DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 37FR

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00830

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245468**

2.STATE VENDOR OR MEDICAID NO.
(L2) **012028600**

3. NAME AND ADDRESS OF FACILITY
(L3) **KARLSTAD HEALTHCARE CENTER INC**
(L4) **304 WASHINGTON AVENUE WEST**
(L5) **KARLSTAD, MN** (L6) **56732**

4. TYPE OF ACTION: **7** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **03/03/2015** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **46** (L18)

13.Total Certified Beds **46** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	46			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Lyla Burkman, HFE NEII 03/05/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 03/09/2015 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
04/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
03/03/2015
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245468

March 9, 2015

Mr. Timothy Bush, Administrator
Karlstad Healthcare Center Inc
304 Washington Avenue West
Karlstad, Minnesota 56732

Dear Mr. Bush:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective February 13, 2015 the above facility is certified for:

80 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 80 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

March 5, 2015

Mr. Timothy Bush, Administrator
Karlstad Healthcare Center Inc
304 Washington Avenue West
Karlstad, Minnesota 56732

RE: Project Number S5468025

Dear Mr. Bush:

On January 23, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on January 15, 2015 that included an investigation of complaint number . This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On March 3, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on February 26, 2015 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on January 15, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of February 13, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on January 15, 2015, effective February 13, 2015 and therefore remedies outlined in our letter to you dated January 23, 2015, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File 5468r15

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245468	A. Building B. Wing	3/3/2015

Name of Facility	Street Address, City, State, Zip Code
KARLSTAD HEALTHCARE CENTER INC	304 WASHINGTON AVENUE WEST KARLSTAD, MN 56732

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0167** Reg. # **483.10(g)(1)** LSC	Correction Completed **02/13/2015**	ID Prefix **F0176** Reg. # **483.10(n)** LSC	Correction Completed **02/13/2015**	ID Prefix **F0248** Reg. # **483.15(f)(1)** LSC	Correction Completed **02/13/2015**
ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **02/13/2015**	ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **02/13/2015**	ID Prefix **F0281** Reg. # **483.20(k)(3)(i)** LSC	Correction Completed **02/13/2015**
ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **02/13/2015**	ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	Correction Completed **02/13/2015**	ID Prefix **F0356** Reg. # **483.30(e)** LSC	Correction Completed **02/13/2015**
ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **02/13/2015**	ID Prefix **F0456** Reg. # **483.70(c)(2)** LSC	Correction Completed **02/13/2015**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	LB/mm	03/05/2015	28035	03/03/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
1/15/2015			

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245468	A. Building B. Wing **01 - MAIN BUILDING 01**	2/26/2015

Name of Facility	Street Address, City, State, Zip Code
KARLSTAD HEALTHCARE CENTER INC	304 WASHINGTON AVENUE WEST KARLSTAD, MN 56732

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix	Correction Completed **01/31/2015**	ID Prefix	Correction Completed **02/02/2015**	ID Prefix	Correction Completed **02/02/2015**
Reg. # **NFPA 101** LSC K0050		Reg. # **NFPA 101** LSC K0052		Reg. # **NFPA 101** LSC K0054	
ID Prefix	Correction Completed **02/02/2015**	ID Prefix	Correction Completed **02/02/2015**	ID Prefix	Correction Completed **02/02/2015**
Reg. # **NFPA 101** LSC K0062		Reg. # **NFPA 101** LSC K0067		Reg. # **NFPA 101** LSC K0154	
ID Prefix	Correction Completed **02/02/2015**	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # **NFPA 101** LSC K0155		Reg. # LSC		Reg. # LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # LSC		Reg. # LSC		Reg. # LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # LSC		Reg. # LSC		Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/mm	03/05/2015	27200	02/26/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
1/15/2015			

DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 37FR

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00830

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245468**

2.STATE VENDOR OR MEDICAID NO.
(L2) **012028600**

3. NAME AND ADDRESS OF FACILITY
(L3) **KARLSTAD HEALTHCARE CENTER INC**
(L4) **304 WASHINGTON AVENUE WEST**
(L5) **KARLSTAD, MN** (L6) **56732**

4. TYPE OF ACTION: **2** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **01/15/2015** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **46** (L18)

13.Total Certified Beds **46** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	46			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Theresa Gullingsrud, HFE NEII 02/12/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 02/26/2015 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
_____ 1. Facility is Eligible to Participate
_____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
04/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 03/03/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7013 2250 0001 6357 1027
January 23, 2015

Mr. Timothy Bush, Administrator
Karlstad Healthcare Center Inc
304 Washington Avenue West
Karlstad, Minnesota 56732

RE: Project Number S5468025

Dear Mr. Bush:

On January 15, 2015, a standard 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 constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

<u>Informal Dispute Resolution</u> - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

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

Lyla Burkman , Unit Supervisor
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, Minnesota 56601
Telephone: (218)308-2104 Fax: (218)308-2122

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by February 24, 2015, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by February 24, 2015 the following remedy will be imposed:

• Per instance civil money penalties. (42 CFR 488.430 through 488.444)

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and

sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Include signature of provider and date.

If an acceptable PoC 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:

• Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

• Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable PoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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 PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will

recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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 April 15, 2015 (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). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by July 15, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. 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.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at:

http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at:
http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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.

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:

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Health Regulations Division
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245468	A. BUILDING _____ B. WING _____	01/15/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KARLSTAD HEALTHCARE CENTER INC	304 WASHINGTON AVENUE WEST KARLSTAD, MN 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
F 000	INITIAL COMMENTS The facility's plan of correction (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. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure the most recent state survey results were readily available and accessible to residents, families and visitors of the facility which had the potential to affect all 33 residents residing in the facility, families and/or visitors. Findings include:	F 167	F 167 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because provisions of state and federal law require it. Without waiving the foregoing statement, the facility states with respect to: 1. The most recent survey results were placed on the counter next to reception on 1/17/2015. 2. A sign was posted at reception to let residents and visitors know where to locate survey results on 1/20/2015.	

Approved w/ Addendum 2/12/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: VP of Operations — (X6) DATE: 2-11-15

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245468	A. BUILDING _____ B. WING _____	01/15/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 167	Continued From page 1 On 1/12/15, at 3:17 p.m. during the initial tour of the facility the most recent state survey results were not observed to be posted. On 1/13/15, at 8:30 a.m. the most recent state survey results were not observed to be posted. On 1/14/15, at 1:15 p.m. the administrator was asked where the survey results were posted. The administrator was also unable to find the survey results. At this time the medical records staff stated she had placed the survey results which were in a binder in the business office. She added, the survey results were moved when the Christmas Village was placed on the counter where the survey results binder had laid. The medical records staff member stated the survey results had remained in the office during the holiday season while the decorations were up. The medical records staff member and the administrator looked for the survey results binder and were unable to locate them. At 2:30 p.m. the director of nursing (DON) stated there would not be a policy related to the survey results as their standard of practice was to have them posted. On 1/15/15, at 7:58 a.m. the medical records staff member stated the Christmas Village was set up about the middle of December.	F 167	3. There had been no concerns or questions regarding the results availability since they had been temporarily moved in December 2014 for holiday decorations. 4. The Administrator or designee will check daily for one week, then weekly for 4 weeks, then monthly. The data collected will be presented to the QA committee by the DNS. The data will be reviewed/discussed at the Quarterly Quality Assurance Meeting. At this time the QA Committee will make the decision/recommendation regarding any necessary follow-up studies. Completion Date 2/13/15	

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F 167	Continued From page 2 On 1/15/15, at 8:25 a.m. the DON stated they were still unable to find the original survey results binder, however, had printed a new copy which was now back on the counter by the front entrance of the facility.	F 167		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the self administration of medications was deemed safe 1 of 1 resident (R13) observed to self administer medication. Findings include: R13's quarterly Minimum Data Set (MDS) dated 10/3/14, indicated R13 was cognitively intact and had diagnoses that included end stage renal disease, anxiety, depression and post traumatic stress disorder. The MDS also identified R13 received dialysis. R13's undated care plan directed nursing staff to administer medications as ordered.	F 176	F 176 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because provisions of state and federal law require it. Without waiving the foregoing statement, the facility states with respect to: 1. Resident 13 has had a Medication Self-Administration Safety Screen completed on 2/2/15. It showed that at this time resident is unable to self administer her medications. She falls back to sleep/does not take as ordered. 2. All resident's will be reviewed with quarterly care conferences and as needed for the need for a Medication Self-Administration Safety Screen.	

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F 176	Continued From page 3 R13's medical record lacked a self administration assessment. R13's Medication Administration Record (MAR) dated 1/1/15-1/31/15, identified orders that included Renvela tablet 800 mg (sevelamer carbonate) give 2 tablets by mouth three times a day for phosphate binder. The MAR lacked orders for self administration of medications. The MAR dated 1/15/14, at 12:00 p.m. indicated R14 had received the medication. On 1/15/2015, at 12:16 p.m. R13 was observed positioned on her back with the head of the bed elevated approximately 75 degrees. A bedside table was placed over R13's bed. The dietary manager (DM) delivered R13's noon meal. A medication cup with 2 pills was observed on the bedside table. R13 stated the medication was her Renvela and registered nurse (RN)-D had delivered it to her room at 11:30 a.m. so she could take it when she began eating her meal. R13 was then observed to take the medication. On 1/15/2015, at 1:41 p.m. RN-D confirmed she had left the Renvela in a cup on the bedside table so R13 could take the noon dose when her meal tray arrived. RN-D stated she probably shouldn't have left the medication in the room, but she did so because if she didn't bring the pills right away R13 would refuse to take them.	F 176	3. Nurses will be In-serviced on resident self administration of medications on or before 2/13/15. 4. The Director of Nurses/designee will perform audits 2 times a week for one month, then weekly for one month, then monthly. The data collected will be presented to the QA committee by the DNS. The data will be reviewed/discussed at the Quarterly Quality Assurance Meeting. At this time the QA Committee will make the decision/recommendation regarding any necessary follow-up studies. Completion Date 2/13/15	

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F 176	Continued From page 4 On 1/15/2015, at 2:14 p.m. the director of nursing (DON) confirmed R13 did not have an assessment completed to determine R13's ability to safely self administer medication. The DON also confirmed R13 did not have a physician's order to self administer medications. The DON stated R13's medications should not have been left in her room rather the nurse should have administered them as ordered. The Self Administration of Medication policy dated 2014, indicated the Medication Self Administration Safety Screen would be completed prior to the resident initiating self administration of medications and with any medication changes, changes in function/condition that might affect the resident's ability to safely self administer medication. The policy also indicated on-going evaluations should occur at a minimum of quarterly. The policy indicated the interdisciplinary team would review the summary on the Medication Self Administration Safety Screen to determine appropriateness of self administration of medications. The determination would include whether the resident could self administer medications unsupervised, with supervision or was not safe to administer medications. Additionally, the policy indicated a physician order would be obtained indicating which medications the resident may self administer and with or without supervision.	F 176		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES	F 248		

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F 248	Continued From page 5 The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide an individualized 1 to 1 activity program which consisted of visits and music for 1 of 3 residents reviewed for activities. Findings include: R31's annual Minimum Data Set (MDS) dated 6/24/14, indicated R31 was diagnosed with dementia and Parkinson's disease and had short and long term memory impairment. The MDS also indicated R31's activity preferences were unable to be assessed related to his cognitive impairment. The Cognitive Care Area Assessment (CAA) dated 6/26/14, indicated R31's mental function varied throughout the day and he struggled with inattention, disorganized thinking and expressed frustration at not being able to communicate his wishes. The Activity CAA dated 7/1/14, indicated the community life staff would encourage R31 and invite him to activities of interest and assist as needed. R31's care plan dated 1/7/15, indicated R31 was to receive 1:1 interactions, encouragement to	F 248	F 248 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because provisions of state and federal law require it. Without waiving the foregoing statement, the facility states with respect to: 1. The care plan for resident 31 has been reviewed and revised on 1/15/15. Resident 31 is being encouraged to participate in small group activities and is receiving 1:1 visits 2-3 times per week. 2. All residents have been reviewed for the need of 1:1 visits by Community Life staff. 2 other residents have been added to the 1:1 needs list. 3. Education has been completed with Community Life staff regarding the importance of 1:1 visits. All residents will be reviewed for the need for 1:1 visits upon admission, quarterly, with any significant change per Community Life Director or designee.	

