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	12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Warroad Care Center	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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure staff completed COVID-19 self-testing per manufacturer guidelines and Centers for Disease Control (CDC) guidelines for 13 of 19 staff (DA-B, DA-C, HSKG-A, HSKG-B, LA-A, NA-J, NA-O, NA-P, LPN-B, LPN-C, RN-C, administrator) observed to complete COVID-19 testing. This had the potential to affect all residents residing in the nursing home. Findings include:The facility Line List dated [DATE], identified 15 residents had tested positive for COVID-19 since [DATE] and the facility was in current outbreak status.During an interview on [DATE] at 1:51 p.m., licensed practical nurse (LPN)-B stated she was informed a resident tested positive for COVID-19 when she arrived at the facility on [DATE] at approximately 7:30 a.m. Day shift staff were already at the facility, LPN-B placed the testing supplies at the timeclock and asked staff to test as they came on to their shift. LPN-B stated she was told staff had tests available on each wing in the nurses' stations and a lot of staff went to the nurses' stations to test themselves. LPN-B did not educate staff on how to do the testing correctly and stated I didn't feel like I needed to teach them how to do that because staff had been testing since the beginning of the pandemic. New staff had also been testing since [DATE] and LPN-B didn't teach them how to test correctly either because there were directions in the box. The CorDx COVID-19 Ag Test Quick Reference Instructions revised [DATE], identified the following instructions for use: Wash hands before testing. Check expiration date on the package. Do not use expired test kit! Remove the test cassette from the pouch and place it on a clean, flat surface. Insert the tube in the pre-made hole on the back of the kit box. Remove the foil from the top of the tube. Remove the swab from the pouch. Carefully insert the swab tip into one nostril about 1/2 to 3/4 inch. Firmly and slowly rotate the swab 5 times; brushing against the inside walls of the nostril to ensure both mucus and cells are collected. Do not push the swab further if you meet resistance. Using the same swab, repeat the process for the other nostril to ensure an adequate sample was collected from both nostrils. Insert the swab in tube to the bottom. Rotate the swab at least 10 times while pressing the swab head against the bottom and side of the tube. Remove the swab while squeezing the sides of the tub to express as much liquid as possible from the swab. Attach the drop tip firmly onto the tube. Gently squeeze the tube and dispense 3 drops of solution into the sample well. A false negative or invalid result may occur if less than 3 drops of fluid are added to the sample well. Wait 10 minutes. Read the result at 10 minutes. Do not read the result after 30 minutes. The result is valid when read at 10-30 minutes. If a positive result is obtained within 10 minutes, it should also be considered valid. Serial testing should be performed in all individuals with negative results; Individuals with symptoms of COVID-19 and initial negative results should be tested again after 48 hours. Individuals without symptoms of COVI0-19, and with initial negative results, should be tested again after 48 hours and. if the 2nd test is also negative, a 3rd time after an additional 48 hours. You may need to purchase additional tests to perform this serial (repeat) testing. If you test negative but continue to have symptoms of COVID-19, and both your first and second tests are negative, you may not have COVID-19, however you should follow-up with your healthcare provider. If your test is positive, then proteins from the virus that (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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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	causes COVID-19 have been found in your sample, and you likely have COVID-19.Staff testing was observed on [DATE] and identified the following:At 5:50 a.m., dietary aide (DA)-A entered the building at the timeclock entrance and put on a surgical mask. DA-A then opened a large box containing multiple CorDx COVID Ag tests. DA-A carried a test box into the breakroom where two staff were already sitting unmasked.At 5:52 a.m., housekeeping (HSKG)-A entered the building and stood at the timeclock. I'm new here. Well, new enough. HSKG-A put on a surgical mask and brought a test with her. The other staff left the breakroom.At 5:53 a.m., DA-A completed the test and laid the soiled testing products on the table. DA-A used both swabs in the test box. At 5:54 a.m., DA-A explained to HSKG-A how to do the COVID-19 test by whispering together by the sink. DA-A threw away her tests and wrote negative next to her name on the form. DA-A did not clean the table after throwing away her soiled testing supplies. However, DA-A collected the test result after 2 minutes. At 5:55 a.m., HSKG-A opened the package, then used a swab to swab her nostril for less than 10 seconds. HSKG-A swished the swab in the tube and poured the entire contents of the tube onto the sample well. HSKG-A used the second swab and repeated the process. At 5:58 a.m., DA-B entered the breakroom with a test. HSKG-A threw away her test and wrote negative next to her name on the form. HSKG-A then stated, why is the table so dirty when we're all adults? However, HSKG-A did not clean the table and collected the