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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 3Y9Z

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00830

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245468**
2.STATE VENDOR OR MEDICAID NO.
(L2) **012028600**

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

4. TYPE OF ACTION: **7** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **04/11/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **46** (L18)
13.Total Certified Beds **46** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE — Date :
Jana Bromenshenkel, HFE NEII — 04/21/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath
Enforcement Specialist — 05/18/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
04/12/2016
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245468

May 19, 2016

Mr. Tyler Ahlf, Administrator
Karlstad Healthcare Center Inc
304 Washington Avenue West
Karlstad, Minneosta 56732

Dear Mr. Ahlf:

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 April 6, 2016 the above facility is certified for:

46 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 46 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 eNotice.

Sincerely,

Mark Meath

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

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
April 21, 2016

Mr. Tyler Ahlf, Administrator
Karlstad Healthcare Center Inc
304 Washington Avenue West
Karlstad, Minnesota 56732

RE: Project Number S5468026

Dear Mr. Ahlf:

On March 16, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on March 4, 2016. 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 April 11, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on April 7, 2016 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 March 4, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 6, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on March 4, 2016, effective April 6, 2016 and therefore remedies outlined in our letter to you dated March 16, 2016, 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.

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

Sincerely,

Mark Meath

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245468 Y1	A. Building B. Wing Y2	4/11/2016 Y3

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0225	Correction	ID Prefix F0226	Correction	ID Prefix F0250	Correction
Reg. # 483.13(c)(1)(ii)-(iii), (c)(2) - (4)	Completed	Reg. # 483.13(c)	Completed	Reg. # 483.15(g)(1)	Completed
LSC	04/06/2016	LSC	04/06/2016	LSC	04/06/2016
ID Prefix F0371	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.35(i)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	04/06/2016	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
[x]	TL/mm	04/21/2016	36536	04/11/2016
REVIEWED BY CMS RO [ ]	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
3/4/2016

[ ] CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? [ ] YES [ ] NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245468 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	4/7/2016 Y3

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0018	04/06/2016	LSC K0050	04/06/2016	LSC K0052	04/06/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0062	04/06/2016	LSC K0067	04/06/2016	LSC K0069	04/06/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0072	03/30/2016	LSC K0144	04/06/2016	LSC K0147	03/01/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
[x]	LB/mm	04/21/2016	32601	04/047/2016
REVIEWED BY CMS RO [ ]	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
3/1/2016

[ ] CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? [ ] YES [ ] NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 3Y9Z

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00830

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245468**
2.STATE VENDOR OR MEDICAID NO.
(L2) **012028600**

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

4. TYPE OF ACTION: **2** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **03/04/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **46** (L18)
13.Total Certified Beds **46** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE — Date :
Jana Bromenshenkel, HFE NII — 04/01/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath
Enforcement Specialist — 04/07/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN: 24 5468

On March 4, 2016 a standard survey was completed at this facility. The most serious deficiencies were found to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), whereby corrections are required. In addition at the time of the standard survey an investigation of complaint number H5468003 was conducted and found to be unsubstantiated. The facility has been given an opportunity to correct before remedies would be imposed. Post Certification Revisit (PCR) to follow. Refer to the CMS 2567 forms for both health and life safety code along with the facility's plan of correction.

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
March 16, 2016

Mr. Tyler Ahlf, Administrator
Karlstad Healthcare Center Inc
304 Washington Avenue West
Karlstad, Minnesota 56732

RE: Project Number S5468026, H5468003

Dear Mr. Ahlf:

On March 4, 2016, 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. In addition, at the time of the March 4, 2016 standard survey the Minnesota Department of Health completed an investigation of complaint number H5468003.

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. In addition, at the time of the March 4, 2016 standard survey the Minnesota Department of Health completed an investigation of complaint number H5468003 that was found to be unsubstantiated.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

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

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

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

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

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

Informal Dispute Resolution - 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
Bemidji Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
705 5th Street Northwest, Suite A
Bemidji, Minnesota 56601-2933
Email: Lyla.burkman@state.mn.us
Phone: (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 April 13, 2016, 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 April 13, 2016 the following remedy will be imposed:

- Per instance civil money penalty. (42 CFR 488.430 through 488.444)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC 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,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

• 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 ePoC 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 ePoC 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 ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, 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 ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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 June 4, 2016 (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 September 4, 2016 (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
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC 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 electronic 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:

Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Phone: (651) 430-3012 Fax: (651) 215-0525