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F 248	Continued From page 6 participate in small groups and offered the CD player for individual music enjoyment. On 1/13/15, at 10:00 a.m. a group of residents were observed in a circle with small balls they were using for exercise class. R31 was observed to put the small ball on the floor and was not engaged in the small group activity. On 1/14/15, at 7:01 a.m. R31 was observed in his room, dressed and seated in the wheelchair. -At 7:29 a.m. R31 remained the same. -At 7:40 a.m. R31 remained the same. -At 7:53 a.m. R31 was observed at the breakfast table. -At 8:07 a.m. R31 was being fed his meal. -At 9:07 a.m. R31 was observed in his room. The TV was on to a morning news program and R31 had his back to the TV. -At 9:09 a.m. R31 was bent over in the wheelchair and was trying to touch the floor with his right hand. -At 9:15 a.m. R31 observed propelling his wheelchair in his room with his feet and leaned forward a couple of times reaching his right hand towards the floor. -At 9:23 a.m. R31 remained up in the wheelchair in his room. R31's back remained to the TV. At 12:45 p.m. the community life assistant (CLA)-A stated R31 had an activity goal for 3 to 4 1:1 visits per week. The CLA-A stated R31 loved watching the Twins on TV, watching the birds in the aviary and had a past love of hunting. The CLA-A stated R31 was hard to understand when he spoke and stated when she talked with R31	F 248	4. The Community Life Director or designee will audit 1:1 compliance with resident Care Plan weekly times 3 months. The data collected will be presented to the QA committee by the Community Life Director. The data will be reviewed/discussed at the Quarterly Quality Assurance Meeting. At this time the QA Committee will make the decision/recommendation regarding any necessary follow-up studies. Completion Date 2/13/15	

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F 248	Continued From page 7 while he was being fed his breakfast meal that was considered a 1:1 activity. At 12:57 p.m. R31's wife was visiting in his room. The activity's In-Room 1:1 charting was reviewed for the months of September 2014, to December 2014, and the following was revealed: -September- out of 12 opportunities R31 received 1:1 interactions two times. -October- out of 12 opportunities, R31 received 1:1 interactions five times. -November- out of 12 opportunities R31 received 1:1 interactions five times. -December- out of 12 opportunities R31 received 1:1 interactions nine times. At 1:05 p.m. R31's wife was having lunch with R31. She stated she did not know what activity programs R31 was receiving as he could not do much anymore. She stated she knew they came into his room to visit him and reminisce. The surveyor explained to R31's wife the staff were documenting talking to R31 at breakfast time as a 1:1 activity. She stated that was not an activity and was "part of the job." On 1/15/15, at 9:00 a.m. the activity supervisor (AS) stated R31 was to receive a 1:1 visit 3 to 4 times a week. The AS stated herself and the CLA-A provided the 1:1 activity. The AS stated R31's most alert time was right away in the morning and a 1:1 visit prior to the breakfast meal would be the best. In addition, the AS stated she would not consider a 1:1 visit during a breakfast	F 248		

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F 248	Continued From page 8 meal an activity. At this time, the director of nursing (DON) stated they needed to revise R31's care plan to identify how many times a week the 1:1 visits would occur. In addition, the AS stated R31 liked 70s rock and roll music and was an avid fisherman and hunter. On 1/15/15 at 9:08 a.m. the activity supervisor (AS) reviewed the In-Room 1:1 charting with the surveyor. The AS verified the documentation showed staff taking credit for 1:1s when feeding R31 his breakfast meal. At 9:17 a.m. the AS stated she would revise the care plan to identify the actual interventions to meet R31's activity interests as R31 did not participate in small groups. At 9:30 a.m. the AS verified R31's activity needs were not being met. The AS stated R31 liked the morning news and she would check and find his CD player so that music could be played. At 9:58 a.m. the AS stated she found R31's CD player in his room with a 5 CD changer on it. The AS stated she worked full time and in the last month had only heard the CD player on twice. The undated Activity Department policy and procedure indicated an activity program would be designed to provide each resident with the opportunities to meet their activity needs.	F 248		
F 279	483.20(d), 483.20(k)(1) DEVELOP	F 279		

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F 279 SS=D	Continued From page 9 COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop care plan interventions related to positioning for 1 of 4 residents (R15) reviewed for positioning. Failed to develop care plan interventions related to the care of an indwelling urinary catheter for 1 of 1 resident (R15) reviewed with a catheter and failed to develop care plan interventions related to oxygen use for 1 of 2 residents (R15) reviewed with oxygen. In addition, the facility failed to develop care plan interventions to monitor the side effects of anticoagulation medication use for 1 of 1 resident (R17) reviewed on Coumadin.	F 279	F 279 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because provisions of state and federal law require it. Without waiving the foregoing statement, the facility states with respect to: 1. Resident 15's care plan has been reviewed and revised to include oxygen use, urinary catheter and repositioning for prevention of skin issues as of 1/20/15. Resident 17's care plan has been revised to include the monitoring of the side effects of anticoagulation therapy as of 1/20/15. 2. All resident care plans of those receiving oxygen, on anticoagulant therapy or having catheters have been reviewed and revised if needed. 3. All care plans will be reviewed and updated, if needed, by the Interdisciplinary Team quarterly and with significant change beginning 1/22/15.	

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F 279	Continued From page 10 Findings include: R15's care plan lacked interventions for positioning, catheter care and the use of oxygen. R15's quarterly Minimum Data Set (MDS) dated 11/14/14, indicated R15 was cognitively intact. The MDS identified R15 had diagnoses that included heart failure, hypertension neurogenic bladder, Parkinson's disease, muscle weakness, and chronic obstructive pulmonary disease (COPD). The MDS also indicated R15 required extensive assist of two staff for bed mobility, transfers and ambulation and utilized an indwelling urinary catheter and received oxygen therapy. R15's Urinary Care Area Assessment (CAA) dated 2/13/14 indicated R15 had a history of neurogenic bladder and decompensated bladder so she required an indwelling urinary catheter. Due to R15's history of frequent urinary tract infections (UTI) and sepsis related to UTI's, she had a leg bag on at all times which was emptied every 2 hours around the clock to keep the system closed by limiting possible contamination. R15's Pressure Ulcer CAA dated 2/13/14, indicated R15's skin was currently dry and intact, she required extensive assist of one staff to reposition or offload. The CAA also indicated R15 was on a repositioning program of every 2-3 hours and received continuous oxygen.	F 279	4. Director of Nursing/ MDS Coordinator/ or designee will audit 5 charts monthly for 3 months. The data collected will be presented to the QA committee by the DNS. The data will be reviewed/discussed at the Quarterly Quality Assurance Meeting. At this time the QA Committee will make the decision/recommendation regarding any necessary follow-up studies. Completion Date 2/13/15	

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F 279	Continued From page 11 R15's current care plan dated 5/14/14, failed to identify interventions detailing her repositioning program, her diagnosis of neurogenic bladder and corresponding interventions regarding R15's indwelling urinary catheter, as well as R15's diagnosis of COPD and corresponding interventions such as the use of oxygen. On 1/14/2015, at 11:25 a.m. registered nurse (RN)-A verified R15 had a urinary catheter and used oxygen. RN-A confirmed R15's care plan did not have interventions to address positioning, urinary catheter care or the use of oxygen. On 1/15/2015, at 2:04 p.m. the director of nursing (DON) confirmed the care plan should have addressed positioning, urinary catheter care and oxygen use. The Care Plan Completion policy dated 8/2013, indicated all care plans should include individual and/or combined focus problems that address current acute and chronic clinical conditions for which they are receiving medications, treatment and/or care which may include: diabetes, COPD, heart disease. The policy also indicated the care plan should include elimination including frequency of catheter care, oxygen and type of assistance required for all activities of daily living (transfers/bed mobility/ambulation).	F 279		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245468	A. BUILDING _____ B. WING _____	01/15/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KARLSTAD HEALTHCARE CENTER INC	304 WASHINGTON AVENUE WEST KARLSTAD, MN 56732

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F 279	Continued From page 12	F 279		

R17's care plan lacked interventions to monitor the side effects of Coumadin (an anticoagulation medication used to eliminate or reduce the risk of blood clots).

R17's Diagnosis List dated 10/31/14, identified R17's diagnoses as atrial fibrillation (irregular heart rate), hypertension (high blood pressure) and congested heart failure (decrease in heart function to pump blood).

R17's admission Minimum Data Set (MDS) dated 11/7/14, indicated R17 received anticoagulant therapy.

R17's Physician Order sheet dated 1/2/2015, indicated R17 was ordered to be given Coumadin 2 milligrams (mg) daily.

