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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: DRZT
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 **04/28/2014** (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: * Code: **A** (L12)

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

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): Post Certification Revisit (PCR) completed on April 14, 2014 by review of plan of correction (POC) and onsite on April 28, 2014. Based on the POC, it has been determined that the deficiencies issued at the time of the standard survey have been corrected, effective April 8, 2014. Refer to the CMS 2567b for both health and life safety code.

Effective April 18, 2014, the facility is certified for 46 skilled nursing facility beds.

17. SURVEYOR SIGNATURE Date :
Lyla Burkman, Unit Supervisor 05/06/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date: MPM
Mark Meath, Enforcement Specialist 06/02/2014 (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
04/30/2014
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5468

June 1, 2014

Ms. Becky Beito, Administrator
Karlstad Healthcare Center, Inc
304 Washington Avenue West
Karlstad, Minnesota 56732

Dear Ms. Beito:

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 18, 2014 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 letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

May 6, 2014

Ms. Becky Beito, Administrator
Karlstad Healthcare Center, Inc
304 Washington Avenue West
Karlstad, Minnesota 56732

RE: Project Number S5468024

Dear Ms. Beito:

On March 11, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 27, 2014. 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 14, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on April 28, 2014 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 February 27, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of . Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 27, 2014, effective April 18, 2014 and therefore remedies outlined in our letter to you dated March 11, 2014, 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 Notice.

Sincerely,

Mark Meath

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

cc: Licensing and Certification File 5468r14

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245468	A. Building B. Wing	4/14/2014

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

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix F0456 Reg. # 483.70(c)(2) LSC	04/08/2014	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	MM/LB	05/06/2014	28035	04/14/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 2/27/2014

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245468	A. Building / B. Wing: 01 - MAIN BUILDING 01	4/28/2014

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

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0046	03/31/2014	ID Prefix Reg. # NFPA 101 LSC K0062	04/18/2014	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By MM/PS	Date: 05/06/2014	Signature of Surveyor: 03006	Date: 04/28/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 2/27/2014		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: DRZT

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 **02/27/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE): **On February 27, 2014 a standard survey was completed at this facility. Deficiencies were found. 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 for health and life safety code along with the plan of correction.**

17. SURVEYOR SIGNATURE
Jane Aandal, HFE NEII
Date : 04/03/2014
(L19)

18. STATE SURVEY AGENCY APPROVAL
Mark Meath, Enforcement Specialist
Date: 04/27/2014
(L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

FORM CMS-1539 (7-84) (Destroy Prior Editions) 020499

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7002 0860 0006 5192 3964

March 11, 2014

Ms.. Becky Beito, Administrator
Karlstad Healthcare Center, Inc
304 Washington Avenue West
Karlstad, Minnesota 56732

RE: Project Number S5468024

Dear Ms.. Beito:

On February 27, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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
Minnesota Department of Health
705 5th Street Northwest, Suite A
Bemidji, Minnesota 56601-2933

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 8, 2014, 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 8, 2014 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

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

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

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

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

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

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

- Include signature of provider and date.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's PoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the PoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by May 27, 2014 (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 August 27, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

This request must be sent within the same ten days you have for submitting a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Enclosure

cc: Licensing and Certification File 5468s14.rtf

PRINTED: 03/11/2014
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245468	A. BUILDING _____ B. WING _____ RECEIVED MAR 26 2014	02/27/2014

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 PLAN OF CORRECTION (POC) WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.	F 000	F 456 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because provisions of state and federal law require it. Without waiving the foregoing statement, the facility states, with respect, to: 1. Defrost freezer and repair drip pan so that water will drain out properly instead of pooling and leaking onto the food boxes and floor of the freezer. 2. Food and paper debris removed from freezer, as well as ice buildup on freezer floor and on boxes of food. Boxes of food will not be placed under or near drip pan until full repairs are made. 3. Preventative maintenance will be scheduled to ensure that automatic defrost is working properly and that drip pan is secured tightly. Cleaning policy will be updated to include weekly checklists. 4. Preventative maintenance and freezer cleaning schedules will be audited on a monthly basis by the quality assurance committee to ensure compliance. 5. April 30th, 2014	4/8/2014 3/31/14 w addendum SD
F 456 SS=F	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the walk-in freezer was appropriately maintained which had the potential to effect all 37 residents who were residing in the facility. Findings include: During the kitchen tour on 2/26/14, at 11:45 a.m. the walk-in freezer was observed to have an area 4-1/2 feet by 2 feet and ½ inch thick of ice on the floor on the right side of the freezer floor. Two croissants, large food crumbs and pieces of	F 456		

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

Rebecca Sorenson | Administrator | 3-25-14

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.

