



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 25, 2023

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

RE: CCN: 245329
Cycle Start Date: September 8, 2023

Dear Administrator:

On September 20, 2023, we notified you a remedy was imposed. On October 20, 2023 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of October 20, 2023.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective NO DATA be discontinued as of October 20, 2023. (42 CFR 488.417 (b))

In our letter of September 20, 2023, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from October 5, 2023. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink that reads '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

October 25, 2023

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

Re: Reinspection Results
Event ID: QPSE12

Dear Administrator:

On October 20, 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 September 8, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink that reads '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 Submitted
September 20, 2023

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

RE: CCN: 245329
Cycle Start Date: September 8, 2023

Dear Administrator:

On September 8, 2023, survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

REMOVAL OF IMMEDIATE JEOPARDY

On September 8, 2023, the situation of immediate jeopardy to potential health and safety cited at F689 was removed. However, continued non-compliance remains at the lower scope and severity of D.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement 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 § 488.417(a), effective October 5, 2023.

This Department is also recommending that CMS impose a civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

Warroad Care Center

September 20, 2023

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The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective October 5, 2023, (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective October 5, 2023, (42 CFR 488.417 (b)).

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

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than \$11,995; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective September 8, 2023. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

SUBSTANDARD QUALITY OF CARE

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

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely

Warroad Care Center

September 20, 2023

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will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Warroad Care Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective September 8, 2023. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

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

DEPARTMENT CONTACT

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

**Susie Haben, Rapid Response
Licensing and Certification Program
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557**

Warroad Care Center

September 20, 2023

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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 their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by March 8, 2024 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

APPEAL RIGHTS DENIAL OF PAYMENT

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at <https://dab.efile.hhs.gov> no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A

copy of the hearing request shall be submitted electronically to:

Steven.Delich@cms.hhs.gov

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

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

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

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

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

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

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

Washington, D.C. 20201

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

INFORMAL DISPUTE RESOLUTION (IDR) / 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/lrc_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 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,



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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/12/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245329	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/08/2023
NAME OF PROVIDER OR SUPPLIER WARROAD CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1401 LAKE STREET NORTHWEST WARROAD, MN 56763		
(X4) ID PREFIX TAG	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	<p>INITIAL COMMENTS</p> <p>On 9/6/23 through 9/8/23, a standard abbreviated and extended survey was conducted at your facility. Your facility was found to be not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.</p> <p>The following complaint was reviewed: H53295098C (MN96270) with a deficiency cited at F689.</p> <p>The IJ began on 8/22/23, when R1 exited the facility via the attached Assisted Living wing of the facility after staff left her unattended in the lobby for the second time during the overnight shift at 4:15 a.m. R1 was not located again until 4:45 a.m. when she was attempting to re-enter the building. The director of nursing (DON), administrator and licensed social worker (LSW)-A were notified of the IJ on 9/7/23, at 1:00 p.m. The IJ was removed on 9/8/23, at 11:00 a.m., but noncompliance remained at the lower scope and severity level D, with no actual harm with potential for more than minimal harm that was not immediate jeopardy.</p> <p>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.</p> <p>Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the</p>	F 000		

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

TITLE

(X6) DATE

Electronically Signed

09/29/2023

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 000 F 689 SS=J	<p>Continued From page 1 regulations has been attained.</p> <p>Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)</p> <p>§483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and</p> <p>§483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to maintain resident safety when a resident with a history of exiting the facility unsupervised, eloped through the Assisted Living (AL) wing of the facility at approximately 4:15 a.m. on 8/22/23. This resulted in an immediate Jeopardy (IJ) situation for R1. In addition, the facility failed to implement a system to ensure proper functioning of their Wander Alert system resulting in 1 of 3 residents (R3) reviewed for elopement, exiting the unit unnoticed by staff during the survey.</p> <p>The IJ began on 8/22/23, when R1 exited the facility via the attached AL wing of the facility after staff left her unattended in the lobby for the second time during the overnight shift at 4:15 a.m. R1 was not located again until 4:45 a.m. when she was attempting to re-enter the building. The director of nursing (DON), administrator and licensed social worker (LSW)-A were notified of the IJ on 9/7/23, at 1:00 p.m. The IJ was removed on 9/8/23, at 11:00 a.m., but noncompliance remained at the lower scope and severity level D,</p>	F 000 F 689	<p>On 8/22/23 R1 was assessed for injury including bruising and pain. Resident showed no signs or symptoms of pain or injury. Extremities were warm to touch. R1 stated it is a little chilly for a walk and decided to come back into the building. R1 declined a roam alert to be placed upon returning to room. A sensor mat was placed outside of her room to alert staff if leaving. Updated care plan. R1 on 9/7 was placed on visual checks to insure she was in her room. A motion sensor was added to the inside of her room to alert staff when someone was entering room. Track phones were purchased and staff educated to have on at all times if resident chose to leave to have supervision with her at all times. 9/8 wander risk scale was completed. Care plan reviewed again. 9/21 R1 was placed on locked unit within the facility. To Identify other resident having the potential to be affected by the same deficient practice on 9/12 updated</p>	10/16/23