R17's current care plan dated 12/1/2014, failed to identify her diagnosis of atrial fibrillation and corresponding interventions which directed staff to observe for side effects of anticoagulation therapy usage, such as excessive bleeding, bruising and international normalized ratio

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F 279	Continued From page 13 monitoring (INR - lab work to identify blood clotting levels). On 1/15/15, at 9:56 a.m. registered nurse (RN)-B verified R17 was on a daily dose of Coumadin. RN-B confirmed R17's care plan lacked identification of R17's diagnosis of atrial fibrillation and the side effect monitoring for anticoagulation therapy. On 1/15/15, at 10:25 a.m. the director of nursing (DON) confirmed R17's care plan should have identified the atrial fibrillation diagnosis and subsequent Coumadin therapy usage. The Care Plan Completion policy dated 8/2013, indicated care plans should be individualized and identify medication therapy monitoring such as Coumadin for abnormal bleeding and bruising.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs,	F 280	F 280 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because provisions of state and federal law require it. Without waiving the foregoing statement, the facility states with respect to:	

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F 280	Continued From page 14 and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to revise the care plan to include the frequency of an activity program and activity preferences for 1 of 3 residents (R31) reviewed for activities. Findings include: R31's care plan dated 1/7/15, indicated R31 was to receive 1:1 interactions, encourage participation in small groups, and offer the CD player for individual music enjoyment. On 1/14/15, at 12:45 p.m. the community life assistant (CLA)-A stated R31 had an activity goal for 3 to 4 1:1 visits per week. The CLA-A stated R31 loved watching the Twins on TV, watching the birds in the aviary and had a past love of hunting. The CLA-A stated R31 was hard to understand when he spoke therefore stated if she talked with R31 while he was being fed his breakfast meal that was considered a 1:1 activity.	F 280	1. The care plan for resident 31 has been reviewed and revised on 1/15/15. Resident 31 is being encouraged to participate in small group activities and is receiving 1:1 visits 2-3 times per week. 2. . All residents have been reviewed for the need of 1:1 visits by Community Life staff. 2 other residents have been added to the 1:1 needs list. 3. Members of the Interdisciplinary Team (IDT) and professional nurses will be in-serviced on the process of care plan revision when there are changes identified that would require a change in the care plan on or before 2/13/15. The IDT meets daily at 9am, Monday thru Friday. Resident change in condition or incidents will be discussed. At that time the appropriate department will be accountable for checking the care plan to determine if revisions are needed, and if so have been done.	

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F 280	Continued From page 15 The activity In-Room 1:1 charting was reviewed for the months of September 2014, to December 2014. -September- out of 12 opportunities R31 received 1:1 interactions twice. -October- out of 12 opportunities, R31 received 1:1 interactions five times. -November- out of 12 opportunities R31 received 1:1 interactions five times. -December- out of 12 opportunities R31 received 1:1 interactions nine times. On 1/15/15, at 9:00 a.m. the activity supervisor (AS) stated R31 was to receive a 1:1 visits 3 to 4 times a week. At this time, the director of nursing (DON) stated they needed to revise the care plan to identify how many times a week the 1:1 visits would occur. In addition, the AS stated R31 liked 70s rock and roll music and was also an avid fisherman and hunter. At 9:17 a.m. the AS stated she would revise the care plan to identify the actual interventions to meet R31's activity interests as R31 did not participate in small groups. At 9:30 a.m. the AS verified R31's activity needs were not being met. The AS stated R31 liked the morning news, and she would check and find his CD player. At 9:58 a.m. the AS stated she found R31's CD player in his room with a 5 CD changer on it. The AS stated she worked full time and in the last month had only heard the CD player on twice.	F 280	4. 2 chart audits will be done weekly for 3 months by the Director of Nursing or designee. The data collected will be presented to the QA committee by the DNS. The data will be reviewed/discussed at the Quarterly Quality Assurance Meeting. At this time the QA Committee will make the decision/recommendation regarding any necessary follow-up studies. Completion Date 2/13/15	

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F 280	Continued From page 16 The Resident Care Planning Procedure Nurses Responsibility dated 8/98, indicated resident care plans should accurately reflect the resident's problems and needs. If a nurse identified a change in the resident's condition that was not reflected on the care plan they would notify the case manager in writing and she would be responsible for updating the care plan.	F 280		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop an admission (initial) care plan to identify safety interventions in order to minimize falls for 1 of 3 residents (R64) reviewed for accidents. The facility also failed to monitor blood glucose levels for 1 of 1 resident (R64) reviewed who received insulin 4 times per day. Findings include: R64's initial care plan lacked interventions to minimize falls. R64's Diagnosis List dated 1/9/15, indicated R64 had diagnoses that included diabetes,	F 281	F 281 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because provisions of state and federal law require it. Without waiving the foregoing statement, the facility states with respect to: 1. Resident 64 has a care plan that encompasses the following: falls, safety and fall precautions. Physician orders have been obtained for gluco-scans twice daily. 2. All new admissions in the past 4 months have been reviewed and changes made if needed. Any new admission will have the Temporary Care Plan completed the day of admission.	

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F 281	Continued From page 17 osteoporosis and mixed incontinence. R64's Admission Nursing Data Collection dated 1/9/15, identified R64's reason for admission was generalized weakness and confusion. The Admission Nursing Data Collection also indicated R64 had a history of falls with a fall occurrence within the previous month prior to admission and a fall within the last 2-6 months prior to admission. R64's Morse Fall Scale dated 1/12/14 identified R64 had a high risk for falling. R64's undated Temporary Care Plan included a field for documentation of safety/fall preventions to include wandering risk, restraints, assuasive devices, fall risk and personal alarms. This safety interventions field was blank. On 1/15/15, at 10:36 a.m. registered nurse (RN)-B confirmed she would have expected fall risk and interventions to have been addressed on the care plan upon admission. On 1/15/2015, at 2:06 p.m. the director of nursing (DON) verified R64's temporary care plan lacked interventions to minimize falls and confirmed safety/fall risk should have been identified on the temporary care plan. The undated Individual Resident Care Plan Guidelines indicated an individual resident care	F 281	3. IDT staff have been educated that all new residents must have a detailed personalized care plan by the 21st day of their initial admission. Care plans need to be reviewed and changed quarterly. Significant changes in resident status must be noted in the care plan when change noted. 4. Audits of care plan being completed within the first 21 days will be done on all new admits by the Director of Nurses or designee. Audits will be done weekly for 3 months. The data collected will be presented to the QA committee by the DNS. The data will be reviewed/discussed at the Quarterly Quality Assurance Meeting. At this time the QA Committee will make the decision/recommendation regarding any necessary follow-up studies. Completion Date 2/13/15	

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F 281	Continued From page 18 plan must be initiated upon admission to the facility. The guideline did not address the content of the initial/temporary care plan. R64 received insulin four times a day and did not receive blood glucose monitoring. R64's Admission Record identified R64 was admitted to the facility from the hospital on 1/9/15. R64's hospital progress noted dated 1/7/15, indicated R64 had type 2 diabetes mellitus with sub-optimal blood sugar control that still required active evaluation, monitoring and management. R64's hospital nurses noted dated 1/7/15, indicated R64 received blood glucose testing four times per day while in the hospital. R64's undated hospital After Visit Summary (AVS) identified medications that had changed to include insulin glargine 100 unit/ml injection inject 25 units into the skin nightly for diabetes and insulin lispro 100 unit/ml injection, commonly known as Humalog, inject 12 units into the skin three times daily before meals for diabetes. The AVS also identified items to continue included Sure Comfort pen needles, Sure Comfort insulin syringes and Truetest Test strips (glucose blood test strips). These items on the AVS were noted to have a handwritten question mark located in the left margin next to the item on the AVS paper form.	F 281		

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F 281	Continued From page 19 R64's Physician Orders dated 1/9/14, included insulin glargine 100 units (u)/milliliters (ml) inject 25 u subcutaneous (sq) nightly for diabetes, and Humalog 100 u/ml inject 12 units sq before meals for diabetes. The Physician Orders lacked an order for blood glucose monitoring. On 1/13/15, at 9:33 a.m. R64 was observed ambulating in the hallway with assist of one staff and gait belt. Her gait was steady. On 1/14/15, at 11:39 a.m. R64 was observed seated in a wheelchair in the activity room. R64 was seated by herself, sitting quietly at the table, with her arms crossed at her waist. On 1/15/15, at 10:36 a.m. RN-B confirmed R64 was receiving insulin four times per day and did not have blood glucose monitoring checks done. RN-B stated R64 had not had any signs or symptoms of hyper or hypoglycemia since her admission. RN-B also confirmed the hospital discharge instructions included an entry for test strips with a question mark handwritten next to it which indicated clarification was needed on the order. RN-B stated she would have questioned the orders and checked to see if an order for blood glucose testing was required. On 1/15/2015, at 2:09 p.m. the DON confirmed R64 probably should have had daily blood glucose checks and indicated she would clarify	F 281		

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F 281	Continued From page 20 this with the physician immediately. A policy regarding the care of diabetic residents was requested but none was given.	F 281		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure oral cares were provided as directed by the care plan for 2 of 3 residents (R48, R61) who required assistance with oral care. Findings include: R48's care plan directed staff to assist him with oral cares and the facility failed to provide this assistance. R48's care plan dated 5/13/14, identified R48 had a deficit with self-care performance with activities of daily living (ADL's) and required staff assist with personal hygiene cares. R48's quarterly Minimum Data Set (MDS) dated 10/29/14, indicated R48 had moderate cognitive impairment and required extensive assist with	F 282	F 282 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because provisions of state and federal law require it. Without waiving the foregoing statement, the facility states with respect to: 1. Residents 48 and 61 are receiving oral care as stated in 2. Residents care plan and staff assignment sheets have been reviewed to assure oral cares are addressed. 3. Nursing staff were re-educated to oral care needs.	

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F 282	Continued From page 21 personal hygiene. The nursing assistant care sheet [undated] directed staff to assist R48 with personal hygiene cares and indicated oral cares should be done twice a day (once in the morning and once in the evening). On 1/14/15, at 7:35 a.m. nursing assistant (NA)-B and NA-F were observed to enter R48's room and proceed to complete R48's personal cares. NA-B and NA-F were observed to bathe R48 while he remained in his bed, change his brief, and dress him. when dressed, NA-B and NA-F transferred R48 to his wheelchair. NA-B was observed to shave R48 and NA-F combed his hair. NA-F then transported R48 to the dining room. During this time, R48 was not offered or assisted with oral care. On 1/14/15, at 8:45 a.m. R48 finished his breakfast and NA-F transferred R48 to the activity room and situated him at one of the tables. R48 was not offered or assisted with oral care following breakfast. R61's care plan directed staff to assist him with oral cares and the facility failed to provide this assistance.	F 282	4. The DNS and/or her designee will audit 3 residents weekly for one month and then one resident weekly for two months for completion of oral cares through visual observation. The data collected will be presented to the QA Committee by the DNS. The data collected will be reviewed/discussed at the quarterly QA meeting. At this time the QA Committee will make the decision/recommendation regarding any follow-up studies. Completion date 2/13/15	

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F 282	Continued From page 22 R61's DIAGNOSIS LIST [undated] identified R61's diagnoses as cerebral vascular accident (stroke), severe right sided hemiparesis (weakness), and encephalopathy (brain disorder). R61's Individual Temporary Care Plan dated 1/13/2015, indicated R61 was nonverbal, had no natural teeth or dentures and required assistance with oral cares. The nursing assistant care sheet [undated] directed staff to assist R61 with personal hygiene cares and indicated oral cares should be done twice a day (once in the morning and once in the evening). R61's Nursing Admission Screening dated 1/14/15, indicated R61 was totally dependent on staff for personal hygiene cares. On 1/14/15, at 8:20 a.m. NA-B and NA-F were observed to enter R61's room and proceed to complete R61's personal cares. NA-B and NA-F were observed to bathe R61 while he remained in bed, change his brief and dress him. At 8:37 a.m. NA-B and NA-F transferred R61 from his bed to his wheelchair and NA-F transported R61 to the dining room. During this time, R61 was not offered or assisted with oral care. On 1/14/15, at 9:23 a.m. the speech therapist (ST)-A transported R61 out of the dining room to the therapy room.	F 282		

