CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: 37FR

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

		PAKI	I - TO BE COM	PLETED BY I.	HE STAT	E SURVEY AGENCY	Fa	icility ID: 00830
MEDICARE/MEDICAID PRO (L1)			3. NAME AND ADD (L3) KARLSTAD (L4) 304 WASHIN (L5) KARLSTAD,	HEALTHCARE GTON AVENUE	CENTER	(L6) 56732	4. TYPE OF ACTION: 1. Initial 3. Termination 5. Validation	7(L8) 2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE (L9)	OF OWNERSHIP		7. PROVIDER/SUP		Y 09 ESRD	02 (L7) 13 PTIP 22 CLIA	7. On-Site Visit 8. Full Survey After Con	9. Other
	03/03/2015 (— () 1 TJC 3 Other	(L34) L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDING I	DATE: (L35)
11. LTC PERIOD OF CERTIFICA From (a): To (b): 12. Total Facility Beds 13. Total Certified Beds	46	(L18) (L17)	B. Not in Comp	ce With quirements		And/Or Approved Waivers Of The 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SNF) 5. Life Safety Code * Code: A	6. Scope of Servic 7. Medical Directo	or
	19 SNF 46	19 SNF (L39)	ICF	IID (L43)		15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)	
16. STATE SURVEY AGENCY F								
17. SURVEYOR SIGNATURE Lyla Burkman, H	HFE NEII		Date :	03/05/2015	(L19)	18. STATE SURVEY AGENCY AP		Date: 13t
	PART I	II - TO I	BE COMPLETEI	D BY HCFA RE	EGIONAL	OFFICE OR SINGLE STAT	E AGENCY	(220)
19. DETERMINATION OF ELIC _X	ole to Participate	(L21)		PLIANCE WITH C	IVIL	21. 1. Statement of Financi 2. Ownership/Control I 3. Both of the Above :	nal Solvency (HCFA-2572) nterest Disclosure Stmt (HCFA-	-1513)
22. ORIGINAL DATE OF PARTICIPATION 04/01/1987 (L24)		AGREEME SINNING E		4. LTC AGREEME ENDING DATE (L25)		26. TERMINATION ACTION: VOLUNTARY 00 01-Merger, Closure 02-Dissatisfaction W/ Reimbursement	INVOLUNTA 05-Fail to Med	et Health/Safety
25. LTC EXTENSION DATE:	A. Su	uspension o	SANCTIONS f Admissions: ension Date:	(L44) (L45)		03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	OTHER 07-Provider S 00-Active	Status Change
28. TERMINATION DATE:		29.	INTERMEDIARY/C	ARRIER NO.		30. REMARKS		
	(L28)		03001		(L31)			
31. RO RECEIPT OF CMS-1539	(L32)	32.	DETERMINATION C 03/03/2015	OF APPROVAL DAT	TE (L33)	DETERMINATION APPRO		
	(1.52)				(122)	DETERMINATION APPRO	VAL	



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 Weath

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



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

Form Approved OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1)	Provider / Supplier / CLIA / Identification Number 245468	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 3/3/2015
Nam	e of Facility		Street Address, City, State, Zip Code	
KA	ARLSTAD HEALTHCARE CENTER IN	С	304 WASHINGTON AVENUE W KARLSTAD, MN 56732	EST

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 Reg. # LSC	F0167 483.10(g)(1)		Correction Completed 02/13/2015		F0176 483.10(n)	Correction Completed 02/13/2015	ID Prefix Reg. # LSC	F0248 483.15(f)(1)		Correction Completed 02/13/2015
ID Prefix Reg. # LSC	F0279 483.20(d), 48	3.20(k)(1)	Correction Completed 02/13/2015	ID Prefix Reg. # LSC	F0280 483.20(d)(3), 483.10(k)(Correction Completed 02/13/2015 2)	ID Prefix Reg. # LSC	F0281 483.20(k)(3)(i)		Correction Completed 02/13/2015
ID Prefix Reg. # LSC	F0282 483.20(k)(3)(i		Correction Completed 02/13/2015	ID Prefix Reg. # LSC	F0312 483.25(a)(3)	Correction Completed 02/13/2015	Reg. #	F0356 483.30(e)		Correction Completed 02/13/2015
	F0431 483.60(b), (d)		Correction Completed 02/13/2015		F0456 483.70(c)(2)	Correction Completed 02/13/2015				
Reg. #				Reg. #						
Reviewed E	Зу	Reviewed	I By	Date:	Signature of Sur	veyor:	1		Date:	
State Agen	су	LB/mn	1	03/05/20	15	28035	5		03/0	3/2015
Reviewed E	Зу	Reviewed	I Ву	Date:	Signature of Sur	veyor:			Date:	
Followup t	o Survey Cor 1/15/	npleted or 2015	1:		Check for any Unco				YES	NO

Form Approved OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 245468	(Y2) Multiple Construction A. Building B. Wing 01 - MAIN BUILDING 01	(Y3) Date of Revisit 2/26/2015
Name of Facility	Street Address, City, State, Zip Code	

KARLSTAD HEALTHCARE CENTER INC

Street Address, City, State, Zip Code 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
		Correction				Correction					Correction
ID Prefix		Completed 01/31/2015	ID Prefix			Completed 02/02/2015		ID Prefix			Completed 02/02/2015
•	NFPA 101		_	NFPA 101				•	NFPA 101		
LSC	K0050		LSC	K0052			<u> </u>	LSC	K0054		-
		Correction				Correction					Correction
ID D ('		Completed	15.5 (Completed					Completed
ID Prefix		02/02/2015				02/02/2015					02/02/2015
	NFPA 101 K0062			NFPA 101 K0067				•	NFPA 101 K0154		_
	K0002		150	N0007					K0154		_
		Correction				Correction					Correction
ID Dog for		Completed	ID Doctor			Completed		ID Destis			Completed
ID Prefix	-	02/02/2015									_
	NFPA 101 K0155		Reg. #					Reg. #			_
	110100										
		Correction				Correction					Correction
ID Profiv		Completed	ID Profix			Completed		ID Profix			Completed
											<u> </u>
Reg. # LSC			Reg. # LSC					Reg. # LSC			<u> </u>
		0 "				0 "					0 "
		Correction Completed				Correction Completed					Correction Completed
ID Prefix			ID Prefix					ID Prefix			
Reg. #			Reg. #					Reg. #			
LSC			LSC					LSC			_
Reviewed I	Ву F	Reviewed By	Date:	Signature	of Sur	veyor:	1			Date:	
State Agen	су	PS/mm	03/05/20	15		272	00			02/	26/2015
Reviewed I	Ву Г	Reviewed By	Date:	Signature	of Sur	veyor:				Date:	
CMS RO											
Followup t	o Survey Com	•		Check for any	Uncor	rected Defic	cienci	es. Was a	Summary of the Facility?	1	
	1/15/2	1015		Uncorrecte	a Delic	ielicies (CIV	13-230	n j Sent to	tile Facility?	YES	NO

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: 37FR

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

	PART	I - TO BE COM	PLETED BY T	THE STAT	E SURVEY AGENCY		Fac	cility ID: 00830
MEDICARE/MEDICAID PROVIDER NO. (L1) 245468 2.STATE VENDOR OR MEDICAID NO. (L2) 012028600		3. NAME AND AD (L3) KARLSTAD (L4) 304 WASHIN (L5) KARLSTAD	HEALTHCARE	CENTER	(L6) 56732	1. In 3. Te 5. Va	ermination alidation	2 (L8) 2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF OWNE (L9)		7. PROVIDER/SUI	05 HHA	09 ESRD	02 (L7) 13 PTIP 22 CL	8. Fu	n-Site Visit ull Survey After Com	9. Other plaint
6. DATE OF SURVEY 01/15/2 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	(L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL	YEAR ENDING D	ATE: (L35)
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds	46 (L18) 46 (L17)	X B. Not in Com	nce With equirements	n	And/Or Approved Waive 2. Technical Pers 3. 24 Hour RN 4. 7-Day RN (Ru 5. Life Safety Co * Code: B*	onnel6 ral SNF)8	Requirements: 5. Scope of Service 7. Medical Director 8. Patient Room Siz 9. Beds/Room	r
14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 46	19 SNF	ICF	IID		15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)	
(L37) (L38) 16. STATE SURVEY AGENCY REMARKS	(L39)	(L42) SHOW LTC CANCELL	(L43) LATION DATE):					
17. SURVEYOR SIGNATURE Theresa Gullingsrud, I			02/12/2015	(L19)	18. STATE SURVEY AGE	المر , Enforce		Date: 9t 02/26/2015 (L20)
DETERMINATION OF ELIGIBILITY		20. COM	D BY HCFA R I IPLIANCE WITH CHTS ACT:			of Financial Solvency (Control Interest Discl	(HCFA-2572)	1513)
22. ORIGINAL DATE OF PARTICIPATION 04/01/1987 (L24)	23. LTC AGREEMI BEGINNING (L41)		24. LTC AGREEMI ENDING DAT (L25)		26. TERMINATION ACT VOLUNTARY 01-Merger, Closure 02-Dissatisfaction W/ Reim 03-Risk of Involuntary Term	bursement	(L2 INVOLUNTA 05-Fail to Mee 06-Fail to Mee	RY t Health/Safety
25. LTC EXTENSION DATE: (L27)	27. ALTERNATIVI A. Suspension of B. Rescind Sus	of Admissions:	(L44) (L45)		04-Other Reason for Withdra		OTHER 07-Provider St 00-Active	tatus Change
28. TERMINATION DATE:	(L28)	. INTERMEDIARY/C	ARRIER NO.	(L31)	30. REMARKS Posted 03/03/2	015 Co.		
31. RO RECEIPT OF CMS-1539	(L32)	. DETERMINATION (OF APPROVAL DA	(L33)	DETERMINATION A	APPROVAL		



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:

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

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

<u>Remedies</u> - 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;

<u>Potential Consequences</u> - 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

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

(X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 01/15/2015 B. WING 245468 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 304 WASHINGTON AVENUE WEST KARLSTAD HEALTHCARE CENTER INC KARLSTAD, MN 56732 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 000 **INITIAL COMMENTS** F 000 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 167 483.10(g)(1) RIGHT TO SURVEY RESULTS -F 167 F 167 SS=C | READILY ACCESSIBLE A resident has the right to examine the results of The preparation of the following plan the most recent survey of the facility conducted by of correction for this deficiency does Federal or State surveyors and any plan of not constitute and should not be correction in effect with respect to the facility. interpreted as an admission nor an agreement by the facility of the truth The facility must make the results available for of the facts alleged or conclusions examination and must post in a place readily set forth in the statement of accessible to residents and must post a notice of deficiencies. The plan of correction their availability. prepared for this deficiency was executed solely because provisions of state and federal law require it. This REQUIREMENT is not met as evidenced Without waiving the foregoing statement, the facility states with by: Based on observation and interview, the facility respect to: failed to ensure the most recent state survey 1. The most recent survey results results were readily available and accessible to were placed on the counter next to residents, families and visitors of the facility which reception on 1/17/2015. had the potential to affect all 33 residents residing 2. A sign was posted at reception to in the facility, families and/or visitors. let residents and visitors know where to locate survey results on 1/20/2015. Findings include: (X6) DATE TITLE LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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

DEITHOR	S SOR MEDICADE 9	MEDICAID SERVICES				OMB NC	0. 0938-0391
I STATEMENT OF DEFICIENCIES		1		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245468	B. WING			01/	15/2015
	/EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	304 WASHINGTON AVENUE WEST KARLSTAD, MN 56732 ID PROVIDER'S PLAN OF COR. ULL PREFIX (EACH CORRECTIVE ACTION S		ARLSTAD, MN 56732 PROVIDER'S PLAN OF CORRECTIVE ACTION SHOU	JLD BE	(X5) COMPLETION DATE
F 167	Continued From page On 1/12/15, at 3:17 the facility the most were not observed to On 1/13/15, at 8:30 survey results were On 1/14/15, at 1:15 asked where the su administrator was a results. At this time stated she had place were in a binder in added, the survey remedical records staresults had remaine holiday season wholiday season	p.m. during the initial tour of recent state survey results to be posted. a.m. the most recent state not observed to be posted. p.m. the administrator was rvey results were posted. The lso unable to find the survey the medical records staff the business office. She results were moved when the vas placed on the counter results binder had laid. The laft member stated the survey results binder had laid. The laft member stated the survey results binder had laid. The laft member stated the survey results binder had laid. The laft member stated the survey results binder to locate them. Trector of nursing (DON) stated a policy related to the survey ndard of practice was to have		167	DEFICIENCY)	erns or ults een mber s. signee k, then onthly. resented e DNS. liscussed surance DA	

STATEMENT O AND PLAN OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		245468	B. WING			01/	15/2015
	OVIDER OR SUPPLIER HEALTHCARE CENTI	ER INC		304	REET ADDRESS, CITY, STATE, ZIP CODE 4 WASHINGTON AVENUE WEST ARLSTAD, MN 56732		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 176	were still unable to fi binder, however, had was now back on the entrance of the facilit 483.10(n) RESIDEN DRUGS IF DEEMED An individual resider the interdisciplinary §483.20(d)(2)(ii), ha practice is safe. This REQUIREMEN by: Based on observative review, the facility fadministration of most of 1 resident (R13) medication. Findings include: R13's quarterly Min 10/3/14, indicated Faddiagnoses that disease, anxiety, destress disorder. The received dialysis.	a.m. the DON stated they nd the original survey results d printed a new copy which e counter by the front ty. IT SELF-ADMINISTER D SAFE Int may self-administer drugs if team, as defined by s determined that this IT is not met as evidenced tion, interview and document ailed to ensure the self edications was deemed safe 1 observed to self administer imum Data Set (MDS) dated R13 was cognitively intact and included end stage renal expression and post traumatic e MDS also identified R13		176	F 176 The preparation of the follow of correction for this deficien not constitute and should no interpreted as an admission agreement by the facility of the facts alleged or concluset forth in the statement of deficiencies. The plan of coprepared for this deficiency executed solely because profistate and federal law requivithout waiving the foregoin statement, the facility states respect to: 1. Resident 13 has had a Medication Self-Administrat Safety Screen completed on It showed that at this time requality to self administer he medications. She falls back sleep/does not take as order 2. All resident's will be review quarterly care conferences needed for the need for a Medication Self-Administrat Safety Screen.	cy does t be nor an the truth usions rrection was ovisions uire it. ng with ion 1 2/2/15. esident is r k to ered. ewed with and as	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245468	B. WING			01.	/15/2015
	ROVIDER OR SUPPLIER D HEALTHCARE CENTE	ER INC	·	30	TREET ADDRESS, CITY, STATE, ZIP CODE 04 WASHINGTON AVENUE WEST ARLSTAD, MN 56732		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	1	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 176	assessment.	e 3 I lacked a self administration ministration Record (MAR)	F	176	3. Nurses will be In-serviced or resident self administration of medications on or before 2/13/4. The Director of Nurses/desiwill perform audits 2 times a we for one month, then weekly for month, then monthly. The data collected will be presented to the	15. gnee eek one a ne	
	dated 1/1/15-1/31/15 included Renvela tab carbonate) give 2 tab day for phosphate bi orders for self admin	, identified orders that olet 800 mg (sevelamer olets by mouth three times a onder. The MAR lacked istration of medications. The at 12:00 p.m. indicated R14			QA committee by the DNS. The data will be reviewed/discusse the Quarterly Quality Assurance Meeting. At this time the QA Committee will make the decision/recommendation regardly necessary follow-up studies. Completion Date 2/13/15	ne d at ee arding	
	positioned on her ba elevated approximate table was placed over manager (DM) deliver medication cup with bedside table. R13 sher Renvela and reg delivered it to her roo could take it when sher R13 was then observed.	16 p.m. R13 was observed ck with the head of the bed ely 75 degrees. A bedside er R13's bed. The dietary ered R13's noon meal. A 2 pills was observed on the stated the medication was istered nurse (RN)-D had om at 11:30 a.m. so she he began eating her meal. Eved to take the medication.					
	had left the Renvela so R13 could take th tray arrived. RN-D s have left the medica	1 p.m. RN-D confirmed she in a cup on the bedside table are noon dose when her meal stated she probably shouldn't tion in the room, but she did dn't bring the pills right away take them.					