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245468	A. BUILDING _____ B. WING _____	03/04/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an 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. Investigation of complaint H5468003 was also completed. The complaint was not substantiated.	F 000		
F 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported	F 225		4/6/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 03/25/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245468	A. BUILDING _____ B. WING _____	03/04/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 1 immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to immediately report and thoroughly investigate potential abuse/mistreatment, elopement and bruises of unknown origin for 4 of 7 incidents reviewed which involved 4 residents (R47, R25, R39, R5). Findings include: The Resident Incident Report dated 8/6/15, indicated R47 was found to have an 8.0 centimeter (cm) x 5.0 cm bruise to her right underarm area and a 2.0 cm x 2.0 cm bruise to the right forearm. A typewritten report was attached to the incident report indicated R47 had	F 225	F 225 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because provisions of state and federal law require it. Without waiving the foregoing statement, the facility states with respect to: 1. These four residents (R5, R25, R39, and R47) have been reported to MDH and thoroughly investigated for potential abuse/mistreatment, elopement and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245468	A. BUILDING _____ B. WING _____	03/04/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 2 a large purplish bruise to her right lateral breast area. The report included the following statement: this investigation has not found a perpetrator and has been inconclusive about the exact cause. We are assuming that she has caused her own bruise due to her anxiety with rocking/thrashing in her wheelchair. The Incident Report indicated the administrator was notified but, the SA was not notified. A handwritten note at the bottom of the Incident Report identified "determined not abuse or neglect." The Resident Incident Report dated 8/15/15, indicated an empty wheelchair was found unattended and an alarm was sounding on the Country Wing. The report indicated R25 had gotten through the facility exit door and was found approximately 15 minutes later seated on a bench by the facility storage building located outside. The report further indicated R25 was wearing a Wanderguard at the time of the incident and had a history of confusion, elopement and wandering off. The report indicated the adminstrator was notified but, the SA was not notified. No harm was indicated as the reason the incident was not reported. The Resident Incident Report dated 10/3/15, indicated R39 was found with a bruise which measured 8.0 inches x 6.0 inches on his right side, rib/back area at 9:00 p.m. Unsure how bruise occurred. R39 pointed at wheelchair and stated "hurt me." The report indicated R39 was transferred to the hospital at 9:50 p.m. The immediate intervention implemented was identified as "to emergency room related to blood loss, will pad back of wheelchair." The report	F 225	bruises of unknown origin. No abuse or neglect were found. 2. Executive Director and DNS or assigned designee are notified per facility policy and procedure of incidents to determine if additional reporting to MDH, law enforcement or other agencies are required. All incidents are reviewed at IDT to assure staff followed proper reporting and monitoring procedures. 3. Staff will be re-educated prior to April 6, 2016, regarding the policy and procedure of reporting all injuries and allegations, completion of an incident report, initiation of the investigation, notification of Administrator and DNS and the notification of the Common Entry Point and/or MDH. 4. Executive Director and DNS review all incident reports to assure proper reporting and monitoring procedures are followed. The incident reports will be reviewed/discussed at the Monthly QAPI and Quarterly QA meeting. At this time the QA committee will make the decision/recommendation regarding any follow-up studies.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245468	A. BUILDING _____ B. WING _____	03/04/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 3 indicated the administrator was notified but the SA was not notified as the resident stated what caused injury as reason not reported. However, R39's quarterly Minimum Data Set (MDS) indicated R39 had severe cognitive impairment / decision making skills and required extensive assistance of 2+ persons for transfers, ambulation and extensive assist of one person for locomotion on and off the unit. The SNF Resident Council Meeting Agenda and Minutes dated 11/9/15, included a note under the Social Services individual department update which indicated R5 was upset because a nursing assistant had grabbed her. No further information regarding the incident was documented. No Resident Incident Report or investigation into the allegation was available and the Resident Council Meeting Minutes dated 12/7/15, lacked follow up regarding R5's allegation. On 3/3/16, at 1:02 p.m. Activity director (AD) stated she had informed licensed social worker (LSW)-A about the concern voiced by R5 at the 11/9/15, resident council meeting. The AD stated LSW-A had told AD R5's concern had been followed up and resolved. AD confirmed she had not reported R5's incident any further. On 3/3/16, at 1:19 p.m. LSW-A stated she was unaware of the concern R5 had voiced at the 11/9/15, resident council meeting. On 03/04/2016, at 1:48 p.m. the director of	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245468	A. BUILDING _____ B. WING _____	03/04/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 4 nursing (DON) and adminstrator were interviewed regarding the facility abuse prohibition practices. The DON indicated all staff were trained on how to file a verbal report to the Common Entry Point (CEP). The DON also indicated she was called for any incident and the usual practice was for the DON or assistant (DON) to file the vulnerable adult report with the SA. The aforementioned incident reports were reviewed with both the DON and adminstrator which revealed the following: --R47: The DON confirmed R47's bruise was not immediately reported to the SA and indicated at the time of the incident, the credentials for the staff member to sign into the CEP website had been lost therefore she had conducted an investigation while concurrently attempting to obtain access. The DON confirmed she could have made a verbal report but stated it hadn't occurred to her to do so. --R25: The DON confirmed R25's elopement incident and stated she had not reported the incident to the CEP as an elopement as R25 was found and was uninjured. The DON indicated the circumstances surrounding the elopement would determine when/if she would report it. The DON stated she would report an elopement if an injury occurred, if R25 had left the facility grounds or if there had been inclement weather. The DON indicated R25's chair alarm and Wanderguard were functioning however, R25 had bypassed the exit door at the end of the Country wing as the exit door would open if continuously pressed for 30 seconds --R39: The DON indicated R39 had been experiencing a gastrointestinal (GI) bleed at the	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245468	A. BUILDING _____ B. WING _____	03/04/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 5	F 225		

time the bruise was identified. The DON stated R39 would go in every couple of weeks for blood transfusions due to this GI bleed. DON also indicated when R39's hemoglobin was low he experienced a decline in his cognition. DON confirmed R39 was sent to the emergency room for a blood transfusion after the bruise was discovered. The DON confirmed she did not report the bruise to the SA as she trusted what R39 had told her even though he may have had a change in cognition due to low hemoglobin.