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F 282	Continued From page 23 On 1/14/15, at 9:47 a.m. the ST-A transported R61 to the activity room. R61 was not offered or assisted with oral care following breakfast. On 1/14/15, at 9:51 a.m. the NA-B verified routine morning cares for the residents included brushing their teeth or mouth care. NA-B confirmed she had not offered or assisted R48 or R61 with oral cares and stated they absolutely should have been done. On 1/14/15, at 12:14 p.m. the director of nursing (DON) confirmed R48 and R61 should have had mouth care done or at least offered mouth care during morning cares. The Care Plan Completion policy dated 8/2013, indicated all care plans should be individualized, identify the oral/dental needs of the resident which included the level of assistance required with personal hygiene needs.	F 282		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 312	F 312 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because provisions of state and federal law require it. Without waiving the foregoing statement, the facility states with respect to:	

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F 312	Continued From page 24 review, the facility failed to provide assistance with oral hygiene cares for 2 of 3 residents (R48, R61) who were dependent on staff to provide assistance with oral care. Findings include: R48 was not assisted with oral care during routine morning cares. R48's quarterly Minimum Data Set (MDS) dated 10/29/14, identified R48's diagnoses as schizophrenia, seizure disorder, anxiety and depression. In addition, R48 had moderate cognitive impairment and required extensive assist with personal hygiene. R48's care plan dated 5/13/14, identified R48 had a deficit with self-care performance with activities of daily living (ADL's) and required staff assist with personal hygiene cares. The nursing assistant care sheet [undated] directed staff to assist R48 with personal hygiene cares and indicated oral cares should be done twice a day (once in the morning and once in the evening). On 1/14/15, at 7:35 a.m. nursing assistant (NA)-B and NA-F were observed to enter R48's room and proceed to complete R48's personal cares. NA-B and NA-F were observed to bathe R48 while he remained in his bed, change his brief,	F 312	1. Residents 48 and 61 are receiving oral care as stated in 2. Residents care plan and staff assignment sheets have been reviewed to assure oral cares are addressed. 3. Nursing staff were re-educated to oral care needs. 4. The DNS and/or her designee will audit 3 residents weekly for one month and then one resident weekly for two months for completion of oral cares through visual observation. The data collected will be presented to the QA Committee by the DNS. The data collected will be reviewed/discussed at the quarterly QA meeting. At this time the QA Committee will make the decision/recommendation regarding any follow-up studies. Completion date 2/13/15	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245468	A. BUILDING _____ B. WING _____	01/15/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KARLSTAD HEALTHCARE CENTER INC	304 WASHINGTON AVENUE WEST KARLSTAD, MN 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
F 312	Continued From page 25 and dress him. When dressed, NA-B and NA-F transferred R48 to his wheelchair. NA-B was observed to shave R48 and NA-F combed his hair. NA-F then transported R48 to the dining room. During this time, R48 was not offered or assisted with oral care. On 1/14/15, at 8:45 a.m. R48 finished his breakfast and NA-F transferred R48 to the activity room and situated him at one of the tables. R48 was not offered or assisted with oral care following breakfast. R61 was not assisted with oral care during routine morning cares. R61's Diagnosis List [undated] identified R61's diagnoses as cerebral vascular accident (stroke), severe right sided hemiparesis (weakness), and encephalopathy (brain disorder). R61's Individual Temporary Care Plan dated 1/13/2015, indicated R61 was nonverbal, had no natural teeth or dentures and required assistance with oral cares. R61's Nursing Admission Screening dated 1/14/15, indicated R61 was totally dependent on staff for personal hygiene cares.	F 312		

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	245468	A. BUILDING _____ B. WING _____	01/15/2015

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F 312	Continued From page 26 The nursing assistant care sheet [undated] directed staff to assist R61 with personal hygiene cares and indicated oral cares should be done twice a day (once in the morning and once in the evening). On 1/14/15, at 8:20 a.m. NA-B and NA-F were observed to enter R61's room and proceed to complete R61's personal cares. NA-B and NA-F were observed to bathe R61 while he remained in bed, change his brief and dress him. At 8:37 a.m. NA-B and NA-F transferred R61 from his bed to his wheelchair and NA-F transported R61 to the dining room. During this time, R61 was not offered or assisted with oral care. On 1/14/15, at 9:23 a.m. the speech therapist (ST)-A transported R61 out of the dining room to the therapy room. On 1/14/15, at 9:47 a.m. the ST-A transported R61 to the activity room. R61 was not offered or assisted with oral care following breakfast. On 1/14/15, at 9:51 a.m. the NA-B verified routine morning cares for the residents included brushing their teeth or mouth care. NA-B confirmed she had not offered or assisted R48 or R61 with oral cares and stated they absolutely should have been done. On 1/14/15, at 12:14 p.m. the director of nursing	F 312		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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	245468	A. BUILDING _____ B. WING _____	01/15/2015

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F 312	Continued From page 27 (DON) confirmed R48 and R61 should have had mouth care done or at least offered mouth care during morning cares. The ORAL HYGIENE INDEPENDENT RESIDENT policy dated 11/2002, directed staff to assist or supervise oral hygiene care in the morning, at bedtime and when needed.	F 312		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse	F 356	F 356 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because provisions of state and federal law require it. Without waiving the foregoing statement, the facility states with respect to: 1. No concerns or complaints from residents and/or families regarding previous postings. 2. The posting form has been re-constructed to include the specific shift times each discipline is scheduled as well as actual hours worked.	

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F 356	Continued From page 28 staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to post the required nurse staffing information. This practice had the potential to affect all 33 residents who resided in the facility as well as visitors. Findings include: On 1/12/15, at 3:08 p.m. during the initial tour of the facility, the daily nurse staff posting was observed on the wall next to the business office. The day shift hours were identified as 6:00 a.m. to 2:30 p.m.; the evening shift hours were 2:00 p.m. to 10:30 p.m. and night shift hours were 10:00 p.m. to 6:30 a.m. The nursing assistant (NA) hours for the day shift indicated four NAs worked 24 hours and their actual hours worked were not posted. Also, there was one registered nurse (RN) listed for eight hours on the day shift, and there were two RNs working the day shift. In addition, the evening shift indicated two RNs for 12 hours and their actual hours worked were not posted. Also, there were no night shift hours indicated for any staff. On 1/13/14, at 3:53 p.m. there was one RN listed for eight hours on the day shift, and there were two RNs working the day shift. The NA hours for the day shift indicated 3.3 NAs worked 24 hours.	F 356	3. Staff will be in-serviced on the new form on or before 2/13/15. 4. The Director of Nurses or Designee will audit for correct usage 3 times per week for 1 month, then weekly for 2 months. The data collected will be presented to the QA committee by the DNS. The data will be reviewed/discussed at the Quarterly Quality Assurance Meeting. At this time the QA Committee will make the decision/recommendation regarding any necessary follow-up studies. Completion Date 2/13/15	

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F 356	Continued From page 29 However, their actual hours worked were not posted. In addition, there were 2.5 NAs listed for the evening shift for a total of 20 hours, and their actual hours worked was not posted. On 1/14/15, at 1:20 p.m. the nurse posting lacked the date and current census. In addition, the actual hours worked for the NAs was not posted for all three shifts. On 1/15/15, at 8:08 a.m. the director of nursing (DON) provided a copy of the regulation and stated that served as their facility policy regarding the posting of the nursing staff hours. At 8:11 a.m. the DON stated they had not been counting the Minimum Data Set (MDS) RN in their total nursing hours for the day shift and they should have been. The DON verified the findings and stated she would provide staff education on the regulation requirements and also change the format of the form to include documentation space for all the required information to be posted.	F 356		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	F 431	F 431 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because provisions of state and federal law require it. Without waiving the foregoing statement, the facility states with respect to:	

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F 431	Continued From page 30 Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to properly label 2 of 7 insulin vials with a "when opened" date in order to determine expiration date which had the potential to affect 2 of 4 residents (R3, R13) who received insulin. Findings include:	F 431	1. Residents 3 and 13 insulin bottles are correctly labeled with the date opened on it. 2. All residents receiving insulin have been audited for correctly labeled vials, and corrections made if needed. 3. Staff will be re-educated with regards to properly labeling insulin bottles. 4. 4 Insulin bottles will be audited weekly for one month, then 4 bottles per month for 2 months. The data collected will be presented to the QA committee by the DNS. The data will be reviewed/discussed at the Quarterly Quality Assurance Meeting. At this time the QA Committee will make the decision/recommendation regarding any necessary follow-up studies. Completion Date 2/13/15	

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F 431	Continued From page 31 On 1/15/15, at 1:22 p.m. the Country medication cart was reviewed with registered nurse (RN)-D. R13's open Novolog insulin 10 milliliter (ml) vial lacked a label or marking which indicated when the insulin vial had been opened. RN-D verified the insulin vial had been used for R13 and the vial was not labeled with a "when opened" date. RN-D stated the insulin vials should be labeled with the date they are opened. On 1/15/15, at 1:40 p.m. the Heritage medication cart was reviewed with RN-B. R3's open Lantus insulin 10 ml vial lacked a label or marking which indicated when the insulin vial had been opened. RN-B confirmed the insulin vials should be labeled with the date they are opened. On 1/15/15, at 1:50 p.m. RN-A stated the facility policy was to date insulin vials with a "when opened" date. In addition, if the insulin vial was not labeled it should not be used. On 1/15/15, at 2:25 p.m. the director of nursing (DON) confirmed her expectation was that insulin vials should be labeled with a "when opened" date. The Multi-Dose Vials policy dated 9/9/2008, directed staff to date insulin vials when first opened.	F 431		
F 456 SS=F	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential	F 456	F 456 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because provisions of state and federal law require it. Without waiving the foregoing statement, the facility states with respect to:	