test result after three minutes. HSKG-A stated she had tested before. Why did I do it wrong? Stated the first time she tested; she came to work and there were four people standing at the timeclock and everyone just did it together. At 6:00 a.m., DA-B completed the test by using both swabs in the test box.At 6:01 a.m., DA-C entered the breakroom with a test. DA-C used one swab to collect the test sample At 6:02 a.m., DA-B stated negative and left the breakroom after throwing away her test. DA-B did not clean the table after throwing away her soiled testing supplies. However, DA-B collected the test result after 2 minutes. At 6:04 a.m., DA-C threw away her test supplies then cleaned the table with a sanitizing disposable wipe. DA-C stated her test was negative. However, DA-C collected the test result after 3 minutes. At 6:09 a.m., NA-S entered the breakroom and stated she collected her test at home. That way I get into work faster. At 6:15 a.m., DA-D stated her test was negative, threw away her soiled supplies and wrote the result next to her name on the form. DA-D cleaned the table with a sanitizing disposable wipe. NA-S returned to the timeclock and pulled her test from her pocket. NA-S stated she always brought her test with her to show she was not lying that she was negative. I just feel if I have COVID-19, I shouldn't bring it into the building.At 6:21 a.m., NA-P entered the building. NA-P put on a surgical mask and brought a test into the breakroom. NA-P opened the test package and stated there were two tests in each box. I was so confused. NA-P was unsure if there was a swab for each nostril. NA-P rotated the swab in her nares x 5, then repeated on the other side. NA-P then swished the swab in the tube. NA-P dispensed 10 drops of solution into the sample well. NA-P set her phone time for 10 minutes then set the test down on the table. At 6:26 a.m. HSKG-B entered the breakroom and sat down next to NA-P. HSKG-B rotated the swab 5 times in each nares then swished the swab in the test tube.At 6:28 a.m., LPN-C collected her test sample while standing at the timeclock and then carried the test in her hand and stood in the breakroom doorway. At 6:28 a.m., NA-P stated she would just take the test with her and placed the test in her pocket. NA-P went to B wing before having a test result. HSKG-B left the breakroom and went down the hall. At 6:29 a.m., RN-C entered building and picked up a test. LPN-C stated she was negative, threw her test away and then wrote her result on the form next to her name. RN-C rotated the swab in each nares 5 times and then swished the swab in the tube for approximately 30 seconds, then dropped 10 drops of solution into the sample well. RN-C threw away his testing supplies and placed the test on the breakroom windowsill. At 6:32 a.m., NA-J rotated the swab in each nares 5 times, then swished the swab in the tube for approximately 20-30 seconds, then dropped 10 drops of test solution into the sample well.At 6:33 a.m., RN-C stated his test was negative and threw away his test after 4 minutes.At 6:34 a.m., NA-O and NA-T stood at the timeclock together and completed their tests. HSKG-B returned to the timeclock and wrote her negative result on the form.At 6:38 a.m., NA-A and (continued on next page)

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LSW opened the test package and inserted a swab into her nares approximately 3/4 inch, rotated the swab 10 times, then swished the swab in the tube for approximately 30 seconds. LSW then placed 5 drops of test solution into the sample well and set a timer for 10 minutes. LSW stated staff tested in the breakroom. If there were a lot of people testing. LSW would probably take her test to her office and test there. LSW stated she had been educated on testing by LPN-B but had read the instructions the first time she did it.At 7:11 a.m., laundry aide (LA)-A stood at the timeclock to test. LA-A rotated the swab in each nares 4 times, swished the swab in the tube 5 times, then placed 10 drops of test solution in the sample well. At 7:15 a.m., LA-A wrote negative results on the form after 4 minutes and stated, I'll hang on to it for a while. LA-A picked up her test and began walking down the hall. LA-A then stated she guessed she could wait in the breakroom. LA-A sat down with LSW and laid the test on the table. At 7:18 a.m., LSW's timer sounded. LA-A asked how long to wait, 10 minutes? LSW replied yes, 10 minutes. LSW threw away her test supplies and wrote her negative result on the log. At 7:20 a.m., LA-A threw away her test after 9 minutes and went to the floor for her shift. LA-A did not clean the table. At 7:30 a.m., LPN-B entered the building and punched in at the timeclock.At 7:31 a.m., LPN-B pulled out a test. At that time, the administrator entered the building, grabbed a test and went to her office. The administrator stated I'll be back. I just need to put this in my office.At 7:33 a.m., LPN-B rotated the swab in each nostril 5 times, swished the swab in the tube and dropped the solution into the sample well. LPN-B then used hand sanitizer. At 7:34 a.m., the receptionist stopped at the timeclock and punched. LPN-B was standing at the timeclock as well without wearing a surgical mask. The receptionist rotated the swab in each nares, then put on the surgical mask after LPN-B put on a surgical mask. The receptionist then placed the swab into the tube and swished the swab, then dropped the solution into the sample well.At 7:37 a.m., the administrator returned with her test in her hand with a surgical mask on.At 7:39 