DEPARTMENT	OF HEALTH AN	D HUMA	N SERVICES			CENTERS FOR MEDICARE & MEDICAID SERVICES			
						ND TRANSMITTAL E SURVEY AGENCY	ID: DRZT Facility ID: 00830		
1. MEDICARE/MEDIC (L1) 245468 2.STATE VENDOR OF (L2) 01202860	R MEDICAID NO.		 3. NAME AND ADDRESS OF FACILITY (L3) KARLSTAD HEALTHCARE CENTII (L4) 304 WASHINGTON AVENUE WEST (L5) KARLSTAD, MN 			<i>'</i>	4. TYPE OF ACTION: 7 (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other		
5. EFFECTIVE DATE CHANGE OF OWNERSHIP 7. PROVIDER/SUPPLIER CATEGORY (L9) 01 Hospital 05 HHA 09 ESRD					<u>02</u> (L7) 13 PTIP 22 CLIA	8. Full Survey After Complaint			
 DATE OF SURVEY ACCREDITATION 0 Unaccredited 2 AOA 		(L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 12/31		
11LTC PERIOD OF C	CERTIFICATION		10.THE FACILITY	IS CERTIFIED	AS:				
From (a):			X A. In Complian	nce With		And/Or Approved Waivers	Of The Following Requirements:		
To (b):				equirements e Based On:		 Technical Person 24 Hour RN 	nel6. Scope of Services Limit 7. Medical Director		
12.Total Facility Beds	4	16 (L18)	1. Ao	cceptable POC		4. 7-Day RN (Rural 5. Life Safety Code	SNF)8. Patient Room Size		
13.Total Certified Beds	- 4	16 (L17)		pliance with Progents and/or Appli		* Code: A	(L12)		
14. LTC CERTIFIED B	ED BREAKDOWN					15. FACILITY MEETS			
18 SNF	18/19 SNF 46	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)		
(L37)	(L38)	(L39)	(L42)	(L43)					

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 :	18. STATE SURVEY AGENCY APPROV	AL Date: MPM
<u>Lyla Burkman, Unit Sup</u>	ervisor	05/06/2014 (L19)	Mark Meath, Enforcement Spe	ecialist 06/02/2014 (L20)
PA	RT II - TO BE COMP	LETED BY HCFA REGIONA	L OFFICE OR SINGLE STATE A	GENCY
19. DETERMINATION OF ELIGIBI	LITY	20. COMPLIANCE WITH CIVIL	21. 1. Statement of Financial Solver	
X 1. Facility is Eligible to Participate		RIGHTS ACT:	 Ownership/Control Interest I Both of the Above : 	Disclosure Stmt (HCFA-1513)
2. Facility is not Eligible	le (L21)			_
22. ORIGINAL DATE	23. LTC AGREEMENT	24. LTC AGREEMENT	26. TERMINATION ACTION:	(L30)
OF PARTICIPATION	BEGINNING DATE	ENDING DATE	<u>VOLUNTARY</u> 00	INVOLUNTARY
04/01/1987			01-Merger, Closure	05-Fail to Meet Health/Safety
(L24)	(L41)	(L25)	02-Dissatisfaction W/ Reimbursement	06-Fail to Meet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATIVE SAN	CTIONS	03-Risk of Involuntary Termination	OTHER
	A. Suspension of Admi	ssions:	04-Other Reason for Withdrawal	07-Provider Status Change
(L27)	B. Rescind Suspension	(L44) Date:		00-Active
		(L45)		
28. TERMINATION DATE:	29. INTER	MEDIARY/CARRIER NO.	30. REMARKS	
	03	001		
	(L28)	(L31)		
31. RO RECEIPT OF CMS-1539	32. DETER	MINATION OF APPROVAL DATE		
	(L32) 04/30	(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



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

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number 245468	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 4/14/2014
Name of Facility		Street Address, City, State, Zip Code	
KARLSTAD HEALTHCARE CENTER, INC		304 WASHINGTON AVENUE WEST KARLSTAD, MN 56732	Г