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F 456	Continued From page 32 mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to properly maintain the convection oven and walk-in freezer which had the potential to effect 32 of 33 residents who received meals prepared in the kitchen. Findings include: Convection oven: On 1/12/15, at 3:25 p.m. during the kitchen tour with the dietary manager (DM) the two chamber convection oven was observed to be dirty. Both the top and bottom inside of the oven chambers were observed to have tin foil particles stuck in the side grates. In addition, the sides and bottom of the inside of the oven chambers were observed to have hardened, buildup, black, dried food debris and grease like substance. The DM confirmed at least 90% of the oven chambers were covered with this buildup of dried food debris and grease like substance. The DM verified the ovens needed to be cleaned and stated it had been some time since they had last been cleaned. On 1/14/15, at 12:19 p.m. the inside of the upper and lower convection oven chambers were observed to remain covered with a buildup of black, hardened, dried food debris and grease	F 456	1. The Convection ovens have been cleaned. The walk-in freezer has been cleaned and maintenance has been completed on it. 2. All dietary cleaning schedules have been reviewed and updated. 3. Staff have been inserviced on cleaning duties. 4. Audits will be done by the Dietary Manager that all cleaning is being done in accordance with policy. Audits will be done 3 times per week for one month, then weekly for 2 months. The data collected will be presented to the QA committee by the DNS. The data will be reviewed/discussed at the Quarterly Quality Assurance Meeting. At this time the QA Committee will make the decision/recommendation regarding any necessary follow-up studies. Completion Date 2/13/15	

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F 456	Continued From page 33 like substance. The DM stated the ovens had not been cleaned yet. On 1/15/15, at 10:55 p.m. the DM verified the double stacked convection oven was supposed to be cleaned weekly. The DM stated her best guess of when the ovens were last cleaned was probably around April 2014. The Cleaning Schedules for the last three months (November 2014 - January 2015) were reviewed and lacked documentation of the convection ovens being cleaned during this time. The Dakota Food Equipment manufacture guidelines for the electric convection ovens dated 3/17/2003, recommended cleaning the interior of the ovens daily. Walk-in freezer: On 1/12/15, at 3:30 p.m. during the kitchen tour with the DM the walk-in freezer was observed to have frozen condensation on the ceiling near the fans. In addition, this frozen condensation had cascaded on to and was frozen solid on the following items on the second and third shelves: · 1 box of 12 pounds of smoked cocktail franks · 1 box of 10 pounds of sausage pork links · 1 box of 20 pounds of chicken patties · 1 box of 10 pound diced white chicken · 1 box of four - 4 pound wild rice soup mixes The above boxes were frozen to the shelving	F 456		

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F 456	Continued From page 34 units and to each other. The DM confirmed the dietary staff was responsible to maintain and clean the walk-in freezer. On 1/14/15, at 12:39 p.m. the environmental service director (ESD) confirmed there was a lot of frozen condensation by the condenser fan in the walk-in freezer. In addition, the condensation had accumulated and ice had cascaded down on to several boxes of food on the second and third shelves. The ESD confirmed they needed to get the walk-in freezer looked at and fixed. On 1/14/15, at 2:00 p.m. the EVS provided an invoice from Jeff's Refrigeration dated 5/22/14, and stated this had been the last time the freezer had been maintained. On 1/15/15, at 10:55 p.m. the DM verified the walk-in freezer was supposed to be cleaned weekly. The Cleaning Schedules for the last three months (November 2014 - January 2015) were reviewed and lacked documentation of the walk-in freezer being cleaned during this time.	F 456		

Karlstad Senior Living

Addendum to:

F 279

Education will be completed with nursing staff and Care Plan team, with regards to importance of individualized resident care plans, and the need for them to be updated in real time.

All new admissions will be audited by the Director of Nurses/designee for 3 months for the following:

- Individual Temporary Care Plan completed within the first 2 days after admission.

-Actual detailed Care plan completed by all disciplines by day 21 after admission.

F 281

Education will be done with IDT staff regarding the importance of completing the temporary care plan within the first 2 days of admission.

All new admissions will be audited by the Director of Nurses/designee for 3 months for the following:

- Individual Temporary Care Plan completed within the first 2 days after admission.

-Actual detailed Care plan completed by all disciplines by day 21 after admission.

Laura Dunning 2-11-15

Laura Dunning, RN, BSN, PHN

Director of Nurses

Karlstad Senior Living

Approved
2/12/15

FS468023

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/23/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245468	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	01/15/2015

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K 000	INITIAL COMMENTS FIRE SAFETY 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. 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. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey Karlstad Healthcare Center 01 Main Building was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or	K 000	POC ok FS 2-12-15 RECEIVED FEB 11 2015 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

Dc: 2-3-15
EXIT: 1-15-15

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

TITLE: VP of Operations

(X6) DATE: 2/18/15

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KARLSTAD HEALTHCARE CENTER INC	304 WASHINGTON AVENUE WEST KARLSTAD, MN 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
K 000	Continued From page 1 By e-mail to: Marian.Whitney@state.mn.us and Angela.kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. 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 separated with at least a 2-hour fire barrier from the original building. 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 entire building is protected with an automatic fire sprinkler system installed in accordance with NFPA 13 Standard for the Installation of Automatic Sprinkler Systems 1999 edition. The facility has a fire alarm system with smoke detection at the smoke barrier doors and in the corridor system with extended spacing, installed	K 000		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245468	A. BUILDING 01 - MAIN BUILDING 01 B. WING	01/15/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KARLSTAD HEALTHCARE CENTER INC	304 WASHINGTON AVENUE WEST KARLSTAD, MN 56732

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K 000	Continued From page 2 in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition. The fire alarm system is monitored for automatic fire department notification. Hazardous areas have either heat detection or smoke detection that are on the fire alarm system in accordance with the Minnesota State Fire Code 2007 edition. The facility is divided into 4 smoke zones with at least 30 minute fire barriers. The facility has a capacity of 46 beds and had a census of 33 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on review of reports, records and staff interview, it was determined that the facility failed to conduct fire drills in accordance with NFPA Life Safety Code 101(00), 19.7.1.2, during the last 12-month period. This deficient practice could affect how staff react in the event of a fire. Improper reaction by staff would affect the safety	K 050	K 50 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because provisions of state and federal law require it. Without waiving the foregoing statement, the facility states with respect to:	

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K 050	Continued From page 3 of all residents. Findings include: On facility tour between 11:30 PM and 3:30 PM on 01/15/2015, during the review of all available maintenance documentation and interview with the Director of Maintenance (BN) it was revealed that the facility failed to conduct 9 of 12 fire drills during the last 12-month period. This deficient practice was verified by the Director of Maintenance (BN).	K 050	1. We will be Using our TELS program which has a monthly schedule to follow, to complete all required fire drills, and file them in our LSC book, TELS program also automatically emails the ED if items are not completed 2. Completion date January 31, 2015 3. Completed by Maintenance Director	
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on observation and staff interview, it was revealed that the facility had failed to install and maintain the fire alarm system in accordance with the requirements of 2000 NFPA 101, Sections 19.3.4.1 and 9.6, as well as 1999 NFPA 72, Sections 7.1. This deficient condition could	K 052	K 52 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission	

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K 052	Continued From page 4 adversely affect the functioning of the fire alarm system, and could delay the timely notification and emergency actions for the facility thus negatively affecting all residents, staff, and visitors of the facility. Findings include: On facility tour between 11:30 PM and 3:30 PM on 01/15/2015, a review of all available fire alarm documentation for the last 12 months, and an interview with the Director of Maintenance (BN), revealed that at the time of the inspection the facility had failed to conduct semi-annual tests of the DACT for the facility's fire alarm system. This deficient practice was verified by the Director of Maintenance (BN).	K 052	nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because provisions of state and federal law require it. Without waiving the foregoing statement, the facility states with respect to: 1. Prior documentation was found from 4/21/2014, proving compliance with NFPA 70& NFPA 72, all documents will be filed in LSC book as of 2015 2. Completion date 2/2/2015 3. Completed by Maintenance Director	
K 054 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: Based on staff interview and a review of the available documentation, the facility has not conducted that required sensitivity testing of the smoke detectors on the fire alarm system in accordance with NFPA 72 National Fire Alarm Code (99), Sec. 7-3.2.1. This deficient practice could affect all residents, visitors, and staff.	K 054	K 54 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the	

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K 054	Continued From page 5 Findings include: On facility tour between 11:30 PM and 3:30 PM on 01/15/2015, a review of the facility's available fire alarm maintenance and testing documentation revealed that at the time of the inspection the facility could not provide any current documentation verifying the completion of the required sensitivity testing of each smoke detector located throughout the facility. The last smoke detector sensitivity test was 04/18/2012. This deficient practice was verified by the Director of Maintenance (BN).	K 054	facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because provisions of state and federal law require it. Without waiving the foregoing statement, the facility states with respect to: 1. Prior documentation was found and shows it was completed on 4/21/2014, proving compliance with NFPA 72, all documents will be filed in LSC book as of 2015 2. Completion date 2/2/2015 3. Completed by Maintenance Director	
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on documentation review and interview with staff, the facility has failed to properly inspect and maintain the automatic sprinkler system in accordance with NFPA 101 Life Safety Code (00), Section 19.7.6, and 4.6.12, NFPA 13 Installation of Sprinkler Systems (99), and NFPA 25 Standard for the Inspection, Testing and Maintenance of Water Based Fire Protection Systems, (98). This deficient practice does not ensure that the fire sprinkler system is functioning properly and is fully operational in the event of a fire and could negatively affect residents, staff and visitors.	K 062	K 62 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission	

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K 062	Continued From page 6 Findings include: On facility tour between 11:30 AM and 3:30 PM on 01/15/2015, a review of documentation and interview with the Director of Maintenance (BN), revealed the facility failed to conduct 1 of 4 quarterly fire sprinkler flow tests and the annual fire sprinkler test that are required by NFPA 13(99) and NFPA 25(98). This deficient practice was verified by the Director of Maintenance (BN).	K 062	nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because provisions of state and federal law require it. Without waiving the foregoing statement, the facility states with respect to: 1. Prior documentation found that on 7/1/14 our sprinkler system had been tested in our facility, all documentation will be filed in our LSC book 2. Completion date 2/2/2015 3. Completed by Maintenance Director K 67 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the	
K 067 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: Based on documentation review, the fire/smoke damper system has not been maintained in accordance with the requirements of NFPA 90(99) section 3-4.7. This deficient practice does not ensure the proper operation of the fire/smoke dampers and could allow smoke migration to negatively affect the safety of all residents, staff and visitors in the event of a fire. Findings include:	K 067		

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K 067	Continued From page 7 On facility tour between 11:30 PM and 3:30 PM on 01/15/2015, it was revealed during the review of the facility's fire and smoke damper test/inspection documentation and was confirmed by interview with the Director of Maintenance (BN), that the facility failed to provide documentation that the fire and smoke dampers have been tested/inspected within the last 4 years in accordance with NFPA 90(99) section 3-4.7. This deficient practice was verified by the Director of Maintenance (BN).	K 067	facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because provisions of state and federal law require it. Without waiving the foregoing statement, the facility states with respect to: 1. Documentation was found dated 4/14/13 and shows compliance, it will now be entered in our TELS program on a 4 year schedule 2. Completion date 2/2/2015 3. Completed by Maintenance Director	
K 154 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 This STANDARD is not met as evidenced by: Based on a record review and staff interview, the facility has failed to provide a complete and acceptable written policy containing procedures to be followed in the event that the automatic fire sprinkler system has to be placed out-of-service for four or more hours in a 24 hour period. This deficient practice could affect the facility's ability for early response and notification of a fire and would affect the safety of all residents, visitors and staff.	K 154	K 154 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission	

