



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

May 27, 2026

Administrator
Karlstad Healthcare Center Inc
304 WASHINGTON AVENUE WEST
KARLSTAD, MN 56732

RE: CCN:245468

Cycle Start Date: May 19, 2026

Dear Administrator:

On May 19, 2026, a survey was completed at your facility by the Minnesota Departments 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 widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), 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:

Jen Bahr, RN, Regional Operations Supervisor
Bemidji District Office
Health Regulation Division
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, Minnesota 56601-2933
Email: Jennifer.bahr@state.mn.us
Office: (218) 308-2104

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 August 19, 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 November 19, 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.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

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



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May 27, 2026

Administrator
Karlstad Healthcare Center Inc
304 WASHINGTON AVENUE WEST
KARLSTAD, MN 56732

Re: State Nursing Home Licensing Orders
Event ID: 22DFCD-H1

Dear Administrator:

The above facility survey was completed on 5/19/2026 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 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:

Jen Bahr, RN, Regional Operations Supervisor
Bemidji District Office
Health Regulation Division
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, Minnesota 56601-2933
Email: Jennifer.bahr@state.mn.us
Office: (218) 308-2104

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245468	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING	(X3) DATE SURVEY COMPLETED 05/20/2026
NAME OF PROVIDER OR SUPPLIER Karlstad Healthcare Center Inc			STREET ADDRESS, CITY, STATE, ZIP CODE 304 WASHINGTON AVENUE WEST , KARLSTAD, Minnesota, 56732	
(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
K0000 Bldg. 01	<p>INITIAL COMMENTS</p> <p>FIRE SAFETY</p> <p>An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 05/20/2026. At the time of this survey, Karlstad Healthcare Center Inc was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code.</p> <p>THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE.</p> <p>UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.</p> <p>PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:</p> <p>If PARTICIPATING IN THE E-POC PROCESS, a paper copy of the plan of correction is not required.</p> <p>Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145</p>	K0000		06/03/2026

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
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K0000 Bldg. 01	Continued from page 1 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: A detailed description of the corrective action taken or planned to correct the deficiency. Address the measures that will be put in place to ensure the deficiency does not reoccur. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. Identify who is responsible for the corrective actions and monitoring of compliance. The actual or proposed date for completion of the remedy. Karlstad Healthcare Center is a 1-story building without a basement and constructed at 2 different times. The original building was constructed in 1974, was determined to be of Type II(222) construction. In 1983 an addition was constructed south of the original building, which was determined to be of Type II (000) construction and is not separated from the original building with a 2-hour fire barrier so the construction type is Type II (000). Attached to the original building at the south west corner and separated with a 2-hour fire barrier is a connecting link to an assisted living building. The facility has a capacity of 46 beds and had a census of 42 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K0000		06/03/2026
K0918 SS = F Bldg. 01	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion	K0918	This plan of correction is submitted as the facility's credible allegation of compliance for K0918. 1.Detailed description of the corrective action taken or planned to correct the deficiency: The Maintenance Director was educated on the facility policy which requires the generators are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised	06/30/2026

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K0918 SS = F Bldg. 01	Continued from page 2 is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to install and maintain generators per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, 6.4.1.1.16.2 and 6.4.1.1.17, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, sections 8.4.9, 8.4.9.1, 8.4.9.2 and 8.4.9.5.1. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 05/20/2026, at 12:51pm, it was revealed by a review of available documentation of the emergency generator maintenance and testing that the facility could not provide documentation that a 36 month four (4) hour load bank test had been performed. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K0918	Continued from page 2 once every 36 months for 4 continuous hours by the Administrator. Karlstad Healthcare Facility Maintenance Director scheduled a 4-hour Generator Load test to be performed by APS on June 19th as required by regulation standards and facility policy. 2.Address the measures that will be put in place to ensure the deficiency does not reoccur. The 4-hour load test required to be performed every 36 months was added into the Tels system and will post reminders as the due date approaches. 3.Indicate how the facility plans to monitor future performance to ensure solutions are sustained. The 4-hour load test required to be performed every 36 months was added into the Tels system and will post reminders as the due date approaches. 4.Identify who is responsible for the corrective action and monitoring of compliance The maintenance director or designee will monitor for future compliance. A comprehensive life-safety audit is conducted annually by Accura Resource Center. The cited findings will be inspected during this review. A written report will be sent to the Administrator who will review it at QAPI. 5.Corrective action completion date: June 30, 2026	06/30/2026
K0353 SS = E Bldg. 01	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101	K0353	This plan of correction is submitted as the facility's credible allegation of compliance for K0353. 1.Detailed description of the corrective action taken	06/30/2026