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

(Y4) Item		(Y5)	Date	(Y4)	Item	(Y5)	Date	(Y4)	ltem		(Y5)	Date
		(Correction				Correction					Correction
ID Prefix	E0466		Completed 04/08/2014		ID Profix		Completed		ID Profix			Completed
		'	04/00/2014		D "							
Reg. # LSC	483.70(c)(2)				Reg. # LSC				Reg. # LSC			
								+-				
		(Correction				Correction					Correction
			Completed				Completed					Completed
ID Prefix												
Reg. # LSC					Reg. # LSC				Reg. #			
								+-				
		(Correction				Correction					Correction
			Completed				Completed					Completed
ID Prefix					ID Prefix				ID Prefix			
Reg. # LSC					Reg. # LSC				Reg. #			
LSC									LSC			
		(Correction				Correction					Correction
			Completed				Completed					Completed
ID Prefix					ID Prefix				ID Prefix			
Reg. #					Reg. #				Reg. #			
LSC									LSC			
		(Correction				Correction					Correction
		(Completed				Completed					Completed
ID Prefix					ID Prefix				ID Prefix			
Reg. #					Reg. #				Reg. #			
LSC					LSC				LSC			
Reviewed By	Revi	iewed B	у	Dat	ie:	Signature of Surve	yor:				Date:	
State Agency	, Ml	M/LB	1	05/	/06/2014	280)35				04/1	4/2014
Reviewed By	/ Revi	iewed B	у	Dat	ie:	Signature of Surve	yor:				Date:	
CMS RO												
Followup to	Survey Completed of	on:				Check for any				-		
	2/27/2014	4				Uncorrecte	d Deficiencies	6 (CMS	-2567) Sent t	o the Facility?	YES	NO

Post-Certification Revisit Report

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

(Y1)	Provider / Supplier / CLIA / Identification Number 245468	(Y2) Multiple Construc A. Building B. Wing	I BUILDING 01	(Y3) Date of Revisit 4/28/2014
Name	of Facility		Street Address, City, State, Zip Code	
KARLSTAD HEALTHCARE CENTER, INC			304 WASHINGTON AVENUE WEST KARLSTAD, MN 56732	T
			KARLSTAD, WIN 50752	

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

(Y4) Item	(Y5)	Date	(Y4) Item	(Y5)	Date	(Y4) Item	(Y5)	Date
		Correction			Correction			Correction
ID Prefix		Completed 03/31/2014	ID Prefix		Completed 04/18/2014	ID Prefix		Completed
	NFPA 101	_		NFPA 101	_			
-	K0046	-	-	K0062	-			
		Correction			Correction			Correction
ID Prefix		Completed	ID Prefix		Completed	ID Prefix		Completed
Reg. #		-	Reg. #		-			
						LSC		
		Correction Completed			Correction Completed			Correction Completed
ID Prefix			ID Prefix			ID Prefix		
Reg. #			Reg. #			Reg. #		
LSC		-	LSC					_
		Correction			Correction			Correction
		Completed			Completed			Completed
ID Prefix		-	ID Prefix		-	ID Prefix		
Reg. #			Reg. #			Reg. #		
LSC			LSC					
		Correction			Correction			Correction
		Completed			Completed			Completed
		-			-			
Reg. # LSC		-	Reg. #			Reg. #		
Reviewed By			Date:	Signature of Surve		<i>r</i>	Date:	0/2014
State Agency	y MM/P	5	05/06/20	14	0300	6	04/2	28/2014
Reviewed By	/ Reviewed I	Ву	Date:	Signature of Surve	yor:		Date:	
CMS RO								
Followup to	Survey Completed on: 2/27/2014			•		eficiencies. Was a S (CMS-2567) Sent to t	•	NO
							120	