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

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	CONSTRUCTION	(X3) DATE S	
	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _		COMPL	EIED
		245468	B. WING			01/1	5/2015
NAME OF PE	ROVIDER OR SUPPLIER	1		i	TREET ADDRESS, CITY, STATE, ZIP CODE		
KARLSTA	D HEALTHCARE CENTE	R INC			14 WASHINGTON AVENUE WEST ARLSTAD, MN 56732		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	1	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 176	Continued From page	e 4	F	176			
	(DON) confirmed R1: assessment complet to safely self adminis also confirmed R13 of order to self administ stated R13's medica	ed to determine R13's ability Iter medication. The DON Itel not have a physician's Iter medications. The DON Itions should not have been It the nurse should have					
	dated 2014, indicate Administration Safet prior to the resident imedications and with changes in function/resident's ability to smedication. The polevaluations should quarterly. The policy interdisciplinary tear on the Medication Screen to determine administration of me would include wheth administer medications. Additing physician order would include which medications that is administer and with	icy also indicated on-going occur at a minimum of y indicated the in would review the summary elf Administration Safety appropriateness of self idications. The determination for the resident could self ons unsupervised, with not safe to administer onally, the policy indicated a ld be obtained indicating the resident may self or without supervision.					
F 248 SS=D	483.15(f)(1) ACTIVI	TIES MEET	F	248	3		

Event ID: 37FR11

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMF	SURVEY
		245468	B. WING _			01.	15/2015
	ROVIDER OR SUPPLIER			30-	REET ADDRESS, CITY, STATE, ZIP CODE 4 WASHINGTON AVENUE WEST ARLSTAD, MN 56732		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	.D BE	(X5) COMPLETION DATE
F 248	Continued From pag	ge 5	F 2	248	F 248		
	of activities designed the comprehensive the physical, mental of each resident. This REQUIREMENT by: Based on observation review, the facility faindividualized 1 to 1 consisted of visits a reviewed for activitien findings include: R31's annual Minimal 6/24/14, indicated Fadementia and Parkiand long term memalso indicated R31's unable to be assess impairment. The Coassessment (CAA) R31's mental function and he struggled withinking and expressible to communicated 7/1/14, indicated 7/1/14, indi	activity program which nd music for 1 of 3 residents es. from Data Set (MDS) dated R31 was diagnosed with nson's disease and had short ory impairment. The MDS is activity preferences were sed related to his cognitive organitive Care Area dated 6/26/14, indicated on varied throughout the day ith inattention, disorganized issed frustration at not being the his wishes. The Activity CAA ated the community life staff R31 and invite him to activities st as needed.			The preparation of the follow of correction for this deficient not constitute and should not interpreted as an admission ragreement by the facility of the facts alleged or concluset forth in the statement of deficiencies. The plan of corprepared for this deficiency we executed solely because proof state and federal law requivithout waiving the foregoing statement, the facility states respect to: 1. The care plan for resident been reviewed and revised of 1/15/15. Resident 31 is bein encouraged to participate in group activities and is received visits 2-3 times per week. 2. All residents have been refor the need of 1:1 visits by Community Life staff. 2 other residents have been added to 1:1 needs list. 3. Education has been composite with Community Life staff registers will be reviewed for need for 1:1 visits upon adminimized per Community Life or designee.	cy does t be nor an he truth disions rection was visions ire it. g with t 31 has on ig small ing 1:1 eviewed er to the bleted garding All or the hission, ot	
		ted 1/7/15, indicated R31 was					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION	COMPLETED
		245468	B. WING		01/15/2015
	ROVIDER OR SUPPLIER	ITER INC		STREET ADDRESS, CITY, STATE, ZIP COD 304 WASHINGTON AVENUE WEST KARLSTAD, MN 56732	E
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLET
F 248	participate in small player for individual on 1/13/15, at 10: were observed in were using for exet to put the small be engaged in the small be engaged in the small on 1/14/15, at 7:00 m, dressed an -At 7:29 a.m. R31 -At 7:40 a.m. R31 -At 7:53 a.m. R31 table. -At 8:07 a.m. R31 TV was on to a m had his back to the -At 9:09 a.m. R31 wheelchair and whis right hand. -At 9:15 a.m. R31 wheelchair in his forward a couple towards the floorAt 9:23 a.m. R31 in his room.	Il groups and offered the CD al music enjoyment. O0 a.m. a group of residents a circle with small balls they ercise class. R31 was observed all on the floor and was not nall group activity. O1 a.m. R31 was observed in his diseated in the wheelchair. remained the same. remained the same. was observed at the breakfast was being fed his meal. was observed in his room. The orning news program and R31 were TV. Was bent over in the last trying to touch the floor with loserved propelling his room with his feet and leaned of times reaching his right hand	F 2	48 4. The Community Life designee will audit 1:10 with resident Care Plantimes 3 months. The dwill be presented to the committee by the Committee by the Committee of the data will reviewed/discussed at Quality Assurance Meetime the QA Committee the decision/recommer regarding any necessal studies. Completion Date 2/13/	compliance weekly ata collected QA munity Life be the Quarterly eting. At this e will make ndation ry follow-up

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '		NSTRUCTION	(X3) DATE SURVEY COMPLETED			
		245468	B. WING				01/15/2015	
	ROVIDER OR SUPPLIER D HEALTHCARE CEN	NTER INC		STREET ADDRESS, CITY, STATE, ZIP COI 304 WASHINGTON AVENUE WEST KARLSTAD, MN 56732		DE .		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREF TAG	- 1	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 248	while he was bein was considered a	g fed his breakfast meal that	F	248				
	The activity's In-F for the months of 2014, and the followard of 1:1 interactions to 1:1 interactions for November out of 1:1 interactions for 1:1 interacti	Room 1:1 charting was reviewed September 2014, to December owing was revealed: of 12 opportunities R31 received on times. 2 opportunities, R31 received over times. f 12 opportunities R31 received over times. f 12 opportunities R31 received over times. f 12 opportunities R31 received						
	R31. She stated a programs R31 was much anymore. Sinto his room to visurveyor explained documenting talk	s wife was having lunch with she did not know what activity as receiving as he could not do the stated she knew they came isit him and reminisce. The ed to R31's wife the staff were ing to R31 at breakfast time as a stated that was not an activity the job."						
	(AS) stated R31 times a week. The CLA-A provided R31's most alert morning and a 1 would be the best	00 a.m. the activity supervisor was to receive a 1:1 visit 3 to 4 to AS stated herself and the the 1:1 activity. The AS stated time was right away in the 1 visit prior to the breakfast meal st. In addition, the AS stated she er a 1:1 visit during a breakfast						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		NSTRUCTION .	(X3) DATE SURVEY COMPLETED	
		245468	B. WING			01/	15/2015
	ROVIDER OR SUPPLIER D HEALTHCARE CENTE	ER INC		304 V	ET ADDRESS, CITY, STATE, ZIP CODE VASHINGTON AVENUE WEST LSTAD, MN 56732	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 248	nursing (DON) stated care plan to identify l 1:1 visits would occu	nis time, the director of d they needed to revise R31's now many times a week the r. In addition, the AS stated nd roll music and was an	F	248			
	(AS) reviewed the In surveyor. The AS ve	.m. the activity supervisor -Room 1:1 charting with the rified the documentation credit for 1:1s when feeding eal.					
	care plan to identify	stated she would revise the the actual interventions to nterests as R31 did not groups.					
	were not being met. morning news and s	verified R31's activity needs The AS stated R31 liked the she would check and find his usic could be played.					
	player in his room w AS stated she work	stated she found R31's CD vith a 5 CD changer on it. The ed full time and in the last and the CD player on twice.					
F 279	procedure indicated designed to provide	y Department policy and I an activity program would be each resident with the et their activity needs.	1	- 279			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTER:	S FOR MEDICARE &	MEDICAID SERVICES				CIVID NO	. 0936-039 1
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245468	B. WING			01/	15/2015
NAME OF PE	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				30	04 WASHINGTON AVENUE WEST		
KARLSTA	D HEALTHCARE CENTE	ER INC		K	ARLSTAD, MN 56732		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 279 SS=D	COMPREHENSIVE A facility must use the to develop, review and comprehensive plan. The facility must develop plan for each resident objectives and timeted medical, nursing, and needs that are ident assessment. The care plan must to be furnished to at highest practicable psychosocial well-bereast.	care plans the results of the assessment of revise the resident's of care. The lop a comprehensive care of that includes measurable ables to meet a resident's of mental and psychosocial ified in the comprehensive the services that are tain or maintain the resident's obysical, mental, and the long as required under	F	279	F 279 The preparation of the following of correction for this deficiency not constitute and should not be interpreted as an admission nor agreement by the facility of the of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corresprepared for this deficiency was executed solely because provision of state and federal law requires Without waiving the foregoing statement, the facility states with respect to: 1. Resident 15's care plan has	ction s sions it.	
	§483.25; and any set be required under § due to the resident's §483.10, including t under §483.10(b)(4)	ervices that would otherwise 483.25 but are not provided s exercise of rights under he right to refuse treatment).			been reviewed and revised to include oxygen use, urinary ca and repositioning for preventic skin issues as of 1/20/15. Resident 17's care plan has be revised to include the monitorion the side effects of anticoagula	theter n of een ng of	
	by: Based on interview facility failed to devirelated to positionin reviewed for position plan interventions reindwelling urinary c (R15) reviewed with develop care plan i use for 1 of 2 reside oxygen. In addition care plan intervention of anticoagulation residence.	and document review, the elop care plan interventions g for 1 of 4 residents (R15) wining. Failed to develop care elated to the care of an atheter for 1 of 1 resident in a catheter and failed to interventions related to oxygen ents (R15) reviewed with in, the facility failed to develop ons to monitor the side effects medication use for 1 of 1 ewed on Coumadin.			therapy as of 1/20/15. 2. All resident care plans of the receiving oxygen, on anticoagh 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 quarte with significant change begin 1/22/15.	nose ulant ave wed e rly and	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245468	B. WING			01/1	5/2015
	(EACH DEFICIENC	ER INC TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	30- K.A X	REET ADDRESS, CITY, STATE, ZIP CODE 4 WASHINGTON AVENUE WEST ARLSTAD, MN 56732 PROVIDER'S PLAN OF CORRECTIV (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	D BE	(X5) COMPLETION DATE
F 279			Coordin charts n data col the QA data wil the Qua Meeting Commit decisior any neo		4. Director of Nursing/ MDS Coordinator/ or designee will charts monthly for 3 months. data collected will be present the QA committee by the DN data will be reviewed/discuss the Quarterly Quality Assurat Meeting. At this time the QA Committee will make the decision/recommendation re any necessary follow-up stud Completion Date 2/13/15	The ted to S. The sed at nce garding	
	dated 2/13/14 indicated neurogenic bladder so she required and Due to R15's history infections (UTI) and had a leg bag on at every 2 hours arour system closed by ling R15's Pressure Ulc indicated R15's skir she required extens reposition or offload was on a reposition	Area Assessment (CAA) ated R15 had a history of and decompensated bladder indwelling urinary catheter. If yof frequent urinary tract is sepsis related to UTI's, she all times which was emptied and the clock to keep the miting possible contamination. Her CAA dated 2/13/14, the was currently dry and intact, sive assist of one staff to d. The CAA also indicated R15 thing program of every 2-3 continuous oxygen.					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		NSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245468	B. WING			c	1/15/2015	
	ROVIDER OR SUPPLIER D HEALTHCARE CENT	ER INC	1	304 V	ET ADDRESS, CITY, STATE, ZIP CODE VASHINGTON AVENUE WEST LSTAD, MN 56732			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 279	Continued From pag	ge 11	F	279				
	identify interventions program, her diagno and corresponding i indwelling urinary ca diagnosis of COPD interventions such a On 1/14/2015, at 11 (RN)-A verified R15 used oxygen. RN-A did not have interve urinary catheter car (DON) confirmed the addressed position oxygen use. The Care Plan Conindicated all care pi	:25 a.m. registered nurse had a urinary catheter and A confirmed R15's care plan entions to address positioning, e or the use of oxygen. 04 p.m. the director of nursing the care plan should have ling, urinary catheter care and enpletion policy dated 8/2013, lans should include individual						
	and/or combined for current acute and of which they are rece and/or care which is heart disease. The plan should include frequency of cather	cus problems that address chronic clinical conditions for eiving medications, treatment may include: diabetes, COPD, e policy also indicated the care e elimination including ter care, oxygen and type of d for all activities of daily living						
	· Mariana Adalasa Adal							