a.m., LPN-B picked up her test and threw it in the trash, then wrote negative on the form. However, LPN-B collected the test result after 6 minutes. At 7:40 a.m., the receptionist wrote negative on the form and threw her test away. The administrator looked at her test, threw it in the trash and wrote negative on the form. The administrator stated she usually did test in her office because it was just right there. The administrator stated there usually wasn't a bunch of staff all at the same time but guessed they try to space apart. Is doing it in my office not ok? Even if it's right there? I have a mask on. During an interview on [DATE] at 7:55 a.m., LPN-B stated staff were not testing correctly. Staff should not go into their office to test. I thought after 5-6 years they would know how to do it. Staff were expected to wait the full 10 minutes. There were two tests in each box and staff should be social distancing when they test. It's just a lot. LPN-B stated they could not ensure staff were not working while positive for COVID-19 because they were not testing correctly. We just can't. During an interview on [DATE] at 8:18 a.m., the DON stated the facility needed to do facility wide staff education related to testing. They have all been exposed with the risk of covid. Potentially, there was a risk of staff coming to work sick.During an interview on [DATE] at 8:42 a.m., the administrator stated she expected staff to test accurately and to follow CDC guidelines. It's interesting people didn't know through all this time how to test. The administrator stated she expected staff to be competent in testing and be able to test accordingly before they entered the building. The facility Infectious Disease Outbreak Policy revised [DATE], identified outbreak surveillance and control is a high priority for the Infection Prevention and Control Program. When one (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	resident test positive for and any others exhibit similar symptoms of any type of infectious illness, an outbreak within the facility will be considered. Resident and staff illnesses will be monitored by the WSLC Infection Preventionist, since healthy personnel may acquire and transmit virulent pathogens. When a resident or resident has been identified to have a new cough or new shortness of breath and/or a fever (temperature >100 degrees), [NAME], tests will be performed in coordination and under the direction of [NAME], a medical provider and local Emergency Department. CDC and [NAME] guidance will be followed for all staff and resident testing based on community and facility positivity rates/cases.The CDC guidelines Infection Control Guidance: SARS-CoV-2 for HealthCare Providers dated [DATE], identified Source control is recommended more broadly as described in CDC's Core IPC Practices in the following circumstances: By those residing or working on a unit or area of the facility experiencing a SARS-CoV-2 or other outbreak of respiratory infection; universal use of source control could be discontinued as a mitigation measure once the outbreak is over (e.g., no new cases of SARS-CoV-2 infection have been identified for 14 days); or Facility-wide or, based on a facility risk assessment, targeted toward higher risk areas (e.g., emergency departments, urgent care) or patient populations (e.g., when caring for patients with moderate to severe immunocompromise) during periods of higher levels of community SARS-CoV-2 or other respiratory virus transmission (See Appendix) Optimize the Use of Engineering Controls and Indoor Air Quality: Optimize the use of engineering controls to reduce or eliminate exposures by shielding HCP and other patients from infected individuals (e.g., physical barriers at reception / triage locations and dedicated pathways to guide symptomatic patients through waiting rooms and triage areas). Take measures to limit crowding in communal spaces, such as scheduling appointments to limit the number of patients in waiting rooms or treatment areas.The CDC guidelines Interim Guidelines for Collecting and Handling of Clinical Specimens for COVID-19 Testing: for Health Care Providers dated [DATE], identified: For healthcare providers who are handling specimens but are not directly involved in collection (e.g. handling self-collected specimens) and not working within 6 feet of the patient, follow Isolation Precautions. Healthcare providers should wear a form of source control (face mask) at all times while in the healthcare facility. Healthcare providers can minimize PPE use if patients collect their own specimens while maintaining at least 6 feet of separation. For example, the provider should wear a face mask, gloves, and a gown.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to follow Centers for Disease Control (CDC) guidelines including transmission-based precautions and documenting testing procedures 7 of 14 (R11, R16, R43, R34, R41, R20, R14) reviewed for COVID-19 procedures; and failed to ensure 26 of 50 staff (RN-A, RN-B, LPN-A, NA-A, NA-C, NA-D, NA-E, NA-F, NA-G, AA-A, LPN-A, NA-B, NA-G, NA-H, RN-D, NA-J, administrator, DON, RN-C, LPN-B, TMA-A, NA-I, NA-K, NA-L, NA-M, NA-N) were tested according to CDC broad based testing guidelines; and the facility failed to monitor and track staff illness for 2 of 2 (AA-A, AA-B) staff who called in during a COVID-19 outbreak; and the facility failed to ensure resident signs/symptoms of illness were tracked during monthly surveillance for 2 of 14 (R19, R35) residents reviewed for illness. In addition, the facility failed to ensure