--R5: The DON stated she was unaware of R5's report during a resident council meeting of being grabbed by a nursing assistant. The DON confirmed the activity director should have reported the allegation to her or another nurse immediately. DON indicated she would follow up with R5 right away.

The VA [vulnerable adult] Policy dated 2/25/16, indicated mandated reporters employed by Karlstad Senior Living or providing services in the facility would report abuse, neglect, mistreatment, misappropriation of resident property and injuries of unknown source sustained by a vulnerable adult that was not reasonably explained immediately (as soon as possible) after the discovery of the incident. The policy indicated an injury should be classified as an "injury of unknown source" when the source of the injury was not observed by any person or the source of the injury could not be explained by the resident and the injury was suspicious because of the extent of the injury or the location of the injury or the number of injuries observed at one particular point in time or the incidence of injuries over time.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245468	A. BUILDING _____ B. WING _____	03/04/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 6	F 226		
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement their abuse policy and procedure related to the immediate reporting of potential abuse/mistreatment, elopement and bruises of unknown origin to the State agency (SA) for 4 of 7 incidents involving 4 residents (R47, R25, R39, R5) reviewed for abuse prohibition. Findings include: The facility's VA [vulnerable adult] Policy dated 2/25/16, indicated mandated reporters employed by Karlstad Senior Living or providing services in the facility would report abuse, neglect, mistreatment, misappropriation of resident property and injuries of unknown source sustained by a vulnerable adult that was not reasonably explained immediately (as soon as possible) after the discovery of the incident. The policy indicated an injury should be classified as an "injury of unknown source" when the source of the injury was not observed by any person or the source of the injury could not be explained by the resident and the injury was suspicious because	F 226	F 225 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because provisions of state and federal law require it. Without waiving the foregoing statement, the facility states with respect to: 1. These four residents (R5, R25, R39, and R47) have been reported to MDH and thoroughly investigated for potential abuse/mistreatment, elopement and bruises of unknown origin. No abuse or neglect were found. 2. Executive Director and DNS or assigned designee are notified per facility policy and procedure of incidents to determine if additional reporting to MDH, law enforcement or other agencies are required. All incidents are reviewed at IDT to assure staff followed proper reporting and monitoring procedures.	4/6/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245468	A. BUILDING _____ B. WING _____	03/04/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 7 of the extent of the injury or the location of the injury or the number of injuries observed at one particular point in time or the incidence of injuries over time. The Resident Incident Report dated 8/6/15, indicated R47 was found to have an 8.0 centimeter (cm) x 5.0 cm bruise to her right underarm area and a 2.0 cm x 2.0 cm bruise to the right forearm. A typewritten report was attached to the incident report indicated R47 had a large purplish bruise to her right lateral breast area. The report included the following statement: this investigation has not found a perpetrator and has been inconclusive about the exact cause. We are assuming that she has caused her own bruise due to her anxiety with rocking/thrashing in her wheelchair. The Incident Report indicated the administrator was notified but, the SA was not notified. A handwritten note at the bottom of the Incident Report identified "determined not abuse or neglect." The Resident Incident Report dated 8/15/15, indicated an empty wheelchair was found unattended and an alarm was sounding on the Country Wing. The report indicated R25 had gotten through the facility exit door and was found approximately 15 minutes later seated on a bench by the facility storage building located outside. The report further indicated R25 was wearing a Wanderguard at the time of the incident and had a history of confusion, elopement and wandering off. The report indicated the adminstrator was notified but, the SA was not notified. No harm was indicated as the reason the incident was not reported.	F 226	3. Staff will be re-educated prior to April 6, 2016, regarding the policy and procedure of reporting all injuries and allegations, completion of an incident report, initiation of the investigation, notification of Administrator and DNS and the notification of the Common Entry Point and/or MDH. 4. Executive Director and DNS review all incident reports to assure proper reporting and monitoring procedures are followed. The incident reports will be reviewed/discussed at the Monthly QAPI and Quarterly QA meeting. At this time the QA committee will make the decision/recommendation regarding any follow-up studies.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245468	A. BUILDING _____ B. WING _____	03/04/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 8	F 226		

The Resident Incident Report dated 10/3/15, indicated R39 was found with a bruise which measured 8.0 inches x 6.0 inches on his right side, rib/back area at 9:00 p.m. Unsure how bruise occurred. R39 pointed at wheelchair and stated "hurt me." The report indicated R39 was transferred to the hospital at 9:50 p.m. The immediate intervention implemented was identified as "to emergency room related to blood loss, will pad back of wheelchair." The report indicated the administrator was notified but the SA was not notified as the resident stated what caused injury as reason not reported. However, R39's quarterly Minimum Data Set (MDS) indicated R39 had severe cognitive impairment / decision making skills and required extensive assistance of 2+ persons for transfers, ambulation and extensive assist of one person for locomotion on and off the unit.