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCT			E SURVEY MPLETED
		245468	B. WING			0	1/15/2015
	ROVIDER OR SUPPLIER D HEALTHCARE CENTE	ER INC		STREET ADDRESS, CITY, STATE, ZIP CO 304 WASHINGTON AVENUE WEST KARLSTAD, MN 56732		ODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRE EACH CORRECTIVE ACTION SH DSS-REFERENCED TO THE API DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 279	Continued From pag	e 12	F	279			
	the side effects of Co	ed interventions to monitor oumadin (an anticoagulation sliminate or reduce the risk of					
	R17's diagnoses as heart rate), hyperter	t dated 10/31/14, identified atrial fibrillation (irregular asion (high blood pressure) t failure (decrease in heart bod).					
	R17's admission Mil 11/7/14, indicated R therapy.	nimum Data Set (MDS) dated 17 received anticoagulant					
	R17's Physician Ord indicated R17 was of 2 milligrams (mg) da	der sheet dated 1/2/2015, ordered to be given Coumadin aily.					
	to identify her diagn corresponding inter to observe for side therapy usage, such	olan dated 12/1/2014, failed losis of atrial fibrillation and ventions which directed staff effects of anticoagulation has excessive bleeding, ational normalized ratio					

	of DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245468	B. WING			01/1	5/2015
	ROVIDER OR SUPPLIER D HEALTHCARE CENTE	R INC		304	REET ADDRESS, CITY, STATE, ZIP CODE WASHINGTON AVENUE WEST RLSTAD, MN 56732		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 279	Continued From page monitoring (INR - lat clotting levels). On 1/15/15, at 9:56 a verified R17 was on RN-B confirmed R17 identification of R17 and the side effect matherapy. On 1/15/15, at 10:25 (DON) confirmed R1 identified the atrial fill subsequent Coumacon The Care Plan Comindicated care plans identify medication to Coumadin for abnorus 483.20(d)(3), 483.10 PARTICIPATE PLANT The resident has the incompetent or other	e 13 b work to identify blood a.m. registered nurse (RN)-B a daily dose of Coumadin. 's care plan lacked s diagnosis of atrial fibrillation conitoring for anticoagulation a.m. the director of nursing 7's care plan should have corillation diagnosis and din therapy usage. pletion policy dated 8/2013, should be individualized and therapy monitoring such as mal bleeding and bruising. D(k)(2) RIGHT TO UNING CARE-REVISE CP e right, unless adjudged rwise found to be		2279	F 280 The preparation of the followin of correction for this deficiency not constitute and should not be interpreted as an admission not constitute and admissio	does oe	
	participate in planning changes in care and A comprehensive care within 7 days after the comprehensive assinterdisciplinary team physician, a register for the resident, and	the laws of the State, to any care and treatment or a treatment. are plan must be developed the completion of the essment; prepared by an any, that includes the attending ared nurse with responsibility of other appropriate staff in mined by the resident's needs,			agreement by the facility of the of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corresprepared for this deficiency was executed solely because provious state and federal law require Without waiving the foregoing statement, the facility states we respect to:	e truth ions ection as isions e it.	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i i	PLE CONSTRUCTION G		E SURVEY PLETED
		245468	B. WING _		01	/15/2015
,	ROVIDER OR SUPPLIER D HEALTHCARE CENTE	ER INC		STREET ADDRESS, CITY, STATE, ZIP COI 304 WASHINGTON AVENUE WEST KARLSTAD, MN 56732	DE .	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE BE APPROPRIATE	(X5) COMPLETION DATE
F 280	the resident, the resilegal representative; and revised by a tea each assessment. This REQUIREMEN by: Based on interview facility failed to revising frequency of an actipate preferences for 1 of for activities. Findings include: R31's care plan data to receive 1:1 interaparticipation in smaplayer for individual On 1/14/15, at 12:4 assistant (CLA)-A significant for the distance of the birds in the aviation that the birds in the aviation of the birds in the birds in the aviation of the birds in	acticable, the participation of dent's family or the resident's and periodically reviewed m of qualified persons after T is not met as evidenced and document review, the e the care plan to include the vity program and activity 3 residents (R31) reviewed ed 1/7/15, indicated R31 was ctions, encourage II groups, and offer the CD	F 2	1. The care plan for rebeen reviewed and rev 1/15/15. Resident 31 is encouraged to participa group activities and is visits 2-3 times per were 2. All residents have reviewed for the need by Community Life staresidents have been at 1:1 needs list. 3. Members of the Interesident revision where changes identified that require a change in the or before 2/13/15. The daily at 9am, Monday Resident change in coincidents will be discustime the appropriate desident to determine are needed, and if so done.	rised on s being ate in small receiving 1:1 ek. been of 1:1 visits ff. 2 other dded to the erdisciplinary ssional nurses he process of an there are twould e care plan on the IDT meets thru Friday. Indition or ssed. At that the partment will ecking the erif revisions	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245468	B. WING			01/	15/2015
	ROVIDER OR SUPPLIER D HEALTHCARE CENT	ER INC		30-	REET ADDRESS, CITY, STATE, ZIP CODE 4 WASHINGTON AVENUE WEST ARLSTAD, MN 56732		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 280	The activity In-Roor for the months of Se 2014September- out of 1:1 interactions twic -October- out of 12 1:1 interactions five -November- out of 1 1:1 interactions five	m 1:1 charting was reviewed eptember 2014, to December 12 opportunities R31 received e. opportunities, R31 received times. 2 opportunities R31 received times. 12 opportunities R31 received times. 12 opportunities R31 received	F	280	4. 2 chart audits will be don weekly for 3 months by the of Nursing or designee. The collected will be presented to QA committee by the DNS. data will be reviewed/discuss the Quarterly Quality Assura Meeting. At this time the QA Committee will make the decision/recommendation reany necessary follow-up stu	Director e data to the The esed at ance A	
	(AS) stated R31 wa times a week. At thi (DON) stated they r to identify how man would occur. In add	a.m. the activity supervisor s to receive a 1:1 visits 3 to 4 s time, the director of nursing needed to revise the care plan y times a week the 1:1 visits lition, the AS stated R31 liked usic and was also an avid er.			Completion Date 2/13/15		
	care plan to identify	stated she would revise the the actual interventions to interests as R31 did not groups.					
	were not being met	s verified R31's activity needs The AS stated R31 liked the She would check and find his					
	player in his room was AS stated she work	S stated she found R31's CD with a 5 CD changer on it. The ked full time and in the last ard the CD player on twice.				`	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245468	B. WING		01/15/2015
	ROVIDER OR SUPPLIER D HEALTHCARE CENTE	ER INC	3	TREET ADDRESS, CITY, STATE, ZIP CODE 04 WASHINGTON AVENUE WEST (ARLSTAD, MN 56732	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 280	Continued From pag	e 16	F 280		
F 281 SS=D	Responsibility dated plans should accurate problems and needs change in the reside reflected on the care case manager in writer responsible for upda 483.20(k)(3)(i) SERV PROFESSIONAL STATE The services provide must meet profession. This REQUIREMEN by: Based on observation review, the facility faction (initial) care plan to its order to minimize factive reviewed for accident monitor blood glucotom (R64) reviewed who day. Findings include: R64's initial care plan minimize falls.	VICES PROVIDED MEET TANDARDS ed or arranged by the facility small standards of quality. IT is not met as evidenced on, interview and document siled to develop an admission identify safety interventions in Ills for 1 of 3 residents (R64) ents. The facility also failed to see levels for 1 of 1 resident or received insulin 4 times per ear lacked interventions to	F 281	F 281 The preparation of the following of correction for this deficiency not constitute and should not be interpreted as an admission no agreement by the facility of the of the facts alleged or conclusic set forth in the statement of deficiencies. The plan of corre prepared for this deficiency wa executed solely because provis of state and federal law require Without waiving the foregoing statement, the facility states w respect to: 1. Resident 64 has a care plar encompasses the following: fasfety and fall precautions. Physician orders have been obtained for gluco-scans twice 2. All new admissions in the pmonths have been reviewed a changes made if needed. An admission will have the Temp Care Plan completed the day admission.	r an truth ons ction s sions e it. ith that alls, e daily. oast 4 and y new orary

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURV COMPLETED	
		245468	B. WING			01.	/15/2015
	ROVIDER OR SUPPLIER	ER INC		30-	REET ADDRESS, CITY, STATE, ZIP CODE 4 WASHINGTON AVENUE WEST ARLSTAD, MN 56732		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 281	1/9/15, identified Regeneralized weakner Admission Nursing R64 had a history of within the previous a fall within the last admission. R64's Morse Fall Strate R64's undated Temfield for documentate to include wandering devices, fall risk an safety interventions. On 1/15/15, at 10:3 (RN)-B confirmed strick and intervention the care plan upon On 1/15/2015, at 2 (DON) verified R64 interventions to mit safety/fall risk show temporary care plan upon and the care plan upon temporary care plan upo	ursing Data Collection dated 64's reason for admission was ess and confusion. The Data Collection also indicated of falls with a fall occurrence month prior to admission and 2-6 months prior to cale dated 1/12/14 identified of falling. apporary Care Plan included a ation of safety/fall preventions and risk, restraints, assuasive dipersonal alarms. This is field was blank. 66 a.m. registered nurse she would have expected fall and to have been addressed on admission. 106 p.m. the director of nursing the stemporary care plan lacked mimize falls and confirmed all have been identified on the in.	F	281	3. IDT staff have been educate that all new residents must hat detailed personalized care plathe 21 st day of their initial adm Care plans need to be reviewed changed quarterly. Significant changes in resident status munoted in the care plan when consted. 4. Audits of care plan being completed within the first 21 cwill be done on all new admits the Director of Nurses or designative will be done weekly for months. The data collected was presented to the QA committed the DNS. The data will be reviewed/discussed at the Quality Assurance Meeting. It is the decision/recommendation regarding any necessary follows tudies. Completion Date 2/13/15	ve a n by ission. ed and t ist be hange lays s by gnee. 3 vill be ee by uarterly At this nake	
		dual Resident Care Plan ed an individual resident care					

OLIVILA	O I OIL WILDIOANL O	I VILDICAID SERVICES				()(0) 5 475	NUDVEN	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245468	B. WING			01/1	15/2015	
	ROVIDER OR SUPPLIER D HEALTHCARE CENT	ER INC		304	REET ADDRESS, CITY, STATE, ZIP CODE 4 WASHINGTON AVENUE WEST ARLSTAD, MN 56732			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 281	plan must be initiate	ed upon admission to the ne did not address the content	F	281				
	R64 received insuli receive blood glucc	n four times a day and did not use monitoring.						
	R64's Admission Readmitted to the faci	ecord identified R64 was lity from the hospital on 1/9/15.						
	indicated R64 had sub-optimal bloods	gress noted dated 1/7/15, type 2 diabetes mellitus with sugar control that still required monitoring and management.						
	R64's hospital nurs indicated R64 rece times per day while	ses noted dated 1/7/15, sived blood glucose testing four e in the hospital.						
	identified medication include insulin glar 25 units into the skinsulin lispro 100 units from as Humalog three times daily but also identified Sure Comfort pen syringes and Truer test strips). These to have a handwrite	spital After Visit Summary (AVS) ons that had changed to gine 100 unit/ml injection inject kin nightly for diabetes and unit/ml injection, commonly g, inject 12 units into the skin efore meals for diabetes. The ditems to continue included needles, Sure Comfort insulin test Test strips (glucose blood e items on the AVS were noted then question mark located in kt to the item on the AVS paper						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ı	(X2) MULTIPLE CONSTRUCTION A. BUILDING			TE SURVEY MPLETED	
		245468	B. WING			01/15/2015		
	ROVIDER OR SUPPLIER D HEALTHCARE CEN	TER INC		STREET ADDRESS, CITY, STATE, ZIP CODE 304 WASHINGTON AVENUE WEST KARLSTAD, MN 56732				
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 281	Continued From pa	ige 19	F	281				
	insulin glargine 100 25 u subcutaneous Humalog 100 u/ml	rders dated 1/9/14, included 0 units (u)/milliliters (ml) inject (sq) nightly for diabetes, and inject 12 units sq before meals Physician Orders lacked an cose monitoring.						
	On 1/13/15, at 9:3 ambulating in the hand gait belt. Her	3 a.m. R64 was observed nallway with assist of one staff gait was steady.						
	seated in a wheeld	39 a.m. R64 was observed chair in the activity room. R64 self, sitting quietly at the table, sed at her waist.		AMBRET DESIGNATION OF THE AMBRET				
	was receiving insunot have blood gluken-B stated R64 symptoms of hyperadmission. RN-B discharge instruct strips with a quest which indicated cluder. RN-B states	36 a.m. RN-B confirmed R64 alin four times per day and did acose monitoring checks done, that not had any signs or er or hypoglycemia since her also confirmed the hospital ions included an entry for test tion mark handwritten next to it arification was needed on the ed she would have questioned ecked to see if an order for ting was						
	R64 probably sho	2:09 p.m. the DON confirmed ould have had daily blood nd indicated she would clarify						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245468	B. WING			01/1	5/2015	
NAME OF PROVIDER OR SUPPLIER KARLSTAD HEALTHCARE CENTER INC			.	STREET ADDRESS, CITY, STATE, ZIP CODE 304 WASHINGTON AVENUE WEST KARLSTAD, MN 56732				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	1	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	Ē KTE	(X5) COMPLETION DATE	
F 281	this with the physicial A policy regarding the was requested but not 483.20(k)(3)(ii) SERN PERSONS/PER CAI The services provided must be provided by accordance with each care. This REQUIREMEN by: Based on observation review, the facility far provided as directed residents (R48, R61 with oral care. Findings include: R48's care plan directed oral cares and the far assistance. R48's care plan date a deficit with self-care.	e care of diabetic residents one was given. VICES BY QUALIFIED RE PLAN ed or arranged by the facility qualified persons in the resident's written plan of T is not met as evidenced on, interview and document filled to ensure oral cares were by the care plan for 2 of 3 (a) who required assistance ected staff to assist him with acility failed to provide this ed 5/13/14, identified R48 had re performance with activities and required staff assist		281	F 282 The preparation of the following of correction for this deficiency of not constitute and should not be interpreted as an admission nor agreement by the facility of the tof the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correct prepared for this deficiency was executed solely because provision of state and federal law require. Without waiving the foregoing statement, the facility states wit 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 a addressed. 3. Nursing staff were re-educational care needs.	an truth ns tions it.		
	10/29/14, indicated	imum Data Set (MDS) dated R48 had moderate cognitive uired extensive assist with						

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

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION				(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDI	A. BUILDING			PLETED	
		245468	B. WING			01/	15/2015	
NAME OF 5	מאוויים אין פון וויים	243400			REET ADDRESS, CITY, STATE, ZIP CODE		, 5,2010	
NAME OF PI	ROVIDER OR SUPPLIER				4 WASHINGTON AVENUE WEST			
KARLSTA	D HEALTHCARE CENT	TER INC			ARLSTAD, MN 56732			
	01111111111	OTATEMENT OF DEFICIENCIES	ID	<u> </u>	PROVIDER'S PLAN OF CORREC	CTION	(X5)	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	COMPLETION DATE	
F 282	Continued From pa	ge 21	F	282				
1 202	personal hygiene.	9021			4. The DNS and/or her des	sianee		
	personal hygiene.				will audit 3 residents weekly		A	
	The nursing assista	ant care sheet [undated]	ļ		month and then one reside			
	directed staff to ass	sist R48 with personal hygiene			for two months for completi	on of oral		
	cares and indicated	d oral cares should be done			cares through visual observ	zation.		
	1	(once in the morning and once in the			The data collected will be p	resented		
	evening).				to the QA Committee by the	e DNS.		
					The data collected will be			
			***		reviewed/discussed at the			
	On 1/14/15, at 7:35			QA meeting. At this time the	ie QA			
	and NA-F were observed to enter R48's room				Committee will make the	caardina		
	and proceed to cor	proceed to complete R48's personal cares.			decision/recommendation r	egarding		
		ere observed to bathe R48			any follow-up studies.			
	while he remained	in his bed, change his brief, en dressed, NA-B and NA-F			Completion date 2/13/15			
	and dress nim. who	his wheelchair. NA-B was			Completion date 2/13/13			
		R48 and NA-F combed his						
		nsported R48 to the dining			1 1 1			
	room. During this	time, R48 was not offered or						
	assisted with oral of							
	1							
		D40 Suight dhia						
	On 1/14/15, at 8:45	5 a.m. R48 finished his	1					
	preaktast and NA-	F transferred R48 to the activity him at one of the tables. R48						
		assisted with oral care						
	following breakfast							
	John William Dicarract							
1								
	1							
		the state of the second						
	R61's care plan di	rected staff to assist him with						
	1	facility failed to provide this						
	assistance.				·			

