Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
September 20, 2023

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

RE: CCN: 245329
Cycle Start Date: July 19, 2023

Dear Administrator:

On September 6, 2023, the Minnesota Department(s) of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 20, 2023

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

Re: Reinspection Results
Event ID: 5TJ512

Dear Administrator:

On September 6, 2023 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on July 19, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 28, 2023

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

RE: CCN: 245329
Cycle Start Date: July 19, 2023

Dear Administrator:

On July 19, 2023, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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"and/or an "E" tag), i.e., the plan of correction should be directed to:

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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 October 19, 2023 (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 January 19, 2024 (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,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

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 07/19/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 7/18/23 through 7/19/23, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed. H53293537C (MN95159) H53293744C (MN95011) As a result of the survey deficiencies were cited at F609 and F610. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §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	F 609		8/28/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 08/07/2023

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

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F 609	Continued From page 1	F 609		

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 adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.

§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.
This REQUIREMENT is not met as evidenced by:
Based on interview and document review the facility failed to timely report an allegation of abuse to the state agency (SA) and administrator for 1 of 1 resident (R1) who alleged employee to resident abuse.

Findings include:

A report to the SA dated 7/10/23, at 3:29 p.m. indicated on 7/9/23, at 9:00 a.m. R1 had been tearful when a nursing assistant (NA) was assisting her to the bathroom. When asked what was wrong, R1 stated the "girl last night had hit her." R1 said she had been hit in the chest, then showed the NA by smacking her own chest. R1 then told the NA "she broke it" pointing to her lamp. R1 also described the incident to her family member (FM) and registered nurse (RN) and said

On 7/10/ 23 R 1 was assessed for injury including bruising of the soft tissue and pain. The resident did not have any bruising or pain. R1 did not display signs of being fearful of staff, nor could she identify the AP. The resident's representative was notified of the incident. The resident was interviewed and did not recall the incident. Interviews with the alleged perpetrators, staff, resident and resident's representative were completed. The resident's care plan was updated and includes trauma informed care.

To identify other residents having the potential to be affected by the same deficient practive, on 7/10/23 residents that may have had contact with the AP

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F 609 Continued From page 2

the staff was mean to her and hit her. R1 then demonstrated what the staff member had done to her at which time R1 grabbed the RN's wrists, then pushed the RN away by his wrists.

During interview on 7/19/23, at 8:51 a.m. licensed social worker (LSW)-A stated staff had become aware of the allegation on 7/9/23, when R1 reported it to the NA. LSW-A said the NA then reported it to the nurse on duty who told her the call the clinical coordinator if she had concerns. LSW-A stated the NA reached out to the clinical coordinator at 7:00 p.m. on 7/9/23, via text message. LSW-A stated she received a call around 8:00 p.m. on 7/9/23, and said she should have reported to the SA at that time but she did not have her laptop with her.

During interview on 7/19/23, at 2:12 p.m. the DON stated if an allegation of abuse was reported after hours or on a weekend, the person who learned of the incident should tell the charge nurse, clinical coordinator or LSW-A. The DON stated she was also available and was on call 24/7. The DON stated no one had called and reported the incident to her. The DON stated she was not aware of the allegation until 7/10/23, in the morning and said the administrator was notified at that time.

Facility policy Resident Abuse Prohibition Policy dated 6/7/23, indicated Employees must report abuse immediately to supervisor in house or designee. Supervisor in house or designee must then notify the Administrator immediately. The facility must designate a facility staff member on each shift responsible for receiving complaints and conducting complaint investigations. The policy further indicated if an incident or allegation

F 609

were interviewed and skin checks completed . Resident care plans reviewed.

To assure sustainability going forward all the Warroad Care center has hired a consultant to complete on-site education on the current Abuse Prohibition Policy and procedure to all mandated reporters. A gap analysis will be completed on the reporting mechanisms of allegations of abuse, neglect, exploitations or mistreatment and current facility systems. IDT stand up meetings will include a 24-48 hour report. The IDT team will review residents changes in condition, injuries of unknown origin, resident behaviors . Weekly high risk meetings will focus on current reports of abuse, neglect, exploitations and mistreatment to ensure timely reporting and completion of the events that caused the allegation.

Audits will be conducted to ensure employees understand the current Abuse Prohibition Policy. This will be completed weekly x 8 and monthly for 3 months. The results for the audit will be reviewed in the regularly scheduled QAPI Committee and reccomendations will follow.

Responsibility : Social Service/DON and or designee.

