Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 9, 2024

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

RE: CCN: 245329
Cycle Start Date: November 22, 2023

Dear Administrator:

On December 6, 2023, we notified you a remedy was imposed. On January 4, 2024 the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of December 22, 2023.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective December 21, 2023 be discontinued as of December 22, 2023. (42 CFR 488.417 (b))

In our letter of December 6, 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 December 21, 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,

Kamala Fiske-Downing

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

January 9, 2024

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

Re: Reinspection Results
Event ID: KKKR12

Dear Administrator:

On December 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 November 22, 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
December 6, 2023

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

RE: CCN: 245329
Cycle Start Date: November 22, 2023

Dear Administrator:

On November 22, 2023, a survey was completed at your facility by the Minnesota Department(s) of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

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(ies) 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 December 21, 2023.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective December 21, 2023. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective December 21, 2023.

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.

This Department is also recommending that CMS impose:

• 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.

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.

If you have not achieved substantial compliance by December 21, 2023, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Warroad Care Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from December 21, 2023. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

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. 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 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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by May 22, 2024 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and

1919(h)(3)(D) and Federal regulations at 42 CFR § 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

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.

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,

Kamala Fiske-Downing

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245329	A. BUILDING _____ B. WING _____	C 11/22/2023

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 11/21/23 through 11/22/23, 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 with NO deficiencies cited: H53297409C (MN97071) H53297406C (MN91558) The following complaints was reviewed: H53297187C (MN98460) with a deficiency cited at F689. Deficient practice was identified related to incidental finding with a deficiency cited at F604. 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 604 SS=D	. Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including:	F 604		12/15/23

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

Electronically Signed | 12/13/2023

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 604	Continued From page 1 §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to assess for and failed to ensure 1 of 2 residents (R4) was free from the use of physical restraints when placed in recliner chairs that prevented rising independently. Findings include: R4's quarterly MDS dated 9/25/23, identified severe cognitive impairment and indicated she required substantial assistance from staff for	F 604	To correct the deficient practice for R4, a Physical Device Data Collection and Review was done to assess if the resident was appropraite to use an electric recliner. She was determined to be unsafe due to cognition andd the chair was disabled. Attachment 1. A restraint/physical evealuation was done to assesss if residnet was restrained while in a chair. The assessment showed she was not restrained. Attachement 2. R4	

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F 604	Continued From page 2 transfers and toileting. R4's care plan dated 6/29/23, identified a self care deficit and a risk for falls related to cognitive impairment and balance problems. The care plan directed staff to ensure call light in reach, anticipate needs, and use of alarms. R4's facility Progress Note dated 10/23/23, indicated R4's alarm sounded and she was found on her hands and knees on the floor at the foot of the recliner which was still reclined. R4 was unable to verbalize what she was trying to do. During observation on 11/22/23, at 9:46 a.m. R4 was seated in a power recliner chair in a common area of the unit. NA-C stated R4 used an alarm because she was a fall risk and was "sneaky." NA-C said she had not seen R4 use the controls on the chair but she usually placed the control in the pocket of the chair out of R4's reach. When asked how she knew who was safe to be placed in a recliner chair and left unattended, NA-C stated, "I guess I just know." At 10:57 a.m. NA-C stated R4 could not operate the chair to get out of it safely. During interview on 11/22/23, at 11:57 a.m. the interim director of nursing (DON) stated the facility had not been using assessment to determine restraint use. The DON stated if a resident was totally dependent on staff the facility should look at rights, talk to family and the residents and care plan accordingly. The DON stated there was no criteria for determining if a device was a restraint. Facility Policy Restraints dated 4/4/23, indicated a facility must not impose physical restraints for purposes of discipline or convenience. The facility	F 604	care plan was reviewed and updated. The facility identified 13 residents using electric lift chairs and at risk for deficient practice. They were each assessed for appropriateness to be certain that they were safe to use the chair. To be certain that the deficient practice will not occur, upon admission all residnets will have a restraint assessment done. A Physical Device Data Collecetion and Review will also be completed on admission and quarterly. Education for all CNA's was done at a meeting on 12-12-23. Attachment 3. Education for nurses will be done on 12-14-23. Attachment 4. The restraint and physical deveice assessments will be reviewed with them. The DON or designee will audit all admissions and quarterlys for completion of the assessmnets, for the three months. Results of audits will be reviewed at monthly QAPI/QA meetings.	