Event ID: 37FR11

				B) DATE SURVEY COMPLETED				
		245468	B. WING			01/1	5/2015	
	ROVIDER OR SUPPLIER D HEALTHCARE CENTE	ER INC		STREET ADDRESS, CITY, STATE, ZIP CODE 304 WASHINGTON AVENUE WEST KARLSTAD, MN 56732				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE	
F 282	R61's diagnoses as of (stroke), severe right (weakness), and end	IST [undated] identified berebral vascular accident sided hemiparesis ephalopathy (brain disorder).	F	282				
	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.							
	directed staff to assistance cares and indicated	nt care sheet [undated] st R61 with personal hygiene oral cares should be done the morning and once in the						
	R61's Nursing Admis 1/14/15, indicated R staff for personal hy	ssion Screening dated 61 was totally dependent on giene cares						
	observed to enter R complete R61's pers were observed to be bed, change his brie NA-B and NA-F tranhis wheelchair and I	a.m. NA-B and NA-F were 61's room and proceed to sonal cares. NA-B and NA-F athe R61 while he remained in 6f and dress him. At 8:37 a.m. asferred R61 from his bed to NA-F transported R61 to the this time, R61 was not with oral care.						
	On 1/14/15, at 9:23 (ST)-A transported the therapy room.	a.m. the speech therapist R61 out of the dining room to						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	JLTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		245468	B. WING			01/1	5/2015
NAME OF PROVIDER OR SUPPLIER KARLSTAD HEALTHCARE CENTER INC				30	TREET ADDRESS, CITY, STATE, ZIP CODE 04 WASHINGTON AVENUE WEST ARLSTAD, MN 56732		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX (EACH COF		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE ATE	(X5) COMPLETION DATE
F 282	Continued From page 23 On 1/14/15, at 9:47 a.m. the ST-A transported		F	282			
	R61 to the activity ro	om. R61 was not offered or re following breakfast.					
	morning cares for the their teeth or mouth of had not offered or as	a.m. the NA-B verified routine e residents included brushing care. NA-B confirmed she sisted R48 or R61 with oral y absolutely should have					
	(DON) confirmed R4	p.m. the director of nursing 8 and R61 should have had at least offered mouth care s.					
F 312 SS=D	indicated all care plate identify the oral/dent which included the lewith personal hygier 483.25(a)(3) ADL CADEPENDENT RESIDATE A resident who is unusually living receives	ARE PROVIDED FOR	F	⁻ 312	F 312 The preparation of the followin of correction for this deficiency not constitute and should not be interpreted as an admission of agreement by the facility of the of the facts alleged or conclusiset forth in the statement of deficiencies. The plan of corresprepared for this deficiency was executed solely because provious state and federal law requires	does oe or an e truth ions ection as	
	by:	T is not met as evidenced on, interview and document			Without waiving the foregoing statement, the facility states w respect to:		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	MULTIPLE CONSTRUCTION UILDING		(X3) DATE SURVEY COMPLETED		
		245468	B. WING_			01/	15/2015	
NAME OF PROVIDER OR SUPPLIER KARLSTAD HEALTHCARE CENTER INC				STREET ADDRESS, CITY, STATE, ZIP CODE 304 WASHINGTON AVENUE WEST KARLSTAD, MN 56732				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFII TAG	PREFIX (EACH CORRECTIVE ACTION SHOL			(X5) COMPLETION DATE	
F 312	with oral hygiene car R61) who were deperance assistance with oral Findings include: R48 was not assiste routine morning care R48's quarterly Minit 10/29/14, identified It schizophrenia, seizu depression. In additicognitive impairment assist with personal R48's care plan date a deficit with self-car of daily living (ADL's with personal hygien. The nursing assistate directed staff to assicares and indicated twice a day (once in evening). On 1/14/15, at 7:35 and NA-F were obstand proceed to com NA-B and NA-F were	illed to provide assistance res for 2 of 3 residents (R48, endent on staff to provide care. In a staff care care care. In a staff care care care care care. In a staff care care care care care care care care	F	312	1. Residents 48 and 61 are receiving oral care as stated in 2. Residents care plan and state assignment sheets have been reviewed to assure oral cares addressed. 3. Nursing staff were re-educatoral care needs. 4. The DNS and/or her design will audit 3 residents weekly for month and then one resident of for two months for completion cares through visual observation the QA Committee by the Data collected will be reviewed/discussed at the quay QA meeting. At this time the decision/recommendation regany follow-up studies. Completion date 2/13/15	are ated to aee are one veekly of oral on. sented aNS. arterly		

STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245468	B. WING	·		01	/15/2015
	ROVIDER OR SUPPLIER D HEALTHCARE CENTE	ER INC		304	EET ADDRESS, CITY, STATE, ZIP CODE WASHINGTON AVENUE WEST RLSTAD, MN 56732		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF TAG		PROVIDER'S PLAN OF CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPRIDEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 312	and dress him. Wher transferred R48 to hi observed to shave R hair. NA-F then trans room. During this tin assisted with oral ca On 1/14/15, at 8:45 a breakfast and NA-F room and situated hi	n dressed, NA-B and NA-F s wheelchair. NA-B was 48 and NA-F combed his sported R48 to the dining ne, R48 was not offered or	F	312			
	R61's Diagnosis Lis diagnoses as cereb severe right sided h encephalopathy (branche) R61's Individual Ter 1/13/2015, indicated	t [undated] identified R61's ral vascular accident (stroke), emiparesis (weakness), and					
	R61's Nursing Adm 1/14/15, indicated F staff for personal hy	ission Screening dated R61 was totally dependent on giene cares.					

CLIVILIN	3 TON MEDICANE &	T CONTROL OF THE CONT				(V2) DATE	CHDVEV
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		NSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245468	B. WING			01/	15/2015
NAME OF PI	ROVIDER OR SUPPLIER				ET ADDRESS, CITY, STATE, ZIP CODE		
KARLSTA	D HEALTHCARE CENTE	ER INC			VASHINGTON AVENUE WEST LSTAD, MN 56732		
	CUITALA DV CT	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTI	ION	· (X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	COMPLETION DATE
F 312	Continued From page	e 26	F	312			
	directed staff to assist cares and indicated of	t care sheet [undated] st R61 with personal hygiene oral cares should be done the morning and once in the					
	observed to enter R6 complete R61's pers were observed to ba bed, change his brie NA-B and NA-F transhis wheelchair and N	a.m. NA-B and NA-F were 61's room and proceed to onal cares. NA-B and NA-F the R61 while he remained in f and dress him. At 8:37 a.m. sferred R61 from his bed to NA-F transported R61 to the this time, R61 was not with oral care.					
	On 1/14/15, at 9:23 (ST)-A transported F the therapy room.	a.m. the speech therapist R61 out of the dining room to					
	R61 to the activity ro	a.m. the ST-A transported nom. R61 was not offered or tre following breakfast.					
	morning cares for the their teeth or mouth had not offered or as	a.m. the NA-B verified routine e residents included brushing care. NA-B confirmed she ssisted R48 or R61 with oral ey absolutely should have					
	On 1/14/15, at 12:14	4 p.m. the director of nursing					

PRINTED: 01/23/2015 FORM APPROVED

OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245468	B. WING			01/	15/2015
NAME OF PROVIDER OR SUPPLIER KARLSTAD HEALTHCARE CENTER INC				304	REET ADDRESS, CITY, STATE, ZIP CODE WASHINGTON AVENUE WEST RLSTAD, MN 56732	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
F 356 SS=C	(DON) confirmed Ramouth care done or during morning care The ORAL HYGIEN RESIDENT policy dassist or supervise morning, at bedtime 483.30(e) POSTED INFORMATION The facility must poa daily basis: o Facility name. o The current date. o The total number by the following cat unlicensed nursing resident care per sland to Registered nursident care per sland to Resident census. The facility must pospecified above on of each shift. Data o Clear and readate o In a prominent pland residents and visite. The facility must, unake nurse staffing for review at a cost standard.	at least offered mouth care at least of the at least offered staff to oral hygiene care in the and when needed. NURSE STAFFING and the actual hours worked egories of licensed and staff directly responsible for nift: rses. At least of licensed as defined under State law). As a daily basis at the beginning must be posted as follows: one format. Accepted the staffing data and a daily basis at the beginning must be posted as follows: one format. Accepted the staffing data and all posted as follows: one format. Accepted the staffing data and all posted as follows: one format. Accepted the staffing data and all posted as follows: one format.		356	F 356 The preparation of the follow of correction for this deficient not constitute and should no interpreted as an admission agreement by the facility of the facts alleged or concluset forth in the statement of deficiencies. The plan of coprepared for this deficiency executed solely because proof state and federal law requivithout waiving the foregoin statement, the facility states respect to: 1. No concerns or complain residents and/or families reprevious postings. 2. The posting form has be constructed to include the shift times each discipline is scheduled as well as actual worked.	cy does t be nor an he truth usions rrection was ovisions uire it. ng with ots from garding en re- pecific	

	TOTAL TOTAL AND THE STATE OF TH			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED	
		245468	B. WING				15/2015	
	ROVIDER OR SUPPLIER			ST 30	REET ADDRESS, CITY, STATE, ZIP CODE 4 WASHINGTON AVENUE WEST ARLSTAD, MN 56732			
(X4) ID PREFIX TAG	(EACH DEFICIENT	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	ıx	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APPROPRIES (CROSS-REFERENCY)	ULD BE	(X5) COMPLETIO DATE	
F 356	staffing data for a m required by State law This REQUIREMEN by: Based on observatireview, the facility far nurse staffing inform potential to affect all the facility as well as Findings include: On 1/12/15, at 3:08 the facility, the daily observed on the way The day shift hours to 2:30 p.m.; the ev p.m. to 10:30 p.m. a 10:00 p.m. to 6:30 a 1	inimum of 18 months, or as w, whichever is greater. T is not met as evidenced on, interview and document ailed to post the required nation. This practice had the 33 residents who resided in a visitors. p.m. during the initial tour of nurse staff posting was Il next to the business office. were identified as 6:00 a.m. ening shift hours were a.m. ant (NA) hours for the day shift worked 24 hours and their d were not posted. Also, there nurse (RN) listed for eight inft, and there were two RNs ift. In addition, the evening shift for 12 hours and their actual not posted. Also, there were	F	356	3. Staff will be in-serviced new form on or before 2/13 4. The Director of Nurses of Designee will audit for corrors a times per week for 1 morn weekly for 2 months. The collected will be presented QA committee by the DNS data will be reviewed/discuthe Quarterly Quality Assumeting. At this time the Committee will make the decision/recommendation any necessary follow-up stock the Completion Date 2/13/15	of/15. or ect usage of the the to the the trance of the transfer of th		
	indicated two RNs hours worked were no night shift hours On 1/13/14, at 3:53 for eight hours on t	for 12 hours and their actual						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245468	B. WING			01/	15/2015
NAME OF PROVIDER OR SUPPLIER KARLSTAD HEALTHCARE CENTER INC				304	REET ADDRESS, CITY, STATE, ZIP CODE 4 WASHINGTON AVENUE WEST ARLSTAD, MN 56732		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE [(X5) COMPLETION DATE
F 356	posted. In addition, the evening shift for a actual hours worked On 1/14/15, at 1:20 pthe date and current actual hours worked for all three shifts. On 1/15/15, at 8:08 a (DON) provided a costated that served as the posting of the nu At 8:11 a.m. the DOI counting the Minimu	I hours worked were not here were 2.5 NAs listed for a total of 20 hours, and their was not posted. D.m. the nurse posting lacked census. In addition, the for the NAs was not posted a.m. the director of nursing the regulation and as their facility policy regarding	F	356			
F 431 SS=D	would provide staff of requirements and all form to include docurequired information 483.60(b), (d), (e) DLABEL/STORE DRUTHE facility must emalicensed pharmac of records of receipt controlled drugs in saccurate reconciliat records are in order	e findings and stated she education on the regulation so change the format of the imentation space for all the to be posted. RUG RECORDS, UGS & BIOLOGICALS apploy or obtain the services of ist who establishes a system and disposition of all sufficient detail to enable an ion; and determines that drug and that an account of all maintained and periodically	F	· 431	F 431 The preparation of the following of correction for this deficience not constitute and should not interpreted as an admission magreement by the facility of the facts alleged or conclusive set forth in the statement of deficiencies. The plan of corresponded for this deficiency we executed solely because proving state and federal law requivalents. Without waiving the foregoing statement, the facility states we respect to:	ey does be nor an ne truth sions rection vas visions re it.	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245468	B. WING			01/	15/2015
,	NAME OF PROVIDER OR SUPPLIER KARLSTAD HEALTHCARE CENTER INC			STREET ADDRESS, CITY, STATE, ZIP CODE 304 WASHINGTON AVENUE WEST KARLSTAD, MN 56732			
(X4) ID PREFIX TAG	(FACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 431	Drugs and biological labeled in accordance professional principle appropriate accesso instructions, and the applicable. In accordance with Stacility must store all locked compartment controls, and permit have access to the lateral permanently affixed controlled drugs listed Comprehensive Drugontrol Act of 1976 abuse, except when package drug distrit quantity stored is more readily detected. This REQUIREMENT by: Based on observators and provided in the facility of insulin vials with a stored in the provided in the facility of insulin vials with a stored in the professional professi	s used in the facility must be be with currently accepted es, and include the ry and cautionary expiration date when State and Federal laws, the I drugs and biologicals in its under proper temperature only authorized personnel to keys. Evide separately locked, compartments for storage of eed in Schedule II of the in g Abuse Prevention and and other drugs subject to in the facility uses single unit oution systems in which the inimal and a missing dose can	F	431	1. Residents 3 and 13 insuli are correctly labeled with the opened on it. 2. All residents receiving in have been audited for correlabeled vials, and correction if needed. 3. Staff will be re-educated regards to properly labeling bottles. 4. 4 Insulin bottles will be aweekly for one month, then per month for 2 months. The collected will be presented QA committee by the DNS. data will be reviewed/discuthe Quarterly Quality Assur Meeting. At this time the QC Committee will make the decision/recommendation is any necessary follow-up st.	e date nsulin ctly ns made with insulin udited 4 bottles e data to the The ssed at rance A	
	to affect 2 of 4 resident insulin. Findings include:	dents (R3, R13) who received					

