Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

Oactober 18, 2024

Administrator
Karlstad Healthcare Center Inc
304 Washington Avenue West
Karlstad, MN 56732

RE: CCN: 245468
Cycle Start Date: July 24, 2024

Dear Administrator:

On August 16, 2024, Center for Medicare & Medicaid Services (CMS) forwarded the results of the Federal Monitoring Survey (FMS) to you and informed you that your facility was not in substantial compliance with the applicable Federal requirements for nursing homes participating in the Medicare and Medicaid programs and imposed enforcement remedies.

On August 16, 2024 the Minnesota Departments of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of September 18, 2024.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective October 24, 2024, did not go into effect. (42 CFR 488.417 (b))

In our letter of July 30, 2024, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from October 24, 2024 due to denial of payment for new admissions. Since your facility attained substantial compliance on September 18, 2024, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing

Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

October 18, 2024

Administrator
Karlstad Healthcare Center Inc
304 Washington Avenue West
Karlstad, MN 56732

Re: Reinspection Results
Event ID: H2PS12

Dear Administrator:

On August 16, 2024 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on July 24, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 30, 2024

Administrator
Karlstad Healthcare Center Inc
304 Washington Avenue West
Karlstad, MN 56732

RE: CCN: 245468
Cycle Start Date: July 24, 2024

Dear Administrator:

On July 24, 2024, a 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 constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Jen Bahr, RN, Regional Operations Supervisor
Bemidji District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, Minnesota 56601-2933
Email: Jennifer.bahr@state.mn.us
Office: (218) 308-2104

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or

Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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 October 24, 2024 (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).

In addition, if substantial compliance with the regulations is not verified by January 24, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

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 _____	07/24/2024

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
E 000	Initial Comments On 7/22/24 through 7/24/24, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained.	E 000		
F 000	INITIAL COMMENTS On 7/22/24 - 7/24/24, recertification survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. Your facility was NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		

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

Electronically Signed | 08/07/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245468	A. BUILDING _____ B. WING _____	07/24/2024

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KARLSTAD HEALTHCARE CENTER INC	304 WASHINGTON AVENUE WEST KARLSTAD, MN 56732

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F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure pillows were not used in a manner to restrain residents while in bed for 1 of 1 residents (R17) reviewed for restraints.	F 604	F604 PLAN OF CORRECTION Karlstad Healthcare Center denies it violated any federal or state regulations. Accordingly, this plan of correction does	8/8/24

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	245468	A. BUILDING _____ B. WING _____	07/24/2024

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F 604	Continued From page 2 Findings include: R17's quarterly Minimum Data Set (MDS) dated 5/16/24, identified R17 had severe cognitive impairment and diagnoses of dementia and legal blindness. R17 used no restraints. R17's care plan reviewed 5/31/24, identified R17 had limited physical mobility and was a fall risk related to poor vision and weakness. R17 used a grab bar on the exiting side of R17's bed to enable R17 to go from lying to sitting, to aid in turning/repositioning and to get in and out of bed. Staff were directed to assess R17's grab bars routinely and with changes in condition to assure appropriateness of use, safety/security of the bar to the bed frame and potential for entrapment. R17 used a landing pad next to his bed as R17 liked to purposefully crawl out of bed onto the floor. R17's care plan did not identifiy the use of pillows under his fitted sheet to prevent R17 from crawling out of bed. R17's Physical Device Evaluation dated 5/16/24, identified R17 used a right and left grab bar, hi-low bed, and floor mats by his bed. However, the assessment did not identify the use of pillows to prevent R17 from rolling out of bed. R17's Morse Fall Scale 6-16 V3 dated 5/16/24, identified R17 was at high risk for falls. During an observation on 7/23/24 at 8:34 a.m., R17 was lying on his back in the middle of his bed with his blankets covering to his chest. On R17's right side two pillows were tucked under the fitted sheet and ran along R17's body from his shoulders to his knees. R17's bed was in low	F 604	not constitute an admission or agreement by the provider to the accuracy of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. Completion dates are provided for procedural processing purposes and correlation with the most recently completed or accomplished corrective action and do not correspond chronologically to the date the facility maintains it is in compliance with the requirements of participation, or that corrective action was necessary. 1. In continuing compliance with F604, Right to be Free from Physical Restraints, Karlstad Healthcare Center corrected the deficiency by removing the inappropriate restraint from R17 on 7/23/2024. On 7/23/2024 Director of Nursing visually observed all residents to ensure they were not being restrained inappropriately. 2. To correct the deficiency and to ensure the problem does not recur all staff were educated by 8/8/2024 on Types of restraints in nursing homes and the requirements that are required to implement a restraint in a nursing home. The Director of Nursing Services (DNS) and/or designee will visually audit all residents for inappropriate use of restraints 3x per week for 4 weeks, weekly x 4 weeks and then randomly to ensure continued compliance. 3. As part of Karlstad Healthcare Center’s	