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<p>NAME OF PROVIDER OR SUPPLIER Karlstad Healthcare Center Inc</p>		<p>STREET ADDRESS, CITY, STATE, ZIP CODE 304 WASHINGTON AVENUE WEST , KARLSTAD, Minnesota, 56732</p>		
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<p>K0353 SS = E Bldg. 01</p>	<p>Continued from page 3 Sprinkler System - Maintenance and Testing</p> <p>Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.</p> <p>a) Date sprinkler system last checked _____</p> <p>b) Who provided system test _____</p> <p>c) Water system supply source _____</p> <p>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25</p> <p>This STANDARD is NOT MET as evidenced by:</p> <p>Based on observation and staff interview, the facility failed to maintain spacing between storage and the sprinkler system per NFPA 101 (2012 edition), Life Safety Code, Section 9.7.5, NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Section 5.2.1.2, and NFPA 13 (2010 edition), Standard for the Installation of Sprinkler Systems, Sections 8.6.5.3.2 and 8.15.9. These deficient findings could a patterned impact on the residents within the facility.</p> <p>Findings include:</p> <p>On 05/20/2026 at the following times, it was revealed by observation that storage materials had been placed on a storage rack, bringing the storage materials within the required 18 inch clearance area under the sprinkler heads. These obstructions were found in:</p> <p>1) at 1:37pm, in the activities meeting room</p> <p>2) at 1:39pm, in the Nurse Storage room</p> <p>An interview with the Maintenance Director verified these deficient findings at the time of discovery.</p>	<p>K0353</p>	<p>Continued from page 3 or planned to correct the deficiency:</p> <p>The Maintenance Director educated the Activity Director and Nursing staff on the regulation that storage must be kept at least 18 inches below and away from the sprinkler head. Boxes were removed from the activity upper shelf and the nurse storage upper shelf.</p> <p>2.Address the measures that will be put in place to ensure the deficiency does not reoccur.</p> <p>The maintenance director will monitor boxes and other items that are closer than 18 inches when he does his facility walk through and remove any items that are out of compliance.</p> <p>3.Indicate how the facility plans to monitor future performance to ensure solutions are sustained.</p> <p>The maintenance director will audit for compliance with the 18-inch rule on a weekly basis for 1 month and monthly for 6 months.</p> <p>4.Identify who is responsible for the corrective action and monitoring of compliance</p> <p>The maintenance director or designee will monitor for future compliance and bring the results to QAPI.</p> <p>5.Corrective action completion date:</p> <p>June 30, 2026</p>	<p>06/30/2026</p>

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K0355 SS = D Bldg. 01	<p>Portable Fire Extinguishers</p> <p>CFR(s): NFPA 101</p> <p>Portable Fire Extinguishers</p> <p>Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers.</p> <p>18.3.5.12, 19.3.5.12, NFPA 10</p> <p>This STANDARD is NOT MET as evidenced by:</p> <p>Based on observation and staff interview, the facility failed to maintain access to portable fire extinguishers per NFPA 101 (2012 edition), Life Safety Code, section 9.7.4.1, and NFPA 10 (2010 edition), Standard for Portable Fire Extinguishers, section 7.3.1.1.1. This deficient finding could have an isolated impact on the residents within the facility.</p> <p>Findings include:</p> <p>On 05/20/2026, at 1:24pm, it was revealed by documentation review that the fire extinguishers annual inspection documentation did not name service technician and/or missing signature.</p> <p>An interview with the Maintenance Director verified these deficient findings at the time of discovery.</p>	K0355	<p>This plan of correction is submitted as the facility's credible allegation of compliance for K0355.</p> <p>1.Detailed description of the corrective action taken or planned to correct the deficiency:</p> <p>The Maintenance Director was educated on the requirement that the annual fire extinguisher document must contain the name of the service technician and the signature of the tech completing the service. The company completing the service was contacted and will supply the necessary signed documents as required.</p> <p>2.Address the measures that will be put in place to ensure the deficiency does not reoccur.</p> <p>The maintenance director will inspect the annual fire extinguisher documents to ensure they contain the proper names and signatures required by the regulations.</p> <p>3.Indicate how the facility plans to monitor future performance to ensure solutions are sustained.</p> <p>The maintenance director will inspect the annual fire extinguisher documents to ensure they contain the proper names and signatures. The documents will be reviewed by the corporate maintenance team as a second step compliance review.</p> <p>4. Identify who is responsible for the corrective action and monitoring of compliance</p> <p>The maintenance director or designee will monitor for future compliance and bring the results to QAPI.</p> <p>5. Corrective action completion date:</p> <p>June 30, 2026</p>	06/30/2026
K0761 SS = D Bldg. 01	<p>Maintenance, Inspection & Testing - Doors</p> <p>CFR(s): NFPA 101</p> <p>Maintenance, Inspection & Testing - Doors</p> <p>Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives.</p> <p>Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program.</p>	K0761	<p>This plan of correction is submitted as the facility's credible allegation of compliance for K0761.</p> <p>1.Detailed description of the corrective action taken or planned to correct the deficiency:</p> <p>The Maintenance Director was educated on the requirement to complete a 13-point door inspection on an annual basis by the regional maintenance director.</p> <p>2.Address the measures that will be put in place to ensure the deficiency does not reoccur.</p>	06/30/2026

