DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
June 26, 2025

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

RE: CCN: 245468
Cycle Start Date: April 17, 2025

Dear Administrator:

On May 19, 2025, the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 1, 2025

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

RE: CCN: 245468
Cycle Start Date: April 17, 2025

Dear Administrator:

On April 17, 2025, 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
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 July 17, 2025 (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 October 17, 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)

In accordance with 42 CFR 488.331 **and Minnesota Statute 144A.10 subd 15**, 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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:
https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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

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Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

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 _____	C 04/17/2025

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 4/14/25 through 4/17/25, a survey for compliance with §483.73, Appendix Z, Emergency Preparedness Requirements for Long Term Care Facilities was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 4/14/25 through 4/17/25, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed with NO deficiencies cited: H54682807C (MN111461). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments 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		
F 641	Accuracy of Assessments	F 641		5/9/25

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

Electronically Signed | 05/09/2025

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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F 641 SS=D	Continued From page 1 CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to accurately code the Minimum Data Set (MDS) for 1 of 2 residents (R8) reviewed for weight loss and 1 of 1 resident (R18) reviewed for falls. Findings include: R8: R8's significant change MDS dated 4/3/25, identified R8 had diagnoses of malnutrition and cancer. The MDS did not identify if there was a significant weight loss or gain. R8's recorded weights identified on 3/7/25, the resident weighed 132 lbs. On 3/28/25, the resident weighed 124 pounds which was a -6.06 % loss of weight. The MDS Resident Assessment Instrument (RAI) Manual dated 4/1/25 identified a loss of weight of 5% or more in the last month was a significant weight loss. R18: R18's annual MDS dated 3/6/25, identified severe cognitive impairment with wandering and required substantial/maximal assist with ambulation. R18's MDS did not identify any falls since last MDS assessment dated 12/5/24.	F 641	F 641 PLAN OF CORRECTION Karlstad Senior Living denies it violated any federal or state regulations. Accordingly, this plan of correction does 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 F641, Accuracy of Assessments, Karlstad Senior Living corrected the deficiency by correcting the MDS for R8, R18 and all like residents. 2. To correct the deficiency and to ensure the problem does not recur MDSC was educated on 05/08/2025 on Accura's Conducting an Accurate Resident	

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F 641	Continued From page 2 R18's progress notes identified: -12/8/24, R18 had a witnessed fall with no injury. -12/12/24, R18 had an unwitnessed fall with no injury. -12/18/24, R18 had an unwitnessed fall with injury. During an interview on 4/16/25 at 2:15 p.m., registered nurse (RN)-B stated she had prepared the MDS's for R8 and R18. In R8's weights, an algorithm was used to identify percent of weight loss or gain. RN-B entered the weights in the algorithm, and it identified a significant weight loss, and stated it should have been recorded as such on R8's significant change MDS dated 4/3/25. R18's falls should have been pulled in the electronic medical record for review and was not sure why they did not. R18's annual MDS dated 3/6/25 should have captured the falls but did not. During an interview on 4/16/25 at 3:10 p.m., the director of nursing (DON) stated it was important for MDS data to be entered correctly as it directly correlates with the development and the quality of the resident's care plans. A policy on coding the MDS was requested and not received.	F 641	Assessment Guideline by the Director of Nursing Services. The DNS and/or designee will audit 2 MDS's for accurate coding of weight loss and falls weekly for 4 weeks, monthly for two months and then randomly to ensure continued compliance. 3. As part of Karlstad Senior Living's commitment to quality assurance, the DNS and/or designee will report identified concerns through the community's QA Process.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable	F 880		5/16/25

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F 880	Continued From page 3 diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility	F 880		

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F 880	Continued From page 4 must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure enhanced barrier precautions (EBP) were consistently implemented in accordance with Centers for Disease Control (CDC) recommendations to reduce the risk of infection for 1 of 4 residents (R16) reviewed for EBP; and failed to ensure cross contamination to reduce the spread of infection for 1 of 1 residents (R4) observed who was transferred with a potentially contaminated lift sheet. Findings include: R16's quarterly Minimum Data Set (MDS) dated 2/6/25, identified R16 had a severe cognitive impairment and had diagnoses that included type 2 diabetes, legal blindness and dementia.	F 880	F 880 PLAN OF CORRECTION Karlstad Senior Living denies it violated any federal or state regulations. Accordingly, this plan of correction does 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	

