Electronically Delivered
February 10, 2021

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

RE: CCN: 245329
Cycle Start Date: January 29, 2021

Dear Administrator:

On February 3, 2021, the Minnesota Department of Health, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

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

cc: Licensing and Certification File

Electronically delivered
January 11, 2021

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

RE: CCN: 245329
Cycle Start Date: December 29, 2020

Dear Administrator:

On December 29, 2020, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

## ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

## DEPARTMENT CONTACT

Questions regarding 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 should be directed to:

Jen Bahr, RN, Unit Supervisor
Bemidji District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, MN 56601-2933
Email: Jennifer.bahr@state.mn.us
Office: (218) 308-2104 Mobile: (218) 368-3683

## PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

## VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by March 29, 2021 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by June 29, 2021 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

## INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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.
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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245329 | A. BUILDING _____ B. WING _____ | C 12/29/2020 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| F 000 | INITIAL COMMENTS<br><br>On 12/28/20 and 12/29/20, an abbreviated survey was completed at your facility by surveyors from the Minnesota Department of Health (MDH) to conduct complaint investigation(s). The facility was found not to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities.<br><br>The following complaint was found to be substantiated:<br><br>H5329015C (MN68437) with a deficiency issued at F600.<br><br>As a result of the investigation an additional deficiency was issued at F609.<br><br>The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.<br><br>Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. | F 000 | | |
| F 600 SS=D | Free from Abuse and Neglect<br>CFR(s): 483.12(a)(1)<br><br>§483.12 Freedom from Abuse, Neglect, and Exploitation<br>The resident has the right to be free from abuse, neglect, misappropriation of resident property, | F 600 | | 1/29/21 |

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

Electronically Signed | 01/21/2021

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| F 600 | Continued From page 1<br>and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.<br><br>§483.12(a) The facility must-<br><br>§483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to ensure residents were free from verbal abuse for 1 of 3 residents (R1) reviewed for employee to resident abuse.<br><br>Findings include:<br><br>R1's quarterly Minimum Data Set (MDS) dated 12/4/20, identified R1 had severe cognitive impairment and required total assistance with with all activities of daily living (ADL)'s, including dressing, bathing, toileting and transfers. Diagnoses included dementia with Lewy bodies, mood affective disorder, dementia and anxiety.<br><br>An incident report submitted to the State Agency (SA) on 12/23/20, at 11:10 a.m. indicated nursing assistant (NA)-B overheard NA-A making potentially abusive statements to R1, when R1 was making loud, repetitive verbalizations during care.<br><br>During telephone interview on 12/29/20, at 10:46 a.m. NA-A stated she had a rough night and had been under a lot of stress. R1 was making repetitive, loud verbalizations and she kept telling | F 600 | The facility has remedied the situations in the findings through their initial follow up and investigation. The facility finds that other than a matter of reporting within appropriate timeframes, the policy and procedural steps taken were according to design and were in fact successfully carried out with an appropriate outcome. NA-A was terminated from her employment with us as a result of her actions to R1.<br><br>In addition the facility has discussed the need for further investigation into other possible similar situations and has found no evidence that any similar situation exists.<br><br>A facility policy on resident abuse prohibition was reviewed and found that it accurately reflected the process and expectation of behavior and reporting. [Despite an error in reporting in this case.] Minor changes were made and will be shared with team members regarding the proper order of reporting within the | |

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| F 600 | Continued From page 2<br>R1 to be quiet and to calm down. NA-A indicated she had commented, "I am going to lose my shit" quietly, under her breath. NA-A stated if you have one bad day everyone comes down on you.<br><br>During telephone interview on 12/29/20, at 11:07 a.m. NA-B stated she was working with NA-A to get R1 up for the day. R1 was making vocalizations and NA-A indicated she was getting very annoyed by R1. NA-B stated they assisted R1 into her wheelchair and NA-A said to R1, "if you do not stop, I am going to lose my shit." It was very loud and clear. NA-B asked NA-A to leave the room and she would finish getting R1 ready. NA-A rolled her eyes and left the room. NA-B finished cares with R1 and R1 calmed down. NA-B indicated she had heard from other co-workers NA-A was not the "best" around the residents. NA-B did not know if NA-A had other incidents with residents but knew reports were made regarding interactions with other residents.<br><br>NA-A's employee record identified NA-A had abuse and dementia training completed on 6/2/20.<br><br>When interviewed on 12/29/20, at 11:41 a.m. the director of nursing (DON) stated she had received a report NA-A had made threatening comments toward a resident. The DON indicated she had interviewed NA-B about what had occurred. NA-B had stated she did not feel the resident knew what had been said or was upset by the incident and behaved in her normal manner for the remainder of her cares. The DON indicated the DON was fairly new to her position and reviewed NA-A's employee record. NA-A had no previous incidents with residents, but had some incidents with other employees. NA-A was | F 600 | building. It was not a factor in this situation, but became a process question in our policy review.<br><br>Facility will incorporate a heightened emphasis on the timeliness of reporting in general orientation, attended by new employees and by all employees on an annual basis, beginning with our session on January 19, 2021. In addition nursing meetings will highlight the same expectation over the next 6 months. In addition facility will look for additional ways of addressing team member burnout as a possible contributing factor, including a discussion during all orientation sessions. Existing materials already incorporated into orientation on team member self care will be reviewed and updated as necessary.<br><br>Facility will continue to fill out complete paperwork on all VA reports and evaluate for any trends or deviation from requirements. Reports will be reviewed by the Social Worker, the Administrator and will be forwarded to high risk meetings, QAPI discussions and leadership meetings as appropriate. | |