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K 154	Continued From page 8 Findings include: On facility tour between 11:30 PM and 3:30 PM on 01/15/2015, during record review and an interview with the Director of Maintenance (BN), the facility failed to update and provide a complete list of contact information on the automatic fire sprinkler system out of service policy. The policy was lacking any contact information for the Deputy State Fire Marshal. This deficient practice was verified by the Director of Maintenance (BN).	K 154	nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because provisions of state and federal law require it. Without waiving the foregoing statement, the facility states with respect to: 1. Fire protection system out of service policy was updated on 2/2/2015 2. Completion date 2/2/2015 3. Completed by Maintenance Director	
K 155 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 This STANDARD is not met as evidenced by: Based on a record review and staff interview, the facility has failed to provide a complete and acceptable written policy containing procedures to be followed in the event that the automatic fire sprinkler system has to be placed out-of-service for four or more hours in a 24 hour period. This deficient practice could affect the facility's ability	K 155	K 155 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed	

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K 155	Continued From page 9 for early response and notification of a fire and would affect the safety of all residents, visitors and staff. Findings include: On facility tour between 11:30 PM and 3:30 PM on 01/15/2015, during record review and an interview with the Director of Maintenance (BN), the facility failed to update and provide a complete list of contact information on the automatic fire alarm system out of service policy. The policy was lacking any contact information for the Deputy State Fire Marshal. This deficient practice was verified by the Director of Maintenance (BN).	K 155	solely because provisions ot state and federal law require it. Without waiving the foregoing statement, the facility states with respect to: 1. Fire protection system out of service policy was updated on 2/2/2015 2. Completion date 2/2/2015 3. Completed by Maintenance Director	

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7013 2250 0001 6357 1027

January 23, 2015

Mr. Timothy Bush, Administrator
Karlstad Healthcare Center Inc.
304 Washington Avenue West
Karlstad, Minnesota 56732

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5468025

Dear Mr. Bush:

The above facility was surveyed on January 12, 2015 through January 15, 2015 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, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 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 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 deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). 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 after the statement, "This Rule

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.

When all orders are corrected, the order form should be signed and returned to Lyla Burkman at Minnesota Department of Health, 705 5th Street Nw Bemidji, MN 56601. 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 me.

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 note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Health Regulations Division
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00830	A. BUILDING: _____ B. WING _____	01/15/2015

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2 000	Initial Comments	2 000		

*****ATTENTION******

NH LICENSING CORRECTION ORDER

In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

INITIAL COMMENTS:
On January 12-15, 2015 surveyors of this Department's staff visited the above provider and the following licensing orders were issued. When corrections are completed, please sign and date on the bottom of the first page in the line marked with "Laboratory Director's or Provider/Supplier Representative's signature." Make a copy of

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On January 12-15, 2015 surveyors of this Department's staff visited the above provider and the following licensing orders were issued. When corrections are completed, please sign and date on the bottom of the first page in the line marked with "Laboratory Director's or Provider/Supplier Representative's signature." Make a copy of	2 000		

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2 000	Continued From page 1 these orders for your records and return the original to the address below: Minnesota Department of Health 705 Fifth Street NW, Suite A, Bemidji, MN 56601-2933 c/o Lyla Burkman, Unit Supervisor	2 000		
2 302	MN State Statute 144.6503 Alzheimer's disease or related disorder train ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING: MN St. Statute 144.6503 (a) If a nursing facility serves persons with Alzheimer's disease or related disorders, whether in a segregated or general unit, the facility's direct care staff and their supervisors must be trained in dementia care. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and related disorders; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; and (4) communication skills. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. (d) The facility shall document compliance with this section.	2 302		

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	00830	A. BUILDING: _____ B. WING _____	01/15/2015

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2 302	Continued From page 2 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to provide the required Alzheimer's training for 3 of 3 nursing assistants (NA-A, NA-B, NA-C) and for 1 of 2 licensed practical nurses (LPN-A) who provided direct care services. In addition, the facility failed to provide consumers with written information regarding the Alzheimer's training program. This had the potential to affect all 33 residents who resided in the facility and their families. Findings include: LPN-A was hired on 10/15/14, and the employee record lacked evidence of having received the required Alzheimer's training. NA-A was hired on 11/17/14, and the employee record lacked evidence of having received the required Alzheimer's training. NA-B was hired on 10/16/14, and the employee record lacked evidence of having received the required Alzheimer's training. NA-C was hired on 12/22/14, and the employee record lacked evidence of having received the required Alzheimer's training. On 1/15/15, at 8:00 a.m. the director of nursing	2 302		

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2 302	Continued From page 3 (DON) stated they currently were not providing information to the consumers regarding dementia training provided for their staff. The DON, added, they would include this information in the admission packet going forward. At 8:36 a.m. the DON stated the Alzheimer's training was available for staff to watch on the computer. The DON verified the above findings and stated there was no proof in their personnel files they had the training. In addition, the DON stated the staff who had been responsible for staff development had resigned and this had been assigned to another employee. A policy related to Alzheimer's training was requested and none was provided. SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) could develop and implement policies and procedures related to the required Alzheimer's training program requirements. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty (21) days.	2 302		

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2 560	Continued From page 4	2 560		
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b). This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to develop care plan interventions related to positioning for 1 of 4 residents (R15) reviewed for positioning. Failed to develop care plan interventions related to the care of an indwelling urinary catheter for 1 of 1 resident (R15) reviewed with a catheter and failed to develop care plan interventions related to oxygen use for 1 of 2 residents (R15) reviewed with oxygen. In addition, the facility failed to develop care plan interventions to monitor the side effects of anticoagulation medication use for 1 of 1 resident (R17) reviewed on Coumadin. Findings include: R15's care plan lacked interventions for positioning, catheter care and the use of oxygen. R15's quarterly Minimum Data Set (MDS) dated 11/14/14, indicated R15 was cognitively intact.	2 560		

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2 560	Continued From page 5 The MDS identified R15 had diagnoses that included heart failure, hypertension neurogenic bladder, Parkinson's disease, muscle weakness, and chronic obstructive pulmonary disease (COPD). The MDS also indicated R15 required extensive assist of two staff for bed mobility, transfers and ambulation and utilized an indwelling urinary catheter and received oxygen therapy. R15's Urinary Care Area Assessment (CAA) dated 2/13/14 indicated R15 had a history of neurogenic bladder and decompensated bladder so she required an indwelling urinary catheter. Due to R15's history of frequent urinary tract infections (UTI) and sepsis related to UTI's, she had a leg bag on at all times which was emptied every 2 hours around the clock to keep the system closed by limiting possible contamination. R15's Pressure Ulcer CAA dated 2/13/14, indicated R15's skin was currently dry and intact, she required extensive assist of one staff to reposition or offload. The CAA also indicated R15 was on a repositioning program of every 2-3 hours and received continuous oxygen. R15's current care plan dated 5/14/14, failed to identify interventions detailing her repositioning program, her diagnosis of neurogenic bladder and corresponding interventions regarding R15's indwelling urinary catheter, as well as R15's diagnosis of COPD and corresponding interventions such as the use of oxygen. On 1/14/2015, at 11:25 a.m. registered nurse	2 560		

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2 560	Continued From page 6 (RN)-A verified R15 had a urinary catheter and used oxygen. RN-A confirmed R15's care plan did not have interventions to address positioning, urinary catheter care or the use of oxygen. On 1/15/2015, at 2:04 p.m. the director of nursing (DON) confirmed the care plan should have addressed positioning, urinary catheter care and oxygen use. The Care Plan Completion policy dated 8/2013, indicated all care plans should include individual and/or combined focus problems that address current acute and chronic clinical conditions for which they are receiving medications, treatment and/or care which may include: diabetes, COPD, heart disease. The policy also indicated the care plan should include elimination including frequency of catheter care, oxygen and type of assistance required for all activities of daily living (transfers/bed mobility/ambulation). R17's care plan lacked interventions to monitor the side effects of Coumadin (an anticoagulation medication used to eliminate or reduce the risk of blood clots).	2 560		

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2 560	Continued From page 7 R17's Diagnosis List dated 10/31/14, identified R17's diagnoses as atrial fibrillation (irregular heart rate), hypertension (high blood pressure) and congested heart failure (decrease in heart function to pump blood). R17's admission Minimum Data Set (MDS) dated 11/7/14, indicated R17 received anticoagulant therapy. R17's Physician Order sheet dated 1/2/2015, indicated R17 was ordered to be given Coumadin 2 milligrams (mg) daily. R17's current care plan dated 12/1/2014, failed to identify her diagnosis of atrial fibrillation and corresponding interventions which directed staff to observe for side effects of anticoagulation therapy usage, such as excessive bleeding, bruising and international normalized ratio monitoring (INR - lab work to identify blood clotting levels). On 1/15/15, at 9:56 a.m. registered nurse (RN)-B verified R17 was on a daily dose of Coumadin. RN-B confirmed R17's care plan lacked identification of R17's diagnosis of atrial fibrillation and the side effect monitoring for anticoagulation therapy. On 1/15/15, at 10:25 a.m. the director of nursing (DON) confirmed R17's care plan should have identified the atrial fibrillation diagnosis and subsequent Coumadin therapy usage.	2 560		

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2 560	Continued From page 8 The Care Plan Completion policy dated 8/2013, indicated care plans should be individualized and identify medication therapy monitoring such as Coumadin for abnormal bleeding and bruising. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could review/ revise policies and procedures related to care plan development and provide education to staff to address the importance of developing a comprehensive care plan to meet each resident's needs. Resident care plans could be reviewed/ revised for compliance. The quality assessment and assurance committee could establish a system to audit care plans to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 560		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure oral cares were	2 565		

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2 565	Continued From page 9 provided as directed by the care plan for 2 of 3 residents (R48, R61) who required assistance with oral care. Findings include: R48's care plan directed staff to assist him with oral cares and the facility failed to provide this assistance. R48's care plan dated 5/13/14, identified R48 had a deficit with self-care performance with activities of daily living (ADL's) and required staff assist with personal hygiene cares. R48's quarterly Minimum Data Set (MDS) dated 10/29/14, indicated R48 had moderate cognitive impairment and required extensive assist with personal hygiene. The nursing assistant care sheet [undated] directed staff to assist R48 with personal hygiene cares and indicated oral cares should be done twice a day (once in the morning and once in the evening). On 1/14/15, at 7:35 a.m. nursing assistant (NA)-B and NA-F were observed to enter R48's room and proceed to complete R48's personal cares. NA-B and NA-F were observed to bathe R48 while he remained in his bed, change his brief, and dress him. when dressed, NA-B and NA-F transferred R48 to his wheelchair. NA-B was observed to shave R48 and NA-F combed his hair. NA-F then transported R48 to the dining	2 565		