The SNF Resident Council Meeting Agenda and Minutes dated 11/9/15, included a note under the Social Services individual department update which indicated R5 was upset because a nursing assistant had grabbed her. No further information regarding the incident was documented. No Resident Incident Report or investigation into the allegation was available and the Resident Council Meeting Minutes dated 12/7/15, lacked follow up regarding R5's allegation.

On 3/3/16, at 1:02 p.m. Activity director (AD) stated she had informed licensed social worker (LSW)-A about the concern voiced by R5 at the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245468	A. BUILDING _____ B. WING _____	03/04/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 9	F 226		

11/9/15, resident council meeting. The AD stated LSW-A had told AD R5's concern had been followed up and resolved. AD confirmed she had not reported R5's incident any further.

On 3/3/16, at 1:19 p.m. LSW-A stated she was unaware of the concern R5 had voiced at the 11/9/15, resident council meeting.

On 03/04/2016, at 1:48 p.m. the director of nursing (DON) and adminstrator were interviewed regarding the facility abuse prohibition practices. The DON indicated all staff were trained on how to file a verbal report to the Common Entry Point (CEP). The DON also indicated she was called for any incident and the usual practice was for the DON or assistant (DON) to file the vulnerable adult report with the SA. The aforementioned incident reports were reviewed with both the DON and adminstrator which revealed the following:

--R47: The DON confirmed R47's bruise was not immediately reported to the SA and indicated at the time of the incident, the credentials for the staff member to sign into the CEP website had been lost therefore she had conducted an investigation while concurrently attempting to obtain access. The DON confirmed she could have made a verbal report but stated it hadn't occurred to her to do so.

--R25: The DON confirmed R25's elopement incident and stated she had not reported the incident to the CEP as an elopement as R25 was found and was uninjured. The DON indicated the circumstances surrounding the elopement would

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245468	A. BUILDING _____ B. WING _____	03/04/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 10 determine when/if she would report it. The DON stated she would report an elopement if an injury occurred, if R25 had left the facility grounds or if there had been inclement weather. The DON indicated R25's chair alarm and Wanderguard were functioning however, R25 had bypassed the exit door at the end of the Country wing as the exit door would open if continuously pressed for 30 seconds --R39: The DON indicated R39 had been experiencing a gastrointestinal (GI) bleed at the time the bruise was identified. The DON stated R39 would go in every couple of weeks for blood transfusions due to this GI bleed. DON also indicated when R39's hemoglobin was low he experienced a decline in his cognition. DON confirmed R39 was sent to the emergency room for a blood transfusion after the bruise was discovered. The DON confirmed she did not report the bruise to the SA as she trusted what R39 had told her even though he may have had a change in cognition due to low hemoglobin. --R5: The DON stated she was unaware of R5's report during a resident council meeting of being grabbed by a nursing assistant. The DON confirmed the activity director should have reported the allegation to her or another nurse immediately. DON indicated she would follow up with R5 right away.	F 226		
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.	F 250		4/6/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245468	A. BUILDING _____ B. WING _____	03/04/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 250	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide medically related social services in order to attain or maintain the highest practicable physical, mental and psychosocial well-being for 1 of 1 resident (R9) with chronic health issues, had exhibited ongoing behavioral issues and ineffective coping skills. Findings include: R9's quarterly Minimum Data Set (MDS) dated 1/6/16, indicated R9 was cognitively intact and had diagnoses of end stage renal disease, diabetes, anxiety, depression, post traumatic stress disorder, acquired absence of right hand and leg, below knee. The MDS indicated R9 required extensive assistance of two staff for bed mobility, dressing and personal hygiene, was totally dependent on two plus staff for transfers and toilet use, was non-ambulatory, required extensive assistance of 1 person for locomotion on and off the unit and required supervision with set up help for eating. The MDS also indicated R9 had mood symptoms of feeling down, depressed or hopeless, feeling tired or having little energy and feeling bad about self. The MDS further indicated R9 exhibited verbal behavioral symptoms directed toward others such as threatening, screaming at or cursing at others and other behavioral symptoms not directed toward others.	F 250	F250 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because provisions of state and federal law require it. Without waiving the foregoing statement, the facility states with respect to: 1. Social Services meets with R9 at a minimum of x2 per week. Continuing schedule of visits will be determined by R9 and SS. Daily journal has been provided for staff to document services provided, for R9 to review to assist in relieving anxiety related to services completed. A comprehensive Care conference will be held on 4/5/16 with R9 and POA to review current and updated plan of care. 2. Community Life Assessment completed on 3/18/16 to identify R9's preferences and hobbies. Care plan has been updated to reflect psychosocial needs, goals and interventions. Identified preferences and hobbies are currently being offered. 3. On 3/10/16 RD met with R9 to review goals and plans for weekly menu and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245468	A. BUILDING _____ B. WING _____	03/04/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 250	Continued From page 12 On 3/1/16, at 6:40 p.m. R9 voiced multiple complaints including staff not following doctors orders, not receiving her medications, verbal abuse, missing personal items, staff not answering her call light, having to wait long periods of time to go to bed, lack of privacy for telephone calls and lack of notification prior to a room change. R9 stated she had copies of her last 6 months of nurses' notes and stated staff had said she was demanding, bossy and loud. R9 indicated she wished staff would tell her when she was loud. R9 stated she had talked with the director of nursing (DON) and social worker (LSW) about it and wanted to be told and worked with when she behaved that way as she wanted to get along with the staff. R9 stated staff had swore at her and admitted she had cursed at them at times. R9 stated she felt like staff were upset with her. R9 stated she could not do things by herself and she needed help. R9 stated if she asked for something more than once she got "reamed" for it and stated "I can't win." With tears and crying, R9 stated she felt like she couldn't ask for what she wanted or she was accused of being bossy or demanding. Review of R9's progress notes dated 9/6/15, to 3/3/16, revealed 55 episodes of yelling/screaming, irritable and demanding behavior. Nine episodes of R9's refusal of care. Ten episodes of accusations against visitors and staff. Ten episodes of emotional upset / crying. Eight episodes of non compliance with prescribed diet and fluid restriction and 31 episodes of refusing prescribed insulin doses. The notes lacked any notation of social service	F 250	dialysis diet option. Dietary Manager or designee meets with R9 on a weekly basis to review menu and dialysis diet. 4. R9 has been referred to a psychologist of choice with an appointment 04/19/2016. 5. All residents receive a SS comprehensive assessment upon admission, quarterly and with a significant change. 6. Social Service policy and procedure has been updated. All staff educated to the updated policy on 3/31/16. 7. Social Services or Designee will meet with R9 at a minimum of X2 each week. The data collected will be presented to the QA Committee by the Social Service Director. The data collected will be reviewed/discussed at the Monthly QAPI and Quarterly QA meeting. At this time the QA committee will make the decision/recommendation regarding any follow-up studies. Completion date: April 6, 2016	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245468	A. BUILDING _____ B. WING _____	03/04/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 250	Continued From page 13	F 250		