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F 689	<p>Continued From page 2</p> <p>with no actual harm with potential for more than minimal harm that was not immediate jeopardy.</p> <p>Findings include:</p> <p>R1's Admission Record indicated she admitted to the facility on 4/13/22. The Admission Record identified diagnosis that included Alzheimer's Disease, dementia and impulse disorder.</p> <p>R1's quarterly Minimum Data Set (MDS) dated 7/14/23, identified moderately impaired cognition and indicated she experienced hallucinations. R1's MDS indicated she ambulated independently on and off the unit and indicated she did not display wandering behaviors.</p> <p>R1's Wandering Risk Scale dated 7/14/23, identified cognitive loss/dementia and indicated she had no history of wandering and no episodes of wandering in the past three months. The Wandering Risk Scale indicated R1 did not wander aimlessly but indicated R1 enjoyed walking down to AL to visit friends who resided in that area of the building. She had Alzheimer's type dementia and verbalized statements regarding her dislike of skilled nursing facility placement and her desire to leave and had made verbal threats to do so. She had exited the building without supervision during the past quarter. R1 was on safety rounds every hour so that staff knew of her whereabouts. A WanderGuard was applied to R1's wrist on 7/3/23, but she subsequently cut it off and refused to wear it. Care Coordinator and Social Worker had been working frequently with resident, family, physician, and behavioral health provider regarding resident's mood/behavioral symptoms that were contributing to her desire to</p>	F 689	<p>admission check list to include if a resident scores > 8 on wander risk assessment a roam alert needs to be placed.</p> <p>If a resident needs a roam alert must add check placement of roam alert every shift to emar, check function every week and to document expiration date on TAR/MAR. 9/13 created elopement prevention policy. Facility is meeting to update missing resident policy and flip chart.</p> <p>To assure sustainability going forward. Box was received and roam alerts checked for function starting on 9/13. Will continue to check weekly, every Wednesday. 9/8 all department heads were educated on the plan for R1, (15 min checks, not being left alone and the need for track phone if leaves room, motion and floor sensors.) Department heads then educated their staff that still needed education. 9/27 elopement prevention policy shared with care coordinators and nurses to understand new roam alert box.</p> <p>Audits done weekly x 4 , monthly x3, that roam alerts are functioning correctly, if not maintenance slips made out and maintenance understands the importance of the system. These will be performed by DON. Will continue to educate staff on missing resident and elopment policy with 1/1 and or G.O per maintenance.</p>	

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F 689	<p>Continued From page 3 leave facility.</p> <p>R1's care plan dated 7/17/23, indicated she had been identified to be vulnerable due to the following factors: Disoriented to person, place, and/or time and functional limitations. The care plan identified target behaviors that included threats/attempts to elope from the facility. The care plan identified the following interventions: Wander Alert, however, R1 had removed per self in the past. Staff were directed to monitor for placement every shift and document if she refuses to wear it or have it placed on her walker. In addition, a Sensor mat was placed outside of R1's door to notify staff if she was leaving her room, due to refusals of the Wander Alert Monitor. Staff were directed to monitor placement of the mat every shift. The care plan further identified a risk for elopement and directed staff to distract R1 from wandering by offering pleasant diversions, structured activities, food, conversation, television or a book and indicated R1 preferred visiting with other residents, staff or family.</p> <p>R1's facility Progress Notes identified the following:</p> <p>6/6/23, Nurse was informed by other nursing/activity staff that R1 was seen walking on the road next to the employee parking lot at 4:24 p.m. This was noted to be on other side of the building from her room. Staff approached her and offered a ride back to facility. R1 stated she was "going to find her friend." Staff offered conversation regarding details of her exact destination. During this time, AL staff approached her with the facility van and were able to get her to agree to return to the nursing home (NH). Staff</p>	F 689		

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F 689	<p>Continued From page 4</p> <p>implemented 30 minute rounding to ensure safety.</p> <p>7/2/23, at 12:26 p.m. R1 was found outside in the front of the building by activities staff. R1 was outside without her walker and stated she was looking for her kids. Staff was able to re-direct R1 back into the building with 30 minutes checks continued. R1 stated it was hot outside and was unsteady on her feet. After returning inside R1 needed to sit down.</p> <p>7/3/23, 3:02 p.m. placed WanderGuard on resident's left wrist this morning. Resident was agreeable to it at the time. Since then, resident has set off the alarm on Birch twice and has threatened to cut it off. Will continue to monitor.</p> <p>8/22/23, R1 had been awake all shift. R1 ambulated to the AL lobby at approximately 3:00 a.m. Staff found R1 and escorted her back to the NH area of the facility. R1 stated she "will get out of here one way or another" and stated "wait until you go to the bathroom or go home" implying that she would attempt to leave the facility again at that point. When asked, R1 stated she was going to see her friend who lived in the AL.</p> <p>8/22/23, R1 was found in the AL lobby area "for the second time this shift" at approximately 3:45 a.m. R1 left her room when staff was out of view assisting other residents. R1 refused to return from the AL lobby and stated "I can sit here if I want to." Due to R1's increased level of agitation writer let R1 sit in the lobby as the front doors were locked and AL staff was made aware of the situation. Upon returning to check on R1 at approximately 3:55 a.m. she was no longer in the lobby. Writer began to check restrooms and other</p>	F 689		