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F 609	Continued From page 3 is considered reportable, the administrator or designee will make a report to the SA online reporting web site immediately, but not later than two hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §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. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to thoroughly investigate an allegation of staff to resident abuse and failed to ensure protection for vulnerable adults pending the investigation results for 1 of 1 residents (R1) who alleged staff to resident abuse. Findings include:	F 610	On 7/10/ 23 R 1 was assessed for injury including bruising of the soft tissue and pain. The resident did not have any bruising or pain. R1 did not display signs of being fearful of staff, nor could she identify the AP. The resident's representative was notified of the incident. The resident was interviewed and did not recall the incident. Interviews with the	8/28/23

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F 610	Continued From page 4 R1's quarterly Minimum Data Set (MDS) dated 5/30/23, identified severe cognitive impairment and indicated she required assistance of one staff for activities of daily living. The MDS indicated R1 did not display hallucinations or delusions. R1's care plan dated 3/1/23, indicated R1 was vulnerable due to the following factors: Communication, difficulty making needs known, disoriented to place an time, functional limitations, confusion and repetitive vocalizations. The care plan indicated R1 may be easily exploited. A report to the SA dated 7/10/23, at 3:29 p.m. indicated on 7/9/23, at 9:00 a.m. R1 had been tearful when a nursing assistant (NA) was assisting her to the bathroom. When asked what was wrong, R1 stated the "girl last night had hit her." R1 said she had been hit in the chest, then showed the NA by smacking her own chest. R1 then told the NA "she broke it" pointing to her lamp. R1 also described the incident to her family member (FM) and registered nurse (RN) and said the staff was mean to her and hit her. R1 then demonstrated what the staff member had done to her at which time R1 grabbed the RN's wrists, then pushed the RN away by his wrists. A facility Vulnerable Adult Internal Investigation dated 7/10/23, indicated no safety plan was needed to ensure the safety of R1 and indicated " not verified." The facility investigation included interviews with residents and staff however, only two of the eight staff who worked the evening and night of the alleged incident were interviewed. During interview on 7/19/23, at 8:51 a.m. the licensed social worker (LSW)-A stated the NA who R1 reported the allegation to had spoken to the nurse on the unit but did not give her the full	F 610	alleged perpetrators, staff, resident and resident's representative were completed. The resident's care plan was updated and includes trauma informed care. To identify other residents having the potential to be affected by the same deficient practive, on 7/10/23 residents that may have had contact with the AP were interviewed and skin checks completed . Resident care plans reviewed. To assure sustainability going forward all the Warroad Care center has hired a consultant to complete on-site education on the current Abuse Prohibition Policy and procedure to all mandated reporters. A gap analysis will be completed on the reporting mechanisms of allegations of abuse, neglect, exploitations or mistreatment and current facility systems. IDT stand up meetings will include a 24-48 hour report. The IDT team will review residents changes in condition, injuries of unknown origin, resident behaviors . Weekly high risk meetings will focus on current reports of abuse, neglect, exploitations and mistreatment to ensure timely reporting and completion of the events that caused the allegation. Audits will be conducted to ensure employees understand the current Abuse Prohibition Policy. This will be completed weekly x 8 and monthly for 3 months. The results for the audit will be reviewed in the regularly scheduled QAPI Committee and reccomendations will	

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F 610	Continued From page 5	F 610		

story. LSW-A said the nurse on duty was only told about the broken lamp. .

On 7/19/23, at 12:19 p.m. RN-A stated R1's communication varied and said her words were typically very jumbled but when she got upset she was more able to get words out. RN-A said she had received a text message from staff on 7/9/23, and staff reported R1 had said another staff had poked her in the chest and had broken her lamp. RN-A said R1 had described to her family member staff grabbing her hands and pushing her. RN-A stated the lamp was broken, and said the shade cracked in half. One of the NA's who worked the night of the allegation said R1 had caught the cord with her walker and the lamp fell and broke.

On 7/19/23, at 2:12 p.m. the director of nursing (DON) stated on 7/10/23, interviews were completed with the nurse who had worked the night shift on 7/8/23, and the nurse that worked the following evening because he had been working when R1's FM came to the facility. The DON stated she and LSW-A had spoken to only one of the NA's that worked the night of 7/8/23. The DON confirmed only two staff that worked the night of the alleged incident had been interviewed.

Facility policy Resident Abuse Prohibition Policy dated 6/7/23, indicated when an incident or suspected incident of abuse, neglect or other maltreatment is reported, the Administrator or designee will investigate the incident with the assistance of appropriate personnel. The policy indicated the investigation will consist of interviews with staff members having contact with the resident during the relevant periods or shifts

follow.

Responsibility : Social Service/DON and or designee.

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F 610	Continued From page 6 of the alleged incident. The policy further indicated ensuring safety and well-being for the vulnerable adult is of utmost priority. Safety, security and support of the resident if applicable and other residents with the potential to be affected will be provided. This should include as appropriate: Remove resident/patient from situation. If it is determined that a resident could be at risk in the same environment, the situation will be evaluated and options will be considered. Employees accused of alleged abuse will be immediately removed from the facility and will remain removed pending the results of a thorough investigation.	F 610		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 28, 2023

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

Re: State Nursing Home Licensing Orders
Event ID: 5TJ511

Dear Administrator:

The above facility was surveyed on July 18, 2023 through July 19, 2023 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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

Please feel free to call me with any questions.