intervention/involvement related to the behaviors in order to determine if R9 had unmet psychosocial needs.

R9's Social Service Evaluation dated 10/2/15, indicated R9 had no communication with or support from family and desired to discharge to an apartment. The evaluation did not identify behavioral, coping or adjustment issues.

R9's social service note dated 10/28/15, indicated when the social worker began to discuss behaviors of swearing and being demanding the past week, R9 denied the behaviors and said it may have been from being in pain, even though earlier she had indicated her pain had been much more in control. No further follow up regarding the behavior was documented.

R9's Social Service Evaluation dated 1/6/16, indicated R9 had no communication with or support from family, desired to discharge to an apartment and had issues of left below knee amputation, right hand amputation and infection with wounds on left hand. The evaluation did not identify behavioral, coping or adjustment issues.

R9's social service note dated 2/17/16, indicated the social worker addressed R9's behaviors of yelling at staff and not following diet recommendations. R9 stated the staff should know she has always been impatient. R9 also denied drinking pop with sugar and when confronted about asking families who visited other residents to buy it for her, R9 stated, "that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245468	A. BUILDING _____ B. WING _____	03/04/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 250	Continued From page 14 was two weeks ago, I am trying now." R9 was crying during most of the meeting. No further follow up regarding the behavior was documented. R9's care plan dated 1/21/16, indicated R9 had a history of depression, bipolar disorder, anxiety and post traumatic stress disorder with many other health issues that contributed to her verbally abusive behavior, striking out at staff and refusal of cares. The plan directed nursing staff to administer medications as ordered and directed social services and nursing to allow R9 to express her feelings/concerns, remove R9 from the common areas and leave in a safe manner and when unable to redirect R9 to explain they would return later, provide much encouragement, assistance and support to maintain as much independence and control over her environment as possible and to invite to activities of choice and offer to escort R9 to activities. The plan further directed staff/social services to observe for signs/symptoms of mania or hypermania (such as racing thoughts or euphoria, increased irritability, frequent mood changes, pressured speech changes, flight of ideas, marked changed in sleep, agitation or hyperactivity), depression (including hopelessness, anxiety, sadness, insomnia, anorexia, verbalizing, negative statements, repetitive anxious or health related complaints, tearfulness) and all staff to observe/record target behaviors/symptoms and document per facility protocol. Although the care plan identified interventions, the care plan lacked specific social service psychosocial needs, goals and interventions/involvement.	F 250		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245468	A. BUILDING _____ B. WING _____	03/04/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 250	Continued From page 15 On 3/1/15, at 7:45 p.m. the director of nursing (DON) stated R9 had been a challenge to work with due to her behaviors. The DON indicated R9 lied and made up stories and believed R9 had experienced many losses, including an amputation of her right hand in the previous year, and her manipulative behaviors were a way for her to control some aspects of her life. On 3/3/16, at 10:54 a.m. R9 was again interviewed, upon her request, regarding her complaints. R9 stated she had talked with the DON about her concerns in the past but had not talked with the LSW. On 3/3/16, at 12:02 p.m. registered nurse (RN)-B stated R9 was manipulative, tried to play staff against each other and was not very truthful. RN-B also stated R9 could not control anything else in her life so she controlled her environment. RN-B futher stated R9 had been upset about what was written in her medical record and had a history of complaining about the nursing home to the dialysis staff and complaining about dialysis staff to the nursing home staff. RN-B indicated R9 had even complained to her about the survey process and stated, "the surveyor had to know everything." On 3/4/16, at 8:43 a.m. nursing assistant (NA)-A stated R9 was a difficult case as she was very demanding and sometimes tried to get staff in trouble. NA-A stated R9 could be manipulative, had never complained of specific staff being abusive to her, however, complained of missing items such as books and papers constantly.	F 250		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245468	A. BUILDING _____ B. WING _____	03/04/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 250	Continued From page 16 NA-A further stated it was hard to address her complaints of missing items since R9 brought many items back and forth with her to dialysis and believed that was when some of her items were lost. On 3/4/16, at 9:06 a.m. RN-B stated R9 had never complained of verbal abuse by staff members, however, always complained of missing items such as books and papers. RN-B stated R9 had stacks of books and papers and didn't always know what she had. RN-B also stated R9 tried to get staff in trouble and has had staff in tears due to her nasty comments directed at them. During the interview, which occurred across from R9's room, R9 was heard to scream and call out for help. RN-B immediately called for additional staff to assist R9. After being told help was on the way, R9 continued to scream and call out for help. NA-B and the DON were observed to enter R9's room within a minute to assist R9 who continued to scream and call out while being assisted. On 3/4/16, at 10:14 a.m. the LSW indicated she saw residents upon admission and tried to see them weekly for the first month after admission, as well as, at care conferences. The LSW stated she didn't have a schedule for resident meetings / visits but would see them as something came up and residents would also approach her with concerns or she would hear of issues through the daily morning meeting. The LSW confirmed she did not have scheduled routine meeting / visit times with R9 but had been working with her on a recent guardianship issue. However, LSW indicated she didn't