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F 880	Continued From page 5 R16's care plan revised 8/7/24, identified R16 had an activities of daily living (ADL) self-care deficit related to poor vision, impaired cognition and weakness. R16 required 1-2 staff to assist with personal cares and hygiene. However, the care plan failed to identify R16 required EBP due to having methicillin-resistant staphylococcus aureus (MRSA) (an infection caused by a type of staph bacteria that's become resistant to many of the antibiotics used to treat ordinary staph infections. Most methicillin-resistant staphylococcus aureus (MRSA) infections occur in people who've been in hospitals or other health care settings, such as nursing homes and dialysis centers. When it occurs in these settings, it's known as health care-associated MRSA (HA-MRSA). health care-associated methicillin-resistant Staphylococcus aureus (HA-MRSA) infections usually are associated with invasive procedures or devices, such as surgeries, intravenous tubing or artificial joints. HA-MRSA can spread by health care workers touching people with unclean hands or people touching unclean surfaces.) in a left second toe wound. R16's wound culture dated 2/12/25, identified R16 had MRSA. R4's quarterly MDS dated 2/4/25, identified R4 had moderate cognitive impairment and diagnoses included type 2 diabetes. R4 was dependent on staff for hygiene and grooming. R4's care plan revised 1/4/23, identified R4 had an activities of daily living (ADL) self-care performance deficit related to need for staff assistance with care due to a history of schizophrenia, depression, anxiety and	F 880	maintains it is in compliance with the requirements of participation, or that corrective action was necessary. 1. In continuing compliance with F880, Infection Prevention & Control, Karlstad Senior Living corrected the deficiency by updating the care plan for EBP for R16 and all like residents. NA-E and NA-F were re-educated on Accura's EBP and hand hygiene guidelines. 2. To correct the deficiency and to ensure the problem does not recur all nursing staff were educated on Accura's EBP and Hand Hygiene Guidelines by the Director of Nursing Services on 5/16/2025. The MDSC was educated on Accura's Comprehensive Care Plan Guideline on 05/08/2025 by the Director of Nursing Services. The DNS and/or designee will audit EBP usage and hand hygiene 3 times per week for 4 weeks, 2 times per week for 4 weeks and then randomly to ensure continued compliance. The DNS and/or designee will audit all residents to ensure those with EBP are care planned monthly for 3 months and then randomly for continued compliance. 3. As part of Karlstad Senior Living's commitment to quality assurance, the DNS and/or designee will report identified concerns through the community's QA Process.	

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F 880	Continued From page 6 developmental delay and limited physical mobility. Staff were directed to provide grooming and hygiene daily and as needed. During an observation on 4/16/25 at 7:12 a.m., nursing assistant (NA)-D and NA-C transferred R16 from R16's bed to R16's wheelchair using the full body mechanical lift. NA-D nor NA-C were wearing gowns or gloves. - At 7:15 a.m., NA-D made R16's bed. NA-D was not wearing a gown, or gloves and NA-D's uniform brushed up against R16's bed and linens. During an interview on 4/16/25 at 7:55 a.m., an enhanced barrier precautions sign on the room door with a post it with a handwritten note that stated R16 only. NA-D stated she wore a gown and gloves to assist R16's morning cares but took them off to leave the room to get the full body mechanical lift. "I just spaced it out." R16 had a sore on his toe but was unable to say why it was important to wear personal protective equipment (PPE). During an observation on 4/16/25 at 7:39 a.m., an enhanced barrier precautions sign on the room door with a post it with a handwritten note that stated R16 only. NA-E entered R4's room with the shower chair and stated R4 was going to have a shower. NA-E gathered R4's clothing, a clean brief and bath supplies. NA-E laid a bath fully body mechanical lift sling on R16's bed. - At 7:41 a.m., NA-F entered R4's room with the full body mechanical lift and picked up the full body mechanical lift sling from R16's bed. NA-E removed R16's incontinent brief. R4 had a small bowel movement (BM), and NA-E cleaned R4's skin with a disposable wipe. - 7:43 a.m., NA-E removed the soiled gloves but	F 880		