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	245468	A. BUILDING _____ B. WING _____	07/24/2024

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 604	Continued From page 3 position with a fall mat next to his bed. - At 8:40 a.m., nursing assistant (NA)-A entered R17's room and greeted R17. R17 declined getting up for the day. NA-A exited R17's room and did not remove the pillows. - At 8:56 a.m., the director of nursing (DON) entered R17's room and turned-on music for R17. The DON did offer to assist R17 with morning cares, but R17 declined. The DON then removed the pillows from underneath R17's fitted sheet and placed them on the unused bed in the room before exiting R17's room. During an interview on 7/23/24 at 8:57 a.m., the DON stated R17 could have significant behaviors. NA-A was a new nursing assistant who had been working day shift for approximately a month and was extremely nervous to be observed. DON stated she was "guessing" the pillows were put underneath the fitted sheet by night shift. R17 could wiggle and move around in the bed and the night shift staff were probably worried R17 was going to fall out of bed. R17 had a mat, and the bed was 6 inches off the floor. R17 was not going to get hurt if there was a fall. The DON stated the pillows should never be placed under the fitted sheet because that was a restraint. The DON removed the pillows and planned to speak to staff and explain why the staff could not do that. NA-A should have removed the pillows and immediately reported the pillows to nursing. During an interview on 7/23/24 at 9:08 a.m., NA-A stated R17's pillows were underneath the fitted sheet so R17 could not roll out of bed, "we do it all the time." R17 can put his legs over the side of the bed and roll out onto the mat. NA-A stated she did not know if R17 could remove the pillows if R17 wanted to and would have to ask the	F 604	ongoing commitment to quality assurance, the Director of Nursing Services (DNS) and/or designee will report identified concerns through the community's QA Process. 4. The Director of Nursing is responsible for this area of compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 604	Continued From page 4 nurse. During an interview on 7/23/24 at 9:20 a.m., NA-B stated "Yea, we put pillows underneath the fitted sheet all the time" because R17 rolled out of bed. R17 could remove the pillows if the pillows were not underneath the fitted sheet. A facility policy related to restraints was requested but not received.	F 604		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 30, 2024

Administrator
Karlstad Healthcare Center Inc
304 Washington Avenue West
Karlstad, MN 56732

Re: State Nursing Home Licensing Orders
Event ID: H2PS11

Dear Administrator:

The above facility was surveyed on July 22, 2024 through July 24, 2024 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Jen Bahr, RN, Regional Operations Supervisor
Bemidji District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, Minnesota 56601-2933
Email: Jennifer.bahr@state.mn.us
Office: (218) 308-2104

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00830	A. BUILDING: _____ B. WING _____	07/24/2024

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) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 7/22/24 - 7/24/24, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 000	Continued From page 1 identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00830	A. BUILDING: _____ B. WING _____	07/24/2024