always document her notes	F 250		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245468	A. BUILDING _____ B. WING _____	03/04/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 250	Continued From page 17 and R9 sometimes did not want to see her and would tell people such. LSW confirmed R9 had numerous complaints such as missing personal items, staff not helping her, and people being mean to her. LSW also confirmed staff had numerous complaints regarding R9 such as demanding and manipulative behaviors and trying to get staff members into trouble. LSW stated they had instituted staff members working in pairs when caring for R9 to protect staff but stated she did not have scheduled appointments / make routine visits with R9 to discuss her issues. LSW confirmed she had not worked proactively with R9 and had not assessed R9's specific psychosocial needs/unmet needs, established goals or developed interventions to assist R9 cope with her issues in order to decrease behaviors and improve well being. Social Service Policy and Procedure Manual Purpose and Goals dated 5/4/2000, indicated social service helped the resident find a satisfactory solution or adjustment to interrelated physical, social, emotional and economic problems.	F 250		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371		4/6/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245468	A. BUILDING _____ B. WING _____	03/04/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 18 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the dietary department was maintained in a clean and sanitary manner, and failed to ensure the chemical sanitization parts per million had been appropriately monitored prior to sanitizing the dishes and utensils to ensure adequate sanitization. This had the potential to affect all 38 residents who received meals from the kitchen. The findings include: A tour of the kitchen was completed on 3/3/16, at 11:30 a.m. with the dietary manager (DM) and the following was identified: -The dish sanitizer chlorine test, water temperature, and quat test logs from 12/1/15, to 3/1/16, were reviewed and showed in December 2015, there were 0 of 31 times the chlorine had been tested, 1 of 31 times the water temperature was monitored, and 1 of 31 times a quat test was performed. In January 2016, the dish sanitizer logs showed 0 of 30 times the chlorine had been tested, 9 of 30 times the water temperature was monitored, and 9 of 30 times a quat test was performed. In February 2016, the dish sanitizer logs showed 5 of 29 times the chlorine had been tested, 5 of 29 times the water temperature was monitored, and 5 of 29 times a quat test was performed. In March 2016, the dish sanitizer logs showed 0 of 1 times the chlorine had been tested, 0 of 1 times the water temperature was	F 371	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because provisions of state and federal law require it. Without waiving the foregoing statement, the facility states with respect to: 1. The following areas have been cleaned: Top and bottom, inside and outside of the convection oven. The back splash in back of grill and 6 burner stove. Inside and outside of cook prep area where pans were stored. Ares where pitcher and their covers are stored. The rest of the kitchen has been deep cleaned. The dishwasher chemicals have been checked for proper sanitation and are in compliance. 2. The facility policy Sanitation of the Dietary Department has been updated. All Dietary staff has been educated to the updated policy. 3. Dietary Manager or designee will audit cleanliness and records of dishwasher chemicals 5x per week for 1 month then weekly for 2 months and then monthly x2 months. The data collected will be presented to the QA Committee by the Dietary Manager or Designee. The data collected will be reviewed/discussed at the Monthly QAPI and Quarterly QA meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245468	A. BUILDING _____ B. WING _____	03/04/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 19 monitored, and 0 of 1 times a quat test was performed. At 11:38 a.m. the DM verified the findings and stated the chlorine, temperature, and quat test should have been performed daily and confirmed they had not been. Additionally, the following area's were found unclean: -Top and bottom inside and outside of the convection oven. -The back splash in back of the grill and 6 burner stove had splattered dried food throughout. -The 6 burner stove top had baked on debris, and the oven of the 6 burner stove had rusted material and baked on debris. -The hood above the grill and 6 burner stove was dirty and had baked on grease. -The inside and outside of the cook prep area where pans were stored was dirty and had chipped missing paint. -The area where drinking pitchers and their covers were stored was low to the floor (foot level) and did not have the ability to be covered was dirty and debris was noted. A facility policy Sanitation Of The Dietary Department (undated) was provided and identified the following: " The dietary staff shall maintain the sanitation of the Dietary Department through compliance with a written, comprehensive cleaning schedule." A policy regarding the chemical and water temperature sanitation was requested but not provided.	F 371	At this time the QA committee will make the decision/recommendation regarding any follow-up studies.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245468	A. BUILDING _____ B. WING _____	03/04/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 20 On 3/3/16, at 11:38 a.m. the DM confirmed the aforementioned areas identified above were not maintained in a clean sanitary manner. The DM further stated the dish sanitizer should have been tested daily to ensure proper sanitation of the dishes and utensils and confirmed the parts per million of the disinfecting agents chlorine, and quat had not been completed and logged daily, as required. On 3/3/16, at approximately 3:45 p.m. the registered dietician verified the findings and stated in the previous months, he had reported the ongoing issues related to the kitchen's sanitation to the Administrator.	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245468	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/01/2016**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey Karlstad Healthcare Center 01 Main Building was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or By e-mail to:	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/25/2016