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| F 600 | Continued From page 3<br>terminated and did not return to the facility following this incident.<br><br>The facility's Resident Abuse Prohibition Policy revised 9/1/20, defined verbal abuse as oral, written or gestured language that willfully includes disparaging and derogatory terms to residents within their hearing distance, regardless of their age, ability to comprehend or disability. The policy directed staff to receive education about resident mistreatment, neglect and abuse upon first employment and annually thereafter. Direct care employees must have training in the areas of Alzheimer's disease, assistance with ADL's, problem solving with challenging behaviors and communication skills. The facility would monitor staff for burnout, which could lead to the potential maltreatment of residents. Staff would be trained in the signs and symptoms of staff burnout. | F 600 | | |
| F 609 SS=D | Reporting of Alleged Violations<br>CFR(s): 483.12(c)(1)(4)<br><br>§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:<br><br>§483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and | F 609 | | 1/29/21 |

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| F 609 | Continued From page 4<br>adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.<br><br>§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to ensure allegations of verbal abuse were reported immediately to the administrator and State agency (SA) in a timely manner for 1 of 3 residents (R1) reviewed for timely reports to the SA.<br><br>Findings include:<br><br>The facility's Resident Abuse Prohibition Policy with revision date of 9/1/20, defined verbal abuse as oral, written or gestured language that willfully includes disparaging and derogatory terms to residents within their hearing distance, regardless of their age, ability to comprehend or disability. Any nursing home employee or volunteer who becomes aware of abuse, mistreatment, neglect or misappropriation shall immediately report to the Nursing Home Administrator or designee; however, the policy failed to identify specific time frames for reporting allegations to the state agency.<br><br>An incident report submitted to the State Agency (SA) on 12/23/20, at 11:10 a.m. indicated nursing | F 609 | The facility has not been able to remedy the situation cited as it is a past event and we are unable to fix this specific incident of error in reporting timeliness.<br><br>However, based on findings in the process we have remedied the situation moving forward through a heightened awareness and discussion of reporting timelines in general orientation and in departmental meetings moving forward. Although no policy changes were needed, a stronger emphasis and discussion during those meetings was recommended.<br><br>A facility policy on resident abuse prohibition was reviewed and found that it accurately reflected the process and expectation of behavior and reporting. [Despite an error in reporting in this case.] Minor changes were made and will be shared with team members regarding the proper order of reporting within the building. It was not a factor in this | |

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| F 609 | Continued From page 5<br>assistant (NA)-B overheard NA-A making potentially abusive statements to R1, when R1 was making loud, repetitive verbalizations during care. The time of the incident was identified as occurring on 12/23/20, at 6:00 a.m.<br><br>During interview on 12/29/20, at 9:13 a.m. registered nurse (RN)-A stated she started her shift on 12/23/20, at around 8:00 a.m. and NA-B had reported to her that verbal abuse had occurred. RN-A stated the nursing assistants usually came to her with their concerns, as they do not like to bother the nurses on the carts, as they were so busy passing medications. RN-A indicated staff were very busy with resident cares in the mornings and it was probably NA-B's first opportunity to report the incident. RN-A then immediately reported the incident to the director of nursing (DON).<br><br>On 12/29/20, at 11:25 a.m. the social worker (SW) stated she was responsible for filling out and investigating vulnerable adult (VA) reports and she had received the incident report from the DON regarding the allegation of staff to resident verbal abuse. Usually VA reports were reviewed with the DON and the administrator to see if they felt an incident was reportable. The SW and the DON had spoken with NA-B about what had occurred and she had finished up submitting the report to the SA. The SW indicated she filed the report at about 10:00 a.m..<br><br>When interviewed on 12/29/20, at 11:41 a.m. the DON stated she had received a report NA-A had made threatening comments toward a resident. NA-B had reported the incident to RN-A when she came on her shift at about 8:00 a.m., the RN then reported the incident to the DON. The DON | F 609 | situation, but became a process question in our policy review.<br><br>Facility will incorporate a heightened emphasis on the timeliness of reporting in general orientation, attended by new employees and by all employees on an annual basis, beginning with our session on January 19, 2021. In addition nursing meetings will highlight the same expectation over the next 6 months. In addition facility will look for additional ways of addressing team member burnout as a possible contributing factor, including a discussion during all orientation sessions.<br><br>Facility will continue to fill out complete paperwork on all VA reports and evaluate for any trends or deviation from requirements. Reports will be reviewed by the Social Worker, the Administrator and will be forwarded to high risk meetings, QAPI discussions and leadership meetings as appropriate. | |

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| F 609 | Continued From page 6<br>indicated she had immediately informed the SW of the incident and that she felt it was a reportable incident. The SW was responsible for submitting the VA reports to the SA. She did not know why NA-B chose to wait until RN-A came in for the day and did not report to the nurse on duty at the time of the incident. NA-A should have made the report immediately to the nurse in charge and not wait until the charge nurse started their shift. | F 609 | | |

DEPARTMENT OF HEALTH

*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered
January 11, 2021

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

Re: Event ID: JVCB11

Dear Administrator:

The above facility survey was completed on December 29, 2020 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

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

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| 2 000 | Initial Comments | 2 000 | | |

*****ATTENTION******

NH LICENSING CORRECTION ORDER

In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.

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

INITIAL COMMENTS:
On 12/28/20, and 12/29/20, a survey was conducted by a surveyor from the Minnesota Department of Health (MDH) to determine compliance for state licensure.

The following complaint(s) were found to be substantiated:

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
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| 2 000 | Continued From page 1<br><br>H5329050C (MN68437): However, no correction order(s) were issued.<br><br>The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents. | 2 000 | | |