple times if pe point R12 did say "yes". nouth to allow you to look at was noted to be grinding her s shift, cold liquids irritate her				
	 on 5/31/18, when see current condition together and would on 6/1/18, R12 was lunch table. on 6/5/18, R12 was area to lower left jan due to tooth decay. appointments as ne on 6/8/18, R12 was 	as grinding her teeth at the as noted to have reddened w and upper right jaw, possibly Will notify family and make				

STATE FORM

	T OF DEFICIENCIES OF CORRECTION	Ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED
		00797	B. WING		06/	14/2018
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE	•	
VARROA	AD CARE CENTER					
			AD, MN 56763			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21390	Continued From pa	age 43	21390			
	shake her upper to - on 6/11/18, R12 w while taking mornir - on 6/11/18 R12 w while getting her Pl Review of Interdisco reports: - on 5/16/18 indicat tooth pain - on 5/30/18, indicat "yes" Call Dentist - on 6/13/18, indicat	ulled her head back and would rso when trying to give food. was noted to be grinding teeth ng medications in milk. as grinding teeth this evening M medications. Siplinary Team daily handwritter ted grinding more - monitor ated teeth? "my teeth twitter" ated teeth? in pain				
	appointment was s	indication that a dental et up for R12 even with ith eating/drinking over past				
		p.m. director of nursing (DON) dentist should have been)			
	written statement in copy of dental cont	a.m. Administrator provided a ndicating still looking for signed ract with a dentist. By end of o signed dental agreement				
	indicated facility off residents. The fac with dental services	ocedure dated 3/9/17, fers routine dental services to ility has a written agreement s that visits on a regular basis. will be completed with the data				
	Pain policy dated 3	/1/17·				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED
		00797	B. WING		06/14/2018	
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
VARRO	AD CARE CENTER		KE STREET I AD, MN 5676	NORTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLET DATE
21390	Continued From pa	ge 44	21390			
		and staff to identify individuals ho are at risk for having pain ental pathology.				
	The Director of Nur develop, review, an procedures to ensu program is develop staff . The Director educate all appropr procedures. The Director of Nur	HOD OF CORRECTION: sing or designee could id/or revise policies and ire an infection control ed and implemented by all of Nursing or designee could iate staff on the policies and sing or designee could systems to ensure ongoing				
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one				
21445	MN Rule 4658.0900 Recreation Program	0 Subp. 3 Activity and n; Director	21445			7/20/18
	The activity and rec	nd recreation program director creation program director must trained or experienced to nd recreation staff and sing home.				
	by: Based on interview facility failed to ens (AD) was in charge	ent is not met as evidenced and document review, the ure a qualified activity director of the activity program. This impact all 47 residents of the		Completed.		
	Findings include:					
	On 6/13/18, at 1:27	p.m., the AD stated she				

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
	00797		B. WING		06/	14/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	ATE, ZIP CODE		
WARRO	AD CARE CENTER		KE STREET NO AD, MN 56763	DRTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
21445	Continued From pa	ge 45	21445			
		on during the summer of 2017 an activity director course				
	they advertised for did not find someor The administrator s worked previously i she met the require experience. In addi	p.m., the administrator stated a qualified activity director but he who met the qualifications. tated the current AD had n activities, and he thought ements based on previous tion, they enrolled the AD in an as immediately upon hiring her				
	confirmed the AD's 7/2012, through 9/2	a.m., the administrator previous experience from 2017, only adds up to 14.5 xperience in the last 5 years; it was 2 years.				
		the qualifications of an activity equested but not provided.				
	The administrator qualified Activity Di organized activities care setting. The ad	HOD OF CORRECTION: or designee, could ensure a rector is provided to direct and recreation in a health dministrator or designee could his requirement is met.				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
21800	MN St. Statute144. Residents of HC Fa	651 Subd. 4 Patients & ac.Bill of Rights	21800			7/16/18
	residents shall, at a are legal rights for	tion about rights. Patients and dmission, be told that there their protection during their r throughout their course of				