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245468	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/01/2016**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 Marian.Whitney@state.mn.us and Angela.kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Karlstad Healthcare Center is a 1-story building without a basement and constructed at 2 different times. The original building was constructed in 1974, was determined to be of Type II(222) construction. In 1983 an addition was constructed south of the original building, which was determined to be of Type II (000) construction and is separated with at least a 2-hour fire barrier from the original building. Attached to the original building at the south west corner and separated with a 2-hour fire barrier is a connecting link to an assisted living building. The entire building is protected with an automatic fire sprinkler system installed in accordance with NFPA 13 Standard for the Installation of Automatic Sprinkler Systems 1999 edition. The facility has a fire alarm system with smoke detection at the smoke barrier doors and in the corridor system with extended spacing, installed in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition. The fire alarm system	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245468	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/01/2016**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 is monitored for automatic fire department notification. Hazardous areas have either heat detection or smoke detection that are on the fire alarm system in accordance with the Minnesota State Fire Code 2007 edition. The facility is divided into 4 smoke zones with at least 30 minute fire barriers. The facility has a capacity of 46 beds and had a census of 39 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the smoke resistance of 2 corridor doors according to NFPA 101 LSC (00) section 19.3.6.3.1. This deficient practice could affect the safety of 15 of the 39 residents and an	K 018	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or	4/6/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245468	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/01/2016**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 018	Continued From page 3 undetermined amount of staff and visitors, if smoke from a fire were allowed to enter the exit access corridors making it untenable. Findings include: On the facility tour between 2:00 pm to 4:45 pm on 03-01-2016 observation and staff interview revealed the the doors to rooms 135 and the activity storage closet did not fit tight in the frame to produce a smoke resistant door. Also, in the mechanical room U34, there was a six inch square penetration in the wall on the corridor side. This deficient condition was verified by the Maintenance Supervisor.	K 018	conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because provisions of state and federal law require it. Without waiving the foregoing statement, the facility states with respect to: 1. Doors to rooms 135 and the activity storage closet have been replaced. In mechanical room U34, 6 inch square penetration has been replaced and sealed. 2. Completion Date: 4/6/16 3. Completed by Maintenance Director	
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2 This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined that the facility failed to conduct fire drills during the last 12-month period in accordance with NFPA Life Safety Code 101(00), 19.7.1.2, This deficient practice could result in improper staff reaction in the event of a fire and could affect the safety of all 39 residents and an	K 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 facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction	4/6/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245468	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/01/2016**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 050	Continued From page 4 undetermined amount of visitors, and staff. Findings include: On the facility tour between 2:00 pm to 4:45 pm on 03-01-2016 record review and staff interview revealed that 9 of the 12 required fire drills were not conducted in the last 12 months. This deficient condition was verified by the Maintenance Supervisor	K 050	prepared for this deficiency was executed solely because provisions of state and federal law require it. Without waiving the foregoing statement, the facility states with respect to: 1. Fire Drills for the month of March have been conducted, our TELS program has been updated and logs will be printed and put into our Life Safety Code binder. 2. Completed 3/22/2016. 3. Completed by Maintenance Director, and will be reviewed quarterly in our QA meetings	
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety shall be, tested, and maintained in accordance with NFPA 70 National Electric Code and NFPA 72 National Fire Alarm Code and records kept readily available. The system shall have an approved maintenance and testing program complying with applicable requirement of NFPA 70 and 72. 9.6.1.4, 9.6.1.7, This STANDARD is not met as evidenced by: Based on observation and staff interview, it was revealed that the facility had failed to install and maintain the fire alarm system in accordance with the requirements of 2000 NFPA 101, Sections 19.3.4.1 and 9.6, as well as 1999 NFPA 72, Sections 7.1. This deficient condition could adversely affect the functioning of the fire alarm system, and could delay the timely notification and emergency actions for the facility thus negatively affecting all 39 residents, staff, and visitors of the facility. Findings include: On the facility tour between 2:00 pm to 4:45 pm	K 052	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because provisions of state and federal law require it. Without waiving the foregoing statement, the facility states with respect to: 1. Following our POC for tag K50 we will be in compliance for testing our fire alarm system. 2. Date completed 3/22/2016	4/6/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245468	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/01/2016**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 052	Continued From page 5 on 03-01-2016 record review and staff interview revealed that the DACT system was only tested in 3 months out of the required 12 months. This deficient condition was verified by the Maintenance Supervisor.	K 052	3. Completed by Maintenance Director	
