DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

February 19, 2026

Administrator
WARROAD CARE CENTER
1401 LAKE STREET NORTHWEST
WARROAD, MN 56763

RE: CCN: 245329
Cycle Start Date: December 4, 2026

Dear Administrator:

On January 7, 2026, we notified you a remedy was imposed. On February 2, 2026 and February 17, 2026 the Minnesota Departments of Health and Public Safety completed revisits to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of February 2, 2026.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective March 4, 2026 did not go into effect. (42 CFR 488.417 (b))

In our letter of January 7, 2026, 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 was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from March 4, 2026, due to denial of payment for new admissions. Since your facility attained substantial compliance on February 2, 2026, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

December 29, 2025

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

RE: CCN:245329
Cycle Start Date: December 4, 2025

Dear Administrator:

On December 4, 2025, a survey was completed at your facility by the Minnesota Departments of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.

What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.

- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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

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

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

DEPARTMENT CONTACT

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

Susie Haben, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

If substantial compliance with the regulations is not verified by March 4, 2026 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by June 4, 2026 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161
Email: joanne.simon@state.mn.us

cc: File

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

December 29, 2025

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

Re: Event ID: 1DD026-H1

Dear Administrator:

The above facility survey was completed on December 4, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

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

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161
Email: joanne.simon@state.mn.us

cc: File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245329	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARROAD CARE CENTER	1401 LAKE STREET NORTHWEST , WARROAD, Minnesota, 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
F0000	INITIAL COMMENTS On 12/3/25 through 12/4/25, a standard abbreviated survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The following complaint was reviewed. H53299003C (2678746) with a deficiency issued at F600. As a result of the survey a deficiency was cited at F657. 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.	F0000		12/30/2025
F0600 SS = D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation 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)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary	F0600	In regard to this statement in the "standard is not met as evidenced by" area, "R2's Progress Note dated 11/25/25, indicated he had an episode of touching a female resident's breast. The medication administration record was updated to include: one to one staff supervision with male staff when in public areas." In reality, the medication administration record states: one to one staff supervision with male resident when in public areas. (see attachment-progress note) Plan of Correction: When the resident is out of the locked unit, resident will have one on one staff supervision and direction/assistance. When on Pine unit, resident is	12/30/2025

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 reverse for further 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245329	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/04/2025

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F0600 SS = D	Continued from page 1 seclusion; This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review the facility failed to implement care planned interventions to reduce the risk of abuse for 1 of 3 residents (R2) who had a history of inappropriately touching female residents. Findings include: R2's Transfer/Discharge Report indicated he admitted to the facility on 2/28/24. R2's diagnosis included adjustment disorder with depressed mood, vascular dementia, and muscle weakness. R2's quarterly Minimum Data Set dated 11/13/25, indicated he was independent with bed mobility, and required supervision to ambulate. R2's care plan dated 11/5/25, identified vulnerability related to functional limitations and poor impulse control and identified behaviors that included touching fellow female residents inappropriately. The care plan identified the use of a motion sensor and floor alarms. The care plan indicated R2 was to be provided one to one staff supervision in common areas to ensure his behaviors were appropriate and fellow residents were free from distress. R2's Progress Note dated 11/25/25, indicated he had an episode of touching a female resident's breast. The medication administration record was updated to include: one to one staff supervision with male staff when in public areas. During interview on 12/3/25 at 1:41 p.m., nursing assistant (NA)-B stated on 11/25/25, she heard the door alarm and saw R1 going down the hall in her wheelchair. NA-B stated the activity aide was with R1 and two other residents. NA-B saw R2's hand in the vicinity of R1's breast and moved his hand away. NA-B was not sure if R2 had his hand on R1's breast but said he had been reaching that way. NA-B stated some of the nurses had told her not to turn her back on R2 because he was "grabby." NA-B stated R2 was not dependent on staff and could ambulate independently. During observation on 12/3/25 at 4:18 p.m., R2 was in his room, lying down with his feet on the floor. R2's floor sensor alarm was approximately a foot away from his bed. Upon entrance and exit from room, R2's motion sensor did not activate.	F0600	Continued from page 1 one to one supervision. Resident will not be seated in direct proximity to female residents when sitting in common areas. WSLC staff will replace floor mat alarm with a bed alarm so when the stands up staff will be notified of resident getting out of be so assistance can be provided.	