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F 604	Continued From page 3 is prohibited from obtaining permission from the resident, or resident representative, for the use of restraints when the restraint is not necessary to treat the resident's medical symptoms.	F 604		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §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 §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 assess safety for 2 of 4 residents (R1, R4) following falls from recliner chairs. This resulted in actual harm for R1 who fell from a recliner chair and sustained lacerations and a brain bleed. Findings include: During observation on 11/21/23, at 3:05 p.m. R1 was lying on his back in bed. In the corner of the room was a manual recliner chair. R1's significant change Minimum Data Set (MDS) dated 10/19/23, identified moderate cognitive impairment and identified no behaviors. The MDS indicated R1 had upper extremity impairment on one side and was dependent on staff for transfers and toilet use. R1's care plan dated 11/7/23, identified a self	F 689	Both residents affected by the deficient practice were given Physical Device Data Collection and Review assessmnets to see if they were safe to use an electric lift chair. Both were noted to be unsafe in the chairs. R1's chair was removed from the room with wife's approval. R4's chair was disabled. Attachemnt 1. The care plans for both residents were reviewed and updated. There were 13 other residents that were identified with electric lift chairs that could be affected by the deficient practice. All residents were given the Physical Deveice Data Collection and Review assessmnet. 4 residents are appropriate to use the electric recliner. The other 9 residents were assessed to be unsafe. All were disabled. Families of all residents were notified and were in agreement. Care plans were all reviewed and updated as	12/15/23

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F 689	Continued From page 4 care deficit and a risk for falls. The care plan directed staff to use a ceiling lift for all transfers and encourage R1 to use a call light for assistance. The care plan further indicated R1 needed prompt response for all requests for assistance, non slip Dycem in his wheel chair and indicated he was on a 30 minute rounding schedule for safety. R1's Morse Fall Scale dated 10/19/23, indicated he was at high risk for falls, had fallen before and overestimated his limits. Facility Progress Note dated 6/16/23, indicated staff responded to R1's chair alarm and found him sitting on the floor in front of his recliner. R1 stated he slipped out of the chair. R1 had an abrasion to his right elbow. A facility document titled Post Fall Investigation Report dated 6/16/23, indicated R1 slipped out of his chair and identified an initial intervention of Dycem in chair. The root cause review section was not completed. Additionally, Post Fall investigation lacked enough evidence to determine if Dycem in chair was appropriate intervention (was chair fully inclined or reclined at time of fall). Facility Progress Note dated 7/19/23, indicated staff found R1 lying on the floor in front of his recliner. R1 stated he had been trying to get up and had raised the chair up high. R1 had an abrasion to his forehead and nose and two skin tears to his left elbow. A facility document titled Post Fall Questions dated 7/19/23, indicated R1 had raised his electric chair up to get out of it. Root Cause Review portion of the form was blank and document lacked identified intervention to prevent future falls.	F 689	necessary. To ensure that the deficient practice will not occur a Physical Device Data Collection and Review assessment will be done on all admissions and quarterly thereafter. The nurses will be educated and review the assessment on 12-14-24. Attachement 4. DON or designee will audit assessment completion upon admission and quarterly for three months. Results of audits will be reviewed at monthly QAPI/QA meetings.	