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245468	B. WING			01/1	5/2015
NAME OF PROVIDER OR SUPPLIER KARLSTAD HEALTHCARE CENTER INC			4	304	EET ADDRESS, CITY, STATE, ZIP CODE WASHINGTON AVENUE WEST RLSTAD, MN 56732		
(X4) ID PREFIX TAG	(EACH DEFICIENT	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	1	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
	cart was reviewed w R13's open Novolog lacked a label or ma the insulin vial had b the insulin vial had b was not labeled with RN-D stated the ins with the date they a On 1/15/15, at 1:40 cart was reviewed v insulin 10 ml vial lac indicated when the RN-B confirmed the labeled with the dat	p.m. the Country medication with registered nurse (RN)-D. I insulin 10 milliliter (ml) vial wrking which indicated when been opened. RN-D verified been used for R13 and the vial as "when opened" date. Ulin vials should be labeled are opened. p.m. the Heritage medication with RN-B. R3's open Lantus ched a label or marking which insulin vial had been opened.	F	431			
	policy was to date i opened" date. In ac not labeled it should On 1/15/15, at 2:25 (DON) confirmed h	p.m. RN-A stated the facility nsulin vials with a "when didition, if the insulin vial was d not be used. b p.m. the director of nursing er expectation was that insulin eled with a "when opened"			F 456 The preparation of the follow of correction for this deficien not constitute and should no interpreted as an admission agreement by the facility of the facts alleged or concluset forth in the statement of	cy does t be nor an he truth	
F 456 SS=F	directed staff to dar opened. 483.70(c)(2) ESSE OPERATING CON	als policy dated 9/9/2008, te insulin vials when first NTIAL EQUIPMENT, SAFE DITION naintain all essential		F 456	deficiencies. The plan of co prepared for this deficiency executed solely because pro of state and federal law requ Without waiving the foregoir statement, the facility states respect to:	was ovisions uire it. og	

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED
245468	B. WING	01/15/2015
	STREET ADDRESS, 0 304 WASHINGTON KARLSTAD, MN	
EFICIENCY MUST BE PRECEDED BY FULL	DREELY (EACH	VIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD BE EFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE
lectrical, and patient care safe operating condition. EMENT is not met as evidenced servation, interview and document cility failed to properly maintain the ren and walk-in freezer which had to effect 32 of 33 residents who is prepared in the kitchen. Ide: Ven: at 3:25 p.m. during the kitchen tour manager (DM) the two chamber wen was observed to be dirty. Both nottom inside of the oven chambers and to have tin foil particles stuck in eas. In addition, the sides and bottom of the oven chambers were have hardened, buildup, black, dried and grease like substance. The DM least 90% of the oven chambers d with this buildup of dried food rease like substance. The DM ovens needed to be cleaned and been some time since they had last d. at 12:19 p.m. the inside of the upper invection oven chambers were	cleaned. been clea been com 2. All die have bee 3. Staff h cleaning d 4. Audits Manager done in a Audits wi for one m months. presente the DNS. reviewed Quality A time the the decis regarding studies.	The walk-in freezer has aned and maintenance has appleted on it. Itary cleaning schedules in reviewed and updated. Itary cleaning schedules in reviewed and updated. Itary been inserviced on duties. Itary be done by the Dietary that all cleaning is being inccordance with policy. It is done 3 times per week fronth, then weekly for 2. The data collected will be it is done the QA committee by itary. The data will be it is done if the Quarterly is surance Meeting. At this QA Committee will make its is incomplete in the property of the will be its incomplete in the property of the property
E ABT CE: S SHOUTE U C SENCE HELDING	ECENTER INC MARRY STATEMENT OF DEFICIENCIES DEFICIENCY MUST BE PRECEDED BY FULL TORY OR LSC IDENTIFYING INFORMATION) Om page 32 Delectrical, and patient care safe operating condition. REMENT is not met as evidenced Deservation, interview and document acility failed to properly maintain the Even and walk-in freezer which had to effect 32 of 33 residents who als prepared in the kitchen. Deservation inside of the oven chambers ary manager (DM) the two chambers ary manager (DM) the two chambers are to have tin foil particles stuck in the sides and bottom of the oven chambers were have hardened, buildup, black, dried and grease like substance. The DM the least 90% of the oven chambers d with this buildup of dried food the least 90% of the oven chambers d with this buildup of dried food the substance. The DM to been some time since they had last d. at 12:19 p.m. the inside of the upper tonvection oven chambers were remain covered with a buildup of	TELER 245468 B. WING STREET ADDRESS. 304 WASHINGTON KARLSTAD, MN MARY STATEMENT OF DEFICIENCIES EFICIENCY MUST BE PRECEDED BY FULL TORY OR LSC IDENTIFYING INFORMATION) TORY OR LSC IDENTIFYING INFORMATION) TAG TAG F 456 1. The Cocleaned. been clear been companies and the later of th

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ISTRUCTION	(X3) DATE SURVEY COMPLETED	
		245468	B. WING			0.	1/15/2015
	ROVIDER OR SUPPLIER D HEALTHCARE CENTE	ER INC		304 W	ET ADDRESS, CITY, STATE, ZIP CODE VASHINGTON AVENUE WEST LSTAD, MN 56732	DE	
(X4) ID PREFIX TAG	(FACH DEFICIENC	TATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	1	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
		e 33 DM stated the ovens had not	F	456			
	double stacked conv	5 p.m. the DM verified the vection oven was supposed to The DM stated her best ovens were last cleaned was ril 2014.	-				
	(November 2014 - J	dules for the last three months lanuary 2015) were reviewed ntation of the convection d during this time.					
	guidelines for the el	quipment manufacture lectric convection ovens dated ended cleaning the interior of					
	with the DM the wa have frozen conder fans. In addition, the cascaded on to and following items on the 1 box of 12 po 1 box of 10 po 1 box of 20 po 1 box of 10 po	p.m. during the kitchen tour lk-in freezer was observed to insation on the ceiling near the his frozen condensation had dwas frozen solid on the the second and third shelves: unds of smoked cocktail franks funds of sausage pork links bunds of chicken patties bund diced white chicken 4 pound wild rice soup mixes					
	The above boxes v	were frozen to the shelving					

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
		245468	B. WING		01/15/2015
NAME OF PROVIDER OR SUPPLIER KARLSTAD HEALTHCARE CENTER INC				STREET ADDRESS, CITY, STATE, ZI 304 WASHINGTON AVENUE WES KARLSTAD, MN 56732	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREF TAG		ACTION SHOULD BE COMPLETION O THE APPROPRIATE DATE
F 456	dietary staff was reclean the walk-in from 1/14/15, at 12:3 service director (E of frozen condensate walk-in freezer had accumulated at the several boxes of shelves. The ESE the walk-in freezer on 1/14/15, at 2:0 invoice from Jeff's and stated this had been maintain on 1/15/15, at 10: walk-in freezer was weekly. The Cleaning Sch (November 2014	other. The DM confirmed the esponsible to maintain and reezer. 39 p.m. the environmental SD) confirmed there was a lot ation by the condenser fan in . In addition, the condensation and ice had cascaded down on food on the second and third confirmed they needed to get rooked at and fixed. 10 p.m. the EVS provided an Refrigeration dated 5/22/14, do been the last time the freezer need. 155 p.m. the DM verified the as supposed to be cleaned needules for the last three months - January 2015) were reviewed nentation of the walk-in freezer	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.

2-11-15

Approcep e//e//5

Laura Dunning, RN, BSN, PHN

Director of Nurses

Karlstad Senior Living

PRINTED: 01/23/2015 FORM APPROVED

OMB NO. 0938-0391

(X3) DATE SURVEY

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	AT) THO MEETING THE TENE		(X3) DATE SURVEY COMPLETED
		245468	B. WING_		01/15/2015
	OVIDER OR SUPPLIER DHEALTHCARE CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 304 WASHINGTON AVENUE WEST KARLSTAD, MN 56732	7
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
,	ALLEGATION OF CODEPARTMENT'S ACSIGNATURE AT THE PAGE OF THE CMS USED AS VERIFICATION RECEIPT OF CONDUCTED TO WAS USED AND THE SAFETY OF CONDUCTED TO WAS USED AND THE SAFETY OF COMPOUNT OF THE SAFETY	C WILL SERVE AS YOUR DMPLIANCE UPON THE DMPLIANCE. YOUR E BOTTOM OF THE FIRST -2567 FORM WILL BE TION OF COMPLIANCE. AN ACCEPTABLE POC, AN F YOUR FACILITY MAY BE ALIDATE THAT IPLIANCE WITH THE S BEEN ATTAINED IN TH YOUR VERIFICATION. Survey was conducted by the ent of Public Safety. At the arlstad Healthcare Center 01 bund not in substantial requirements for participation d at 42 CFR, Subpart by from Fire, and the 2000 ire Protection Association 1, Life Safety Code (LSC), Health Care. THE PLAN OF THE FIRE SAFETY TAGS) TO: E INSPECTIONS HAL DIVISION TREET, SUITE 145	K	RECEIV FEB 1 1 20 MN DEPT. OF PUBLIC STATE FIRE MARSHALL	SAFETY

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.

Facility ID: 00830

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION - MAIN BUILDING 01	COMPLETED	
		245468	B. WNG		01/15/2015	
	ROVIDER OR SUPPLIER	ER INC	30	REET ADDRESS, CITY, STATE, ZIP CODE 14 WASHINGTON AVENUE WEST ARLSTAD, MN 56732		
(X4) ID PREFIX TAG	/EACH DESICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION	
	Continued From pag By e-mail to: Marian.Whitney@sta and Angela.kappenman@ THE PLAN OF COR DEFICIENCY MUST FOLLOWING INFOR 1. A description of with to correct the deficite 2. The actual, or profile. 3. The name and/or responsible for correct prevent a reoccurrer Karlstad Healthcare	e 1 ate.mn.us Destate.mn.us RECTION FOR EACH INCLUDE ALL OF THE RMATION: hat has been, or will be, done ncy. posed, completion date. title of the person action and monitoring to nce of the deficiency. Center is a 1-story building	K 000	DEFICIENCY)		
	without a basement times. The original bit 1974, was determined construction. In 1983 south of the original determined to be of and is separated wit from the original building at the south with a 2-hour fire bat assisted living building. The entire building is fire sprinkler system NFPA 13 Standard fautomatic Sprinkler facility has a fire alar detection at the smooth	and constructed at 2 different uilding was constructed in ed to be of Type II(222) 3 an addition was constructed building, which was Type II (000) construction h at least a 2-hour fire barrier lding. Attached to the original west corner and separated rrier is a connecting link to an ing. s protected with an automatic installed in accordance with				

CENTERS FOR MEDICARE & MEDICAID SERVICES			-	- LUCYDUCTION	(X3) DATE	SURVEY
STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			COMPLETED	
AND PLAN OF CORRECTION	IDENTIFICATION NOMBER.	A, BUILD	NG U1	- MAIN BULDING V	l	
	245468	B. WING			01/1	5/2015
NAME OF PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
	ED INC		ı	4 WASHINGTON AVENUE WEST		
KARLSTAD HEALTHCARE CENT	ER INC		KA	ARLSTAD, MN 56732	1	(X5)
(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	COMPLETION DATE
Alarm Code" 1999 eis monitored for autonotification. Hazardo detection or smoke alarm system in acc State Fire Code 200 divided into 4 smoke minute fire barriers. The facility has a cacensus of 33 at the The requirement at NOT MET as evider NFPA 101 LIFE SAI varying conditions, The staff is familiar that drills are part of Responsibility for plassigned only to conducted between announcement may alarms. 19.7.1.2 This STANDARD is Based on review of interview, it was deto conduct fire drills Safety Code 101(0) 12-month period. Taffect how staff real	NFPA 72 "The National Fire idition. The fire alarm system of the system		050	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 facility statement, the facility states with respect	e n cts of re	

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

CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED A. BUILDING 01 - MAIN BUILDING 01 IDENTIFICATION NUMBER: AND PLAN OF CORRECTION 01/15/2015 B. WING 245468 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 304 WASHINGTON AVENUE WEST KARLSTAD HEALTHCARE CENTER INC KARLSTAD, MN 56732 (X5) COMPLETION DATE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) 1. We will be K 050 Using our Continued From page 3 K 050 TELS program of all residents. which has a Findings include: monthly On facility tour between 11:30 PM and 3:30 PM schedule to on 01/15/2015, during the review of all available follow, to maintenance documentation and interview with complete all the Director of Maintenance (BN) it was revealed that the facility failed to conduct 9 of 12 fire drills required fire during the last 12-month period. drills, and file them in our LSC book, This deficient practice was verified by the Director TELS program of Maintenance (BN). K 052 K 052 NFPA 101 LIFE SAFETY CODE STANDARD also SS=F automatically A fire alarm system required for life safety is installed, tested, and maintained in accordance emails the ED with NFPA 70 National Electrical Code and NFPA if items are not 72. The system has an approved maintenance completed and testing program complying with applicable 2. Completion requirements of NFPA 70 and 72. 9.6.1.4 date January 31, 2015 3. Completed by Maintenance Director This STANDARD is not met as evidenced by: K 52 Based on observation and staff interview, it was The preparation of the revealed that the facility had failed to install and following plan of correction maintain the fire alarm system in accordance with for this deficiency does not the requirements of 2000 NFPA 101, Sections constitute and should not be 19.3.4.1 and 9.6, as well as 1999 NFPA 72, interpreted as an admission Sections 7.1. This deficient condition could

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION 6 01 - MAIN BUILDING 01	COMPLETED
		245468	B. WING	Carlos Villa La Harina	01/15/2015
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
NAME OF	NO VIDEN ON BOTT LIE.			304 WASHINGTON AVENUE WEST	
KARLSTA	D HEALTHCARE CENTE	RINC		KARLSTAD, MN 56732	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD IS CROSS-REFERENCED TO THE APPROPRIDEFICIENCY)	BE COMPLETION
K 052 K 054 SS=F	adversely affect the formal system, and could de and emergency action negatively affecting all visitors of the facility. Findings include: On facility tour between on 01/15/2015, a revidecumentation for the interview with the Direct revealed that at the finding that at the finding had failed to control to the DACT for the facility had failed to control the total that at the finding had failed to control the total that at the finding had failed to control the total that at the finding had failed to control the total that at the finding had failed to control the facility had failed to control the facilit	enctioning of the fire alarm lay the timely notification in sofor the facility thus are tresidents, staff, and see an are the facility thus are alarm to all available fire alarm to all available fire alarm to a last 12 months, and an ector of Maintenance (BN), me of the inspection the conduct semi-annual tests of ity's fire alarm system. The was verified by the Director are the conduct of the conduct of the conduct of the conduct semi-annual tests of ity's fire alarm system.	K 05	alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because provisions state and federal law requi it. Without waiving the foregoing statement, the facility states with respect to 1. Prior documentation was found from 4/21/2014, province compliance with NFPA 70& NFP. 72, all documents will be filed in Legisland.	of records as a second of