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F0600 SS = D	Continued from page 2 During observation and interview on 12/3/25 at 4:22 p.m., NA-A stated R2 required standby assist and staff needed to watch him because he was inappropriate with other residents. NA-A stated R2 got up very quickly and had a monitoring system in his room to alert staff if he got up. R2's room was observed with NA-A who confirmed the motion sensor did not activate upon entrance or exit from the room. NA-A stated the motion sensor had not been turned on. Further NA-A acknowledged the floor mat was not next to the bed and stated R1 may have kicked it out of the way. NA-A said the floor mat should have been next to the bed. During interview on 12/3/25 at 4:27 p.m., licensed practical nurse (LPN)-A stated R2 had to be watched as he liked to touch people inappropriately. Staff supervised him to ensure he was away from female residents. LPN-A stated R2 had alarms to alert staff he left his room. During interview on 12/4/25 at 9:09 a.m., NA-C stated the purpose of R2's alarms was to know where he was, if R2 got up or if someone else was in his room so staff could intercept. NA-C stated R2 wandered on the unit. During observation on 12/4/25 at 9:13 a.m., R2's motion sensor activated. R1 had wheeled into his room. R2 was in the dining room at the time of the observation. Facility Policy Resident Abuse Prohibition Policy dated 11/24/24, defined sexual abuse as non-consensual sexual contact of any type with a resident. The policy indicated; It is the policy of WSLC that each resident will be free from abuse, neglect, mistreatment, exploitation and misappropriation of property. Abuse can include but is not limited to physical harm, pain, mental anguish, verbal abuse (derogatory terms), sexual abuse, or involuntary seclusion from any source. Additionally, residents will be protected from abuse, neglect, and harm while they are residing at the facility. No abuse or harm of any type will be tolerated, and residents and staff will be monitored for protection.	F0600		
F0657 SS = D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the	F0657	Original Plan of Correction: Comprehensive care plans were revised and updated to include mood and behaviors, target behaviors, and interventions that are effective for managing behaviors in dementia residents. (see attachment-care plan) Care plan has been update for staff to remove resident	01/09/2026

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F0657 SS = D	Continued from page 3 comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review the facility failed to develop care planned interventions for 1 of 3 residents (R1) reviewed who displayed behaviors toward other residents. Findings include: R1's Transfer/Discharge Report indicated she admitted to the facility 3/27/25. R1's diagnosis included adjustment disorder, delusional disorders, and dementia. R1's quarterly Minimum Data Set (MDS) dated 9/23/25, indicated she was independent with wheelchair mobility on the unit. The MDS indicated R1 displayed physical, verbal and other behaviors. R1's care plan dated 10/31/25, indicated she was taking psychotropic medications for treatment of behavioral symptoms related to dementia, severe agitation and delusional disorder. The care plan lacked a behavior care plan.	F0657	Continued from page 3 from confrontational situations immediately. Staff to observe resident closely if becoming irritated/agitated with others and intervene as needed. Redirection or distraction with snacks or “babies” will be provided as needed. Additional Plan of Correction for follow up question: Care plan changes are initially discussed in IDT meetings. Care coordinator provided written change to staff (see attached). Moving forward changes will be provided both in PCC communication notes as well as in writing to staff.	

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F0657 SS = D	Continued from page 4 R1's Progress Notes identified the following: 10/27/25, R1 was wandering around the household going into other resident's room. 11/5/25. R1 was wandering around the household, collecting anything she liked along the way. 11/5/25, R2 was found in another resident's room washing her clothes that were covered in feces. 11/6/25. R1 had an altercation with another resident during supper time. R1 got upset and slapped R3 on the arm. R3's quarterly MDS dated 11/25/25 indicated a diagnosis of Early onset Alzheimer's and Severe Dementia with anxiety. During observation on 12/4/25, R1 was propelling on the unit in her wheelchair stating, "I have no place to go." At 7:54 a.m., R1 approached survey and when asked, stated "I am fine, I have my baby (referring to a stuffed dog)." R1 also had a banana, spoon, clothing protector and a newspaper on her lap. At 9:13 a.m., another resident's motion sensor activated as R1 entered the resident's room. During interview on 12/4/25 at 12:46 p.m., licensed practical nurse (LPN)-B stated R1 could be a little "spicy." LPN-B said when she was "in a mood" she tried to keep R1 and R3 away from each other. LPN-B said R1 and R3 had an incident at the dinner table one time and said they had no problem swearing at each other. Facility policy Comprehensive Care Plans dated 12/22/24, indicated It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident’s medical, nursing, and mental and psychosocial needs that are identified in the resident’s comprehensive assessment. The comprehensive care plan will include measurable objectives and timeframes to meet the resident’s needs as identified in the resident’s comprehensive assessment. The objectives will be utilized to monitor the resident’s progress. Alternative interventions will be documented, as needed.	F0657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **12/04/2025**

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20000	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 12/3/25 through 12/4/25, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was in compliance with the MN State Licensure. The following complaints were reviewed during the survey. H53299003C (2678746) Minnesota Department of Health is documenting the State	20000		12/31/2025

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

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **12/04/2025**

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20000	Continued from page 1 Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	20000		