residents were provided an FDA skin-safe approved hand sanitizer during meals. These practices had the potential to affect all residents residing in the nursing home. RESIDENT COVID-19 PROTOCOLS:R11R11's quarterly MDS dated [DATE], identified R11 was [AGE] years old, had a moderate cognitive impairment and diagnoses that included Alzheimer's disease, obesity, heart failure, and venous insufficiency.R11's nursing progress notes identified the following:12/7/25 at 9:30 p.m., R11 had a non-productive cough this evening, showed no other signs of illness until 9:35 p.m., when a nursing assistant summoned this author reporting R11 had a temperature of 101 degrees F. Upon assessment R11was febrile with a temperature of 100.8 degrees F. R11's scheduled dose of Tylenol (an antifever medication) 1000 milligram (mg) was given prior at 8:09 p.m. A rapid COVID-19 test was done and came back positive. Blood pressure 130/77, pulse 67, respirations 24, temperature 101.0 degrees F and oxygen saturations 93 percent on 2 liters (L) of oxygen.12/7/25 at 10:54 p.m., R11's wife was notified of R11's condition.12/8/25 at 12:30 a.m., writer was updated by the evening nurse regarding the R11's status and condition, prompting an immediate assessment. Upon evaluation, R11 presented as weak and pale, with noticeably decreased responsiveness and appearing disoriented. Respiratory effort was significantly compromised; breathing was labored, uneven, and shallow. R11 was observed repeatedly lifting his left arm and puffing his chest with each breath, indicating increased work of breathing and use of accessory muscles. Lung sounds were diminished throughout all fields upon auscultation. Despite being on 2L per nasal cannula, R11 was unable to maintain oxygen saturation levels above 90%, indicating inadequate oxygenation. Writer notified R11's wife of the change in condition and recommended sending the R11 to the emergency department for further evaluation and treatment. The family agreed with the plan. Writer then contacted EMS. EMS arrived at the facility at 12:00 a.m. and departed with R11 on a gurney at 12:15 a.m. The transfer from bed to gurney required extensive assistance and was completed with the support of 2 EMS personnel and 2 facility staff members. Vitals: blood pressure 144/77, pulse 66, temperature 101.1F, respirations 20, and oxygen saturations 82 percent on 2L per nasal canula.12/8/25 at 3:09 a.m., a hospital nurse updated writer of R11's status. R11 will be admitted family were informed as per life care nurse. Diagnosis COVID-19, pneumonia and pleural effusion (the accumulation of fluid in the pleural space around the lungs, which can lead to breathing difficulties). Nurse coordinator updatedDuring an interview on 12/16/25 at 6:13 p.m., nursing assistant (NA)-Q stated R11 was coughing earlier in the evening at supper in the dining room. You could tell R11 was distressed. Then, R11 was supposed to have a bath that night. R11 wasn't doing well. R11 was confused and coughing more. When R11 was in bed, NA-Q notified the nurse of R11's condition.The medical record failed to identify R11 was placed on transmission-based precautions when symptoms were identified. R41R41's quarterly MDS dated [DATE], identified R41 was [AGE] years old, had a mild cognitive impairment and diagnoses that included Alzheimer's disease, and Downs syndrome.R41's nursing progress notes identified the following:12/8/25 at 1:47 p.m., consent obtained for Covid-19 testing, results were negative. Will continue to monitor.12/10/25 at 8:15 p.m., consent obtained for Covid testing earlier day shift, results were negative. This evening (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	R41 had a hoarse voice, did an antigen test and there was a barely visible positive line. R41 put on isolation. Plan of care on going.12/10/25 at 8:39 p.m., R41 tested positive for COVID-19 on 12/10/25 evening shift. Isolation precautions were in place per CDC regulations regarding a positive COVID-19 test. R41 was in a single room with no roommate and private bathroom; all services including meals and medications were brought to R41's room and R41 was encouraged to remain in her room (not very happy about it). R41 had staff that wore personal protective equipment (PPE) for airborne precautions. Staff monitored every shift for symptoms/complications related to COVID-19 virus. R41 active and alert but had a hoarse voice and a sore throat. Temperature 97.2 degrees F, respirations 15, pulse 59, and oxygen saturations at 92 percent on room air. Fluid and rest encouraged. Family notified of R41's status.12/11/25 at 10:23 p.m., R41 remained in room due to COVID-19. R41 remained alert with no changes in cognitive status. Appetite was good this evening. Continued to have cough and hoarse voice. R41 had no concerns this evening.12/15/25 at 7:52 p.m., R41 was observed to be experiencing increased coughing, a noticeably hoarse voice, and a runny nose throughout the shift. R41 reported feeling mildly congested. Denied shortness of breath, chest pain, or any new or significant discomfort. No noticeable fever at this time, and the R41 was alert and oriented to x3.12/15/25 at 8:22 p.m., consent obtained for COVID-19 testing, result was positive.12/19/25 at 9:47 p.m., R41 upset, not understanding why she had to be in isolation. Stated I didn't do anything wrong; I am fine. This is day 8 of isolation. R41 was not coughing at this time and was afebrile. Consented to Covid test and results were negative. R41 begged to come out of room. R41t agreed to wear a mask when out of room