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F 689	Continued From page 5 Facility Progress Note dated 11/9/23, indicated staff responded to R1's call light and found him on the floor in front of his recliner. R1 had a laceration above his left eyebrow and was sent to the emergency department (ED). Other injuries included a skin tear to his left elbow, skin tear to left knee and skin tear to his finger. R1's ED to Hospital Admission Discharge Summary dated 11/10/23, indicated R1 suffered a small subarachnoid hemorrhage (bleeding in the space that surrounds the brain). During interview on 11/21/23, at 3:06 p.m. nursing assistant (NA)- A stated she was aware R1 had a fall history and stated she had heard "it's more when he is in the recliner." NA-A stated R1's recliner had been switched from a remote controlled to a manual recliner. NA-A said R1 like to push the buttons on the remote control and said when R1 needed to use the bathroom he would get very agitated and try to raise the recliner. During interview on 11/21/23, at 3:59 p.m. registered nurse (RN)-A stated R1 had a history of falls and said fall interventions included alarms and frequent rounding. RN-A said R1 had been known to throw himself on the floor when his significant other was gone for a few days. RN-A said during times when R1's significant other was gone staff watched him more and tried to keep him on common areas. RN-A said staff put R1 in the recliner and kept his remote out of reach because they had seen him raise his chair all the way up and then back down. RN-A said R1's power recliner had been removed from his room and replaced with a manual chair.	F 689		

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F 689	Continued From page 6	F 689		

Review of R1's care plan lacked evidence of history to throw himself on the floor or interventions related to more frequent rounding when significant other was out of town.

During interview on 11/21/23, at 4:05 p.m. NA-B stated R1 had always been extremity active and had admitted to the care center because of falls at home. NA-B said staff tried to keep R1 in the recliner with his feet up because he would lean forward and fall out of his chair.

During interview on 11/22/23, at 8:37 a.m. RN-B stated R1 had a fall history. RN-B said when R1's significant other was not at the facility staff "kept more eyes on him." RN-B stated when R1 had the most recent fall from the recliner his chair alarm was sounding and his call light had been on. RN-B said R1 previously had not used the buttons on his recliner. RN-B said the power chair had been removed after the last fall.

During interview on 11/22/23, at 9:46 a.m. NA-C stated she was aware R1 had fallen from his recliner chair but said no else had lately that she was aware of.

During interview on 11/22/23, at 9:53 a.m. licensed practical nurse (LPN)-A stated R1 had fallen from the recliner because his significant other was out of town. LPN-A said staff put R1 in a recliner and tucked the remote away or put him in a recliner without a remote. LPN-A said she was not aware of any criteria related to recliner chair safety.

R4's quarterly MDS dated 9/25/23, identified severe cognitive impairment and indicated she required substantial assistance from staff for

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 11/22/2023

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 689	Continued From page 7 transfers and toileting. R4's care plan dated 6/29/23, identified a self care deficit and a risk for falls related to cognitive impairment and balance problems. The care plan directed staff to ensure call light in reach, anticipate needs, and use of alarms. R4's facility Progress Note dated 10/23/23, indicated R4's alarm sounded and she was found on her hands and knees on the floor at the foot of the recliner which was still reclined. R4 was unable to verbalize what she was trying to do. Post Fall Questions dated 10/23/23, indicated R4 was in the living room by recliner and was found on the floor with the chair still reclined. During observation on 11/22/23, at 9:46 a.m. R4 was seated in a power recliner chair in a common area of the unit. NA-C stated R4 used an alarm because she was a fall risk and was "sneaky." NA-C said she had not seen R4 use the controls on the chair but she usually placed the control in the pocket of the chair out of R4's reach. When asked how she knew who was safe to be placed in a recliner chair and left unattended, NA-C stated, "I guess I just know." At 10:57 a.m. NA-C stated R4 could not operate the chair to get out of it safely. During interview on 11/22/23, at 11:57 a.m. the interim director of nursing (DON) stated the facility did not have a formal assessment tool for safety related to the use of recliners. The DON said after a fall from a recliner she would expect staff to make sure residents were safe to use the chairs. The DON stated she had not been aware R1's fall from the recliner was not his first one and had not been aware R4 had fallen from a	F 689		