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2 565	Continued From page 10 room. During this time, R48 was not offered or assisted with oral care. On 1/14/15, at 8:45 a.m. R48 finished his breakfast and NA-F transferred R48 to the activity room and situated him at one of the tables. R48 was not offered or assisted with oral care following breakfast. R61's care plan directed staff to assist him with oral cares and the facility failed to provide this assistance. R61's DIAGNOSIS LIST [undated] identified R61's diagnoses as cerebral vascular accident (stroke), severe right sided hemiparesis (weakness), and encephalopathy (brain disorder). R61's Individual Temporary Care Plan dated 1/13/2015, indicated R61 was nonverbal, had no natural teeth or dentures and required assistance with oral cares. The nursing assistant care sheet [undated] directed staff to assist R61 with personal hygiene cares and indicated oral cares should be done twice a day (once in the morning and once in the evening). R61's Nursing Admission Screening dated 1/14/15, indicated R61 was totally dependent on staff for personal hygiene cares.	2 565		

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2 565	Continued From page 11 On 1/14/15, at 8:20 a.m. NA-B and NA-F were observed to enter R61's room and proceed to complete R61's personal cares. NA-B and NA-F were observed to bathe R61 while he remained in bed, change his brief and dress him. At 8:37 a.m. NA-B and NA-F transferred R61 from his bed to his wheelchair and NA-F transported R61 to the dining room. During this time, R61 was not offered or assisted with oral care. On 1/14/15, at 9:23 a.m. the speech therapist (ST)-A transported R61 out of the dining room to the therapy room. On 1/14/15, at 9:47 a.m. the ST-A transported R61 to the activity room. R61 was not offered or assisted with oral care following breakfast. On 1/14/15, at 9:51 a.m. the NA-B verified routine morning cares for the residents included brushing their teeth or mouth care. NA-B confirmed she had not offered or assisted R48 or R61 with oral cares and stated they absolutely should have been done. On 1/14/15, at 12:14 p.m. the director of nursing (DON) confirmed R48 and R61 should have had mouth care done or at least offered mouth care during morning cares. The Care Plan Completion policy dated 8/2013, indicated all care plans should be individualized, identify the oral/dental needs of the resident which included the level of assistance required	2 565		

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2 565	Continued From page 12 with personal hygiene needs. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could review/ revise facility policies and procedures related to care plan implementation and provide education to staff to address the importance of following each resident's care plan. Resident care plans could be reviewed/ revised for compliance. The quality assessment and assurance committee could establish a system to audit care plans and monitor for consistent implementation, to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced	2 570		

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2 570	Continued From page 13 by: Based on interview and document review, the facility failed to revise the care plan to include the frequency of an activity program and activity preferences for 1 of 3 residents (R31) reviewed for activities. Findings include: R31's care plan dated 1/7/15, indicated R31 was to receive 1:1 interactions, encourage participation in small groups, and offer the CD player for individual music enjoyment. On 1/14/15, at 12:45 p.m. the community life assistant (CLA)-A stated R31 had an activity goal for 3 to 4 1:1 visits per week. The CLA-A stated R31 loved watching the Twins on TV, watching the birds in the aviary and had a past love of hunting. The CLA-A stated R31 was hard to understand when he spoke therefore stated if she talked with R31 while he was being fed his breakfast meal that was considered a 1:1 activity. The activity In-Room 1:1 charting was reviewed for the months of September 2014, to December 2014. -September- out of 12 opportunities R31 received 1:1 interactions twice. -October- out of 12 opportunities, R31 received 1:1 interactions five times. -November- out of 12 opportunities R31 received 1:1 interactions five times. -December- out of 12 opportunities R31 received 1:1 interactions nine times.	2 570		

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2 570	Continued From page 14 On 1/15/15, at 9:00 a.m. the activity supervisor (AS) stated R31 was to receive a 1:1 visits 3 to 4 times a week. At this time, the director of nursing (DON) stated they needed to revise the care plan to identify how many times a week the 1:1 visits would occur. In addition, the AS stated R31 liked 70s rock and roll music and was also an avid fisherman and hunter. At 9:17 a.m. the AS stated she would revise the care plan to identify the actual interventions to meet R31's activity interests as R31 did not participate in small groups. At 9:30 a.m. the AS verified R31's activity needs were not being met. The AS stated R31 liked the morning news, and she would check and find his CD player. At 9:58 a.m. the AS stated she found R31's CD player in his room with a 5 CD changer on it. The AS stated she worked full time and in the last month had only heard the CD player on twice. The Resident Care Planning Procedure Nurses Responsibility dated 8/98, indicated resident care plans should accurately reflect the resident's problems and needs. If a nurse identified a change in the resident's condition that was not reflected on the care plan they would notify the case manager in writing and she would be responsible for updating the care plan.	2 570		

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2 570	Continued From page 15 SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could review/ revise policies and procedures related to care plan revision and provide education to staff to address the importance of revising care plans when there has been a change in the resident serviceas. Resident care plans could be reviewed/ revised for compliance. The quality assessment and assurance committee could establish a system to audit care plans to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 570		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: 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. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide assistance with oral hygiene cares for 2 of 3 residents (R48, R61) who were dependent on staff to provide assistance with oral care. Findings include:	2 920		

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2 920	Continued From page 16 R48 was not assisted with oral care during routine morning cares. R48's quarterly Minimum Data Set (MDS) dated 10/29/14, identified R48's diagnoses as schizophrenia, seizure disorder, anxiety and depression. In addition, R48 had moderate cognitive impairment and required extensive assist with personal hygiene. R48's care plan dated 5/13/14, identified R48 had a deficit with self-care performance with activities of daily living (ADL's) and required staff assist with personal hygiene cares. The nursing assistant care sheet [undated] directed staff to assist R48 with personal hygiene cares and indicated oral cares should be done twice a day (once in the morning and once in the evening). On 1/14/15, at 7:35 a.m. nursing assistant (NA)-B and NA-F were observed to enter R48's room and proceed to complete R48's personal cares. NA-B and NA-F were observed to bathe R48 while he remained in his bed, change his brief, and dress him. When dressed, NA-B and NA-F transferred R48 to his wheelchair. NA-B was observed to shave R48 and NA-F combed his hair. NA-F then transported R48 to the dining room. During this time, R48 was not offered or assisted with oral care. On 1/14/15, at 8:45 a.m. R48 finished his breakfast and NA-F transferred R48 to the activity	2 920		

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2 920	Continued From page 17 room and situated him at one of the tables. R48 was not offered or assisted with oral care following breakfast. R61 was not assisted with oral care during routine morning cares. R61's Diagnosis List [undated] identified R61's diagnoses as cerebral vascular accident (stroke), severe right sided hemiparesis (weakness), and encephalopathy (brain disorder). R61's Individual Temporary Care Plan dated 1/13/2015, indicated R61 was nonverbal, had no natural teeth or dentures and required assistance with oral cares. R61's Nursing Admission Screening dated 1/14/15, indicated R61 was totally dependent on staff for personal hygiene cares. The nursing assistant care sheet [undated] directed staff to assist R61 with personal hygiene cares and indicated oral cares should be done twice a day (once in the morning and once in the evening). On 1/14/15, at 8:20 a.m. NA-B and NA-F were observed to enter R61's room and proceed to	2 920		

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2 920	Continued From page 18 complete R61's personal cares. NA-B and NA-F were observed to bathe R61 while he remained in bed, change his brief and dress him. At 8:37 a.m. NA-B and NA-F transferred R61 from his bed to his wheelchair and NA-F transported R61 to the dining room. During this time, R61 was not offered or assisted with oral care. On 1/14/15, at 9:23 a.m. the speech therapist (ST)-A transported R61 out of the dining room to the therapy room. On 1/14/15, at 9:47 a.m. the ST-A transported R61 to the activity room. R61 was not offered or assisted with oral care following breakfast. On 1/14/15, at 9:51 a.m. the NA-B verified routine morning cares for the residents included brushing their teeth or mouth care. NA-B confirmed she had not offered or assisted R48 or R61 with oral cares and stated they absolutely should have been done. On 1/14/15, at 12:14 p.m. the director of nursing (DON) confirmed R48 and R61 should have had mouth care done or at least offered mouth care during morning cares. The ORAL HYGIENE INDEPENDENT RESIDENT policy dated 11/2002, directed staff to assist or supervise oral hygiene care in the morning, at bedtime and when needed.	2 920		

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2 920	Continued From page 19 SUGGESTED METHOD OF CORRECTION: The director of nursing or her designee could develop policies and procedures to ensure residents receive oral hygiene as determined necessary by their individualized plan of care. The director of nursing or her designee could educate all appropriate staff on these policies and procedures. The director of nursing or her designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	2 920		
21426	MN St. Statute 144A.04 Subd. 4 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home.	21426		

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21426	Continued From page 20 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure 5 of 5 employees, (nursing assistant (NA)-C, NA-D, NA-E, NA-B, NA-A) received a two-step TST (Tuberculin Skin Test) prior to resident contact. This had the potential to affect all 33 residents residing in the facility. Findings include: NA-C's Tuberculin (Mantoux) Testing form revealed she was hired 12/22/14 and received the initial TST 12/22/14. However, did not receive the second TST. NA-D's Tuberculin (Mantoux) Testing form revealed she was hired 9/26/14, and received the initial TST on 9/30/14. However, did not receive the second TST. NA-E's Tuberculin (Mantoux) Testing form revealed she was hired 10/15/14, and received the initial TST on 10/16/14. However, did not receive the second TST. NA-B's Tuberculin (Mantoux) Testing form revealed she was hired 10/16/14, and received the initial TST on 10/25/14. However, did not receive the second TST. NA-A's Tuberculin (Mantoux) Testing form	21426		

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21426	Continued From page 21 revealed she was hired 11/17/14, however the TST portion of the form was blank which indicated NA-A had not received the TST prior to resident contact. On 1/15/14, at 11:08 a.m. the director of nursing (DON) confirmed the findings and stated the aforementioned employees did not receive the two-step TST as required. The facility's Human Recourses Management Policies and Procedures dated 5/25/14, indicated Mantoux (TST) screening for tuberculosis was required upon hire for all employees as required by statute or regulation. The facility's undated Tuberculosis Infection Control Plan (TBICP) Policy and Procedure indicated healthcare workers would have a pre-placement screening upon hire which included a two step TST / Mantoux or a single TB blood test. SUGGESTED METHOD OF CORRECTION: The administrator or director of nursing could review and / or revise their TB policy and procedure and educate staff accordingly to ensure on-going compliance. The administrator or DON could ensure all employees receive a two-step TST upon hire. The administrator or DON could develop an auditing system to ensure all employees receive the complete two-step TST. The quality assurance and assessment	21426		