CENTER	CENTERS FOR MEDICARE & MEDICAID SERVICES						0. 0938-0391	
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ECONSTRUCTION 11 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED	
		245468	B. WING			01/	15/2015	
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
KARLSTA	D HEALTHCARE CENTE	RINC		1	04 WASHINGTON AVENUE WEST (ARLSTAD, MN 56732			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
K 054	Continued From page Findings include: On facility tour between 01/15/2015, a reversitive alarm maintenance documentation reveatins pection the facility current documentation the required sensitivity detector located throus make detector sense. This deficient practice of Maintenance (BN), NFPA 101 LIFE SAFI Required automatics continuously maintain condition and are insperiodically. 19.7.5 This STANDARD is Based on document with staff, the facility and maintain the automatics accordance with NFF Section 19.7.6, and 4 of Sprinkler Systems for the Inspection, Te Water Based Fire Prodeficient practice does sprinkler system is further system.	en 11:30 PM and 3:30 PM iew of the facility's available are and testing led that at the time of the could not provide any nerifying the completion of y testing of each smoke aghout the facility. The last tivity test was 04/18/2012. The was verified by the Director error of the could not provide any nerified by the Director error of the could not provide any nerified by the Director error of the could not provide any nerified by the Director of the could not provide and tested in reliable operating proceed and tested in the could not expect of the could not properly inspect of the could not provide any nerified to properly inspect of the could not provide any nerified to properly inspect of the could not provide any nerified to properly inspect of the could not provide any nerified to properly inspect of the could not provide any nerified to properly inspect of the could not provide any nerified to properly inspect of the could not provide any nerified not	K	054	facility of the truth of the facility of the truth of the facility of the truth of the facility of the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because provisions of state and federal law required it. Without waiving the foregoing statement, the facility states with respect to 1. Prior documentation we found and shows was completed of 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 62 The preparation of the following plan of correction for this deficiency does not	of re or as it on ang he		
	This deficient practice of Maintenance (BN). NFPA 101 LIFE SAFI Required automatic s continuously maintair condition and are ins periodically. 19.7.6 9.7.5 This STANDARD is Based on document with staff, the facility and maintain the automatic accordance with NFF Section 19.7.6, and 4 of Sprinkler Systems for the Inspection, Te Water Based Fire Prodeficient practice does prinkler system is fully operational in the	e was verified by the Director ETY CODE STANDARD prinkler systems are ned in reliable operating bected and tested i, 4.6.12, NFPA 13, NFPA 25, not met as evidenced by: ation review and interview has failed to properly inspect matic sprinkler system in PA 101 Life Safety Code (00), p.6.12, NFPA 13 Installation (99), and NFPA 25 Standard sting and Maintenance of otection Systems, (98). This as not ensure that the fire	K	062	documentation w found and shows was completed of 4/21/2014, provin compliance with NFPA 72, all documents will b filed in LSC book as of 2015 2. Completion date 2/2/2015 3. Completed by Maintenance Director K 62 The preparation of the following plan of correction	it on ng e k		

PRINTED: 01/23/2015 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION - MAIN BUILDING 01	COMPL	
		245468	B. WING_			01/1	5/2015
NAME OF PI	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
KARLSTA	D HEALTHCARE CENTE	RINC			WASHINGTON AVENUE WEST RLSTAD, MN 56732		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E ATE	(X5) COMPLETION DATE
K 062	on 01/15/2015, a revi interview with the Dir revealed the facility fa quarterly fire sprinkle fire sprinkler test that 13(99) and NFPA 25(en 11:30 AM and 3:30 PM lew of documentation and lector of Maintenance (BN), lealled to conduct 1 of 4 r flow tests and the annual leare required by NFPA	K	062	nor an agreement by the facility of the truth of the facility of the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because provisions of state and federal law requirit. Without waiving the foregoing statement, the facility states with respect to 1. Prior documentation	of e	
K 067 SS=F	of Maintenance (BN) NFPA 101 LIFE SAFI Heating, ventilating, a with the provisions of in accordance with the specifications. 19.3 19.5.2.2 This STANDARD is Based on document damper system has accordance with the 90(99) section 3-4.7. not ensure the proper dampers and could a	ETY CODE STANDARD and air conditioning comply f section 9.2 and are installed the manufacturer's 5.2.1, 9.2, NFPA 90A, not met as evidenced by: ation review, the fire/smoke that been maintained in requirements of NFPA This deficient practice does are operation of the fire/smoke follow smoke migration to safety of all residents, staff	K	067	found that on 7/1/14 our sprink system had been tested in our facility, all documentation w be filed in our LS 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	ill SC	
9	Findings include:				interpreted as an admission nor an agreement by the		

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

CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: A BUILDING 01 - MAIN BUILDING 01 AND PLAN OF CORRECTION 01/15/2015 B. WING 245468 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 304 WASHINGTON AVENUE WEST KARLSTAD HEALTHCARE CENTER INC KARLSTAD, MN 56732 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES ID (EACH CORRECTIVE ACTION SHOULD BE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) facility of the truth of the facts alleged or conclusions set K 067 Continued From page 7 forth in the statement of On facility tour between 11:30 PM and 3:30 PM deficiencies. The plan of on 01/15/2015, it was revealed during the review correction prepared for this of the facility's fire and smoke damper deficiency was executed test/inspection documentation and was confirmed by interview with the Director of Maintenance solely because provisions of (BN), that the facility failed to provide state and federal law require documentation that the fire and smoke dampers it. Without waiving the have been tested/inspected within the last 4 years foregoing statement, the in accordance with NFPA 90(99) section 3-4.7. facility states with respect to: 1. Documentation was found dated This deficient practice was verified by the Director 4/14/13 and of Maintenance (BN). K 154 K 154 NFPA 101 LIFE SAFETY CODE STANDARD shows SS=D compliance, it Where a required automatic sprinkler system is will now be out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, entered in our and the building is evacuated or an approved fire TELS program watch system is provided for all parties left on a 4 year unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 schedule 2. Completion date 2/2/2015 3. Completed by Maintenance This STANDARD is not met as evidenced by: Director Based on a record review and staff interview, the facility has failed to provide a complete and acceptable written policy containing procedures to K 154 be followed in the event that the automatic fire sprinkler system has to be placed out-of-service The preparation of the for four or more hours in a 24 hour period. This following plan of correction deficient practice could affect the facility's ability for this deficiency does not for early response and notification of a fire and constitute and should not be would affect the safety of all residents, visitors interpreted as an admission and staff.

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

CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: A. BUILDING 01 - MAIN BUILDING 01 AND PLAN OF CORRECTION 01/15/2015 A WING 245468 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 304 WASHINGTON AVENUE WEST KARLSTAD HEALTHCARE CENTER INC KARLSTAD, MN 56732 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE PREFIX CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) nor an agreement by the facility of the truth of the facts K 154 Continued From page 8 K 154 alleged or conclusions set forth in the statement of deficiencies. The plan of Findings include: correction prepared for this On facility tour between 11:30 PM and 3:30 PM deficiency was executed on 01/15/2015, during record review and an solely because provisions of interview with the Director of Maintenance (BN), state and federal law require the facility failed to update and provide a it. Without waiving the complete list of contact information on the foregoing statement, the automatic fire sprinkler system out of service facility states with respect to: policy. The policy was lacking any contact 1. Fire protection information for the Deputy State Fire Marshal. system out of service policy was updated on This deficient practice was verified by the Director 2/2/2015 2. Completion date of Maintenance (BN). K 155 K 155 NFPA 101 LIFE SAFETY CODE STANDARD 2/2/2015 Completed by SS=D Where a required fire alarm system is out of Maintenance service for more than 4 hours in a 24-hour period, Director the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is K 155 provided for all parties left unprotected by the shutdown until the fire alarm system has been The preparation of the returned to service. 9.6.1.8 following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the This STANDARD is not met as evidenced by: facility of the truth of the facts Based on a record review and staff interview, the facility has failed to provide a complete and alleged or conclusions set acceptable written policy containing procedures to forth in the statement of be followed in the event that the automatic fire deficiencies. The plan of sprinkler system has to be placed out-of-service correction prepared for this for four or more hours in a 24 hour period. This deficiency was executed deficient practice could affect the facility's ability

PRINTED: 01/23/2015 FORM APPROVED

OMB NO. 0938-0391

A BUILDING 01 - MAIN BUILDING 01 245468 B. WING	3) DATE SURVEY COMPLETED 01/15/2015
240400	01/15/2015
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 304 WASHINGTON AVENUE WEST KARLSTAD HEALTHCARE CENTER INC KARLSTAD, MN 56732	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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 of the Deputy State Fire Marshal. K 155 Solely because provisions of state and federal law require it. Without waiving the foregoing statement, the facilities with respect to: 1. Fire protection system out of system out of service policy was updated on 2/2/2/015 2. Completion date 2/2/2015 3. Completed by Maintenance Director of Maintenance (BN).	



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 <u>only a suggestion</u> 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

Karlstad Healthcare Center Inc January 23, 2015 Page 2

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

Minneent	a Department of Heal	th	7	· · ·		
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	DISTRUCTION E	(X3) DATE COMP	SURVEY PLETED
		00830	B. WING	B 12 2015	01	/15/2015
NAME OF P	ROVIDER OR SUPPLIER			ZPCODE cut of Health		
	D HEALTHCARE CENT		HINGTON AVENUE	E WEST ^{idji}		
NARLSIA	99. T	MARCOT	D, MN 56732	PROVIDER'S PLAN OF COP	RECTION	(X5)
(X4) ID PREFIX TAG	(FACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	COMPLETE DATE
2 000	Initial Comments		2 000			
	*****ATTE	NTION*****				5 0 0
	NH LICENSING	CORRECTION ORDER				
1	In accordance with	Minnesota Statute, section				
	144A.10, this correct	ction order has been issued y. If, upon reinspection, it is				
	found that the defic	iency or deficiencies cited				
	herein are not corre	cted, a fine for each violation				
	not corrected shall	be assessed in accordance ines promulgated by rule of	110			
	the Minnesota Dep	artment of Health.				
	Determination of what corrected requires	hether a violation has been				
	requirements of the	rule provided at the tag				
	number and MN Ru	ule number indicated below.				
	When a rule contai	ns several items, failure to the items will be considered				1
	lack of compliance	Lack of compliance upon	: 1			
	re-inspection with a	any item of multi-part rule will				
	result in the assess	sment of a fine even if the item				
	that was violated of corrected.	uring the initial inspection was				
						on the second
	You may request a	hearing on any assessments				
	that may result from	m non-compliance with these at a written request is made to				
	the Department wi	thin 15 days of receipt of a				
	notice of assessme	ent for non-compliance.				
	INITIAL COMMEN	TS:				
	On January 12-15	, 2015 surveyors of this				and the second s
	Department's staff	visited the above provider and				
	the following licens	sing orders were issued. When mpleted, please sign and date				
	on the bottom of the	ne first page in the line marked				ļ.
	with "Laboratory D	irector's or Provider/Supplier				
	Representative's	signature." Make a copy of				<u> </u>

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

PRINTED: 01/23/2015 FORM APPROVED

Minnesota Department of Health

	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		00830	B. WING		01/15/2015
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA		
KARLSTA	D HEALTHCARE CENTE	R INC	IINGTON AVEN D, MN 56732	UE WEST	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
2 000	Initial Comments		2 000		
	****ATTEN	TION*****			
	NH LICENSING CO	ORRECTION ORDER			
	144A.10, this correcting pursuant to a survey. found that the deficient herein are not correct not corrected shall be with a schedule of fine the Minnesota Depart. Determination of whe corrected requires corrected requires correquirements of the runumber and MN Rule. When a rule contains comply with any of the lack of compliance. Line-inspection with any result in the assessment of the runumber and many result in the assessment of the runumber and many result in the assessment of the runumber and many result in the assessment of the runumber and many result in the assessment of the runumber and many result in the assessment of the runumber and many result in the assessment of the runumber and many result in the assessment of the runumber and many result in the assessment of the runumber and runumber	ther a violation has been			
	that may result from rorders provided that a	earing on any assessments non-compliance with these written request is made to 15 days of receipt of a for non-compliance.			
	the following licensing corrections are compl on the bottom of the f with "Laboratory Direc				

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			D. WING		
		00830	B. WING		01/15/2015
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STAT	,	
KARLSTA	D HEALTHCARE CENTE	R INC	TAD, MN 56732	DE WEST	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE
2 000	Continued From page	: 1	2 000		
	these orders for your original to the address	records and return the s below:			
	Minnesota Departmer 705 Fifth Street NW, 5 56601-2933 c/o Lyla Burkman, Un	Suite A, Bemidji, MN			
2 302	MN State Statute 144 or related disorder tra	.6503 Alzheimer's disease in	2 302		
	ALZHEIMER'S DISEA DISORDER TRAININ MN St. Statute 144.69	G:			
	care staff	•			
	related disorders; (2) assistance with ac (3) problem solving w and (4) communication sk (c) The facility shall p written or electronic fo training program, the trained, the frequency topics covered.	Alzheimer's disease and stivities of daily living; ith challenging behaviors;			

Minnesota Department of Health

STATE FORM 6899 37FR11 If continuation sheet 2 of 34

WIIIIIIESUL	a Department of Fleatt						
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE				
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMF	COMPLETED	
		00830	B. WING		04	/4E/204E	
		1 00030			1 01	/15/2015	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE			
KADI OT:	D LIEALTUCARE CENTE	304 WAS	HINGTON AVEN	UE WEST			
KARLSIA	D HEALTHCARE CENTE	KARLST	AD, MN 56732				
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN O	F CORRECTION	(X5)	
PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE AC	CTION SHOULD BE	COMPLETE	
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO DEFICIEN		DATE	
				<i>DEI</i> 16121			
2 302	Continued From page	e 2	2 302				
	. •						
	This MNI Deguinemen	t is not meet as suideneed					
		t is not met as evidenced					
	by:	nd document review the					
		nd document review, the le the required Alzheimer's					
	-	sing assistants (NA-A, NA-B,					
		licensed practical nurses					
	•	ed direct care services. In					
		ailed to provide consumers					
		on regarding the Alzheimer's					
		s had the potential to affect					
		resided in the facility and					
	their families.	,					
	Findings include:						
		10/15/14, and the employee					
		ce of having received the					
	required Alzheimer's	training.					
	NA A was bired on 11	1/17/14 and the employee					
		1/17/14, and the employee ce of having received the					
	required Alzheimer's	9					
	required Alzheimer 5	uaning.					
	NA-B was hired on 10	0/16/14, and the employee					
		ce of having received the					
	required Alzheimer's	_					
	, 4						
	NA-C was hired on 12	2/22/14, and the employee					
		ce of having received the					
	required Alzheimer's	_					
	•	-					
	On 1/15/15, at 8:00 a	.m. the director of nursing					