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NAME OF PROVIDER OR SUPPLIER Karlstad Healthcare Center Inc			STREET ADDRESS, CITY, STATE, ZIP CODE 304 WASHINGTON AVENUE WEST , KARLSTAD, Minnesota, 56732	
(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
K0761 SS = D Bldg. 01	Continued from page 5 Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect fire doors per NFPA 101 (2012 edition), Life Safety Code section 8.3.3.1, and NFPA 80 (2010 edition), Standard for Fire Doors and Other Opening Protectives, section 5.2.5.2. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 05/20/2026 at 1:29pm, it was revealed by review of available documentation the required annual door inspection documentation the facility failed to provide a document showing all 13 points of the required door inspection was completed. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K0761	Continued from page 5 The 13-point door inspection will be added into the facility Tel's management system to ensure all 13-points of the door inspection are completed and recorded on an annual basis. 3.Indicate how the facility plans to monitor future performance to ensure solutions are sustained.The 13-point door inspection will be added into the facility Tel's management system to ensure all 13 points of the door inspection are completed and recorded on an annual basis. A comprehensive life-safety audit is conducted annually by Accura Resource Center Maintenance Team. The cited findings will be inspected during the review. A written report will be sent to the Administrator after the review. 4. Identify who is responsible for the corrective action and monitoring of compliance The maintenance director or designee will monitor for future compliance and bring the results and the annual Resource Center review to QAPI. 5. Corrective action completion date: June 30, 2026	06/30/2026
K0921 SS = D Bldg. 01	Electrical Equipment - Testing and Maintenance CFR(s): NFPA 101 Electrical Equipment - Testing and Maintenance Requirements The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals	K0921	This plan of correction is submitted as the facility's credible allegation of compliance for K0921. 1. Detailed description of the corrective action taken or planned to correct the deficiency: The Office Manager was educated on the facility policy which prohibits the use of non-compliant space heaters by the Maintenance Director. The space heater was removed by Office Manager. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. The Office Manager was educated on the facility policy which prohibits the non-compliant space heater by the Maintenance Director. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained.	06/30/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245468	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING	(X3) DATE SURVEY COMPLETED 05/20/2026
NAME OF PROVIDER OR SUPPLIER Karlstad Healthcare Center Inc			STREET ADDRESS, CITY, STATE, ZIP CODE 304 WASHINGTON AVENUE WEST , KARLSTAD, Minnesota, 56732	
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K0921 SS = D Bldg. 01	Continued from page 6 are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to provide a policy for appliances not supped by the facility per NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 05/20/2026, at 2:00pm, it was revealed by observation that a non-complainant space heater was found in Office Managers Office. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K0921	Continued from page 6 The maintenance director will audit the business director's office when he completes the safety rounds throughout the building to ensure that there are no non-compliant space heaters present. Any personal equipment will be inspected by the maintenance director prior to being put into use. 4. Identify who is responsible for the corrective action and monitoring of compliance The maintenance director or designee will monitor for future compliance and report to QAPI monthly. 5. Corrective action completion date: June 30, 2026	06/30/2026