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F 689	<p>Continued From page 5</p> <p>common areas of the AL. R1 ambulated in from outside through the AL door. When questioned how she got out, R1 replied, "I'm not telling you." R1 ultimately agreed to return to her room but was complaining about having to "stay in this place" and stated "I could just as well be in prison." Continue 30 minute rounding.</p> <p>8/22/23 at 5:22 a.m., Staff asked R1 if they could put a Wander Alert on her or her walker. R1 stated "No, you are not going to keep me in here." A sensor mat was placed outside of her door to alert staff when R1 stepped out of her room.</p> <p>8/24/23 at 10:37 p.m., R1 was speaking to another resident on the unit and expressing her dislike of the facility. R1 stated to a staff member, "If you're lucky, I won't be here for long."</p> <p>8/25/23 at 2:18 p.m., R1 was talking about her frustrations with staff and the facility. R1 spoke about needing to figure out what to do to get out of the facility.</p> <p>8/27/23 at 2:38 p.m., R1's floor mat alarm went off. R1 was found standing by the double doors of the wing tearful. Author attempted to communicate with R1 who made statements such as "I've been here too long." "They won't let me out of this damn place." "I want you to get me out of here."</p> <p>8/30/23 at 10:31 a.m., R1 had a sensor mat in front of her door which she has figured out to move in front of B100 (room next door) or to go around it at different times.</p> <p>On 9/7/23, at 10:03 a.m. a tour of the AL wing of the facility was conducted with licensed social</p>	F 689		

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F 689	Continued From page 6 worker (LSW)-A. The main entrance of the wing had a set of entry doors with a vestibule leading to a second set of doors. On the wall on the inside of the facility, outside the doors was a green button that could be pushed to exit the doors. LSW-A stated she was unsure if the button would disengage the lock after hours when the doors were locked. LSW-A stated she thought R1 had exited through the AL wing of the facility. To the left of the front door was a short hall that led to a longer hall which led to a garage on the end and to the right an interior door which led to an exit door to the outside The door could not be opened from the outside therefore, R1 would not have been able to get back into the building unassisted. Outside the garage and the exit door of the independent living wing was a large partially fenced construction site. Surrounding the facility was a highway to the south and west and a housing development to the east. At 10:18 a.m. the video surveillance camera was reviewed with LSW-A. LSW-A stated the time was off on the camera by approximately two hours. On 8/22/23, at approximately 3:09 a.m. (actual time), R1 was seen in the lobby of the AL. R1 moved out of view of the camera and was seen again at approximately 3:10 a.m. pushing on the entry doors numerous times. R1 then left her walker and returned to the doors and continued to push on them. At approximately 3:12 a.m. registered nurse (RN)-A was seen speaking with R1 and walked with R1 out of view of the camera. At approximately 4:00 a.m. RN-A was seen back in the lobby with R1. At approximately 4:15 a.m. RN-A was seen walking away from the door toward the AL wing. R1 was not visible on the camera. At approximately 4:38 a.m. RN-A returned to the lobby in view of the camera and R1 was not there. At 4:45 a.m. RN-A is seen	F 689		

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F 689	<p>Continued From page 7</p> <p>talking on the phone in the lobby and R1 appeared at the front door from outside the building.</p> <p>During interview on 9/6/23, at 4:32 p.m. NA-B stated she was aware of R1's attempts to leave the facility and said there had been a "handful" of attempts. NA-B stated R1 had a sensor mat outside her door and had a Wander Alert bracelet but said she heard R1 had cut the bracelet off. NA-B said R1 was on a rounding schedule, "either hour or half hour." NA-B stated if R1 attempted to leave staff were supposed to follow her but said she was not sure what to do if R1 refused to return and said she had not had to deal with that before.</p> <p>On 9/6/23, at 4:44 p.m. NA-A stated R1 "just does whatever she wants, sometimes she jumps the mat so we can't hear it." NA-A said a little while earlier she saw R1 walk out the door and go in through the other door and said R1 went to see someone on the other side of the unit and she had to go see where R1 had gone. When asked what she was supposed to do if R1 left, NA-A stated she had never been there when it had happened so she was not sure. NA-A further stated she had been told to try to get her back and said R1 was not on any extra checks that she was aware of. At that time (NA)-A demonstrated how R1's alarming floor mat worked. When NA-A stepped on the mat the alarm did not sound. At 4:50 p.m. NA-A returned to the mat with NA-B holding a small plastic box at which time the alarming floor mat sounded when stepped on.</p> <p>On 9/6/23, at 5:13 p.m. NA-D stated he had been working on the night of 8/22/23, but said he had not been aware R1 had been outside the facility.</p>	F 689		