and agreed to eat at a table in the living room. Staff would remind R41 to wear her mask. Will retest on 12/19/25 to follow up.During an observation on 12/15/25 at 1:28 p.m., R41 stated she was just off precautions due to COVID-19 today. R41 was in the dining room eating lunch. R41 was seated at a small table with another resident seated across from her. R41's eyes are red rimmed. R41 denied itching or burning. R41 had an occasional loose sounding cough. R41's face was flushed and did not appear to be feeling well. On 12/15/25 at 4:18 p.m., nursing assistant (NA)-Q stated when he came in that morning R41 was off precautions. R41 was excited to be coming off precautions yesterday and was feeling ok yesterday but R41 did not look well. R41 wasn't acting right, R41's face was all red and kind of drawn. NA-Q was not sure why R41 came off precautions and would have to ask the nurse. R41 was coughing a lot when she first got sick but not so much anymore. NA-Q checked R41's temperature which was 98.3 degrees F. On 12/15/25 at 4:47 p.m., RN-D stated R41 was allowed to come out of isolation because R41 no longer had symptoms of COVID-19, and it had been 5 days since she tested positive for COVID-19. Business office assistant greeted R41 and stated, every time I see you today, you seem stuffier and stuffier. R41 stated she was ok. R41 was very congested, voice was hoarse and reddened face. RN-D stated R41's temperature that day was 98.2 degrees F.At 5:05 p.m., R41 was in the lobby area sitting with eyes closed. R41 was coughing heavily and sniffling At 5:09 p.m., R41 was wandering about the dining room without a mask, making coffee and sat down at her table with another resident seated directly across from her. At 5:23 p.m., R41 was coughing in the dining room. R41 made no attempt to cover her cough. R41 was up and down, filling her cup with water at water dispenser and coffee dispenser. At 6:10 p.m., RN-D stated no one directed him to offer R41 a mask to wear since out of isolation that day or to keep R41 away from other residents. RN-D stated R41 would wear a mask if offered one. During an interview on 12/15/25 at 5:47 p.m., LPN-B stated R41 tested positive for COVID-19 on 12/10/25 and was in isolation for 5 days but staff couldn't keep R41 in isolation any longer. LPN-B suggested R41 wear a mask, but R41 refused, and LPN-B couldn't make R41 wear a mask. LPN-B stated she was unaware R41 would sit in the dining room and LPN-B stated she had not directed staff to keep R41 away from other residents. LPN-B was unaware if other staff had encouraged R41 to wear a mask either. LPN-B thought R41 would eat in the living room area. The facility liked to keep all positive COVID-19 residents in transmission-based precautions for 7-10 days, but it was hard enough keeping R41 in for 5 days. R41 had been walking down to LPN-B's office that morning and when LPN-B told R41 she needed to go (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	back to the unit, R41 stated it had been 5 days, and she couldn't stay in her room anymore. Staff should have been offering a mask every time R41 was out of her room. R41 was a tough one. R41 fought staff on everything, and staff did not want to hurt R41's feelings. Today was not a good day.R16's medical record lacked evidence on how the facility staff were managing R16's symptoms to try and mitigate transmission to others on the unit. R16R16's quarterly MDS dated [DATE], identified R16 was [AGE] years old, had a moderate cognitive impairment and diagnoses that included Alzheimer's disease.R16's nursing progress notes identified the following:12/9/25 at 8:20 p.m., R16 tested positive for COVID-19. Isolation precautions were in place per CDC regulations regarding a positive COVID-19 test. R16 was in a single room with no roommate and private bathroom; all services including meals and medications were brought to R16's room and R16 was encouraged to remain in her room. R16 had staff that wore PPE equipment for airborne precautions. Staff monitored every shift for symptoms/complications related to COVID -19 virus. R16 tired, weak, had a poor appetite, hoarse voice and clammy. Temperature 97.3, respirations 20, and oxygen saturations at 91 percent on room air. Fluid encouraged when awake. Family notified of R16's status.12/10/25 at 6:23 a.m., R16 afebrile, denied pain or discomfort. No complaints shortness of breath or chest pain. R16 did vomit once. Will continue to monitor.12/10/25 at 3:15 p.m., R16 afebrile this shift, ate 100% for breakfast about 25% for lunch. Tired, periodic twitching, congested, as needed tussin (a medication that helps loosen phlegm and think bronchial secretions) given. Plan of care on going.12/10/25 at 10:02 p.m., R16's temperature was 101.1 degrees F later this shift, pulse 102, 02 91percent on room air, and respirations 20. As needed tussin given. R16 looked pale and clammy, awake most of the shift watching television and tinkering with her blanket. Fluid and rest encouraged. Plan of care on going.12/11/25 at 5:16 a.m., writer sending R16 to the emergency room (ER) for further management and evaluation. R16 was noted having shortness of breath. Oxygen saturations 81 percent at room air. R16 started oxygen at 2L per nasal canula, and oxygen saturations increased to 85 percent. Pulse 138, wheezing noted. Family updated on R16's condition.12/11/25 10:16 a.m., received nurse to nurse report identifying R16 would return to the facility on comfort cares.12/11/25 11:10 a.m., R16 returned to facility around 10:50 a.m. via ambulance. Upon arrival R16 was