Minnesota Department of Health

STATE FORM 6899 37FR11 If continuation sheet 3 of 34

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 304 WASHINGTON AVENUE WEST KARLSTAD HEALTHCARE CENTER INC (X4) ID PREFIX (EACH DEFICIENCES) TAG CONTINUED TO THE APPROPRIATE DATE (CA) ID PREFIX TAG (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 B. WING		T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION		E SURVEY PLETED
CACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DEFICIENCY DATE 2 302 Continued From page 3 CDON) 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			00830	B. WING		01	/15/2015
CARLSTAD HEALTHCARE CENTER INC CARLSTAD, MN 56732	NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE		
(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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	KARLSTA	D HEALTHCARE CENTE	R INC		JE WEST		
(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	PREFIX	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	SHOULD BE	COMPLETE
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	(DON) stated they cuinformation to the contraining provided for they would include the admission packet goin. At 8:36 a.m. the DON training was available computer. The DON and stated there was files they had the train stated the staff who his staff development had been assigned to another acquired and none with the director of nursin implement policies ar required Alzheimer's requirements. The quassurance committee audits to ensure committee audits to ensure committee.	rrently were not providing asumers regarding dementia heir staff. The DON, added, is information in the ng forward. I stated the Alzheimer's for staff to watch on the verified the above findings no proof in their personnel ning. In addition, the DON ad been responsible for diresigned and this had other employee. Their employee. Their employee and develop and addition to the training program ality assessment and could perform random pliance.	2 302			

Minnesota Department of Health

STATE FORM 6899 37FR11 If continuation sheet 4 of 34

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SU COMPLE	
			D WING			
		00830	B. WING		01/1	5/2015
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA			
KARLSTA	D HEALTHCARE CENTE	RINC	IINGTON AVEN D, MN 56732	OE WEST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 560	Continued From page	2 4	2 560			
2 560	MN Rule 4658.0405 S Plan of Care; Content	Subp. 2 Comprehensive ts	2 560			
	objectives and timetal long- and short-term of and mental and psychidentified in the compassessment. The commust include the indiversequired by Minnesota subdivision 14, parage	of care must list measurable bles to meet the resident's goals for medical, nursing, nosocial needs that are rehensive resident mprehensive plan of care vidual abuse prevention plan a Statutes, section 626.557, raph (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 lacke positioning, catheter of	ed interventions for care and the use of oxygen.				
		num Data Set (MDS) dated 15 was cognitively intact.				

Minnesota Department of Health

STATE FORM 8899 37FR11 If continuation sheet 5 of 34

PRINTED: 01/23/2015 FORM APPROVED

Minnesota Department of Health

	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00830	B. WING		01	/15/2015	
	ROVIDER OR SUPPLIER D HEALTHCARE CENTE	R INC	DRESS, CITY, STA IINGTON AVEN D, MN 56732				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE ITHE APPROPRIATE	(X5) COMPLETE DATE	
2 560	included heart failure, bladder, Parkinson's and chronic obstructiv (COPD). The MDS a extensive assist of tw transfers and ambula	15 had diagnoses that hypertension neurogenic disease, muscle weakness, ve pulmonary disease lso indicated R15 required o staff for bed mobility,	2 560				
	dated 2/13/14 indicated neurogenic bladder at so she required an indicated Due to R15's history of infections (UTI) and shad a leg bag on at a every 2 hours around	rea Assessment (CAA) ed R15 had a history of nd decompensated bladder dwelling urinary catheter. of frequent urinary tract epsis related to UTI's, she Il times which was emptied the clock to keep the ting possible contamination.					
	she required extensive reposition or offload.	vas currently dry and intact, e assist of one staff to The CAA also indicated R15 g program of every 2-3					
	identify interventions program, her diagnos and corresponding in	. •					
	On 1/14/2015 at 11:2	25 a.m. registered nurse					

Minnesota Department of Health

STATE FORM 6899 37FR11 If continuation sheet 6 of 34

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00830	B. WING		01/15/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
KARLSTA	D HEALTHCARE CENTE	R INC	INGTON AVEN D, MN 56732	UE WEST	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
2 560	Continued From page	: 6	2 560		
	(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				
		care plan should have g, urinary catheter care and			
	indicated all care plan and/or combined focu current acute and chr which they are receivi and/or care which ma heart disease. The pi plan should include el frequency of catheter	care, oxygen and type of or all activities of daily living			
	the side effects of Co	d interventions to monitor umadin (an anticoagulation iminate or reduce the risk of			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		00830	B. WING		01	/15/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
KARLSTA	D HEALTHCARE CENT	ER INC	SHINGTON AVENUI	E WEST		
	CLIMMADY C		TAD, MN 56732	DDOMDEDIC DI AM OI	F CORRECTION	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 560	Continued From pag	ge 7	2 560			
	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).					
	verified R17 was on RN-B confirmed R17 identification of R17	a.m. registered nurse (RN)-B a daily dose of Coumadin. 7's care plan lacked s diagnosis of atrial fibrillation nonitoring for anticoagulation				
	(DON) confirmed R1	5 a.m. the director of nursing 7's care plan should have brillation diagnosis and din therapy usage.				

Minnesota Department of Health

STATE FORM 6899 37FR11 If continuation sheet 8 of 34

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00830	B. WING		01/15/2015	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
KARLSTA	D HEALTHCARE CENTE	R INC	HINGTON AVEN AD, MN 56732	UE WEST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE		
2 560	Continued From page	8	2 560			
	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 (Twenty-one (21) days					
2 565	MN Rule 4658.0405 S Plan of Care; Use	Subp. 3 Comprehensive	2 565			
		nprehensive plan of care ersonnel involved in the				
	by: Based on observation	t is not met as evidenced n, interview and document ed to ensure oral cares were				

Minnesota Department of Health

STATE FORM 6899 37FR11 If continuation sheet 9 of 34

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED		
		00830	B. WING		01	1/15/2015	
	ROVIDER OR SUPPLIER	R INC	ADDRESS, CITY, STATE SHINGTON AVENUI IAD, 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	PREFIX (EACH CORRECTIVE ACTION SH		(X5) COMPLETE DATE	
2 565	TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		2 565				
	and NA-F were obser and proceed to comp NA-B and NA-F were while he remained in and dress him. when transferred R48 to his observed to shave R4	.m. nursing assistant (NA)-B ved to enter R48's room lete R48's personal cares. observed to bathe R48 his bed, change his brief, dressed, NA-B and NA-F s wheelchair. NA-B was 48 and NA-F combed his					

Minnesota Department of Health

STATE FORM 6899 37FR11 If continuation sheet 10 of 34

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00830	B. WING		01/15/2015		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 304 WASHINGTON AVENUE WEST							
KARLSTA	D HEALTHCARE CENTE	R INC	D, MN 56732	02 11201			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE		
2 565	Continued From page	10	2 565				
	room. During this tim assisted with oral care	e, R48 was not offered or e.					
	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).						
	1/13/2015, indicated F	oorary Care Plan dated R61 was nonverbal, had no res and required assistance					
	cares and indicated o	care sheet [undated] t R61 with personal hygiene ral cares should be done he morning and once in the					
	R61's Nursing Admission Screening dated 1/14/15, indicated R61 was totally dependent on staff for personal hygiene cares.						

Minnesota Department of Health

STATE FORM 8899 37FR11 If continuation sheet 11 of 34

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00830	B. WING		0.	1/15/2015	
	ROVIDER OR SUPPLIER	304 WA	ADDRESS, CITY, STATE				
KARLSTA	D HEALTHCARE CENTE	ER INC	TAD, 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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE	
2 565	Continued From pag	e 11	2 565				
	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.						
	morning cares for the their teeth or mouth of had not offered or as	a.m. the NA-B verified routine e residents included brushing care. NA-B confirmed she sisted R48 or R61 with oral y absolutely should have					
	(DON) confirmed R4	p.m. the director of nursing 8 and R61 should have had at least offered mouth care s.					
	indicated all care pla identify the oral/denta	oletion policy dated 8/2013, ns should be individualized, al needs of the resident evel of assistance required					

Minnesota Department of Health

STATE FORM 8899 37FR11 If continuation sheet 12 of 34

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00830	B. WING		01/15/2015	,
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	-	
KARLSTA	D HEALTHCARE CENTE	R INC	INGTON AVEN D, MN 56732	UE WEST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMP	PLETE
2 565	Continued From page	: 12	2 565			
	with personal hygiene	e needs.				
2 570	The director of nursin revise facility policies care plan implementa to staff to address the each resident's care proculd be reviewed/ requality assessment at could establish a syst monitor for consistent ongoing compliance. TIME PERIOD FOR OTWENTY-one (21) days MN Rule 4658.0405 SPlan of Care; Revision Subp. 4. Revision. A care must be reviewed interdisciplinary team physician, a registere for the resident, and of	Subp. 4 Comprehensive A comprehensive plan of d and revised by an that includes the attending d nurse with responsibility other appropriate staff in ned by the resident's needs,	2 570			
	participation of the res guardian or chosen re quarterly and within s the comprehensive re by part 4658.0400, se	sident, the resident's legal epresentative at least even days of the revision of esident assessment required				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		00830	B. WING		01	/15/2015
	ROVIDER OR SUPPLIER D HEALTHCARE CENTE	R INC	DDRESS, CITY, STATE SHINGTON AVENU (AD, MN 56732			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
2 570	facility failed to revise frequency of an activi	e 13 Ind document review, the the care plan to include the try program and activity residents (R31) reviewed	2 570			
	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.					
	assistant (CLA)-A sta for 3 to 4 1:1 visits pe R31 loved watching t the birds in the aviary hunting. The CLA-A s understand when he talked with R31 while	p.m. the community life ted R31 had an activity goal er week. The CLA-A stated he Twins on TV, watching and had a past love of stated R31 was hard to spoke therefore stated if she he was being fed his as considered a 1:1 activity.				
	for the months of Sep 2014. -September- out of 12 1:1 interactions twice -October- out of 12 of 1:1 interactions five to -November- out of 12 1:1 interactions five to	pportunities, R31 received mes. copportunities R31 received mes. copportunities R31 received				

Minnesota Department of Health

STATE FORM 8899 37FR11 If continuation sheet 14 of 34

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S	
AND FLAN	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING: _		COWIFE	LIED
		00830	B. WING		01/1	5/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
KARI STA	D HEALTHCARE CENTE	R INC	INGTON AVEN	UE WEST		
		KARLSTA	D, MN 56732			
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)) BE	(X5) COMPLETE DATE
2 570	Continued From page 14		2 570			
	(AS) stated R31 was times a week. At this (DON) stated they ne to identify how many would occur. In additing rock and roll must fisherman and hunter. At 9:17 a.m. the AS scare plan to identify the meet R31's activity in participate in small gr	tated she would revise the ne actual interventions to terests as R31 did not oups.				
	were not being met. T	erified R31's activity needs The AS stated R31 liked the the would check and find his				
	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.					
	Responsibility dated 8 plans should accurate problems and needs. change in the residen	t's condition that was not plan they would notify the ng and she would be				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00830	B. WING		01/15/2015	
NAME OF PI	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE. ZIP CODE	1 01/19/2015	
KARLSTA	D HEALTHCARE CENTE	R INC 304 WASH	INGTON AVEN	UE WEST		
		KARLSTAI	D, MN 56732		T	
(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 CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
2 570	Continued From page 15		2 570			
2 920	The director of nursing revise policies and proplem revision and proplem reviewed/ revised for assessment and assuestablish a system to compliance. TIME PERIOD FOR Convention of the proplem revision of the proplem revision and proplem revi	compliance. The quality grance committee could audit care plans to ensure	2 920			
	Subp. 6. Activities of comprehensive reside home must ensure the B. a resident who is activities of daily living services to maintain gand personal and ora. This MN Requirement by: Based on observation review, the facility failwith oral hygiene care.	daily living. Based on the ent assessment, a nursing at: unable to carry out greceives the necessary good nutrition, grooming, I hygiene. It is not met as evidenced a, interview and document ed to provide assistance es for 2 of 3 residents (R48, andent on staff to provide				
	Findings include:					

Minnesota Department of Health

STATE FORM 8899 37FR11 If continuation sheet 16 of 34

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
		00830	B. WING		01	/15/2015
	ROVIDER OR SUPPLIER	R INC	DDRESS, CITY, STATE			
		KARLST	AD, MN 56732			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 920	Continued From page	e 16	2 920			
	R48 was not assisted routine morning cares					
	10/29/14, identified R schizophrenia, seizur depression. In addition	e disorder, anxiety and on, R48 had moderate and required extensive				
	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).					
	and NA-F were obser and proceed to comp NA-B and NA-F were while he remained in and dress him. When transferred R48 to his observed to shave R4 hair. NA-F then trans	i.m. nursing assistant (NA)-B rved to enter R48's room lete R48's personal cares. observed to bathe R48 his bed, change his brief, dressed, NA-B and NA-F is wheelchair. NA-B was 48 and NA-F combed his ported R48 to the dining he, R48 was not offered or e.				
	On 1/14/15, at 8:45 a breakfast and NA-F to	.m. R48 finished his ransferred R48 to the activity				

Minnesota Department of Health

STATE FORM 8899 37FR11 If continuation sheet 17 of 34

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		' '	CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		00830	B. WING		01	/15/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
KARLSTA	D HEALTHCARE CENTE	R INC	HINGTON AVEN AD, MN 56732	UE WEST		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 920	Continued From page room and situated hir was not offered or as following breakfast.	m at one of the tables. R48	2 920			
	R61 was not assisted routine morning care:	I with oral care during s.				
	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 Admis 1/14/15, indicated R6 staff for personal hyg	1 was totally dependent on				
	directed staff to assis	t care sheet [undated] t R61 with personal hygiene oral cares should be done the morning and once in the				
		.m. NA-B and NA-F were 1's room and proceed to				

Minnesota Department of Health

STATE FORM 8899 37FR11 If continuation sheet 18 of 34

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	(X3) DATE SURVEY COMPLETED		
		00830	B. WING		01/15/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	,
KARI STA	D HEALTHCARE CENTE	R INC	HINGTON AVEN	UE WEST	
IVAILUIA	D TILALITIOANE OLIVIE	KARLST	AD, MN 56732		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	OULD BE COMPLETE
2 920	Continued From page	: 18	2 920		
	complete R61's person were observed to bath bed, change his brief NA-B and NA-F trans	onal cares. NA-B and NA-F he R61 while he remained in and dress him. At 8:37 a.m. ferred R61 from his bed to A-F transported R61 to the his time, R61 was not			
	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.				
	(DON) confirmed R48 mouth care done or a during morning cares				
	The ORAL HYGIENE RESIDENT policy dat assist or supervise or morning, at bedtime a	ed 11/2002, directed staff to all hygiene care in the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			B. WING			_,,
NAME OF D	ROVIDER OR SUPPLIER	00830		TE 7/D CODE	01/1	5/2015
		304 WASHI	RESS, CITY, STATE NGTON AVEN			
KARLSTA	D HEALTHCARE CENTE	R INC KARLSTAE	, 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 CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
2 920 21426	director of nursing or policies and procedur receive oral hygiene a their individualized planursing or her designappropriate staff on the procedures. The direct designee could development on the procedure on the procedure on the procedure of th	OD OF CORRECTION: The her designee could develop es to ensure residents as determined necessary by an of care. The director of ee could educate all nese policies and ctor of nursing or her op monitoring systems to sliance. CORRECTION: Twenty-one 04 Subd. 4 Tuberculosis of provider must establish and	2 920 21426			
	 (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. 					