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F 689	Continued From page 8 recliner chair. The DON said at the time of the first falls the residents should have been assessed and the chairs should have been removed. During interview on 11/22/23, at 12:59 p.m. RN-B stated no assessments or interventions had been implemented following R1 or R4's falls from the recliner. A device assessment policy was requested but not received.	F 689		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 6, 2023

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

Re: State Nursing Home Licensing Orders
Event ID: KKKR11

Dear Administrator:

The above facility was surveyed on November 21, 2023 through November 22, 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,

Kamala Fiske-Downing

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00797	A. BUILDING: _____ B. WING _____	11/22/2023

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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 11/21/23 through 11/22/23, 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 with no deficiency issued. H53297409C (MN97071) H53297406C (MN91558) The following complaints were reviewed. H53297187C (MN98460) with a licensing order issued at 0830. 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	2 000		

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2 000	Continued From page 2 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. 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		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to assess safety for 2 of 4 residents (R1, R4) following falls from recliner chairs. This resulted in actual harm for R1 who fell from a recliner chair and sustained lacerations and a brain bleed. Findings include:	2 830	Corrected.	12/15/23

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2 830	Continued From page 3 During observation on 11/21/23, at 3:05 p.m. R1 was lying on his back in bed. In the corner of the room was a manual recliner chair. R1's significant change Minimum Data Set (MDS) dated 10/19/23, identified moderate cognitive impairment and identified no behaviors. The MDS indicated R1 had upper extremity impairment on one side and was dependent on staff for transfers and toilet use. R1's care plan dated 11/7/23, identified a self care deficit and a risk for falls. The care plan directed staff to use a ceiling lift for all transfers and encourage R1 to use a call light for assistance. The care plan further indicated R1 needed prompt response for all requests for assistance, non slip Dycem in his wheel chair and indicated he was on a 30 minute rounding schedule for safety. R1's Morse Fall Scale dated 10/19/23, indicated he was at high risk for falls, had fallen before and overestimated his limits. Facility Progress Note dated 6/16/23, indicated staff responded to R1's chair alarm and found him sitting on the floor in front of his recliner. R1 stated he slipped out of the chair. R1 had an abrasion to his right elbow. A facility document titled Post Fall Investigation Report dated 6/16/23, indicated R1 slipped out of his chair and identified an initial intervention of Dycem in chair. The root cause review section was not completed. Additionally, Post Fall investigation lacked enough evidence to determine if Dycem in chair was appropriate intervention (was chair fully inclined or reclined at time of fall).	2 830		

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2 830	Continued From page 4 Facility Progress Note dated 7/19/23, indicated staff found R1 lying on the floor in front of his recliner. R1 stated he had been trying to get up and had raised the chair up high. R1 had an abrasion to his forehead and nose and two skin tears to his left elbow. A facility document titled Post Fall Questions dated 7/19/23, indicated R1 had raised his electric chair up to get out of it. Root Cause Review portion of the form was blank and document lacked identified intervention to prevent future falls. Facility Progress Note dated 11/9/23, indicated staff responded to R1's call light and found him on the floor in front of his recliner. R1 had a laceration above his left eyebrow and was sent to the emergency department (ED). Other injuries included a skin tear to his left elbow, skin tear to left knee and skin tear to his finger. R1's ED to Hospital Admission Discharge Summary dated 11/10/23, indicated R1 suffered a small subarachnoid hemorrhage (bleeding in the space that surrounds the brain). During interview on 11/21/23, at 3:06 p.m. nursing assistant (NA)- A stated she was aware R1 had a fall history and stated she had heard "it's more when he is in the recliner." NA-A stated R1's recliner had been switched from a remote controlled to a manual recliner. NA-A said R1 like to push the buttons on the remote control and said when R1 needed to use the bathroom he would get very agitated and try to raise the recliner. During interview on 11/21/23, at 3:59 p.m. registered nurse (RN)-A stated R1 had a history of falls and said fall interventions included alarms and frequent rounding. RN-A said R1 had been	2 830		