awake, smiling, and with eyes open. R16 transferred to her bed with assist of 4, hygiene cares completed and tolerated well. Oxygen saturations 95% on 4L per nasal cannula, pulse 112, temp 97.8. R16 tolerated care well, no signs of acute distress noted at this time. New orders for Morphine 10mg every 2 hours as needed for pain. Xanax (an antianxiety medication) 13mg every 2 hours as needed for anxiety and 1 drop of atropine every hour as needed for secretions. Family at bedside.12/11/25 at 9:06 p.m., R16 had involuntary limb movement. Grimacing at times. Morphine given for comfort/pain per order.12/11/25 at 10:16 p.m., R16 was awake on and off this shift. Involuntary movements noted to extremities. Facial expression appeared to be fearful/anxious at times. Ativan and morphine given per orders. Family has been present this shift. Vitals stable. Afebrile. Continued oxygen therapy keeping sats above 90%.12/12/25 at 4:44 p.m., R16 continued to have involuntary muscle movements. Family reported R16 reporting she was having pain today. Family requested to continue with scheduled morphine every 2 hours along with Ativan every 4 hours as felt this was helpful to resident relax with less muscle spasticity.12/14/25 at 6:59 a.m., R16 received as needed morphine 0.5 ml every hour this shift. As needed Ativan 0.25ml every 4 hours. Respirations remain regular but shallow. Per discussion with daughters, oxygen was removed 2:00 a.m. as R16 oxygen saturations were 78-80 percent at 11:00 p.m. Pulse remains elevated at130-140. Temperature noted to be elevated at103.2 degrees F at 3:00 a.m. Day shift nurse to give Tylenol suppository. R16 was resting comfortably all shift. Turned and repositioned every 2 hours. Family at bedside.12/14/25 at 09:34 AM, R16 was found unresponsive in bed with no signs of life. No respiratory effort was noted, and heart and lung sounds were absent upon auscultation.R16's medical record failed to identify if she had been tested for COVID-19 during outbreak testing on 12/8/25.R43R43's quarterly MDS dated [DATE], identified R43 was [AGE] years old, had a severe cognitive impairment and had diagnoses that included dementia.R43's nursing (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	progress notes identified the following:12/10/25 at 8:18 a.m., R43 tested positive for COVID on 12/10/25. Isolation precautions were in place per CDC regulations regarding a positive COVID test. Staff attempted to isolate R43 as best as possible. R43 was in a single room with no roommate and private bathroom; all services including meals and medications were brought to R43's room and R43 was encouraged to remain in her room. R43 had staff that wore PPE equipment for airborne precautions. Staff monitored every shift for symptoms/complications related to COVID virus. R43 active and alert but had a hoarse voice. Temperature 97.6 degrees F, respirations 16, and oxygen saturations 93 percent on room air. Fluid encouraged when awake. Plan of care on going.12/10/25 at 4:10 p.m., Writer notified R43's family notified of R43 status.R43's medical record failed to identify if R43 was tested for COVID-19 during outbreak testing on 12/8/25.R34R34's annual MDS dated [DATE], identified R34 was [AGE] years old, had a moderate cognitive impairment and diagnoses that included dementia, hemiplegia, DMII, and hypothyroidism.R34's nursing progress notes identified the following:12/10/25 at 3:23 p.m., R34 tested positive for COVID on 12/10/25. Isolation precautions were in place per CDC regulations regarding a positive COVID-19 test. Staff tried our best to quarantine R34. R34 was in a single room with no roommate and private bathroom; all services including meals and medications were brought to R34's room and R34 was encouraged to remain in her room. R34 had staff that wore PPE equipment for airborne precautions. Staff monitored every shift for symptoms/complications related to COVID-19 virus. R34 active and alert but have a hoarse voice, and yelling for help, help. Temperature 97.8 degrees F, respirations 18, and oxygen saturations 97 percent on room air. Fluid encouraged as R34 would allow. Plan of care on going.12/10/25 at 4:02 p.m., family notified of R34's status.12/11/25 at 10:12 p.m., R34 remained in isolation due to COVID-19 diagnosis. Vitals stable. R34 active and alert. Poor appetite this evening. Hoarse voice with occasional cough. R34 did not appear in any type of distress.R34's medical record failed to identify if R34 was tested for COVID-19 during outbreak testing on 12/8/25.R14R14's quarterly MDS dated [DATE], identified R14 was [AGE] years old, had a severe cognitive impairment and diagnoses that included Alzheimer's disease, sleep apnea, chronic kidney disease, and hypertension.R14's nursing progress notes identified the following:12/12/25 at 4:15 p.m., Consent obtained for COVID-19 testing. R14 tested positive.12/15/25 at 1:19 p.m., R14 tested positive of COVID-19 on 12/12/25. Today, R14 was afebrile with no signs or symptoms of COVID-19. R14 was noncompliant to current isolation precautions as he continued to get out of his room multiple times.During an observation on 12/15/25 at 1:46 p.m., R20 was seated in the common area next to R14. Neither resident was wearing a face mask and were talking back and forth constantly. Staff did not attempt to intervene or encourage either resident to wear a mask.At 2:03 p.m., staff walked up to R20, stated R20 needed to stay away from R14, then asked R14 if he wanted to look at the snow before walking away with R14. At 4:30 p.m., R20 was standing in the dining room