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OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245468	A. BUILDING _____ B. WING _____	02/27/2014

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

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F 456	Continued From page 1 paper food labels were also observed on the floor of the freezer under the freezer racks. The dietary manager (DM) was unsure the last time the walk-in freezer had been cleaned and stated the freezer has had problems with ice buildup. The DM stated the maintenance staff was responsible for cleaning the walk-in freezer floor. The DM confirmed the walk-in freezer floor needed to be cleaned and the ice removed. On 2/26/14, at 1:36 p.m. maintenance (M)-A stated the dietary/kitchen staff was responsible for cleaning the walk-in freezer. On 2/26/14, at 2:39 p.m. cook (C)-A confirmed water condensation from the fans near the ceiling of the walk-in freezer was present. C-A stated the water had dripped down and had frozen on to two boxes of tator tots, one box of hash brown nuggets, one box of cheddar cheese, one box of boneless pork and one box of pork sausage. C-A also confirmed the water had frozen on to these boxes and ice had formed on the outside of the boxes leaving these boxes frozen to the wire racks. On 2/26/14, at 2:45 p.m. C-A provided a [undated] copy of the facility's "Cleaning Check List" which directed dietary staff to wash and clean the freezer floor every Friday. On 2/27/14, at 8:20 a.m. the DM verified this cleaning checklist was current. On 2/27/14, at 8:16 a.m. M-A confirmed the walk-in freezer cooling coils were causing the buildup of ice in the freezer. M-A stated they were supposed to be self-defrosting, however the facility was having issues with ice buildup and had a refrigeration company come and do some	F 456		

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F 456	Continued From page 2 repair. On 2/27/14, at 8:28 a.m. M-A provided copies dated 7/10/13, and 8/20/13, from a refrigeration company which had assessed and conducted some repairs on the walk-in freezer. The facility's "CLEANING REFRIGERATORS" policy [undated] directed staff to wipe up spills and leaks as they are noticed. The policy also indicated the walk-in refrigerator floor was to be mopped monthly.	F 456		

Karlstad Senior Living/ Karlstad Healthcare Center

3/31/14

Addendum to F 456, Item 4

Freezers will be audited every WEEK for 6 weeks, then monthly from then on to ensure compliance.

Director of Nursing Services

Completion date for F456 is 4-8-14

Rebecca Sorenson, Administrator 3/31/14

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 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 Or by e-mail to:	K 000	POC ok FS 4-3-14 RECEIVED APR - 3 2014 MN DEPT OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

Dc: 4-8-14

EXIT: 3-27-14

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

(Rebecca Sorenson) Administrator 4/1/14

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K 000	Continued From page 1 Marian.Whitney@state.mn.us Fax Number 651-215-0525 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		

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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 37 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 046 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. This STANDARD is not met as evidenced by: Based on observations and an interview with staff, it was determined that the facility has failed to insure that all emergency lighting has been maintained in accordance with National Fire Protection Association (NFPA) 101 The Life Safety Code (LSC) 2000 edition Section 7.9 & 19.2.9.1. This deficient practice could affect all 46 residents, all staff and any visitors in the event of an emergency evacuation during a power outage. Findings include: During the facility tour on February 27, 2014, between 11:15 AM and 12:30 PM, observations of the facilities Emergency Power System and an interview with the director of maintenance by surveyor 03006, revealed that the generator installed in early January 2014, could not be	K 046	K 046 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. Documentation has been provided to show that the generator installed on January 10th, 2014 operates the required Life Safety and Emergency Power System of the facility as required. 2. March 31st, 2014 3. Maintenance Director	

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K 046	Continued From page 3 documented that it operates the required Life Safety and Emergency Power System of the facility as required. This deficient practice was confirmed by the Director of Maintenance and the Administrator during the facility survey and at the exit conference.	K 046		
K 062 SS=C	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 automtic 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. Failure to maintain a fire protection system could allow it to fail during a fire which would negatively affect all the residents, staff and quests of the facility. This deficient practice could affect all 46 residents, all staff and any visitors in the event of an emergency evacuation during a power outage. Findings include: During the facility tour on February 27, 2014, between 11:15 AM and 12:30 PM, observations by and an interview with the director of	K 062	K 062 1. The sprinkler head in the walk in freezer has been replaced and is properly functioning. The gauges on the sprinkler system will be replaced. 2. ~~April 30th~~, 2014 3. Maintenance Director 4-18-14 per T/C w/ Admin	

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K 062	Continued From page 4 maintenance by surveyor 03006, revealed that: 1) The sprinkler head in the walk in freezer is fragile bulb head that has no color whihc is an indication that it maybe damaged, and 2) the gauges on the sprinkler system indicate that the last time that they have been replaced was in 2007. These deficient practices were confirmed by the Director of Maintenance and the Administrator during the facility survey and at the exit conference.	K 062		