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION		E SURVEY PLETED
		00797	B. WING		06/14/2018	
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE		
WARRO	AD CARE CENTER		KE STREET I AD, MN 5676	NORTHWEST 33		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE	(X5) COMPLET DATE
21800	Continued From pa	ge 46	21800			
	that these are desc written statement of responsibilities set case of patients add as defined in section statement shall also person 16 years old provided in section shall list the names individuals and orga advocacy and legal residential program accommodations si communication imp speak a language of facility policies, insp local health authorit the written stateme to patients, residen chosen representat to the administrator person, consistent	tenance in the community and ribed in an accompanying f the applicable rights and forth in this section. In the mitted to residential programs n 253C.01, the written o describe the right of a d or older to request release as 253B.04, subdivision 2, and and telephone numbers of anizations that provide services for patients in s. Reasonable hall be made for those with other than English. Current bection findings of state and ties, and further explanation of nt of rights shall be available ts, their guardians or their ives upon reasonable request or other designated staff with chapter 13, the Data section 626.557, relating to				
	by: Based on interview facility failed to give resident rights to ac	ent is not met as evidenced and document review, the the correct version of dmitting residents. This had ct all 47 residents residing in		Corrected.		
	Findings include:					
		y's Resident Handbook given revealed it contained a version				

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If continuation sheet 47 of 55