area, talking with R14. Neither resident was wearing a mask. During an interview on 12/16/25 at 10:02 a.m., RN-C there were six residents positive for COVID-19. Most of the residents stayed in their rooms, they listened to staff and knew they needed to stay in their rooms. R20 and R14 were observed seated in the dining room. Neither resident was wearing a mask.During an observation on 12/17/25 at 7:50 a.m., R14 was seated in the dining room without a mask and waiting for his morning meal.On 12/17/25, at 7:51 a.m., R20 walked out of his room and into the dining room to sit across the table from R14. Both began eating their meal. During an observation on 12/16/25 from 6:30 pm through 8:00 pm observed R20 and R14 walking up/down the hallway or seated in the recliners in the common areas. R14 had a loose, non-productive cough. R20 also had a loose, non-productive cough but was less than R14. Staff did not attempt to encourage either resident to wear a mask.R20 R20's quarterly MDS dated [DATE], identified R20 was [AGE] years old, had a severe cognitive impairment and diagnoses that included dementia, obstructive sleep apnea and atrial fibrillation (irregular heartbeat).R20's nursing progress notes identified the following:12/10/25 at 1:20 p.m., R20's COVID-19 test was negative.12/12/25 at 6:49 p.m., R20's COVID-19 covid test was negative.12/16/25 at 12:07 p.m., received a text message from R20's family (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to provide the most recent Centers for Disease Control (CDC) education regarding the potential risks and benefits of the pneumococcal vaccine for 4 of 5 residents (R11, R13, R32, R35) reviewed for immunizations. Findings include:The Centers for Disease Control and Prevention (CDC) Pneumococcal Vaccine Recommendations dated 10/26/24, identified a pneumococcal vaccination was recommended for adults 50 years or older. Based on shared clinical decision-making, adults 65 years or older have the option to get PCV20 or PCV21, or to not get additional pneumococcal vaccines. They can get PCV20 or PCV21 if they have received bothPCV13 (but not PCV15, PCV20, or PCV21) at any age and PPSV23 at or after the age of [AGE] years old.R11's undated admission Record, identified an admission date of 10/15/24, R11 was [AGE] years old and had diagnoses that included Alzheimer's disease, heart failure, type 2 diabetes, obesity and hypertension.R11's Immunization Audit Report dated 12/18/15, failed to identify if R11 had received a pneumococcal vaccine.R11's Immunization Summary dated 8/11/21, identified the following: On 11/29/06, R11 received a PPSV23. On 2/13/14, R11 received a PPSV23.On 2/18/15, R11 received a PCV13.On 3/19/19, R11 received a PCV13.R11's electronic health record (EHR) did not include evidence R11 or R11's representative received education regarding pneumococcal vaccine booster and there was no indication R11 was offered the pneumococcal vaccine per CDC guidance.R13's undated admission Record, identified an admission date of 6/10/25, R13 was [AGE] years old and had diagnoses that included vascular dementia, sleep apnea, type 2 diabetes, and hypertension.R13's Immunization Audit Report dated12/18/25 identified the following:On 10/1/12, R13 received a PCV13On 3/19/18, R13 received a pneumococcal vaccine, however, the report failed to identify which vaccine was received.R13's electronic health record (EHR) did not include evidence R13 or R13's representative received education regarding pneumococcal vaccine booster and there was no indication R13 was offered the pneumococcal vaccine per CDC guidance.R32's undated admission Record, identified an admission date of 9/30/21, R32 was [AGE] years old and had diagnoses that included dementia, chronic kidney disease and congestive heart failure.R32's Immunization Audit Report dated 12/18/25, identified the following:On 7/25/17, R32 received a dose of pneumococcal vaccine. However, the report failed to identify which vaccine was received.On 10/5/21, R32 received a dose of pneumococcal vaccine. However, the report failed to identify which vaccine was received.R32's electronic health record (EHR) did not include evidence R32 or R32's representative received education regarding pneumococcal vaccine booster and there was no indication R32 was offered the pneumococcal vaccine per CDC guidance.R36's undated admission Record, identified an admission date of 2/12/24, R36 was [AGE] years old and had diagnoses that included dementia, hypertension, and left sided hemiplegia (paralysis) and hemiparesis (weakness).R35's admission Record dated 12/18/25, identified an admission date of 2/12/24, R35 was [AGE] years old and had diagnoses that included dementia, hypertension, and left sided hemiplegia (paralysis) and hemiparesis (weakness).R35's Immunization Audit Report dated 12/18/25, identified the following:On 10/13/15, R35 received a pneumococcal conjugate vaccine (PCV13). On 4/25/24, R35 received a pneumococcal polysaccharide vaccine (PPSV23).R35's electronic health record (EHR) did not include evidence R35 or R35's representative received education regarding pneumococcal vaccine booster and there was no indication R35 was offered the pneumococcal vaccine per CDC guidance.During an interview on 12/18/25 at 9:04 a.m., licensed practical nurse (LPN)-A stated when resident immunizations were offered, she filled out either a paper consent or declination. Those were kept in a binder in her office until the following spring, then the form would be scanned into the medical record. LPN-A would then enter the immunization into the immunization section of the resident's chart. LPN-A stated when she worked in the clinic, if a patient had received a PCV13 and a PCV23, they were complete and a PCV20 or 21 was not required. Because of this, R11, (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R13, R32 and R36 were not offered a PCV20 or 21.The facility policy Pneumococcal Vaccination dated 10/7/25, identified it was the facility's policy to offer residents immunization against pneumococcal disease in accordance with current CDC guidelines and recommendations. Each resident will be offered a pneumococcal immunization unless it is medically contraindicated, or the resident has already been immunized. Following assessment for any medical contraindications, the immunization may be administered in accordance with physician-approved standing orders. 