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F 689	<p>Continued From page 8</p> <p>NA-D said he typically worked on the secured unit but did occasionally move around. NA-D said no one had told him R1 had eloped from the facility and said he was not familiar with what happened on the other wing of the NH.</p> <p>During interview on 9/7/23, at 8:29 a.m. licensed practical nurse (LPN)-A stated R1 had a mind of her own and was extremely difficult to redirect. LPN-A stated R1 thought she could go wherever she wanted but in reality she couldn't and staff could not convey that to her. LPN-A stated she was aware of R1's previous elopement attempts and said R1 needed a one to one but there was not enough staff to provide it. LPN-A stated she was not aware R1 was outside on the night of 8/22/23, until she heard the surveyor was onsite and she was told why. LPN-A stated if R1 left while she was working she would call 911 and said R1 was not safe if she got outside.</p> <p>On 9/7/23, at 8:41 a.m. NA-C stated she had been told R1 had eloped from the facility in the past. NA-C said when she arrived to work she would check to see if R1 was in her room and check on her at half hour to one hour intervals. NA-C stated R1 was allowed to go to the AL side of the facility unsupervised and if she went staff were to keep track of time and see when R1 came back. NA-C stated she thought it had been a while since R1 had attempted to leave the facility and had not been aware of the recent elopement.</p> <p>On 9/7 at 8:48 a.m., the care coordinator LPN-B stated interventions to prevent R1 from eloping from the facility included working with a memory care clinic and recently the alarming floor mat but said R1 would walk over the mat so it would not</p>	F 689		

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F 689	<p>Continued From page 9</p> <p>alarm. LPN-B stated they were working to get R1 to a memory clinic for an in-patient stay but in the meantime staff proved hourly checks and activity staff spent extra time with her.</p> <p>On 9/7 at 9:16 a.m., the DON stated the last she heard R1 was going to an in-patient stay at a memory unit but they did not know when it would occur. The DON stated she believed R1 was on hourly checks. The DON stated she was in the building on 8/22/23, when R1 eloped from the facility. The DON said R1 had been increasingly agitated and the two staff on the unit would peek in on her. She said around 3:20 a.m. RN-A told her R1 was being aggressive and said he could watch her on the cameras. She said RN-A walked to the AL and R1 was sitting by the door and did not want to go back so she directed staff to check on her every 15 - 20 minutes. The DON said she then got a phone call that R1 was not there and RN-A did not know where she was. She said she asked RN-A to talk to the AL staff and she checked the NH. The DON said she went to check the AL doors and they were locked and said RN-A called her shortly after and said R1 returned from outside the front doors of the AL and RN-A had to let her in. The DON said she was not sure how R1 got out of the building but assumed she went out the exit by the stairs because those doors were not locked. The DON said she believed R1 had gone to the AL twice that night shift and had been brought back once and then went back. She said when RN-A went to get her the second time R1 was more verbally aggressive which was why RN-A left her there assuming she could not get out. The DON said they immediately placed an alarming floor mat in front of R1's door and were doing 15 minute checks on her. The DON said R1 was still</p>	F 689		

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F 689	<p>Continued From page 10</p> <p>allowed to go to the AL and they could watch the clips on the camera to see where she ended up and if it had been a little long they did half hour checks. The DON stated they could not provide R1 with one to one staffing.</p> <p>The IJ was removed on 9/8/23, at 1:00 p.m. when it was verified through interview and document review the facility reassessed R1's elopement risk, implemented a motion sensor above R1's door and out of R1's reach, implemented 15 minute safety checks and obtained two phones for staff to utilize for communication should R1 leave her room. Further, staff will supervise R1 when she makes the choice to go to the AL to visit friends. All staff were educated on the procedures.</p> <p>R3's quarterly MDS dated 7/21/23, identified moderate cognitive impairment and indicated he displayed wandering behaviors. The MDS indicated R3 was independent with locomotion on the unit and required supervision when off the unit.</p> <p>R3's care plan dated 11/4/22, indicated he was a wandering risk related to history or attempts to go outside unattended and impaired safety awareness. The care plan directed staff to distract R3 from wandering by offering pleasant diversions, structured activities, food, conversation, television or a book. The care plan further identified the use of a Wander Alert and directed staff to check placement daily.</p> <p>During observation on 9/7/23, at 3:06 p.m. R3 propelled himself to the closed door of the unit, pushed the green button on the right side of the door. The door opened and R3 propelled himself</p>	F 689		

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F 689	<p>Continued From page 11</p> <p>off the unit without staff supervision. Surveyor alerted NA-E that R3 had left the unit. At 3:08 p.m. NA-E and LPN-B were observed placing a new Wander Alert bracelet on R3's wheel chair.</p> <p>During interview on 9/7/23, at 3:09 p.m. LPN-B stated R3 had a Wander Alert on his chair when he exited the unit but it had not functioned correctly.</p> <p>On 9/8/23, at 10:32 a.m. LPN-B stated staff checked function of the Wander Alert by taking the residents by the doors during the day or at night if wheel chairs were being washed. LPN-B stated the facility did not have a device for checking the Wander Alerts for functioning nor was there a clear process for staff to follow to ensure proper functioning on a routine basis.</p> <p>Review of R3's record indicated staff checking Wander Alert placement but lacked evidence of checking Wander Alert function.</p> <p>Facility policy Elopement Prevention dated 7/18/14, indicated transmitters would be replaced according to life expectancy and as needed. Transmitters will be tested weekly and as needed with a hand held device to ensure they are working properly.</p> <p>Facility policy Missing Resident Policy dated 10/19/17, indicated upon return of a missing resident to the facility the charge nurse or designee will assess and plan if elopement occurred and put into place safety measures to prevent further elopements.</p>	F 689		