CENTERS FOR MEDICARE & MEDICAID SERVICES

			ICARE/MEDICA						ID: DRZT Facility ID: 00830	
1. MEDICARE/MEDICAID PR (L1) 245468 2.STATE VENDOR OR MEDIC (L2) 012028600			 NAME AND ADI (L3) KARLSTAD (L4) 304 WASHIN (L5) KARLSTAD, 	HEALTHCARE (GTON AVENUE	CENTER,		56732	4. TYPE OF ACTION 1. Initial 3. Termination 5. Validation	2. Recertification 4. CHOW 6. Complaint	
5. EFFECTIVE DATE CHANG (L9)	GE OF OWNEF	SHIP	7. PROVIDER/SUF 01 Hospital	PPLIER CATEGORY 05 HHA	09 ESRD	<u>02</u> (L7) 13 PTIP	22 CLIA	7. On-Site Visit 8. Full Survey After (9. Other Complaint	
 DATE OF SURVEY ACCREDITATION STATUS 0 Unaccredited 2 AOA 	02/27/20 S: 1 TJC 3 Other	14 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE		FISCAL YEAR ENDIN	G DATE: (L35)
(L37) 16. STATE SURVEY AGENCY Deficiencies were for Post Certification Re	EAKDOWN 18/19 SNF 46 (L38) REMARKS (II und. The		X B. Not in Com Requireme ICF (L42) IOW LTC CANCELLA Deen given an o Refer to the (ce With quirements Based On: cceptable POC pliance with Program ints and/or Applied W IID (L43) TTION DATE): Or popportunity t	n Febru o corre	2. Tech 3. 24 F 4. 7-Da 5. Life * Code: 15. FACILITY Mi 1861 (e) (1) or harry 27, 2014 tect before rem	nical Personnel lour RN ay RN (Rural SNF) Safety Code B* EETS 1861 (j) (1): a standard s nedies would	9. Beds/Room (L12) (L15) survey was compl d be imposed.	vices Limit ictor I Size	cility.
SURVEYOR SIGNATURE 17. Jane Aandal, HFE			Date : 04/03/2		(L19)	Mark Me		ement Specialist	04/27/2014	(L20)
19. DETERMINATION OF EI 1. Facility is EI 2. Facility is not	LIGIBILITY			D BY HCFA RE		21. 1. 5	Statement of Financi	al Solvency (HCFA-2572) nterest Disclosure Stmt (HC	FA-1513)	
22. ORIGINAL DATE OF PARTICIPATION 04/01/1987		23. LTC AGREEMI BEGINNING I		4. LTC AGREEMEN ENDING DATE		26. TERMINAT <u>VOLUNTARY</u> 01-Merger, Closu	00	05-Fail to I	Meet Health/Safety	
(L24) 25. LTC EXTENSION DATE:	: 2 (L27)	(L41) 7. ALTERNATIVI A. Suspension o B. Rescind Susp	of Admissions:	(L25) (L44)		02-Dissanstaction 03-Risk of Involu 04-Other Reason	ntary Termination	OTHER	Meet Agreement	
28. TERMINATION DATE:		29	INTERMEDIARY/C	(L45) ARRIER NO.		30. REMARKS				
31. RO RECEIPT OF CMS-153	39	(L28) 32	DETERMINATION C	OF APPROVAL DAT	(L31) E					
		(L32)			(L33)	DETERMINA	TION APPRO	VAL		



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;

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

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

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

DEPARTMENT CONTACT

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

Lyla Burkman, Unit Supervisor Minnesota Department of Health 705 5th Street 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.

Karlstad Healthcare Center, Inc March 11, 2014 Page 4

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

Karlstad Healthcare Center, Inc March 11, 2014 Page 5

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

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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

Karlstad Healthcare Center, Inc March 11, 2014 Page 6

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

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A, BUILD	IPLE CONSTRUCTION	>	3) DATE SURVEY COMPLETED
		245468	B. WING	MAR 2.6 201	1.	02/27/2014
NAME OF	PROVIDER OR SUPPLIER	- ·		STREET ADDRESS, CIT	TM# STATE, ZIP CODE	
(ARLS1	AD HEALTHCARE CE	ENTER, INC		304 WASHINGTON A KARLSTAD, MN 5		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORF	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIA DEFICIENCY)	
F 000	THE FACILITY PL WILL SERVE AS Y COMPLIANCE UP ACCEPTANCE. YO BOTTOM OF THE CMS-2567 FORM VERIFICATION OF UPON RECEIPT O ONSITE REVISIT CONDUCTED TO SUBSTANTIAL CO REGULATIONS HA ACCORDANCE W 483.70(c)(2) ESSE OPERATING CON The facility must m mechanical, electri equipment in safe This REQUIREME by: Based on observa review, the facility freezer was approp the potential to effer residing in the facil Findings include: During the kitchen the walk-in freezer 4-1/2 feet by 2 feet floor on the right si	AN OF CORRECTION (POC) OUR ALLEGATION OF ON THE DEPARTMENT'S DUR SIGNATURE AT THE FIRST PAGE OF THE WILL BE USED AS COMPLIANCE. DF AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE VALIDATE THAT OMPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION. INTIAL EQUIPMENT, SAFE IDITION maintain all essential ical, and patient care operating condition. NT is not met as evidenced ation, interview and document failed to ensure the walk-in priately maintained which had ect all 37 residents who were		of correction not constitute interpreted a agreement b of the facts a set forth in th deficiencies prepared for executed so of state and Without wais statement, t respect, to: 1. Defrost f pan so that properly ins leaking onto floor of the 2. Food and from freezer on freezer f food. Boxe placed und full repairs 3. Prevent scheduled defrost is w drip pan is policy will t weekly che 4. Prevent freezer cle audited on	tion of the following pla for this deficiency doe e and should not be as an admission nor an by the facility of the trut alleged or conclusions he statement of . The plan of correction r this deficiency was olely because provision federal law require it. ving the foregoing the facility states, with freezer and repair drip water will drain out stead of pooling and o the food boxes and freezer. d paper debris removed er, as well as ice buildu floor and on boxes of es of food will not be ler or near drip pan unt are made. to ensure that automatic	s h 4/8/2014 s d p il be tic at ing 4/8/2014 be tic at ing 4/8/2014

