

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 12/04/2025
NAME OF PROVIDER OR SUPPLIER Warroad Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1401 Lake Street Northwest Warroad, MN 56763	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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.

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

TITLE

(X6) DATE

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE]. R2's diagnosis included adjustment disorder with depressed mood, vascular dementia, and muscle weakness.R2's quarterly Minimum Data Set, dated [DATE], 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. 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.</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE], 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. 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 [DATE] 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.</p>		