Sincerely,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: ______ B. WING ______	C 07/19/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 7/18/23 through 7/19/23, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing order was issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

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2 000	Continued From page 1 identify the date when they will be completed. The following complaints were reviewed. H53293537C (MN95159) H53293744C (MN95011) As a result of the investigation a licensing order was issued at 1980. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility	2 000		

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2 000	Continued From page 2 is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. 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.	2 000		
21980	MN St. Statute 626.557 Subd. 3 Reporting - Maltreatment of Vulnerable Adults Subd. 3. Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has	21980		8/28/23

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21980	Continued From page 3 been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to timely report an allegation of abuse to the state agency (SA) and administrator for 1 of 1 resident (R1) who alleged employee to resident abuse. Findings include: A report to the SA dated 7/10/23, at 3:29 p.m. indicated on 7/9/23, at 9:00 a.m. R1 had been tearful when a nursing assistant (NA) was assisting her to the bathroom. When asked what was wrong, R1 stated the "girl last night had hit her." R1 said she had been hit in the chest, then showed the NA by smacking her own chest. R1	21980	On 7/10/ 23 R 1 was assessed for injury including bruising of the soft tissue and pain. The resident did not have any bruising or pain. R1 did not display signs of being fearful of staff, nor could she identify the AP. The resident's representative was notified of the incident. The resident was interviewed and did not recall the incident. Interviews with the alleged perpetrators, staff, resident and resident's representative were completed. The resident's care plan was updated and includes trauma informed care. To identify other residents having the	

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21980	Continued From page 4 then told the NA "she broke it" pointing to her lamp. R1 also described the incident to her family member (FM) and registered nurse (RN) and said the staff was mean to her and hit her. R1 then demonstrated what the staff member had done to her at which time R1 grabbed the RN's wrists, then pushed the RN away by his wrists. During interview on 7/19/23, at 8:51 a.m. licensed social worker (LSW)-A stated staff had become aware of the allegation on 7/9/23, when R1 reported it to the NA. LSW-A said the NA then reported it to the nurse on duty who told her the call the clinical coordinator if she had concerns. LSW-A stated the NA reached out to the clinical coordinator at 7:00 p.m. on 7/9/23, via text message. LSW-A stated she received a call around 8:00 p.m. on 7/9/23, and said she should have reported to the SA at that time but she did not have her laptop with her. During interview on 7/19/23, at 2:12 p.m. the DON stated if an allegation of abuse was reported after hours or on a weekend, the person who learned of the incident should tell the charge nurse, clinical coordinator or LSW-A. The DON stated she was also available and was on call 24/7. The DON stated no one had called and reported the incident to her. The DON stated she was not aware of the allegation until 7/10/23, in the morning and said the administrator was notified at that time. Facility policy Resident Abuse Prohibition Policy dated 6/7/23, indicated Employees must report abuse immediately to supervisor in house or designee. Supervisor in house or designee must then notify the Administrator immediately. The facility must designate a facility staff member on each shift responsible for receiving complaints	21980	potential to be affected by the same deficient practive, on 7/10/23 residents that may have had contact with the AP were interviewed and skin checks completed . Resident care plans reviewed. To assure sustainability going forward all the Warroad Care center has hired a consultant to complete on-site education on the current Abuse Prohibition Policy and procedure to all mandated reporters. A gap analysis will be completed on the reporting mechanisms of allegations of abuse, neglect, exploitations or mistreatment and current facility systems. IDT stand up meetings will include a 24-48 hour report. The IDT team will review residents changes in condition, injuries of unknown origin, resident behaviors . Weekly high risk meetings will focus on current reports of abuse, neglect, exploitations and mistreatment to ensure timely reporting and completion of the events that caused the allegation. Audits will be conducted to ensure employees understand the current Abuse Prohibition Policy. This will be completed weekly x 8 and monthly for 3 months. The results for the audit will be reviewed in the regularly scheduled QAPI Committee and reccomendations will follow. Responsibility : Social Service/DON and or designee.	

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21980	Continued From page 5 and conducting complaint investigations. The policy further indicated if an incident or allegation is considered reportable, the administrator or designee will make a report to the SA online reporting web site immediately, but not later than two hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop/revise policies or procedures to ensure timely reporting of all allegations of abuse or neglect are within appropriate timeframes for reporting. The facility could re-educate staff to policies and procedures, and audit all complaints of alleged abuse or neglect in a measurable and specific way. The results of those audits could be taken to the Quality Assurance Performance Improvement (QAPI) committee to determine the need for further monitoring or compliance. TIME PERIOD FOR CORRECTION: 21 DAYS	21980		