3. Prior to offering the pneumococcal immunization, each resident or the resident's representative will receive education regarding the benefits and potential side effects of the immunization with the education documented in the clinical record. a. The individual receiving the immunization, or the resident representative, will be provided with a copy of CDC's current vaccine information statement relative to that vaccine. b. If necessary, the vaccine information statement will be supplemented with visual presentations or oral explanations to assist vaccine recipients in understanding.

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	12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Warroad Care Center	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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure the Skilled Nursing Facility Advance Beneficiary Notice (SNFABN CMS10055) was provided to 2 of 3 residents (R1and R5) reviewed for beneficiary notification. Findings include:R1's face sheet dated 12/18/25, identified R1 was admitted to the facility on [DATE], and remained in the facility. R1's diagnoses included liver and bone cancer, pneumonia, weakness, and pleural effusion (a buildup of fluid between the layers of tissues that line the lungs and chest cavity). R1's Notice of Medicare Non-Coverage (NOMNC) dated 11/24/25, identified R1 was being discontinued from services due to lack of meeting services hours five times a week. R1's first day of services was 11/14/25, and the last covered day was 11/26/25. R1's medical record lacked a completed SNFABN to outline services and continued cost of services.R5's face sheet dated 12/18/25, identified R5 was admitted to the facility on [DATE], and remained in the facility. R5's diagnoses included femur fracture and artificial hip. R5's first day of services was 4/7/25, and the last covered day was 6/26/25. R5's NOMNC dated 6/24/25, identified R5's services were ending due to the condition improved. There was also a communication note dated 6/24/25, that identified R5's payor source would change from Medicare Part A to private insurance. The communication form lacked any indication if resident wanted to continue services or what the cost or services covered would entail. R5's medical record lacked a completed SNFABN to outline services and continued cost of services.During an interview on 12/18/25 at 11:31 a.m., the licensed social worker (LSW) stated she was responsible for giving resident the NOMNC when their services had ended. The LSW stated they were never trained to give the SNFABN for when ending services. They were not aware it was needed and had not been done. The facility's Advance Beneficiary Notice (ABN) policy dated 12/20/24, identified the facility will provide an ABN to Medicare beneficiaries in accordance with Centers for Medicare & Medicaid Services (CMS) guidelines. The notice must clearly describe the services, reason for expected denial, and estimated cost.

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	12/18/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on observation, interview, and document review, the facility failed to obtain COVID-19 vaccination information for 1 of 2 facility employees (NA-N) reviewed for immunizations. Findings include:A copy of nursing assistant (NA)-P COVID-19 Informed Consent form was requested but not received.During an interview on 12/17/25 at 6:25 a.m., NA-P stated she was unvaccinated against COVID-19. I don't trust the government.During an interview on 12/18/25 at 9:04 p.m., licensed practical nurse (LPN)-B stated employees were offered COVID-19 every fall during the facility's vaccine clinic. A pink binder was kept with a list of employees. Once the employee was done, the name was highlighted. New employees were added upon hire. However, LPN-B was not listed. When an employee declined the COVID-19 vaccine, a declination form was completed. The forms were kept in the pink binder in alphabetic order, and no form was found for NA-P. NA-P was a new employee and LPN-B stated, I must have missed her. The facility policy COVID-19 Vaccination dated 9/26/25, identified it was a policy of this facility to minimize the risk of acquiring, transmitting or experiencing complications from COVID-19 (SARS-CoV-2) by educating and offering our residents and staff the COVID-19 vaccine. The facility will maintain documentation related to staff COVID-19 vaccination and include at a minimum: a. Education to the staff regarding the risks, benefits, and potential side effects of the COVID-19 vaccine. b. The offering of the COVID-19 vaccine or information on obtaining the COVID-19 vaccine. c. The COVID-19 vaccine status of staff and related information as indicated by NHSN.