K 062 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observations and an interview with staff, it was determined that the facility has failed maintain the automatic fire sprinkler system in accordance with National Fire Protection Association (NFPA) 25 The Standard for the Inspection, Testing, and Maintenance of Water Based Fire Protection Systems 1998 edition section 9.2.7. This deficient practice could affect all 39 residents, and an undetermined amount of visitors and staff. Findings include: On the facility tour between 2:00 pm to 4:45 pm on 03-01-2016 observations and staff interview revealed the facility failed to maintain the sprinkler system in a reliable operation condition due to: 1. The sprinkler head in the kitchen freezer no longer has a red colored bulb which would indicate a damaged sprinkler head. 2. The ceiling tiles in the two east wing dining room closets are missing which would allow heat to escape above the ceiling and may not set off the sprinkler heads.	K 062	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because provisions of state and federal law require it. Without waiving the foregoing statement, the facility states with respect to: 1. Sprinkler head in freezer is a fuseable link and dose not have the red colored bulb 2. Ceiling tiles in country dining room are being replaced by local contractor 3. Completed 4/6/16 4. Completed by Maintenance Director and designee	4/6/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245468	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/01/2016**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 069	Continued From page 7 of proper maintenance could cause a build up of grease, which could result in fire. This deficient practice could affect 16 of the 39 residents, all kitchen staff and visitors. Findings Include: On the facility tour between 2:00 pm to 4:45 pm on 03-01-2016 record review and staff interview revealed that the kitchen hood system has not had the semi-annual inspections completed. This deficient condition was verified by the Maintenance Supervisor.	K 069	facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because provisions of state and federal law require it. Without waiving the foregoing statement, the facility states with respect to: 1. Kitchen hood system has been inspected by contractor and will be put on a biannual inspection schedule. 2. Date completed 4/6/2016 3. Completed by Maintenance Director or designee	
K 072 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects shall obstruct exits, access thereto, egress there from, or visibility thereof shall be in accordance with 7.1.10. 18.2.1, 19.2.1 This STANDARD is not met as evidenced by: Based on observations and staff interview the facility failed to maintain the egress free of all obstructions or impediments to full instant use in the case of fire or other emergency as per NFPA 101 "The Life Safety Code" 2000 edition (LSC) section 7.1.10.2.1. This deficient practice can slow or even prevent exiting. This deficient practice could affect all residents, staff and guests in the west half of the building. Findings include: On the facility tour between 2:00 pm to 4:45 pm on 03-01-2016 observations and staff interview revealed the corridor in D wing was being used	K 072	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because provisions of state and federal law require it. Without waiving the foregoing statement, the facility states with respect to: 1. All storage and combustible trash in the corridor in D wing has been removed. All staff educated.	3/30/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245468	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/01/2016**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 072	Continued From page 8 for storage of combustible trash and equipment. This deficient condition was verified by the Maintenance Supervisor.	K 072	2. Date completed 3/30/2016 3. Completed by Maintenance Director or designee	
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) This STANDARD is not met as evidenced by: Based on record review and staff interview, the facility failed to maintain the emergency generator in accordance with the requirements of NFPA 110 - 1999 edition and NFPA 99 - 1999 edition, section 3-4.1.1.2. This deficient practice could affect the safety of all patients, staff and visitors. Findings include: On the facility tour between 2:00 pm to 4:45 pm on 03-01-2016 record review and staff interview revealed the weekly and monthly generator reports were missing from July of 2015 through January of 2016. This deficient condition was verified by the Maintenance Supervisor	K 144	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because provisions of state and federal law require it. Without waiving the foregoing statement, the facility states with respect to: 1. Generator has been inspected. Weekly and monthly inspections have been implemented using our TELS program in accordance with NFPA code 2. Date completed 4/6/2016 3. Completed by Maintenance Director or designee	4/6/16
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility was using unapproved electrical devices	K 147	The preparation of the following plan of correction for this deficiency does not	3/1/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245468	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/01/2016**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 147	Continued From page 9 that are not in accordance with NFPA 70 (99), National Electrical Code. This deficient practice could negatively affect the safety of the resident in the room and an undetermined amount of staff and visitors. Findings include: On the facility tour between 2:00 pm to 4:45 pm on 03-01-2016 observation and staff interview revealed an unlisted plug adapter being used in room 119. This deficient practice was verified by the Maintenance Supervisor	K 147	constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because provisions of state and federal law require it. Without waiving the foregoing statement, the facility states with respect to: 1. Unlisted plug adapter was removed from room 119 2. Date completed 3/1/2016 3. Completed by Maintenance Director	