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: State Nursing Home Licensing Orders
Event ID: QPSE11

Dear Administrator:

The above facility was surveyed on September 6, 2023 through September 8, 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.

Warroad Care Center

September 20, 2023

Page 2

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,



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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00797	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/08/2023
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2 000	<p>Initial Comments</p> <p style="text-align: center;">*****ATTENTION*****</p> <p style="text-align: center;">NH LICENSING CORRECTION ORDER</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>INITIAL COMMENTS: On 9/6/23 through 9/8/23, 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</p>	2 000		
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Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 09/29/23
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Minnesota Department of Health

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2 000	<p>Continued From page 1</p> <p>identify the date when they will be completed.</p> <p>The following complaint was reviewed. H53295098C (MN96270) with a licensing order issued at (0830.)</p> <p>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.</p> <p>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 is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.</p>	2 000		
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NAME OF PROVIDER OR SUPPLIER WARROAD CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1401 LAKE STREET NORTHWEST WARROAD, MN 56763
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2 000	Continued From page 2	2 000		
2 830	<p>MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General</p> <p>Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to maintain resident safety when a resident with a history of exiting the facility unsupervised, eloped through the Assisted Living (AL) wing of the facility at approximately 4:15 a.m. on 8/22/23. This resulted in an immediate Jeopardy (IJ) situation for R1. In addition, the facility failed to implement a system to ensure proper functioning of their Wander Alert system resulting in 1 of 3 residents (R3) reviewed for elopement, exiting the unit unnoticed by staff during the survey.</p>	2 830	<p>On 8/22/23 R1 was assessed for injury including bruising and pain. Resident showed no signs or symptoms of pain or injury. Extremities were warm to touch. R1 stated it is a little chilly for a walk and decided to come back into the building. R1 declined a roam alert to be placed upon returning to room. A sensor mat was placed outside of her room to alert staff if leaving. Updated care plan. R1 on 9/7 was placed on visual checks to insure she was in her room. A motion</p>	10/16/23