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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CENTER	RS FOR MEDICARE	E & MEDICAID SERVICES		-	(<u> MR NO.</u>	0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMF	SURVEY
		245468	B. WING			02/2	7/2014
NAME OF F	PROVIDER OR SUPPLIER			S	REET ADDRESS, CITY, STATE, ZIP CODE		
KARLST	AD HEALTHCARE CE	ENTER, INC		I .	04 WASHINGTON AVENUE WEST ARLSTAD, MN 56732		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE	(X5) COMPLETION DATE
F 456	of the freezer under manager (DM) was walk-in freezer had freezer has had pro DM stated the main for cleaning the walk cleaned and the ide On 2/26/14, at 1:36 stated the dietary/k for cleaning the walk of cleaning the walk of cleaning the walk for cleaning the walk of the walk-in freezet the water had dripp two boxes of tator nuggets, one box of boneless pork and also confirmed the boxes and ice had boxes leaving these racks. On 2/26/14, at 2:48 [undated] copy of the List" which directed clean the freezer fr at 8:20 a.m. the DI checklist was curred On 2/27/14, at 8:10 walk-in freezer coo buildup of ice in th were supposed to	were also observed on the floor or the freezer racks. The dietary is unsure the last time the d been cleaned and stated the oblems with ice buildup. The intenance staff was responsible alk-in freezer floor. The DM c-in freezer floor needed to be e removed. 6 p.m. maintenance (M)-A kitchen staff was responsible alk-in freezer. 9 p.m. cook (C)-A confirmed in from the fans near the ceiling zer was present. C-A stated ped down and had frozen on to tots, one box of hash brown of cheddar cheese, one box of one box of pork sausage. C-A water had frozen on to these formed on the outside of the se boxes frozen to the wire 5 p.m. C-A provided a the facility's "Cleaning Check ad dietary staff to wash and loor every Friday. On 2/27/14, M verified this cleaning ent. 6 a.m. M-A confirmed the oling coils were causing the e freezer. M-A stated they be self-defrosting, however the		456			
	had a refrigeration	issues with ice buildup and company come and do some	14				
FORM CMS-2	567(02-99) Previous Version	is Obsolete Event ID: DRZT	F F	га	cility ID: 00830 If conti	nuation she	et Page 2 of 3

FORM CMS-2567(02-99) Previous Versions Obsolete

PRINTED: 03/11/2014 FORM APPROVED

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES					0930-0391	
STATEMENT	IT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245468	B. WING			02/27/2014		
NAME OF F	PROVIDER OR SUPPLIER	<u></u>			TREET ADDRESS, CITY, STATE, ZIP CODE			
KARLST	AD HEALTHCARE CE	ENTER, INC		1	04 WASHINGTON AVENUE WEST (ARLSTAD, MN 56732			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU) CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 456	Continued From parepair. On 2/27/14, at 8:28 dated 7/10/13, and company which ha some repairs on the The facility's "CLE policy [undated] dir and leaks as they	age 2 8 a.m. M-A provided copies 8/20/13, from a refrigeration d assessed and conducted		456	DEFICIENCY)			
	<u> </u>				acility ID: 00830 If con	tiquation ob	et Page 3 of :	

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 00830

Karlstad Senior Living/ Karlstad Healthcare Center

3/31/14

Addendum to F 456, Item 4

 $w^{e^{\omega}}$ Freezers will be audited every for 6 weeks, then monthly from then on to ensure compliance.