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E0000	Initial Comments On 5/17/26 through 5/19/26, a survey for compliance with CFR §483.73, Appendix Z, Emergency Preparedness Requirements was conducted during a standard recertification survey. The facility was in compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E0000		05/27/2026
F0000	INITIAL COMMENTS On 5/17/26 through 5/19/26, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was not in compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with no deficiencies cited: H54682433C (254898136) and H54682435C (230052608) 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 substantial compliance with the regulations has been attained.	F0000		05/27/2026
F0677 SS = D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;	F0677	F 0677 PLAN OF CORRECTION Karlstad Healthcare Center denies it violated any federal or state regulations. Accordingly, this plan of correction does not constitute an admission or	06/04/2026

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
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F0677 SS = D	<p>Continued from page 1</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on interview and document review, the facility failed to provide restorative ambulation services and respond to a decline in ambulation status for 1 of 3 residents (R26) reviewed for ADLs.</p> <p>Findings include:</p> <p>R26's quarterly Minimum Data Set (MDS) dated 2/5/26, identified R26 had mild cognitive impairment and required set up/clean up assistance for eating, substantial/maximal assistance for bathing and upper body dressing and was dependent on staff for all other care areas. Diagnoses included dementia, hypertension, diabetes, weakness, and chronic pain.</p> <p>R26's care plan revised 11/6/25, identified R26 had an ADL Self Care Performance Deficit related to weakness and malaise (a general feeling of discomfort, illness, or uneasiness whose exact cause is difficult to identify). Interventions included: Ambulate R26 with front wheeled walker (FWW) and staff assistance of 1 once daily as desired/as tolerated. R26 was able to ambulate short distances. Walker used for transfer in room as able. The care plan also identified R26 had limited physical mobility and was at risk for falls due to weakness, chronic pain, and unsteadied gait/balance. Interventions included: NURSING REHAB: Ambulate daily with 1 staff and FWW-distances as able.</p> <p>R26's Functional Abilities Care Area Assessment (CAA) dated 5/13/25, identified R26 required staff assistance with ADLs. Staff offered morning and evening cares as well as toileting around the clock. R26 was able to alert staff as needed using call lights. R26 was working with therapy to regain independence where she was able. Goal was for R26 to not have any falls.</p> <p>The facility document Daily Rehab Responsibilities updated 3/19/26, identified R26 was to ambulate with 1 staff and forward wheeled walker (FWW)-distances as able.</p> <p>R26's undated, untitled nurse aide care sheet identified staff were to encourage the activity well fit program and R26 was to ambulate with staff and FWW daily.</p> <p>R26's Nursing Rehab Point of Care documentation dated 4/20/26 - 5/19/26, identified the following:</p>	F0677	<p>Continued from page 1 agreement by the provider to the accuracy of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. Completion dates are provided for procedural processing purposes and correlation with the most recently completed or accomplished corrective action and do not correspond chronologically to the date the facility maintains it is in compliance with the requirements of participation, or that corrective action was necessary.</p> <ol style="list-style-type: none"> In continuing compliance with F 0677, ADL Care provided for Dependent Residents. The Karlstad Healthcare Center corrected the deficiency by reviewing all residents (including R26) who ambulate for possible decline and updated restorative program and care plan to reflect current status by 6.3.2026. To correct the deficiency and to ensure the problem does not recur all nursing staff were educated by the Director of Nursing Services (DNS) before 6/4/2026 on the importance for exercise in the elderly, correct completion with documentation and when to notify nursing of resident refusal or physical decline/ no longer able to complete restorative program. MDSC was educated on the need for review of the Restorative Program by the DNS on 6.2.2026. MDSC will review this program monthly for completion. The DNS and/or designee will audit completion and proper documentation of restorative programs twice a week for 4 weeks, monthly for two months and then randomly ensure continued compliance. As part of Karlstad Healthcare Center's ongoing commitment to quality assurance, the Director of Nursing Services (DNS) and/or designee will report identified concerns through the community's QA Process. 	06/04/2026