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	00797	B. WING	B. WING		14/2018
PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
AD CARE CENTER					
(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
Continued From pa	age 47	21800			
designee (SSD) co	nfirmed the 7/1/07 version of				
Combined Federal Rights dated 11/28, resident at one time update. This rights available at the info and the SSD offere However, the SSD not provided to resi	and Minnesota Resident Bill o /16, was provided to every e soon after the 11/28/16, booklet was also currently prmation corner of the facility ed them at care conferences. confirmed the booklets were idents on admission. Rather,	f			
confirmed residents	s were getting an old version o	f			
residents received	the new rights booklet was				
The director of nurse review its policy's a of resident rights up The DON or design State Agency to en updated version of each admission pa could develop an a	sing (DON) or designee could and procedures for notification pon admission to the facility. nee could then contact the sure the facility has the most the Resident Bill of Rights and cket includes them. The facility uditing system that monitors				
	OF CORRECTION PROVIDER OR SUPPLIER AD CARE CENTER SUMMARY STA (EACH DEFICIENC) REGULATORY OR L Continued From particities of of resident rights date current Bill of Rights war admission. The SSD indicated Combined Federal Rights dated 11/28 resident at one time update. This rights available at the information and the SSD offere However, the SSD not provided to resist residents at admission On 6/14/18 at 9:27 confirmed residents their rights at admission A copy of the letter residents received requested but not r SUGGESTED MET The director of nursi- review its policy's at of resident rights up The DON or design State Agency to en updated version of each admission participants could develop an at a could at a co	OF CORRECTION IDENTIFICATION NUMBER: 00797 00797 PROVIDER OR SUPPLIER STREET AI AD CARE CENTER 1401 LAI WARRO, SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 47 of resident rights dated 7/1/07 and not the most current Bill of Rights dated 11/28/16. On 6/14/18, at 8:44 a.m., the social services designee (SSD) confirmed the 7/1/07 version of the Bill of Rights were given to residents upon admission. The SSD indicated the new version of The Combined Federal and Minnesota Resident Bill of Rights dated 11/28/16, was provided to every resident at one time soon after the 11/28/16, update. This rights booklet was also currently available at the information corner of the facility and the SSD offered them at care conferences. However, the SSD confirmed the booklets were not provided to residents on admission. Rather, residents at admission are getting the rights dated 2007. On 6/14/18 at 9:27 a.m., the administrator confirmed residents were getting an old version of their rights at admission. A copy of the letter that indicated the date residents received the new rights booklet was requested but not received from the facility. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review its policy's and procedures for notification of resident rights upon admission to the facility. The DON or designee could then contact the State Agency to ensure the facility has the most updated version of the Resident Bill of Rights and <td>OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: 00797 B. WING PROVIDER OR SUPPLIER STREET ADDRESS, CITY, ST AD CARE CENTER 1401 LAKE STREET NO WARROAD, MN 56763 SUMMARY STATEMENT OF DEFICIENCIES ID REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG Continued From page 47 21800 of resident rights dated 71/107 and not the most current Bill of Rights dated 11/28/16. 21800 On 6/14/18, at 8:44 a.m., the social services designee (SSD) confirmed the 7/1/07 version of the Bill of Rights were given to residents upon admission. 21800 The SSD indicated the new version of The Combined Federal and Minnesota Resident Bill of Rights dated 11/28/16, was provided to every resident at one time soon after the 11/28/16, update. 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WING PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE ND CARE CENTER 1401 LAKE STREET NORTHWEST WARROAD, MN 56763 SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D PREFIX TAG PROVIDER'S PLAN OF (EACH DEFICIENCY WIST BE PRECEDED BY FULL TAG Continued From page 47 21800 Cooss-REFERENCED TO DEFICIENCY (EACH DEFICIENCY WIST BE PRECEDED BY FULL TAG COOSS-REFERENCED TO DEFICIENCY (EACH DEFICIENCY WIST BE PRECEDED BY FULL TAG On 6/14/18, at 8:44 a.m., the social services designee (SSD) confirmed the 7/1/07 version of the Bill of Rights were given to residents upon admission. 21800 The SSD indicated the new version of The Combined Federal and Minnesota Resident Bill of Rights dated 11/28/16, was provided to every resident at one time soon after the 11/28/16, update. This rights booklet was also currently available at the information corner of the facility and the SSD offered them at care conferences. However, the SSD confirmed the booklets were not provided to residents on admission. Rather, residents at admission are getting an old version of their rights at admission. A copy of the letter that indicated the date residents received from the facility. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review its policy's and procedures for notification of resident rights upon admission to the facility. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review i</td> <td>OF CORRECTION IDENTIFICATION NUMBER: A BUILDING: COM 00797 B. WING 06/ PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE AD CARE CENTER 1401 LAKE STREET NORTHWEST WARROAD, MN 56763 WARROAD, MN 56763 Continued From page 47 0 fresident rights dated 7/1/07 and not the most current Bill of Rights wated 21/1/07 and not the most current Bill of Rights wated 11/28/16. On 6/14/18, at 8:44 a.m., the social services designee (SSD) confirmed the 7/1/07 version of the Bill of Rights wate given to residents upon admission. The SSD Indicated the new version of The Combined Federal and Minnesota Resident Bill of Rights wate guiten to resident super on the facility, and the SSD offered them at care conferences. Howwer, the SSD confirmed the tooklets were not provide to residents upon admission. Rather, residents at admission are getting the rights booklet was requested but not received from the facility. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review its policys and procedures for notification of resident system that monitors SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review its policys and procedures for notification of resident system that monitors</td>	OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: 00797 B. WING PROVIDER OR SUPPLIER STREET ADDRESS, CITY, ST AD CARE CENTER 1401 LAKE STREET NO WARROAD, MN 56763 SUMMARY STATEMENT OF DEFICIENCIES ID REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG Continued From page 47 21800 of resident rights dated 71/107 and not the most current Bill of Rights dated 11/28/16. 21800 On 6/14/18, at 8:44 a.m., the social services designee (SSD) confirmed the 7/1/07 version of the Bill of Rights were given to residents upon admission. 21800 The SSD indicated the new version of The Combined Federal and Minnesota Resident Bill of Rights dated 11/28/16, was provided to every resident at one time soon after the 11/28/16, update. This rights booklet was also currently available at the information corner of the facility and the SSD offered them at care conferences. However, the SSD confirmed the booklets were not provided to residents on admission. Rather, residents at admission are getting the rights dated 2007. 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STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION (X	3) DATE SURVEY COMPLETED
		00797	B. WING		06/14/2018
	PROVIDER OR SUPPLIER			STATE, ZIP CODE	00/14/2010
				IORTHWEST	
WARRO	AD CARE CENTER	WARROA	D, MN 5676	3	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	
21800	Continued From pa	ge 48	21800		
	(21) days.				
21870	Residents of HC Fa Subd. 18. Respor residents shall have	651 Subd. 18 Patients & ac.Bill of Rights nsive service. Patients and the right to a prompt and se to their questions and	21870		7/16/18
	by: Based on interview facility failed to add concerns related to and quality, during a council meeting with	ent is not met as evidenced and document review, the ress the resident council's food temperature, quantity a survey initiated resident h 8 of 15 residents (R36, R40, , R41 and R8) active members nt council.		Corrected	
	resident council (R4	p.m., a co-chair of the 13) gave permission for the ew previous minutes of eetings.			
	to 6/2018 revealed -8/7/17: Still having warm enough and t menu items was no -9/11/17: Still have a warm enough. A sta ordered some parts -10/2/17: Food was crispy (shrimp and t	a problem with food not being he quantity of alternative			