Lawardnip Lu Director of Musing Services

Completion date for F456 is 4-8-14

Rebucca Sorenson, administrator 3/31/14

		AND HUMAN SERVICES & MEDICAID SERVICES	7	5468022	>	FORM	03/11/2014 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION			E SURVEY PLETED
		245468	B. WING			02/	27/2014
NAME OF I	PROVIDER OR SUPPLIER				CITY, STATE, ZIP CODE		
KARLST	AD HEALTHCARE CE	NTER, INC		304 WASHINGTON KARLSTAD, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CC	DER'S PLAN OF CORRECT DRECTIVE ACTION SHOU FERENCED TO THE APPRC DEFICIENCY)	LD BE	(X5) COMPLETION DATE
K 000	INITIAL COMMENT	S	КC	00			
	FIRE SAFETY				K		
14	ALLEGATION OF C DEPARTMENT'S A SIGNATURE AT TH	DC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR E BOTTOM OF THE FIRST S-2567 WILL BE USED AS COMPLIANCE.		POC. PS	4-3-14 4-3-14		
2: H-8-	ONSITE REVISIT C CONDUCTED TO V SUBSTANTIAL COR REGULATIONS HA	F AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE S BEEN ATTAINED IN TH YOUR VERIFICATION.					
41-6	Minnesota Departm time of this survey k Main Building was for compliance with the in Medicare/Medicai 483.70(a), Life Safe edition of National F	Survey was conducted by the ent of Public Safety. At the Carlstad Healthcare Center 01 bund not in substantial requirements for participation d at 42 CFR, Subpart ty from Fire, and the 2000 ire Protection Association 01, Life Safety Code (LSC), Health Care.		R	ECEIVE APR - 3 2014		
0	PLEASE RETURN CORRECTION FOR DEFICIENCIES (K-	R THE FIRE SAFETY		MN DE	PS OF PUBLIC SAFETY	N	
EX	Health Care Fire Ins State Fire Marshal E 445 Minnesota Stree St. Paul, MN 55101	Division				-	
	Or by e-mail to:						
Ru	receasore		1	inistrate		4/1/	(X6) DATE

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.