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F0677 SS = D	<p>Continued from page 2</p> <p>4/20/26 R26's ambulation was not applicable.</p> <p>4/25/26 R26's ambulation was not applicable.</p> <p>5/4/26 R26's ambulation was not applicable.</p> <p>5/5/26 R26 refused ambulation.</p> <p>5/6/26 R26's ambulation was not applicable.</p> <p>5/9/26 R26's ambulation was not applicable.</p> <p>5/10/26 R26's ambulation was not applicable.</p> <p>5/12/26 R26 ambulated for 15 minutes.</p> <p>5/17/26 R26's ambulation was not applicable.</p> <p>During an interview on 5/17/26 at 2:41 p.m., R26 stated R26 couldn't walk anymore. The staff needed to help R26 to get in my bed and wheelchair.</p> <p>During an interview on 5/17/26 at 2:41 p.m. R26 stated she did exercises for an hour every week for an activity but doesn't do any exercises with the aides anymore. R26 shook her head and stated "no, I don't do that. I can't do that anymore."</p> <p>During an interview on 5/19/26 at 7:39 a.m., nursing assistant (NA)-A stated the nursing assistants were responsible for resident ambulation. The aides were not completing the task, and the director of nursing (DON) had talked to NA-A about restarting a formal nursing rehab program with an assigned restorative aide. NA-A stated she did not know how that was going to work because the residents who needed those services were in bed when NA-A was working.</p> <p>During an interview on 5/19/26 at 9:17 a.m., NA-B stated the nursing assistants were supposed to do the resident ambulation but "I'm not going to lie, that's not very often." When staff did not complete the task, they documented it as not applicable because it just didn't get done. NA-B stated R26 did not walk at all and used a sit to stand lift with assist of two staff for all transfers. R26 needed this type of assistance for at least several weeks because it just wasn't safe to ambulate R26 with a walker.</p> <p>During an interview on 5/19/26 at 9:22 a.m., registered nurse (RN)-A stated the nursing assistants were responsible to complete the resident ambulation, but it just didn't get done. Nursing did have a meeting "not that long ago" to discuss ideas or to come up with a plan to fix this, but there was no plan created. Staff were expected to complete</p>	F0677		06/04/2026

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F0677 SS = D	Continued from page 3 these tasks because not doing so could lead to contractures or a decline in the residents' ability to perform activities of daily living (ADLs). R26's medical record lacked an assessment for ADL decline including any revision to the ambulation care plan. During an interview on 5/19/26 at 11:52 a.m., the DON stated therapy made recommendations regarding resident restorative needs and the facility had a Well Fit program where the residents performed exercises as able in the activity room. Assignments were listed on the nurse aide care sheet directing staff who had resident ambulation and what that consisted of. The DON stated R26 was care planned to walk daily as tolerated but the care plan needed to be revised because the DON wouldn't transfer R26 with an assist of 1. The care plan stated that exercises were to be done as desired or tolerated, but staff should notify the DON if R26 was not able to perform the task. R26's condition had changed, and a therapy evaluation should have been requested to evaluated R26. On 5/19/2026 at 1:25 p.m., attempted to observe R26's ambulation but R26 declined. "That's just not my thing." Although R26's care plan and restorative program directed daily ambulation with a front wheeled walker and assist of one, staff interviews on 5/19/26 confirmed R26 had not ambulated for several weeks and required a sit-to-stand lift with assist of two for transfers. An ADL or resident ambulation policy was requested but not received.	F0677		06/04/2026
F0688 SS = D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further	F0688	F 0688 PLAN OF CORRECTION Karlstad Healthcare Center denies it violated any federal or state regulations. Accordingly, this plan of correction does not constitute an admission or agreement by the provider to the accuracy of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. Completion dates are provided for procedural processing purposes and correlation with the most recently completed or accomplished corrective	06/04/2026