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2 830	Continued From page 5 known to throw himself on the floor when his significant other was gone for a few days. RN-A said during times when R1's significant other was gone staff watched him more and tried to keep him on common areas. RN-A said staff put R1 in the recliner and kept his remote out of reach because they had seen him raise his chair all the way up and then back down. RN-A said R1's power recliner had been removed from his room and replaced with a manual chair. Review of R1's care plan lacked evidence of history to throw himself on the floor or interventions related to more frequent rounding when significant other was out of town. During interview on 11/21/23, at 4:05 p.m. NA-B stated R1 had always been extremity active and had admitted to the care center because of falls at home. NA-B said staff tried to keep R1 in the recliner with his feet up because he would lean forward and fall out of his chair. During interview on 11/22/23, at 8:37 a.m. RN-B stated R1 had a fall history. RN-B said when R1's significant other was not at the facility staff "kept more eyes on him." RN-B stated when R1 had the most recent fall from the recliner his chair alarm was sounding and his call light had been on. RN-B said R1 previously had not used the buttons on his recliner. RN-B said the power chair had been removed after the last fall. During interview on 11/22/23, at 9:46 a.m. NA-C stated she was aware R1 had fallen from his recliner chair but said no else had lately that she was aware of. During interview on 11/22/23, at 9:53 a.m. licensed practical nurse (LPN)-A stated R1 had	2 830		

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2 830	Continued From page 6 fallen from the recliner because his significant other was out of town. LPN-A said staff put R1 in a recliner and tucked the remote away or put him in a recliner without a remote. LPN-A said she was not aware of any criteria related to recliner chair safety. R4's quarterly MDS dated 9/25/23, identified severe cognitive impairment and indicated she required substantial assistance from staff for transfers and toileting. R4's care plan dated 6/29/23, identified a self care deficit and a risk for falls related to cognitive impairment and balance problems. The care plan directed staff to ensure call light in reach, anticipate needs, and use of alarms. R4's facility Progress Note dated 10/23/23, indicated R4's alarm sounded and she was found on her hands and knees on the floor at the foot of the recliner which was still reclined. R4 was unable to verbalize what she was trying to do. Post Fall Questions dated 10/23/23, indicated R4 was in the living room by recliner and was found on the floor with the chair still reclined. During observation on 11/22/23, at 9:46 a.m. R4 was seated in a power recliner chair in a common area of the unit. NA-C stated R4 used an alarm because she was a fall risk and was "sneaky." NA-C said she had not seen R4 use the controls on the chair but she usually placed the control in the pocket of the chair out of R4's reach. When asked how she knew who was safe to be placed in a recliner chair and left unattended, NA-C stated, "I guess I just know." At 10:57 a.m. NA-C stated R4 could not operate the chair to get out of it safely.	2 830		

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2 830	Continued From page 7 During interview on 11/22/23, at 11:57 a.m. the interim director of nursing (DON) stated the facility did not have a formal assessment tool for safety related to the use of recliners. The DON said after a fall from a recliner she would expect staff to make sure residents were safe to use the chairs. The DON stated she had not been aware R1's fall from the recliner was not his first one and had not been aware R4 had fallen from a recliner chair. The DON said at the time of the first falls the residents should have been assessed and the chairs should have been removed. During interview on 11/22/23, at 12:59 p.m. RN-B stated no assessments or interventions had been implemented following R1 or R4's falls from the recliner. A device assessment policy was requested but not received. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could review/revise policies and procedures related to falls resulting from equipment to assure proper assessment and interventions are being implemented. They could re-educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		