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) COMPLETE DATE
2 000	Continued From page 2 "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 510	MN Rule 4658.0300 Subp. 2 Use of Restraints Subp. 2. Freedom from restraints. Residents must be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure pillows were not used in a manner to restrain residents while in bed for 1 of 1 residents (R17) reviewed for restraints. Findings include: R17's quarterly Minimum Data Set (MDS) dated 5/16/24, identified R17 had severe cognitive impairment and diagnoses of dementia and legal blindness. R17 used no restraints. R17's care plan reviewed 5/31/24, identified R17 had limited physical mobility and was a fall risk related to poor vision and weakness. R17 used a grab bar on the exiting side of R17's bed to enable R17 to go from lying to sitting, to aid in turning/repositioning and to get in and out of bed. Staff were directed to assess R17's grab bars routinely and with changes in condition to assure	2 510	corrected	8/8/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 510	Continued From page 3 appropriateness of use, safety/security of the bar to the bed frame and potential for entrapment. R17 used a landing pad next to his bed as R17 liked to purposefully crawl out of bed onto the floor. R17's care plan did not identifiy the use of pillows under his fitted sheet to prevent R17 from crawling out of bed. R17's Physical Device Evaluation dated 5/16/24, identified R17 used a right and left grab bar, hi-low bed, and floor mats by his bed. However, the assessment did not identify the use of pillows to prevent R17 from rolling out of bed. R17's Morse Fall Scale 6-16 V3 dated 5/16/24, identified R17 was at high risk for falls. During an observation on 7/23/24 at 8:34 a.m., R17 was lying on his back in the middle of his bed with his blankets covering to his chest. On R17's right side two pillows were tucked under the fitted sheet and ran along R17's body from his shoulders to his knees. R17's bed was in low position with a fall mat next to his bed. - At 8:40 a.m., nursing assistant (NA)-A entered R17's room and greeted R17. R17 declined getting up for the day. NA-A exited R17's room and did not remove the pillows. - At 8:56 a.m., the director of nursing (DON) entered R17's room and turned-on music for R17. The DON did offer to assist R17 with morning cares, but R17 declined. The DON then removed the pillows from underneath R17's fitted sheet and placed them on the unused bed in the room before exiting R17's room. During an interview on 7/23/24 at 8:57 a.m., the DON stated R17 could have significant behaviors. NA-A was a new nursing assistant who had been working day shift for approximately a month and	2 510		

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2 510	Continued From page 4 was extremely nervous to be observed. DON stated she was "guessing" the pillows were put underneath the fitted sheet by night shift. R17 could wiggle and move around in the bed and the night shift staff were probably worried R17 was going to fall out of bed. R17 had a mat, and the bed was 6 inches off the floor. R17 was not going to get hurt if there was a fall. The DON stated the pillows should never be placed under the fitted sheet because that was a restraint. The DON removed the pillows and planned to speak to staff and explain why the staff could not do that. NA-A should have removed the pillows and immediately reported the pillows to nursing. During an interview on 7/23/24 at 9:08 a.m., NA-A stated R17's pillows were underneath the fitted sheet so R17 could not roll out of bed, "we do it all the time." R17 can put his legs over the side of the bed and roll out onto the mat. NA-A stated she did not know if R17 could remove the pillows if R17 wanted to and would have to ask the nurse. During an interview on 7/23/24 at 9:20 a.m., NA-B stated "Yea, we put pillows underneath the fitted sheet all the time" because R17 rolled out of bed. R17 could remove the pillows if the pillows were not underneath the fitted sheet. A facility policy related to restraints was requested but not received. SUGGESTED METHOD OF CORRECTION: The DON or designee could audit staff and resident interaction and ensure residents are not being restrained inappropriately. The DON or designee could educate staff on what is a potential restraint and what is required to use a restraint in a nursing home. Those residents	2 510		

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2 510	Continued From page 5 utilizing potential restraints could be comprehensively assessed and the information brought to the interdisciplinary team to ensure it is the least restrictive alternative for each individual and orders obtained. The facility could conduct audits to ensure residents are not being restrained without appropriate assessments and orders in place. TIME PERIOD for CORRECTION: Twenty-one (21) days.	2 510		