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F0688 SS = D	<p>Continued from page 4 decrease in range of motion.</p> <p>§483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on interview and document review, the facility failed to ensure range of motion (ROM) was completed in accordance with therapy recommendations to prevent the loss of mobility for 1 of 3 residents (R3) reviewed for restorative nursing services.</p> <p>Findings include:</p> <p>R3's quarterly Minimum Data Set (MDS) dated 4/9/26, identified R3 had mild cognitive impairment and was dependent on staff for all care areas. Diagnoses included diabetes, hemiplegia (paralysis affecting one side of the body) and hemiparesis (partial weakness affecting one side of the body).</p> <p>R3's Functional Abilities Care Area Assessment (CAA) dated 10/9/25, identified staff assisted R3 every 2-3 hours with toileting and repositioning. Staff anticipated R3's needs and R3 was able to ask for assistance as needed by using the call light. Goal was for R3 to continue at current level of functioning and avoid complications of immobility.</p> <p>R3's care plan revised 1/19/22, identified R3 had limited physical mobility and a fall risk related to weakness, hemiplegia, hemiparesis, involuntary movements, contractures, and limited range of motion. Intervention included:Nursing Rehab: 3 times per week. Bilateral lower extremity passive range of motion (PROn to active range of motion (AROM) See instructions in room, passive hamstring stretch: hold 30 seconds, repeat 3 times and passive Heel Cord Stretch: hold 30 seconds, repeat 3 times. R3 frequently refused stretching exercises. NURSING REHAB: PROM to both hands for finger flexion and extension. The following were to be completed 10 times, being held for 3 seconds, 5 times per week: Hip flexion/extension, Abduction/Adduction, Rotation, and Foot Pronation/Supination- Ankle Inversion/Eversion R3 frequently refused stretching exercises. NURSING REHAB: Assistance with splint or brace at least 3 times per day for 1 hour and overnight as tolerated. Nursing to apply: RIGHT HAND: foam anti-spasticity</p>	F0688	<p>Continued from page 4 action and do not correspond chronologically to the date the facility maintains it is in compliance with the requirements of participation, or that corrective action was necessary.</p> <p>1. In continuing compliance with</p> <p>F 0677, Increase/Prevent Decrease in ROM/Mobility. The Karlstad Healthcare Center corrected the deficiency by reviewing all residents (including R3) receiving Range of Motion programs to reassess their continued need or need for change in program by 6/3/26. Care Plans and assessments also were reviewed to ensure accuracy by 6/3/26.</p> <p>2. To correct the deficiency and to ensure the problem does not recur all nursing staff were educated by 6/4/2026 on the importance for Range of Motion in the elderly and correct completion with documentation by the Director of Nursing Services (DNS). The DNS and/or designee will audit completion and proper documentation of Range of Motion programs twice a week for 4 weeks, monthly for two months and then randomly to ensure continued compliance.</p> <p>3. As part of Karlstad Healthcare Center's ongoing commitment to quality assurance, the Director of Nursing Services (DNS) and/or designee will report identified concerns through the community's QA Process.</p>	06/04/2026

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<p>F0688 SS = D</p>	<p>Continued from page 5 splint with finger separator. LEFT HAND: Cone splint</p> <p>R3's untitled nurse aide care sheet undated, identified R3 had a restorative program and to encourage the Well Fit program in the activity room.</p> <p>R3's Nursing Rehab Point of Care documentation dated 4/20/26-5/19/26, identified R3 wore the hand splints 41 times and was documented as not applicable 20 times out of the 90 opportunities. The documentation failed to identify R3 refused to wear the hand splints. R3's leg stretches were performed 3 times out of the 30 opportunities. The documentation failed to identify why no further leg were or were not performed.</p> <p>During an interview on 5/19/26 at 8:00 a.m., nursing assistant (NA)-B stated staff were to encourage residents to participate in the Well Fit program and R3 only wore his splints when he wanted to. R3 sometimes went to the Well Fit program and other times R3 would just rather watch tv. It just depended on the day. Staff were supposed to do R3's PROM and AROM but it didn't get done very often. Most of the time, staff just documented it as not applicable because it wasn't offered.</p> <p>During an interview on 5/19/26 at 9:22 a.m., registered nurse (RN)-A stated the nursing assistants were responsible to complete the resident restorative programs, but it just didn't get done. Nursing did have a meeting "not that long ago" to discuss ideas or to come up with a plan to fix this, but there was no plan created. Staff were expected to complete these tasks because not doing so could lead to contractures or a decline in the residents' ability to perform activities of daily living (ADLs).</p> <p>During an interview on 5/19/26 at 11:52 a.m., the director of nursing (DON) stated we have therapy make recommendations and we have a well fit program where they do exercises there as able. Assignments were posted on the NA care sheet. R3 was care planned to apply splints to his hands. He had one that he would wear at night when R3 allowed it. R3 was alert and oriented and decided that. R3 was to have ROM to hand and fingers as he allowed, and he hated it. R3 was to also have leg stretches and R3 hated that too. The DON stated staff should have offered the tasks and documented R3's refusals but the DON "supposed" when a resident repeatedly refused staff stopped offering. The DON stated R3's restorative program needed to be updated because it should have been based off what R3 wanted to do. The DON stated she was unaware staff were documenting R3s nursing rehab</p>	<p>F0688</p>		<p>06/04/2026</p>