STATEME	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
	00797		B. WING		06/14/2018	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
NARRO	AD CARE CENTER		KE STREET NO AD, MN 56763			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21870	Continued From pa	ige 49	21870			
	Requests were ma and for soup to be alternate choice for -12/4/17: A residen food could be warm -1/8/18: Food could was requested. -2/5/18: Too many f -3/12/18: They were alternative menu ite -4/9/18: Better -5/7/18: Dietary nee cold food, and som hard to chew. There cucumbers, as the There was no toast -6/11/18: There were temperature of the food more frequent potatoes). Potatoes fully cooked. Resid frequently on the m never goodthey a There was no evide concerns listed in the were available for r On 6/13/18 at 12:30 meeting was held a attended: R36, R40 R8. At the resident cour had concerns about some was not cook	cool on the Angle unit. de for more variety in salads offered more often as the the evening meal. t from the BB unit said the her. I be warmer and more soup repeats on the menu. e running out of certain ems. eds work and there was still e of the meat was tough and e was a request to peel peel was too hard to eat. ter in the BB unit. re still issues with the food, they were running out of ely (especially mashed s in the potato salad were not ents were tired of chicken so uenu and the french fries were re cold or soggy. ence of follow-up to the he minutes. No action forms eview. D p.m., a resident council and the following residents D, R26, R6, R34, R38, R41 and ncil meeting, R36 stated he it the quality of the food, as ted through. R36 also stated if or "two eggs over easy and				

STATEMEN	ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
	00797		B. WING		06/14/2018	
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
NARRO	AD CARE CENTER		KE STREET NO AD, MN 56763			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC\	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21870	Continued From pa	age 50	21870			
	In addition, R38 sta enough.	ated the food was not hot				
	(AD) stated she tak council meetings ar the meeting. The A administrator and a that are raised and know what they say log or written docur concerns raised at confirmed there wa of follow-up to the r stated she feels for was doing the best On 6/13/18, at 2:19 there had not been concerns, stating for issue for the facility kitchen leadership a stated at the May (2 talked about startin would meet more fr resident council me reviewed the minuted	8 p.m., the activities director tes minutes at the resident and the Activity Aide (AA)-A runs D stated she informs the appropriate staff of concerns then lets the resident council y. The AD stated she has no mentation of any follow-up on the resident council. The AD is no evidence in the minutes resident council. Finally, the AD the residents and the facility they could in regards to food. 9 p.m., the administrator stated good follow-up regarding food bod had been a challenging for months, with turnover in and staff. The administrator 2018) resident council they g a resident food group that requently, than the monthly beting. The administrator es and confirmed that d group was not evident in the nistrator stated the residents if food concerns.)			
	Rights revised Nov 5. The resident has	bined Federal and State Bill of ember 2016 included: a right to organize and ent groups in the facility.				
	D. The facility must	t consider the views of a roup and act promptly upon				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
	00797		B. WING		06/	14/2018
NAME OF	PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, ST	ATE, ZIP CODE		
WARRO	AD CARE CENTER		E STREET NO D, MN 56763	DRTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC\	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
21870	Continued From pa	ge 51	21870			
	groups concerning in the facility. a. The facility must response and ration SUGGESTED MET The director of nurs that residents conce upon timely. The dir could review policy monitor systems, ir evaluate the proces upon resident coun- related to food conce	recommendations of such issues of resident care and life be able to demonstrate their nal for such response. HOD OF CORRECTION: ing or designee could assure erns are listened to and acted rector of nursing or designee and procedures, train staff, nterview residents and is to assure the facility acts cil grievances, specifically cerns.				
21925	MN St. Statute 144. Residents of HC Fa Subd. 29. Transfe shall not be arbitrar Residents must be proposed discharge justification no later discharge from the transfer to another in notice shall include the proposed action telephone number of ombudsman pursua Act, section 307(a)(of this right, may ch notice period ends. shortened in situation control, such as a di	ers and discharges. Residents ily transferred or discharged. notified, in writing, of the	21925			7/13/18