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21426	Continued From page 22 committee could establish a system to audit tuberculosis testing to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		
21435	MN Rule 4658.0900 Subp. 1 Activity and Recreation Program; General Subpart 1. General requirements. A nursing home must provide an organized activity and recreation program. The program must be based on each individual resident's interests, strengths, and needs, and must be designed to meet the physical, mental, and psychological well-being of each resident, as determined by the comprehensive resident assessment and comprehensive plan of care required in parts 4658.0400 and 4658.0405. Residents must be provided opportunities to participate in the planning and development of the activity and recreation program. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide an individualized 1 to 1 activity program which consisted of visits and music for 1 of 3 residents reviewed for activities. Findings include: R31's annual Minimum Data Set (MDS) dated	21435		

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21435	Continued From page 23 6/24/14, indicated R31 was diagnosed with dementia and Parkinson's disease and had short and long term memory impairment. The MDS also indicated R31's activity preferences were unable to be assessed related to his cognitive impairment. The Cognitive Care Area Assessment (CAA) dated 6/26/14, indicated R31's mental function varied throughout the day and he struggled with inattention, disorganized thinking and expressed frustration at not being able to communicate his wishes. The Activity CAA dated 7/1/14, indicated the community life staff would encourage R31 and invite him to activities of interest and assist as needed. R31's care plan dated 1/7/15, indicated R31 was to receive 1:1 interactions, encouragement to participate in small groups and offered the CD player for individual music enjoyment. On 1/13/15, at 10:00 a.m. a group of residents were observed in a circle with small balls they were using for exercise class. R31 was observed to put the small ball on the floor and was not engaged in the small group activity. On 1/14/15, at 7:01 a.m. R31 was observed in his room, dressed and seated in the wheelchair. -At 7:29 a.m. R31 remained the same. -At 7:40 a.m. R31 remained the same. -At 7:53 a.m. R31 was observed at the breakfast table. -At 8:07 a.m. R31 was being fed his meal. -At 9:07 a.m. R31 was observed in his room. The TV was on to a morning news program and R31 had his back to the TV. -At 9:09 a.m. R31 was bent over in the	21435		

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21435	Continued From page 24	21435		

wheelchair and was trying to touch the floor with his right hand.
-At 9:15 a.m. R31 observed propelling his wheelchair in his room with his feet and leaned forward a couple of times reaching his right hand towards the floor.
-At 9:23 a.m. R31 remained up in the wheelchair in his room. R31's back remained to the TV.

At 12:45 p.m. the community life assistant (CLA)-A stated R31 had an activity goal for 3 to 4 1:1 visits per week. The CLA-A stated R31 loved watching the Twins on TV, watching the birds in the aviary and had a past love of hunting. The CLA-A stated R31 was hard to understand when he spoke and stated when she talked with R31 while he was being fed his breakfast meal that was considered a 1:1 activity.

At 12:57 p.m. R31's wife was visiting in his room.

The activity's In-Room 1:1 charting was reviewed for the months of September 2014, to December 2014, and the following was revealed:
-September- out of 12 opportunities R31 received 1:1 interactions two times.
-October- out of 12 opportunities, R31 received 1:1 interactions five times.
-November- out of 12 opportunities R31 received 1:1 interactions five times.
-December- out of 12 opportunities R31 received 1:1 interactions nine times.

At 1:05 p.m. R31's wife was having lunch with R31. She stated she did not know what activity programs R31 was receiving as he could not do

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21435	Continued From page 25 much anymore. She stated she knew they came into his room to visit him and reminisce. The surveyor explained to R31's wife the staff were documenting talking to R31 at breakfast time as a 1:1 activity. She stated that was not an activity and was "part of the job." On 1/15/15, at 9:00 a.m. the activity supervisor (AS) stated R31 was to receive a 1:1 visit 3 to 4 times a week. The AS stated herself and the CLA-A provided the 1:1 activity. The AS stated R31's most alert time was right away in the morning and a 1:1 visit prior to the breakfast meal would be the best. In addition, the AS stated she would not consider a 1:1 visit during a breakfast meal an activity. At this time, the director of nursing (DON) stated they needed to revise R31's care plan to identify how many times a week the 1:1 visits would occur. In addition, the AS stated R31 liked 70s rock and roll music and was an avid fisherman and hunter. On 1/15/15 at 9:08 a.m. the activity supervisor (AS) reviewed the In-Room 1:1 charting with the surveyor. The AS verified the documentation showed staff taking credit for 1:1s when feeding R31 his breakfast meal. At 9:17 a.m. the AS stated she would revise the care plan to identify the actual interventions to meet R31's activity interests as R31 did not participate in small groups. At 9:30 a.m. the AS verified R31's activity needs were not being met. The AS stated R31 liked the morning news and she would check and find his	21435		

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21435	Continued From page 26 CD player so that music could be played. At 9:58 a.m. the AS stated she found R31's CD player in his room with a 5 CD changer on it. The AS stated she worked full time and in the last month had only heard the CD player on twice. The undated Activity Department policy and procedure indicated an activity program would be designed to provide each resident with the opportunities to meet their activity needs. SUGGESTED METHOD FOR CORRECTION: The activity director and/or designee could review/revise policy and provide education for staff regarding resident activities. The Quality Assessment and Assurance (QAA) committee could do random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	21435		
21565	MN Rule 4658.1325 Subp. 4 Administration of Medications Self Admin Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician. This MN Requirement is not met as evidenced by:	21565		

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21565	Continued From page 27 Based on observation, interview and document review, the facility failed to ensure the self administration of medications was deemed safe 1 of 1 resident (R13) observed to self administer medication. Findings include: R13's quarterly Minimum Data Set (MDS) dated 10/3/14, indicated R13 was cognitively intact and had diagnoses that included end stage renal disease, anxiety, depression and post traumatic stress disorder. The MDS also identified R13 received dialysis. R13's undated care plan directed nursing staff to administer medications as ordered. R13's medical record lacked a self administration assessment. R13's Medication Administration Record (MAR) dated 1/1/15-1/31/15, identified orders that included Renvela tablet 800 mg (sevelamer carbonate) give 2 tablets by mouth three times a day for phosphate binder. The MAR lacked orders for self administration of medications. The MAR dated 1/15/14, at 12:00 p.m. indicated R14 had received the medication.	21565		

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21565	Continued From page 28 On 1/15/2015, at 12:16 p.m. R13 was observed positioned on her back with the head of the bed elevated approximately 75 degrees. A bedside table was placed over R13's bed. The dietary manager (DM) delivered R13's noon meal. A medication cup with 2 pills was observed on the bedside table. R13 stated the medication was her Renvela and registered nurse (RN)-D had delivered it to her room at 11:30 a.m. so she could take it when she began eating her meal. R13 was then observed to take the medication. On 1/15/2015, at 1:41 p.m. RN-D confirmed she had left the Renvela in a cup on the bedside table so R13 could take the noon dose when her meal tray arrived. RN-D stated she probably shouldn't have left the medication in the room, but she did so because if she didn't bring the pills right away R13 would refuse to take them. On 1/15/2015, at 2:14 p.m. the director of nursing (DON) confirmed R13 did not have an assessment completed to determine R13's ability to safely self administer medication. The DON also confirmed R13 did not have a physician's order to self administer medications. The DON stated R13's medications should not have been left in her room rather the nurse should have administered them as ordered. The Self Administration of Medication policy dated 2014, indicated the Medication Self Administration Safety Screen would be completed prior to the resident initiating self administration of	21565		

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21565	Continued From page 29 medications and with any medication changes, changes in function/condition that might affect the resident's ability to safely self administer medication. The policy also indicated on-going evaluations should occur at a minimum of quarterly. The policy indicated the interdisciplinary team would review the summary on the Medication Self Administration Safety Screen to determine appropriateness of self administration of medications. The determination would include whether the resident could self administer medications unsupervised, with supervision or was not safe to administer medications. Additionally, the policy indicated a physician order would be obtained indicating which medications the resident may self administer and with or without supervision. SUGGESTED METHOD OF CORRECTION: The director of nursing or her designee could development and implement policies and procedures to ensure residents are assessed and monitored to safely self-administer medications. The director of nursing or her designee could then monitor the appropriate staff for adherence to the policies and procedures. TIME PERIOD FOR CORRECTION: Twenty one (21) days	21565		
21620	MN Rule 4658.1345 Labeling of Drugs Drugs used in the nursing home must be labeled in accordance with part 6800.6300.	21620		

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21620	Continued From page 30 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to properly label 2 of 7 insulin vials with a "when opened" date in order to determine expiration date which had the potential to affect 2 of 4 residents (R3, R13) who received insulin. Findings include: On 1/15/15, at 1:22 p.m. the Country medication cart was reviewed with registered nurse (RN)-D. R13's open Novolog insulin 10 milliliter (ml) vial lacked a label or marking which indicated when the insulin vial had been opened. RN-D verified the insulin vial had been used for R13 and the vial was not labeled with a "when opened" date. RN-D stated the insulin vials should be labeled with the date they are opened. On 1/15/15, at 1:40 p.m. the Heritage medication cart was reviewed with RN-B. R3's open Lantus insulin 10 ml vial lacked a label or marking which indicated when the insulin vial had been opened. RN-B confirmed the insulin vials should be labeled with the date they are opened. On 1/15/15, at 1:50 p.m. RN-A stated the facility policy was to date insulin vials with a "when opened" date. In addition, if the insulin vial was not labeled it should not be used. On 1/15/15, at 2:25 p.m. the director of nursing (DON) confirmed her expectation was that insulin	21620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00830	A. BUILDING: _____ B. WING _____	01/15/2015

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21620	Continued From page 31 vials should be labeled with a "when opened" date. The Multi-Dose Vials policy dated 9/9/2008, directed staff to date insulin vials when first opened. A SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could develop and implement policies and procedures to ensure that all medications are labeled and stored properly; educate all staff. Then develop monitoring systems to ensure ongoing compliance and report the findings to the Quality Assurance Committee. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21620		
21942	MN St. Statute 144A.10 Subd. 8b Establish Resident and Family Councils Resident advisory council. Each nursing home or boarding care home shall establish a resident advisory council and a family council, unless fewer than three persons express an interest in participating. If one or both councils do not function, the nursing home or boarding care home shall document its attempts to establish the council or councils at least once each calendar year. This subdivision does not alter the rights of residents and families provided by section 144.651, subdivision 27.	21942		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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21942	Continued From page 32 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to attempt to form a family council within the past calendar year as required. This had the potential to affect all 33 residents who resided in the facility. Findings include: On 1/14/15, at 12:56 p.m. the social worker (SW) indicated the facility did not have a family council. SW stated she began working at the facility on 10/6/14, and had not yet made an attempt to establish a family council. SW stated registered nurse (RN)-A had been responsible for this prior to her employment. On 1/14/15, at 2:210 p.m. RN-A confirmed there had been no attempt to form a family council in the past year. A family council policy was requested and none was provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) and/or designee could review or revise policies, provide education for staff regarding formulation of a Family Council. The Quality Assessment and Assurance (QAA) committee could do random audits to ensure compliance.	21942		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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21942	Continued From page 33 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21942		