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F0688 SS = D	Continued from page 6 tasks as not applicable, and staff would be educated regarding that. Although R3 intermittently refused ROM and splinting interventions, staff interviews confirmed restorative tasks frequently were not offered and were documented as 'not applicable' rather than refused. The facility policy Restorative Program Process updated 10/26/21, the facility would ensure our resident(s) achieve and maintain their highest level of function. Process: a) Upon admission, quarterly, and with significant change the resident's level of function will be assessed by the licensed nurse or in collaboration with therapy. b) Based on the results of the assessment the licensed nurse will develop a care plan showing the resident's individual problems, determine approaches/interventions and set goals. c) The licensed nurse will develop a restorative nursing program with individualized interventions and goals which may include recommendations for strategy and adaptive equipment from therapy. d) The licensed nurse will educate all direct care staff assigned to the resident(s) on their restorative nursing program. e) The licensed nurse will monitor staff and resident(s) to ensure compliance with the restorative nurse program. f) The licensed nurse will monitor the daily restorative nursing program documentation in POC and follow-up with staff as needed. g) The licensed nurse will write a monthly restorative nursing summary to track the resident(s) progress. h) The licensed nurse will update the care plan and the restorative nursing program to reflect the resident(s) specific goals and interventions as needed. i) The licensed nurse will make referrals to therapy as needed. j) The licensed nurse will develop a discharge plan for the resident(s) who no longer need a restorative nursing program.	F0688		06/04/2026

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/19/2026
NAME OF PROVIDER OR SUPPLIER Karlstad Healthcare Center Inc			STREET ADDRESS, CITY, STATE, ZIP CODE 304 WASHINGTON AVENUE WEST , KARLSTAD, Minnesota, 56732	
(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
20000	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>NH LICENSING CORRECTION ORDER</p> <p>In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.</p> <p>Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.</p> <p>You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.</p> <p>INITIAL COMMENTS:</p> <p>On 5/17/26 though 5/19/26, a standard licensing 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 Nursing Home Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.</p> <p>The following complaints were reviewed: H54682433C (254898136) and H54682435C</p>	20000		05/27/2026

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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Minnesota Department of Health

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20920	<p>Continued from page 5 comprehensive resident assessment, a nursing home must ensure that:</p> <p>B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>This LICENSURE REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on interview and document review, the facility failed to provide restorative ambulation services and respond to a decline in ambulation status for 1 of 3 residents (R26) reviewed for ADLs.</p> <p>Findings include:</p> <p>R26's quarterly Minimum Data Set (MDS) dated 2/5/26, identified R26 had mild cognitive impairment and required set up/clean up assistance for eating, substantial/maximal assistance for bathing and upper body dressing and was dependent on staff for all other care areas. Diagnoses included dementia, hypertension, diabetes, weakness, and chronic pain.</p> <p>R26's care plan revised 11/6/25, identified R26 had an ADL Self Care Performance Deficit related to weakness and malaise (a general feeling of discomfort, illness, or uneasiness whose exact cause is difficult to identify). Interventions included: Ambulate R26 with front wheeled walker (FWW) and staff assistance of 1 once daily as desired/as tolerated. R26 was able to ambulate short distances. Walker used for transfer in room as able. The care plan also identified R26 had limited physical mobility and was at risk for falls due to weakness, chronic pain, and unsteady gait/balance. Interventions included: NURSING REHAB: Ambulate daily with 1 staff and FWW-distances as able.</p> <p>R26's Functional Abilities Care Area Assessment (CAA) dated 5/13/25, identified R26 required staff assistance with ADLs. Staff offered morning and evening cares as well as toileting around the clock. R26 was able to alert staff as needed using call lights. R26 was working with therapy to regain independence where she was able. Goal was for R26 to not have any falls.</p> <p>The facility document Daily Rehab Responsibilities updated 3/19/26, identified R26 was to ambulate with 1 staff and forward wheeled walker (FWW)-distances as able.</p>	20920		06/04/2026

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20920	Continued from page 8 days.	20920		06/04/2026