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00797	B. WING		06/14/2018	
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE		
WARRO	AD CARE CENTER		KE STREET I AD, MN 5676	NORTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SF CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLET DATE
21925	residents, a change treatment program, resident's welfare, o prohibited by the pu paying for the resid the medical record. reasonable effort to without disrupting m This MN Requirem	e in the resident's medical or the resident's own or another or nonpayment for stay unless ublic program or programs ent's care, as documented in Facilities shall make a accommodate new residents	21925			
	facility failed to noti	and document review, the fy the ombudsman of a ⁻ 2 of 2 residents (R20, R31) alization.		Corrected.		
	R20's Admission R indicated R20 had Alzheimer's disease of the digestive trac (C-Diff, an infection	ecord, dated 6/13/18, diagnoses that included e, enterocolitis (inflammation ct) due to clostridium difficile of the colon), acute kidney rinary incontinence, diabetes,				
	had 5 large loose s confused than usua R20's condition and received to transfer	e dated 5/13/18, indicated R20 tools, was lethargic and more al; the physician was notified of d a telephone order was R20 to the hospital. R20's s notified of the hospitalization.				
	hospital leave from	dated 6/14/18, indicated a 5/13/18 to 5/17/18.				
	5/17/18, indicated F worsening generalized	scharge Summary dated R20 was hospitalized due to zed weakness and ad been diagnosed with C-Diff				