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2 830	<p>Continued From page 3</p> <p>The IJ began on 8/22/23, when R1 exited the facility via the attached AL wing of the facility after staff left her unattended in the lobby for the second time during the overnight shift at 4:15 a.m. R1 was not located again until 4:45 a.m. when she was attempting to re-enter the building. The director of nursing (DON), administrator and licensed social worker (LSW)-A were notified of the IJ on 9/7/23, at 1:00 p.m. The IJ was removed on 9/8/23, at 11:00 a.m., but noncompliance remained at the lower scope and severity level D, with no actual harm with potential for more than minimal harm that was not immediate jeopardy.</p> <p>Findings include:</p> <p>R1's Admission Record indicated she admitted to the facility on 4/13/22. The Admission Record identified diagnosis that included Alzheimer's Disease, dementia and impulse disorder.</p> <p>R1's quarterly Minimum Data Set (MDS) dated 7/14/23, identified moderately impaired cognition and indicated she experienced hallucinations. R1's MDS indicated she ambulated independently on and off the unit and indicated she did not display wandering behaviors.</p> <p>R1's Wandering Risk Scale dated 7/14/23, identified cognitive loss/dementia and indicated she had no history of wandering and no episodes of wandering in the past three months. The Wandering Risk Scale indicated R1 did not wander aimlessly but indicated R1 enjoyed walking down to AL to visit friends who resided in that area of the building. She had Alzheimer's type dementia and verbalized statements regarding her dislike of skilled nursing facility placement and her desire to leave and had made</p>	2 830	<p>sensor was added to the inside of her room to alert staff when someone was entering room. Track phones were purchased and staff educated to have on at all times if resident chose to leave to have supervision with her at all times. 9/8 wander risk scale was completed. Care plan reviewed again. 9/21 R1 was placed on locked unit within the facility. To identify other resident having the potential to be affected by the same deficient practice on 9/12 updated admission check list to include if a resident scores > 8 on wander risk assessment a roam alert needs to be placed.</p> <p>If a resident needs a roam alert must add check placement of roam alert every shift to emar, check function every week and to document expiration date on TAR/MAR. 9/13 created elopement prevention policy. Facility is meeting to update missing resident policy and flip chart. To assure sustainability going forward. Box was received and roam alerts checked for function starting on 9/13. Will continue to check weekly, every Wednesday. 9/8 all department heads were educated on the plan for R1, (15 min checks, not being left alone and the need for track phone if leaves room, motion and floor sensors.) Department heads then educated their staff that still needed education. 9/27 elopement prevention policy shared with care coordinators and nurses to understand new roam alert box.</p> <p>Audits done weekly x 4 , monthly x3, that roam alerts are functioning correctly, if not maintenance slips made out and</p>	
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2 830	<p>Continued From page 4</p> <p>verbal threats to do so. She had exited the building without supervision during the past quarter. R1 was on safety rounds every hour so that staff knew of her whereabouts. A WanderGuard was applied to R1's wrist on 7/3/23, but she subsequently cut it off and refused to wear it. Care Coordinator and Social Worker had been working frequently with resident, family, physician, and behavioral health provider regarding resident's mood/behavioral symptoms that were contributing to her desire to leave facility.</p> <p>R1's care plan dated 7/17/23, indicated she had been identified to be vulnerable due to the following factors: Disoriented to person, place, and/or time and functional limitations. The care plan identified target behaviors that included threats/attempts to elope from the facility. The care plan identified the following interventions: Wander Alert, however, R1 had removed per self in the past. Staff were directed to monitor for placement every shift and document if she refuses to wear it or have it placed on her walker. In addition, a Sensor mat was placed outside of R1's door to notify staff if she was leaving her room, due to refusals of the Wander Alert Monitor. Staff were directed to monitor placement of the mat every shift. The care plan further identified a risk for elopement and directed staff to distract R1 from wandering by offering pleasant diversions, structured activities, food, conversation, television or a book and indicated R1 preferred visiting with other residents, staff or family.</p> <p>R1's facility Progress Notes identified the following: 6/6/23, Nurse was informed by other</p>	2 830	<p>maintenance understands the importance of the system. These will be performed by DON. Will continue to educate staff on missing resident and elopment policy with 1/1 and or G.O per maintenance.</p>	
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2 830	<p>Continued From page 5</p> <p>nursing/activity staff that R1 was seen walking on the road next to the employee parking lot at 4:24 p.m. This was noted to be on other side of the building from her room. Staff approached her and offered a ride back to facility. R1 stated she was "going to find her friend." Staff offered conversation regarding details of her exact destination. During this time, AL staff approached her with the facility van and were able to get her to agree to return to the nursing home (NH). Staff implemented 30 minute rounding to ensure safety.</p> <p>7/2/23, at 12:26 p.m. R1 was found outside in the front of the building by activities staff. R1 was outside without her walker and stated she was looking for her kids. Staff was able to re-direct R1 back into the building with 30 minutes checks continued. R1 stated it was hot outside and was unsteady on her feet. After returning inside R1 needed to sit down.</p> <p>7/3/23, 3:02 p.m. placed WanderGuard on resident's left wrist this morning. Resident was agreeable to it at the time. Since then, resident has set off the alarm on Birch twice and has threatened to cut it off. Will continue to monitor.</p> <p>8/22/23, R1 had been awake all shift. R1 ambulated to the AL lobby at approximately 3:00 a.m. Staff found R1 and escorted her back to the NH area of the facility. R1 stated she "will get out of here one way or another" and stated "wait until you go to the bathroom or go home" implying that she would attempt to leave the facility again at that point. When asked, R1 stated she was going to see her friend who lived in the AL.</p> <p>8/22/23, R1 was found in the AL lobby area "for the second time this shift" at approximately 3:45</p>	2 830		
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2 830	<p>Continued From page 6</p> <p>a.m. R1 left her room when staff was out of view assisting other residents. R1 refused to return from the AL lobby and stated "I can sit here if I want to." Due to R1's increased level of agitation writer let R1 sit in the lobby as the front doors were locked and AL staff was made aware of the situation. Upon returning to check on R1 at approximately 3:55 a.m. she was no longer in the lobby. Writer began to check restrooms and other common areas of the AL. R1 ambulated in from outside through the AL door. When questioned how she got out, R1 replied, "I'm not telling you." R1 ultimately agreed to return to her room but was complaining about having to "stay in this place" and stated "I could just as well be in prison." Continue 30 minute rounding.</p> <p>8/22/23 at 5:22 a.m., Staff asked R1 if they could put a Wander Alert on her or her walker. R1 stated "No, you are not going to keep me in here." A sensor mat was placed outside of her door to alert staff when R1 stepped out of her room.</p> <p>8/24/23 at 10:37 p.m., R1 was speaking to another resident on the unit and expressing her dislike of the facility. R1 stated to a staff member, "If you're lucky, I won't be here for long."</p> <p>8/25/23 at 2:18 p.m., R1 was talking about her frustrations with staff and the facility. R1 spoke about needing to figure out what to do to get out of the facility.</p> <p>8/27/23 at 2:38 p.m., R1's floor mat alarm went off. R1 was found standing by the double doors of the wing tearful. Author attempted to communicate with R1 who made statements such as "I've been here too long." "They won't let me out of this damn place." "I want you to get me out of here."</p>	2 830		