Minnesota Department of Health

STATE FORM 6899 37FR11 If continuation sheet 20 of 34

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
			A. BUILDING:	A. BUILDING:		
		00830	B. WING		01/	15/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ATE, ZIP CODE		
KARLSTA	D HEALTHCARE CENTE	RINC	HINGTON AVEN AD, MN 56732	IUE WEST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
21426	Continued From page	e 20	21426			
	by: Based on interview ar facility failed to ensure assistant (NA)-C, NA- received a two-step T prior to resident conta	t is not met as evidenced and document review, the e 5 of 5 employees, (nursing -D, NA-E, NA-B, NA-A) ST (Tuberculin Skin Test) act. This had the potential to residing in the facility.				
	Findings include:					
		lantoux) Testing form ed 12/22/14 and received the However, did not receive the				
	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.					
		ed 10/15/14, and received 16/14. However, did not				
		ed 10/16/14, and received 25/14. However, did not				
	NA-A's Tuberculin (M	antoux) Testing form				

Minnesota Department of Health STATE FORM

6899 37FR11 If continuation sheet 21 of 34

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
		00830	B. WING		01	1/15/2015
	ROVIDER OR SUPPLIER	R INC	DDRESS, CITY, STATE SHINGTON AVENUE CAD, MN 56732			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
21426	revealed she was hire TST portion of the for indicated NA-A had n resident contact.	ed 11/17/14, however the	21426			
	(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.					
	Control Plan (TBICP) indicated healthcare pre-placement screen	Tuberculosis Infection Policy and Procedure workers would have a ning upon hire which ST / Mantoux or a single TB				
	SUGGESTED METH	OD OF CORRECTION:				
	review and / or revise procedure and educa ensure on-going com or DON could ensure two-step TST upon hi DON could develop a all employees receive					

Minnesota Department of Health

STATE FORM 8899 37FR11 If continuation sheet 22 of 34

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			B. WING		
		00830	B. WING		01/15/2015
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	
KARLSTA	D HEALTHCARE CENTE	R INC	SHINGTON AVEN AD, MN 56732	UE WEST	
(V4) ID	SLIMMARY STA	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION	N (X5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
21426	Continued From page	22	21426		
	committee could estal tuberculosis testing to	blish a system to audit ensure compliance.			
	TIME PERIOD FOR (Twenty-one (21) days				
21435	21435 MN Rule 4658.0900 Subp. 1 Activity and Recreation Program; General		21435		
	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.				
	by: Based on observation review, the facility failu individualized 1 to 1 a	ctivity program which I music for 1 of 3 residents			
	Findings include:				
	R31's annual Minimur	m Data Set (MDS) dated			

6899

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _	A. BUILDING:		
		00830	B. WING		01	/15/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
KARLSTA	D HEALTHCARE CENTE	RINC	HINGTON AVEN	UE WEST		
	T		AD, MN 56732			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
21435	dementia and Parkins and long term memor also indicated R31's a unable to be assesse impairment. The Cog Assessment (CAA) da R31's mental function and he struggled with thinking and expresse able to communicate dated 7/1/14, indicate would encourage R3' of interest and assist R31's care plan dated to receive 1:1 interact participate in small gr player for individual momentum of the properties of the communicate of the communicate dated 7/1/14, indicate would encourage R3' of interest and assist and assist and assist or eceive 1:1 interact participate in small gr player for individual momentum of 1/13/15, at 10:00 were observed in a ci were using for exercise	1 was diagnosed with son's disease and had short by impairment. The MDS activity preferences were direlated to his cognitive unitive Care Area ated 6/26/14, indicated a varied throughout the day a inattention, disorganized and frustration at not being his wishes. The Activity CAA and the community life staff and invite him to activities as needed.	21435			
	room, dressed and se -At 7:29 a.m. R31 ren -At 7:40 a.m. R31 ren -At 7:53 a.m. R31 wa table. -At 8:07 a.m. R31 wa -At 9:07 a.m. R31 wa	.m. R31 was observed in his cated in the wheelchair. nained the same. nained the same. s observed at the breakfast s being fed his meal. s observed in his room. The ng news program and R31 V.				

Minnesota Department of Health

STATE FORM 8899 37FR11 If continuation sheet 24 of 34

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		1 ' '	SURVEY PLETED
		00830	B. WING		01	/15/2015
	ROVIDER OR SUPPLIER D HEALTHCARE CENTE	R INC	DRESS, CITY, STA		•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
21435	his right hand. -At 9:15 a.m. R31 obswheelchair in his roor forward a couple of titowards the floor. -At 9:23 a.m. R31 ren in his room. R31's ba At 12:45 p.m. the con (CLA)-A stated R31 has 1:1 visits per week. Twatching the Twins of the aviary and had a CLA-A stated R31 was he spoke and stated while he was being fewas considered a 1:1 At 12:57 p.m. R31's was a considered a 1:1 has 1:2 for the months of Sep 2014, and the following -September- out of 12 for the control of 1:2 of 1:1 interactions five titonovember- out of 12 for the root of 12 for the months of sep 2014, and the following -September- out of 12 of 1:1 interactions five titonovember- out of 12 for the root of 12 of 1:1 interactions five titonovember- out of 12 for the root of 12 for the root of 12 for the root of 12 of 1:1 interactions five titonovember- out of 12 for the root of 12 for th	rying to touch the floor with served propelling his m with his feet and leaned mes reaching his right hand mained up in the wheelchair ck remained to the TV. Inmunity life assistant lad an activity goal for 3 to 4 he CLA-A stated R31 loved in TV, watching the birds in past love of hunting. The las hard to understand when when she talked with R31 led his breakfast meal that if activity. In the served was reviewed between 2014, to December lay was revealed: 20 opportunities R31 received lates. Opportunities, R31 received lates. Opportunities R31 received lates. Opportunities R31 received lates. Opportunities R31 received lates.	21435			
	R31. She stated she	fe was having lunch with did not know what activity				

Minnesota Department of Health

STATE FORM 8899 37FR11 If continuation sheet 25 of 34

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			7.1. 20.25.110.			
		00830	B. WING		01/1	5/2015
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
KARLSTA	D HEALTHCARE CENTE	RINC	IINGTON AVEN D, MN 56732	IUE WEST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE	(X5) COMPLETE DATE
21435	into his room to visit h surveyor explained to documenting talking t 1:1 activity. She state and was "part of the ju On 1/15/15, at 9:00 a (AS) stated R31 was times a week. The AS CLA-A provided the 1 R31's most alert time morning and a 1:1 visi	stated she knew they came nim and reminisce. The R31's wife the staff were to R31 at breakfast time as a state that was not an activity ob." .m. the activity supervisor to receive a 1:1 visit 3 to 4 stated herself and the :1 activity. The AS stated was right away in the sit prior to the breakfast meal	21435	BEHOLINOTY		
	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					
	surveyor. The AS ver showed staff taking or R31 his breakfast me At 9:17 a.m. the AS s care plan to identify the	tated she would revise the ne actual interventions to terests as R31 did not				
	were not being met. 7	erified R31's activity needs The AS stated R31 liked the e would check and find his				

Minnesota Department of Health

STATE FORM 8899 37FR11 If continuation sheet 26 of 34

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00830	B. WING		01/15/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
KARLSTA	D HEALTHCARE CENTE	R INC	INGTON AVEN D, MN 56732	UE WEST	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
21435	Continued From page	26	21435		
	CD player so that mus	sic could be played.			
	player in his room with AS stated she worked	tated she found R31's CD h a 5 CD changer on it. The d full time and in the last I the CD player on twice.			
	The activity director a review/revise policy a staff regarding reside Assessment and Asse	OD FOR CORRECTION: nd/or designee could nd provide education for nt activities. The Quality urance (QAA) committee its to ensure compliance.			
	TIME PERIOD FOR (21) days	CORRECTION: Twenty-one			
21565	MN Rule 4658.1325 S Medications Self Adm	Subp. 4 Administration of iin	21565		
	self-administer medic resident assessment care as required in pa 4658.0405 indicate th	stration. A resident may ations if the comprehensive and comprehensive plan of arts 4658.0400 and is practice is safe and there attending physician.			
	This MN Requiremen by:	t is not met as evidenced			

Minnesota Department of Health

STATE FORM 8899 37FR11 If continuation sheet 27 of 34

AND PLAN OF CORRECTION INTERPRETATION NUMBERS		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00830	B. WING		01	15/2015
	ROVIDER OR SUPPLIER D HEALTHCARE CENTE	R INC 304 WASH	DRESS, CITY, STA HINGTON AVEN D, MN 56732			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
21565	Based on observation review, the facility fail administration of med	n, interview and document	21565			
	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 assessment.	lacked a self administration				
	dated 1/1/15-1/31/15, included Renvela tabl carbonate) give 2 tab day for phosphate bir orders for self adminis	ninistration Record (MAR) identified orders that let 800 mg (sevelamer lets by mouth three times a ider. The MAR lacked stration of medications. The lat 12:00 p.m. indicated R14 lication.				

Minnesota Department of Health

STATE FORM 8899 37FR11 If continuation sheet 28 of 34

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		00830	B. WING		0.	/15/2015
	ROVIDER OR SUPPLIER	ER INC	ADDRESS, CITY, STATE SHINGTON AVENUE TAD, MN 56732			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
21565	On 1/15/2015, at 12: positioned on her ba elevated approximat table was placed over manager (DM) deliver medication cup with bedside table. R13 sher Renvela and reg delivered it to her roccould take it when she R13 was then observed. On 1/15/2015, at 1:4 had left the Renvela so R13 could take the tray arrived. RN-D shave left the medicate	16 p.m. R13 was observed ck with the head of the bed ely 75 degrees. A bedside er R13's bed. The dietary ered R13's noon meal. A 2 pills was observed on the stated the medication was istered nurse (RN)-D had om at 11:30 a.m. so she he began eating her meal. Wed to take the medication. 1 p.m. RN-D confirmed she in a cup on the bedside table e noon dose when her meal tated she probably shouldn't tion in the room, but she did dn't bring the pills right away	21565			
	On 1/15/2015, at 2:1 (DON) confirmed R1 assessment complet to safely self administalso confirmed R13 corder to self administated R13's medical left in her room rather administered them at The Self Administration Safety Administration Safety	4 p.m. the director of nursing 3 did not have an ed to determine R13's ability ster medication. The DON did not have a physician's ter medications. The DON tions should not have been er the nurse should have				

Minnesota Department of Health

STATE FORM 8899 37FR11 If continuation sheet 29 of 34

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00830	B. WING		01/15	5/2015
NAME OF PF	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
KARI STA	D HEALTHCARE CENTE	R INC	INGTON AVEN	UE WEST		
TARLOTA	TIEREITIOAKE GENTE	KARLSTA	D, MN 56732			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
21565	Continued From page	29	21565			
	changes in function/c resident's ability to sa medication. The police evaluations should or quarterly. The policy interdisciplinary team on the Medication Set Screen to determine administration of med would include whether administer medication supervision or was not medications. Addition	cy also indicated on-going cour at a minimum of indicated the would review the summary of Administration Safety appropriateness of self ications. The determination of the resident could self ins unsupervised, with the safe to administer inally, the policy indicated a libe obtained indicating in the resident may self				
	The director of nursin development and imp procedures to ensure monitored to safely see The director of nursin then monitor the appropriate to the policies and procedures.	residents are assessed and elf-administer medications. g or her designee could opriate staff for adherence				
6405	(21) days		04053			
21620	MN Rule 4658.1345 L	abeling of Drugs	21620			
	Drugs used in the nur in accordance with pa	rsing home must be labeled art 6800.6300.				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			B. WING	D. WILLIA		
		00830			01/	15/2015
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA HINGTON AVEN			
KARLSTA	D HEALTHCARE CENTE	RINC	D, MN 56732	OL WEST		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
21620	Continued From page		21620			
	by: Based on observatior review, the facility fail insulin vials with a "w determine expiration"	t is not met as evidenced n, interview and document ed to properly label 2 of 7 hen opened" date in order to date which had the potential nts (R3, R13) who received				
	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.					
	cart was reviewed wit insulin 10 ml vial lack					
	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.					
		.m. the director of nursing expectation was that insulin				

Minnesota Department of Health

STATE FORM 8899 37FR11 If continuation sheet 31 of 34

AND DIAN OF CORRECTION INTERPRETATION NUMBERS		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
00830			B. WING	B. WING		
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA			
KARLSTA	D HEALTHCARE CENTE	R INC	IINGTON AVEN D, MN 56732	UE WEST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE COMPLETE	
21620	Continued From page	31	21620			
	vials should be labele date.	d with a "when opened"				
	The Multi-Dose Vials policy dated 9/9/2008, directed staff to date insulin vials when first opened.					
	The director of nursin develop and impleme to ensure that all med stored properly; educ monitoring systems to	t the findings to the Quality				
	TIME PERIOD FOR (21) days.	CORRECTION: Twenty one				
21942	MN St. Statute 144A. Resident and Family		21942			
	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.					

Minnesota Department of Health

STATE FORM 8899 37FR11 If continuation sheet 32 of 34

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING: _		COMPLE	ETED	
		00830	B. WING		01/1	5/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
KARLSTA	D HEALTHCARE CENTE	R INC	IINGTON AVEN	IUE WEST		
		KARLSTA	D, MN 56732			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21942	Continued From page	32	21942			
	by: Based on interview at facility failed to attem within the past calend	t is not met as evidenced and document review, the ot to form a family council lar year as required. This effect all 33 residents who				
	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 METH	OD OF CORRECTION:				
	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.					

Minnesota Department of Health

STATE FORM 8899 37FR11 If continuation sheet 33 of 34

Minnesota Department of Health

		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00830	B. WING		01/15/2015
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	
KARLSTA	D HEALTHCARE CENTE	R INC	IINGTON AVEN D, MN 56732	IUE WEST	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
21942	Continued From page	e 33	21942		
	TIME PERIOD FOR (CORRECTION:			
	Twenty-one (21) days	S.			

Minnesota Department of Health

STATE FORM 8899 37FR11 If continuation sheet 34 of 34