FORM CMS-2567(02-99) Previous Versions Obsolete

J.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 03/11/2014 FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (11) PROVIDERSUPPLIERCIA IDENTIFICATION NUMBER: (02) MULTIPLE CONSTRUCTION A BUILDING 01 - MAIN BUILDING 01 B. WNG (13) PROVIDERS 01 - MAIN BUILDING 01 B. WNG (02) 27/2014 NAME OF PROVIDER OR SUPPLIER 245468 B. WNG (02) 27/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 304 WASHINGTON AVENUE WEST KARL STAD HEALTHCARE CENTER, INC STREET ADDRESS, CITY, STATE, ZIP CODE 304 WASHINGTON AVENUE WEST KARL STAD HEALTHCARE CENTER, INC STREET ADDRESS, CITY, STATE, ZIP CODE 304 WASHINGTON AVENUE WEST KARL STAD HEALTHCARE CENTER, INC (V4) ID YREETK SUMMARY STATEMENT OF DEFICIENCIES TAS ID HEOUXTORY OR LSC IDENTIFITING INFORMATION) TAS PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY 000/WEENC COMPLETED 000/WEENC (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY 000/WEENC CONSTRUCTION, INFORMATION) 000/WEENC CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY 000/WEENC CONSTRUCTION, INFORMATION) 000/WEENC CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY <		RS FOR MEDICARE	& MEDICAID SERVICES		********	<u></u> OI	MB NO	0938-0391
NAME OF PROVIDER OR SUPPLIER U22/1/2014 KARLSTAD HEALTHCARE CENTER, INC STREET ADDRESS, CITY, STATE, ZIP CODE 304 WASHINGTON AVENUE WEST STREET ADDRESS, CITY, STATE, ZIP CODE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG Continued From page 1 PREFIX Marian. Whitney@state.mn.us K 000 Fax Number 651-215-0525 K 000 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 (202) constructed in and monitor was constructed as outh of the original building. Without was determined to the original building with was determined to the original building with was constructed with at least a 2-hour fire barrier for the original building with was determined with west corner and separated with at least a 2-hour fire barrier is a connecting link to an							(X3) DAT COM	E SURVEY IPLETED
NAME OF PROVIDER OR SUPPLER STREET ADDRESS, CITY, STATE, ZIP CODE WARLSTAD HEALTHCARE CENTER, INC 304 WASHINGTON AVENUE WEST WAILD SUMMARY STATEMENT OF DEFICIENCIES 304 WASHINGTON AVENUE WEST PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX CROSS-REFERENCED TO THE APPROPRIATE COMPARIANCE VIEND Continued From page 1 K 000 K 000 K 000 K 000 K 000 K 000 Continued From page 1 K 000 K 000 K 000 K 000 Fax Number 651-215-0525 THE PLAN OF CORRECTION FOR EACH DEFICIENCY DEFICIENCY FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. I. A description of what has been, or will be, done to correct on 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 (202) construction and monitoring to prevent a reoccurrence of the deficiency Karlstad Healthcare Center is a 1-story building without a basement and constructed in 1974, was determined to be of Type II (222) construction. In 1983 an addition was construction and is separated with at least a 2-hour fire barrier from the original building. Attached to the original building with was determined to the original building with was determined with a 2-hour fire barrier is a connecting link to an			245468	B. WING	•		02/	27/2014
(Xa) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDERS PLAN OF CORRECTION (xa) ID PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION; ID ID REACH DEFICIENCY MUST BE PRECEDED BY FULL ID REACH DEFICIENCY MUST BE PRECEDED BY FULL ID REACH DEFICIENCY MUST INS HOLD DE CONFLETIC CONFLETIC CONFLETIC CONFLETIC DEFICIENCY	NAME OF I	PROVIDER OR SUPPLIER	••••••••••••••••••••••••••••••••••••••		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION BHOULD BE CROSS-REFERENCED to THE APPROPRIATE DEFICIENCY) Combining DEFICIENCY K 000 Continued From page 1 Marian. Whitney@state.mn.us K 000 Fax Number 651-215-0525 K 000 THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: K 000 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 in 1974, was determined to be of Type II(2022) 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	KARLST	AD HEALTHCARE CE	INTER, INC					
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 Karistad 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 (2022) construction. In 1983 an addition was constructed a south of the original building, which was determined to be do type II (2022) construction and is separated with at least a 2-hour fire barrier from the original building. Attached to the original building the south west corner and separated with a 2-hour fire barrier is a connecting link to an	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	×	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE	BE	COMPLETION
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		Marian.Whitney@s Fax Number 651-2 THE PLAN OF COF DEFICIENCY MUS FOLLOWING INFO 1. A description of w to correct the deficie 2. The actual, or pro 3. The name and/or responsible for corre prevent a reoccurre Karlstad Healthcare without a basement times. The original to 1974, was determined construction. In 198 south of the original determined to be of and is separated wit from the original buil building at the south with a 2-hour fire ba assisted living buildi The entire building is fire sprinkler system NFPA 13 Standard for Automatic Sprinkler facility has a fire alar detection at the smo corridor system with n accordance with N	tate.mn.us 15-0525 RRECTION FOR EACH T INCLUDE ALL OF THE RMATION: what has been, or will be, done ency. posed, completion date. title of the person ection and monitoring to nce of the deficiency Center is a 1-story building and constructed at 2 different building was constructed in ed to be of Type II(222) 3 an addition was constructed building, which was Type II (000) construction th at least a 2-hour fire barrier Iding. Attached to the original west corner and separated rrier is a connecting link to an ng. s protected with an automatic installed in accordance with or the Installation of Systems 1999 edition. The m system with smoke ke barrier doors and in the extended spacing, installed JFPA 72 "The National Fire	KO	00			

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Facility ID: 00830

If continuation sheet Page 2 of 5

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

		& MEDICAID SERVICES			C		APPROVEI 0938-039
T		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
		245468	B. WING			02/	27/2014
NAME OF	PROVIDER OR SUPPLIER		.	ST	REET ADDRESS, CITY, STATE, ZIP CODE		
KARLST	AD HEALTHCARE CE	NTER, INC			4 WASHINGTON AVENUE WEST ARLSTAD, MN 56732		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETIO DATE
K 000	notification. Hazard detection or smoke alarm system in acc State Fire Code 200 divided into 4 smok minute fire barriers. The facility has a ca census of 37 at the The requirement at NOT MET as evide	omatic fire department ous areas have either heat detection that are on the fire cordance with the Minnesota 07 edition. The facility is e zones with at least 30 apacity of 46 beds and had a time of the survey. 42 CFR, Subpart 483.70(a) is nced by:	KO		K 046		
K 046 SS=C				46	The preparation of the following of correction for this deficiency of not constitute and should not be interpreted as an admission nor agreement by the facility of the to of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correct prepared for this deficiency was executed solely because provision of state and federal law require if Without waiving the foregoing statement, the facility states with respect to: 1. Documentation has been provided to show that the generator installed on January 10 th , 2014 operative the required Life Safety a Emergency Power System of the facility as required. 2. March 31st, 2014 8. Maintenance Director	loes an ruth ns ion ons tes ind	