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2 830	<p>Continued From page 7</p> <p>8/30/23 at 10:31 a.m., R1 had a sensor mat in front of her door which she has figured out to move in front of B100 (room next door) or to go around it at different times.</p> <p>On 9/7/23, at 10:03 a.m. a tour of the AL wing of the facility was conducted with licensed social worker (LSW)-A. The main entrance of the wing had a set of entry doors with a vestibule leading to a second set of doors. On the wall on the inside of the facility, outside the doors was a green button that could be pushed to exit the doors. LSW-A stated she was unsure if the button would disengage the lock after hours when the doors were locked. LSW-A stated she thought R1 had exited through the AL wing of the facility. To the left of the front door was a short hall that led to a longer hall which led to a garage on the end and to the right an interior door which led to an exit door to the outside. The door could not be opened from the outside therefore, R1 would not have been able to get back into the building unassisted. Outside the garage and the exit door of the independent living wing was a large partially fenced construction site. Surrounding the facility was a highway to the south and west and a housing development to the east. At 10:18 a.m. the video surveillance camera was reviewed with LSW-A. LSW-A stated the time was off on the camera by approximately two hours. On 8/22/23, at approximately 3:09 a.m. (actual time), R1 was seen in the lobby of the AL. R1 moved out of view of the camera and was seen again at approximately 3:10 a.m. pushing on the entry doors numerous times. R1 then left her walker and returned to the doors and continued to push on them. At approximately 3:12 a.m. registered nurse (RN)-A was seen speaking with R1 and walked with R1 out of view of the camera. At</p>	2 830		

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2 830	<p>Continued From page 8</p> <p>approximately 4:00 a.m. RN-A was seen back in the lobby with R1. At approximately 4:15 a.m. RN-A was seen walking away from the door toward the AL wing. R1 was not visible on the camera. At approximately 4:38 a.m. RN-A returned to the lobby in view of the camera and R1 was not there. At 4:45 a.m. RN-A is seen talking on the phone in the lobby and R1 appeared at the front door from outside the building.</p> <p>During interview on 9/6/23, at 4:32 p.m. NA-B stated she was aware of R1's attempts to leave the facility and said there had been a "handful" of attempts. NA-B stated R1 had a sensor mat outside her door and had a Wander Alert bracelet but said she heard R1 had cut the bracelet off. NA-B said R1 was on a rounding schedule, "either hour or half hour." NA-B stated if R1 attempted to leave staff were supposed to follow her but said she was not sure what to do if R1 refused to return and said she had not had to deal with that before.</p> <p>On 9/6/23, at 4:44 p.m. NA-A stated R1 "just does whatever she wants, sometimes she jumps the mat so we can't hear it." NA-A said a little while earlier she saw R1 walk out the door and go in through the other door and said R1 went to see someone on the other side of the unit and she had to go see where R1 had gone. When asked what she was supposed to do if R1 left, NA-A stated she had never been there when it had happened so she was not sure. NA-A further stated she had been told to try to get her back and said R1 was not on any extra checks that she was aware of. At that time (NA)-A demonstrated how R1's alarming floor mat worked. When NA-A stepped on the mat the alarm did not sound. At 4:50 p.m. NA-A returned to the mat with NA-B</p>	2 830		
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2 830	<p>Continued From page 9</p> <p>holding a small plastic box at which time the alarming floor mat sounded when stepped on.</p> <p>On 9/6/23, at 5:13 p.m. NA-D stated he had been working on the night of 8/22/23, but said he had not been aware R1 had been outside the facility. NA-D said he typically worked on the secured unit but did occasionally move around. NA-D said no one had told him R1 had eloped from the facility and said he was not familiar with what happened on the other wing of the NH.</p> <p>During interview on 9/7/23, at 8:29 a.m. licensed practical nurse (LPN)-A stated R1 had a mind of her own and was extremely difficult to redirect. LPN-A stated R1 thought she could go wherever she wanted but in reality she couldn't and staff could not convey that to her. LPN-A stated she was aware of R1's previous elopement attempts and said R1 needed a one to one but there was not enough staff to provide it. LPN-A stated she was not aware R1 was outside on the night of 8/22/23, until she heard the surveyor was onsite and she was told why. LPN-A stated if R1 left while she was working she would call 911 and said R1 was not safe if she got outside.</p> <p>On 9/7/23, at 8:41 a.m. NA-C stated she had been told R1 had eloped from the facility in the past. NA-C said when she arrived to work she would check to see if R1 was in her room and check on her at half hour to one hour intervals. NA-C stated R1 was allowed to go to the AL side of the facility unsupervised and if she went staff were to keep track of time and see when R1 came back. NA-C stated she thought it had been a while since R1 had attempted to leave the facility and had not been aware of the recent elopement.</p>	2 830		