					E SURVEY PLETED
	00797	B. WING		06/14/2018	
PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
AD CARE CENTER		-			
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1	TION SHOULD BE	(X5) COMPLET DATE
Continued From pa	age 53	21925			
and was receiving	oral antibiotics.				
-					
R31 had not been f breath; family was condition and indica hospital if needed. the physician was r physician gave a te to the hospital for fu	Teeling well and was short of notified of R31's change of ated R31 should go to the Progress note then indicated notified of R31's condition; the elephone order to transfer R31 urther evaluation. R31 was				
		1			
(SSD) stated notific not been completed transferred to the h	cations to the ombudsman had d for residents whom were ospital and had not been				
Documentation dat discharge forms m the State Ombudsr not specifically add	ed 4/1/17, included: 4) All ust be faxed to the Office of nan for review. The policy did ress Ombudsman notification				
	OF CORRECTION PROVIDER OR SUPPLIER AD CARE CENTER SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From para and was receiving of R20's progress not returned to the faci Review of R20's re ombudsman was no transfer. R31's progress not R31 had not been fact breath; family was condition and indica hospital if needed. the physician gave a tea to the hospital for fact subsequently admi R31's progress not had returned to the p.m. R31's record does was notified of the p.m. R31's record does was notified of the fact On 6/12/18, at 4:13 (SSD) stated notified not been completed transferred to the h aware of the requir Facility policy Trans Documentation dat discharge forms m the State Ombudsr not specifically add	OF CORRECTION IDENTIFICATION NUMBER: 00797 PROVIDER OR SUPPLIER STREET A AD CARE CENTER 1401 LA WARRO. SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 53 and was receiving oral antibiotics. R20's progress note dated 5/17/18, indicated he returned to the facility at 2:10 p.m. Review of R20's record does not reflect the ombudsman was notified of the facility-initiated transfer. R31's progress notes dated 5/12/18, indicated R31 had not been feeling well and was short of breath; family was notified of R31's change of condition and indicated R31 should go to the hospital if needed. Progress note then indicated the physician was notified of R31's condition; the physician gave a telephone order to transfer R31 to the hospital for further evaluation. R31 was subsequently admitted to the hospital. R31's progress note dated 5/14/18, indicated R3' had returned to the facility at approximately 3:10 p.m. R31's record does not reflect the ombudsman was notified of the facility-initiated transfer. On 6/12/18, at 4:13 p.m. social services designed	OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: 00797 B. WING PROVIDER OR SUPPLIER STREET ADDRESS, CITY, ST AD CARE CENTER 1401 LAKE STREET NWARROAD, MN 56763 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG Continued From page 53 and was receiving oral antibiotics. 21925 R20's progress note dated 5/17/18, indicated he returned to the facility at 2:10 p.m. 21925 Review of R20's record does not reflect the ombudsman was notified of the facility-initiated transfer. R31's progress notes dated 5/12/18, indicated R31 had not been feeling well and was short of breath; family was notified of R31's change of condition and indicated R31 should go to the hospital if needed. Progress note then indicated the physician was notified of R31's condition; the physician gave a telephone order to transfer R31 to the hospital of further evaluation. R31 was subsequently admitted to the hospital. R31's progress note dated 5/14/18, indicated R31 had returned to the facility-initiated transfer. On 6/12/18, at 4:13 p.m. social services designee (SSD) stated notifications to the ombudsman was notified of the facility-initiated transfer. On 6/12/18, at 4:13 p.m. social services designee (SSD) stated notifications to the ombudsman had not been completed for residents whom were transferred to the hospital and had not been aware of the requirement. Facility policy Transfer or Discharge Documentation dated 4/1/17, included: 4) All discharge forms	OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: 00797 B. WING PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE AD CARE CENTER 1401 LAKE STREET NORTHWEST WARROAD, MN 56763 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WIDERS BE PRECEDED BY FULL REQULATORY OR LSC IDENTIFYING INFORMATION) D PREPIX TAG PROVIDER'S PLAN OF (EACH DEFICIENCY WIDER'S CONTORIS TO THE STATE OF (EACH DEFICIENCY WIDER'S CONTOURS (OF CORRECTION IDENTIFICATION NUMBER: A BUILDING: COM 00797 B. WING 06/ PROVIDER OR SUPPLER STREET ADDRESS, CITY, STATE, ZIP CODE 1401 LAKE STREET NORTHWEST WARROAD, MN 56763 WARROAD, MN 56763 PROVIDER'S PLAN OF CORRECTION NUMBER: ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY ON LG IDENTIFYING INFORMATION) ID PREFIX PROVIDER'S PLAN OF CORRECTION OF CORRECTION (EACH ORRECTIVE ADD SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY Continued From page 53 21925 and was receiving oral antibiotics. 21925 R20's progress note dated 5/17/18, indicated he returned to the facility at 2:10 p.m. 21925 R31's progress notes dated 5/12/18, indicated he returned to the facility at 2:10 p.m. R31's progress note then indicated R31 had not been feeling well and was short of breath; family was notified of R31's condition; the physician gave a telephone order to transfer R31 to the hospital for further evaluation. R31 was subsequently admitted to the hospital. R31's progress note dated 5/14/18, indicated R31 had returned to the facility approximately 3:10 p.m. R31's progress note dated fo/14/18, indicated R31 had returned to the facility approximately 3:10 p.m. R31's progress note dated fo/14/18, indicated R31 had returned to the hospital and had not been aware of the requirement. R31's progress note dated fo/14/18, indicated R31 had returned to the hospital and had not been aware o

STATEMENT OF DEFICIENCIES (AND PLAN OF CORRECTION				(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00797	B. WING		00/44/0040		
	PROVIDER OR SUPPLIER		DDRESS, CITY, ST		08/	14/2018	
			KE STREET NO				
	AD CARE CENTER	WARRO	AD, MN 56763				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
21925	Continued From pa	age 54	21925				
	review facility polici and discharge notif to ensure the ombu	cial Work or designee could ies and procedures for transfer fication, and develop a system udsman is given notice when a resident transfer to the					
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one					