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Facility ID: 00830

If continuation sheet Page 3 of 5

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

Inverseurs or periodecides in DPLANOF CORRECTION (x1) PROVIDERSUPPLIER (x2) MULTIPLE CONSTRUCTION A BUILDING 01 - MAIN BUILDING 01 (x3) BURKEY COMPLETED INME OF PROVIDER OR SUPPLIER 245468 b. WING (x4) REALTHCARE CENTER, INC STREET ADDRESS, CITY, STATE, 2P CODE 304 WASHINGTON AVENUE WEST KARLSTAD, MR 6732 (x5) MULTIPLE (2000) INME OF PROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCES (acAC) DEFICIENCY OF LISC IDENTIFYING INFORMATION) 00 (200) PREFIX (200) STREET ADDRESS, CITY, STATE, 2P CODE 304 WASHINGTON AVENUE WEST (200) 00 (200) (x1) PROVIDERS PLANOF CORRECTION (200) (x2) OWERT (200) K 046 SUMMARY STATEMENT OF DEFICIENCES (200) 00 (200) PREFIX (200) PREFIX (200) PREFIX (200) (x3) PROVIDER OF UNIC OR CORRECTION (200) (x4) ID (200) (x4) ID (CENTERS FOR MEDICARE & MEDICAID SERVICES				OMB NO. 0938-0					
INME OF PROVIDER OR SUPPLIER STREET ADDRESS, OTTY STATE, ZP CODE XARLSTAD HEALTHCARE CENTER, INC STREET ADDRESS, OTTY STATE, ZP CODE XARLSTAD HEALTHCARE CENTER, INC SUMMARY STATEMENT OF DEFICIENCIES, GRAPH DEFICIENCY WISTS ERFECTED BY PHULL RESULATORY OR LISC IDENTIFYING INFORMATION) PROVIDERS FLAW WEST XARLSTAD, MN 56732 SUMMARY STATEMENT OF DEFICIENCIES, GRAPH DEFICIENCY WISTS ERFECTED BY PHULL RESULATORY OR LISC IDENTIFYING INFORMATION) PROVIDERS FLAW WEST XARLSTAD, MN 56732 SUMMARY STATEMENT OF DEFICIENCIES, GRAPH DEFICIENCY WIST ERFECTED BY PHULL RESULATORY OR LISC IDENTIFYING INFORMATION) PROVIDERS FLAW WEST XARLSTAD, MN 56732 SUMMARY STATEMENT OF DEFICIENCIES, GRAPH DEFICIENCY WIST ERFECTED BY PHULL RESULATORY OR LISC IDENTIFYING INFORMATION) PROVIDERS FLAW NOT CORRECTION (REACH DEFICIENCY) K 046 Continued From page 3 documented that it operates the required LIFe Safety and Emergency Power System of the facility as required. K 046 This deficient practice was confirmed by the Director of Maintenance and the Administrator during the facility survey and at the exit confirmed. K 062 SSEC Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6. 4.6.12, NFPA 25, 9.7.5 K 062 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 automic fre sprinkler system in accordance with National Fire Protection system coud alalow to fail during a fire which would negatively affect										
KARLSTAD HEALTHCARE CENTER, INC 304 WASHINGTON XENUE WEST KARLSTAD, MN 56732 May ID PRETX TAO ISUMMARY STATEMENT OF DEFICIENCIES ISAM DEFICIENCY MST BE PRECEDED BY FULL PRETX TAO D PRETX REQUATORY OR LSG IDENTIFICING INFORMATION (EACH CORRECTION ACTION SHOULD BE CROSS-REFERENCE TO PRET ACTION SHOULD BE CROSS-REFERENCE TO PRATE ACTION SHOULD BE DEFICIENCY Commented Stafety and Emergency Power System of the facility as required. K 046 K 046 Continued From page 3 documented that it operates the required Life Safety and Emergency Power System of the facility as required. K 045 This deficient practice was confirmed by the Director of Maintenance and the Administrator during the facility survey and at the exit confinuously maintained in reliable operating condition and are inspected and tested periodically. 19:7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 K 062 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 autombt fire system in accordance with National 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. Maintenance Director		245468	B. WING				27/2014			
KARLSTAD HEALTHORRE CENTER, INC KARLSTAD, MN 56732 Image: Contended that it constrained by the documented that it operates the required Life Safety and Emergency Power System of the facility as required. Documented that it operates the required Life Safety and Emergency Power System of the documented that it operates the required by the Director of Maintenance and the Administrator during the facility as required. K 046 K 046 K 0462 Continued From page 3 confirmed by the Director of Maintenance and the Administrator during the facility as required. K 046 K 046 K 0462 K 046 K 046 K 046 K 046 Required automatic sprinkler systems are confirmed by the Director of Maintenance and the Statistor during the facility. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 K 062 K 062 Required automatic sprinkler systems are confirmed by the Director of Maintenance of Water Inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 K 062 1. The sprinkler head in the walk in freezer has been replaced. This STANDARD is not met as evidenced by: Based on observations and an interview with staff, it was determined that the facility has radied maintain the automatic of the sprinkler system in accordance with National Fire Protection systems 198 edition section 9.2.7. Failure to maintain a fire protection system side 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. <t< td=""><td>NAME OF PROVIDER OR SUPPLIEF</td><td>२</td><td></td><td></td><td></td><td>DE</td><td></td></t<>	NAME OF PROVIDER OR SUPPLIEF	२				DE				
Mathew Tag (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATIONY OR LSC IDENTIFYING INFORMATION) PREFX TAG (EACH CORRECTIVE ACTION BHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMMETTION INTERCOMMETTION TAG K 046 Continued From page 3 documented that it operates the required Life safety and Emergency Power System of the facility as required. K 046 K 046 This deficient practice was confirmed by the Director of Maintenance and the Administrator during the facility survey and at the exit conference. K 062 K 062 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 K 062 K 062 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 automation fire sprinkler system in accordance with National 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. Hid min. Findings include: During the facility tor on February 27, 2014, between 11:15 Man d12:30 PM, observations Hid min.	KARLSTAD HEALTHCARE C	ENTER, INC								
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 062 K 062 NFPA 101 LIFE SAFETY CODE STANDARD K 062 SS=C 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 K 062 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 3.2.7. 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	PREFIX (EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A	HOULD BE	(X5) COMPLETIO DATE			
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	documented that is Safety and Emergy facility as required This deficient prace Director of Mainte during the facility s conference. NFPA 101 LIFE S. SS=C Required automate continuously main condition and are periodically. 19. 9.7.5	it operates the required Life lency Power System of the l. ctice was confirmed by the nance and the Administrator survey and at the exit AFETY CODE STANDARD tic sprinkler systems are itained in reliable operating inspected and tested .7.6, 4.6.12, NFPA 13, NFPA 25,			2 K 062 1. The sprinkler he walk in freezer h replaced and is functioning. The the sprinkler sys replaced. 2. April 30 th , 2014	has been properly e gauges on stem will be rector	14			
	maintain the autor accordance with N Association (NFP/ Inspection, Testin Based Fire Protect section 9.2.7. Fail system could allow would negatively a quests of the facil affect all 46 reside the event of an en power outage. Findings include: During the facility between 11:15 AM	tour on February 27, 2014, A and 12:30 PM, observations	21			per tl vl Adr	c. MIN			

		AND HUMAN SERVICES				PRINTED: FORM / OMB NO.	APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED		
	24546		B. WING	i		02/2	7/2014
NAME OF	PROVIDER OR SUPPLIER	I,	STREET ADDRESS, CITY, STATE, ZIP CODE				
KARLST	AD HEALTHCARE CE	ENTER, INC		1	04 WASHINGTON AVENUE WEST		
(VA) ID	SLIBAMARY STA	ATEMENT OF DEFICIENCIES	D		PROVIDER'S PLAN OF CORREC	TION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
K 062	Continued From pa			062			
		rveyor 03006, revealed that:		UUZ			
		-					
	fragile bulb head th	ad in the walk in freezer is at has no color whihc is an aybe damaged, and					
	2) the gauges on the that the last time the replaced was in 20						
	•						
	Director of Mainten	actices were confirmed by the ance and the Administrator urvey and at the exit					
	•						
						1	
							,
FORM CMS-2	567(02-99) Previous Versions	s Obsolete Event ID: DRZT	acility ID: 00830 If co	ntinuation she	et Page 5 of 5		