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2 830	<p>Continued From page 10</p> <p>On 9/7 at 8:48 a.m., the care coordinator LPN-B stated interventions to prevent R1 from eloping from the facility included working with a memory care clinic and recently the alarming floor mat but said R1 would walk over the mat so it would not alarm. LPN-B stated they were working to get R1 to a memory clinic for an in-patient stay but in the meantime staff proved hourly checks and activity staff spent extra time with her.</p> <p>On 9/7 at 9:16 a.m., the DON stated the last she heard R1 was going to an in-patient stay at a memory unit but they did not know when it would occur. The DON stated she believed R1 was on hourly checks. The DON stated she was in the building on 8/22/23, when R1 eloped from the facility. The DON said R1 had been increasingly agitated and the two staff on the unit would peek in on her. She said around 3:20 a.m. RN-A told her R1 was being aggressive and said he could watch her on the cameras. She said RN-A walked to the AL and R1 was sitting by the door and did not want to go back so she directed staff to check on her every 15 - 20 minutes. The DON said she then got a phone call that R1 was not there and RN-A did not know where she was. She said she asked RN-A to talk to the AL staff and she checked the NH. The DON said she went to check the AL doors and they were locked and said RN-A called her shortly after and said R1 returned from outside the front doors of the AL and RN-A had to let her in. The DON said she was not sure how R1 got out of the building but assumed she went out the exit by the stairs because those doors were not locked. The DON said she believed R1 had gone to the AL twice that night shift and had been brought back once and then went back. She said when RN-A went to get her the second time R1 was more verbally aggressive which was why RN-A left her there</p>	2 830		
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2 830	<p>Continued From page 11</p> <p>assuming she could not get out. The DON said they immediately placed an alarming floor mat in front of R1's door and were doing 15 minute checks on her. The DON said R1 was still allowed to go to the AL and they could watch the clips on the camera to see where she ended up and if it had been a little long they did half hour checks. The DON stated they could not provide R1 with one to one staffing.</p> <p>The IJ was removed on 9/8/23, at 1:00 p.m. when it was verified through interview and document review the facility reassessed R1's elopement risk, implemented a motion sensor above R1's door and out of R1's reach, implemented 15 minute safety checks and obtained two phones for staff to utilize for communication should R1 leave her room. Further, staff will supervise R1 when she makes the choice to go to the AL to visit friends. All staff were educated on the procedures.</p> <p>R3's quarterly MDS dated 7/21/23, identified moderate cognitive impairment and indicated he displayed wandering behaviors. The MDS indicated R3 was independent with locomotion on the unit and required supervision when off the unit.</p> <p>R3's care plan dated 11/4/22, indicated he was a wandering risk related to history or attempts to go outside unattended and impaired safety awareness. The care plan directed staff to distract R3 from wandering by offering pleasant diversions, structured activities, food, conversation, television or a book. The care plan further identified the use of a Wander Alert and directed staff to check placement daily.</p> <p>During observation on 9/7/23, at 3:06 p.m. R3</p>	2 830		
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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00797	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/08/2023
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NAME OF PROVIDER OR SUPPLIER WARROAD CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1401 LAKE STREET NORTHWEST WARROAD, MN 56763
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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
2 830	<p>Continued From page 12</p> <p>propelled himself to the closed door of the unit, pushed the green button on the right side of the door. The door opened and R3 propelled himself off the unit without staff supervision. Surveyor alerted NA-E that R3 had left the unit. At 3:08 p.m. NA-E and LPN-B were observed placing a new Wander Alert bracelet on R3's wheel chair.</p> <p>During interview on 9/7/23, at 3:09 p.m. LPN-B stated R3 had a Wander Alert on his chair when he exited the unit but it had not functioned correctly.</p> <p>On 9/8/23, at 10:32 a.m. LPN-B stated staff checked function of the Wander Alert by taking the residents by the doors during the day or at night if wheel chairs were being washed. LPN-B stated the facility did not have a device for checking the Wander Alerts for functioning nor was there a clear process for staff to follow to ensure proper functioning on a routine basis.</p> <p>Review of R3's record indicated staff checking Wander Alert placement but lacked evidence of checking Wander Alert function.</p> <p>Facility policy Elopement Prevention dated 7/18/14, indicated transmitters would be replaced according to life expectancy and as needed. Transmitters will be tested weekly and as needed with a hand held device to ensure they are working properly.</p> <p>Facility policy Missing Resident Policy dated 10/19/17, indicated upon return of a missing resident to the facility the charge nurse or designee will assess and plan if elopement occurred and put into place safety measures to prevent further elopements.</p>	2 830		

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2 830	<p>Continued From page 13</p> <p>SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could review/revise policies and procedures related to appropriate supervision to prevent elopement or respond to exit-seeking behavior. The DON or designee could also and ensure appropriate comprehensive assessments and interventions were developed and implemented for all residents with the potential to be affected. The DON or designee could re-educate all staff on policies and procedures, changes to care plans, and the results of assessments for those identified at risk for exit-seeking behaviors and elopement. The DON or designee could develop a system for evaluating and monitoring consistent implementation of policies and procedures and audit to prevent potential elopements and/identify exit-seeking behaviors. The DON or designee could also ensure staff perform a comprehensive assessment or root cause analysis as needed to ensure interventions are effective, in place and re-evaluated as often as necessary. The results of those measurable audits could be routinely brought to the facility's Quality Assurance Performance Improvement (QAPI) committee to determine ongoing compliance.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days.</p>	2 830		
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