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F 880	Continued From page 7 did not use hand sanitizer before putting on clean gloves. - 7:43 a.m., NA-E put the full body mechanical lift sling under R4. NA-E and NA-F assisted R4 to the shower chair using the full body mechanical lift. During an interview on 4/16/25 at 7:52 a.m., NA-E stated only R16 required staff to wear personal protective equipment (PPE) during direct resident care because R16 had a wound on his toe. Staff needed to do that with any resident who had a catheter, a wound, tracheostomy, or "anything like that". Staff were expected to put on a gown or gloves before entering the room because staff never knew what was going to happen and staff might need it. NA-E stated R4's full body mechanical lift sling should not have been lying on R16's bed and used for R4 because it can spread bacteria between the residents. Also, NA-E stated she should have used hand sanitizer before putting on clean gloves. During an interview on 4/16/25 at 12:45 p.m., the director of nursing (DON) stated staff should follow EBP for a resident with a catheter, feeding tube, tracheostomy, open wounds that are draining, and chronic wounds. Staff were also expected to use hand sanitizer or wash their hands when their hands were visibly soiled. The DON stated she had educated and re-educated staff regarding the use of gowns and gloves. The DON worked closely with staff on the floor and followed EBP as an example to staff. The door sign stated exactly when and which type of PPE was expected. Additionally, staff should not put one resident's things on another resident's bed, especially when either resident had an MDRO. The DON stated she was unaware of R16's lab	F 880		

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F 880	Continued From page 8 culture showing MRSA but would immediately notify and educate staff on expectations to protect other residents and themselves. A CDC Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) manual, dated 7/2022, identified MDRO transmission within a nursing home was common and contributed to substantial resident morbidity and mortality. The feature outlined EBP were defined as, " ... expand the use of PPE and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing ... MDROs may be indirectly transferred from resident-to-resident during these high-contact care activities ... residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs." The feature identified several examples of high-contact resident care activities including dressing, bathing, providing hygiene, transferring, changing linens or briefs, and wound care. The facility policy Enhanced Barrier Precautions dated 11/13/24, identified "Enhanced barrier precautions" (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown, and gloves use during high contact resident care activities. High-contact resident care activities include: - Dressing - Bathing - Transferring - Providing hygiene - Changing linens - Changing briefs or assisting with toileting	F 880		

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F 880	Continued From page 9 - Device care or use: central lines, urinary catheters, feeding tubes, tracheostomy /ventilator tubes - Wound care: any skin opening requiring a dressing (excluding shorter-lasting wounds, such as skin breaks or skin tears covered with an adhesive bandage (e.g., Band-Aid®) or similar dressing). - Enhanced barrier precautions should be followed outside the resident's room when performing transfers and assisting during bathing in a shared/ common shower room and when working with residents in the therapy gym, specifically when anticipating close physical contact while assisting with transfers and mobility. EBP applies to the MDRO's that are resistant organisms targeted by CDC. Examples of MDROs targeted by CDC include the following (residents must be in EBP if they currently have these MDRO's or have a history): 1) Pan-resistant organisms 2) Carbapenemase-producing carbapenem-resistant Enterobacterales 3) Carbapenemase-producing carbapenem-resistant Pseudomonas spp. 4) Carbapenemase-producing carbapenem-resistant Acinetobacter baumannii 5) Candida auris Additional epidemiologically important MDROs may include, but are not limited to (residents must be in EBP if they have a current diagnosis of these additional MDROs but EBP is not required if they only have a history): 1) Methicillin-resistant Staphylococcus aureus (MRSA) 2) ESBL-producing Enterobacterales 3) Vancomycin-resistant Enterococci (VRE) 4) Multidrug-resistant Pseudomonas aeruginosa 5) Drug-resistant Streptococcus pneumoniae	F 880		

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F 880	Continued From page 10 h) Enhanced barrier precautions should be used for the duration of the affected resident's stay in the facility or until resolution of the wound or discontinuation of the indwelling medical device that placed them at higher risk. A policy regarding hand hygiene was requested but not received.	F 880		

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 04/17/2025. At the time of this survey, Karlstad Healthcare Center Inc was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/10/2025

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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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Karlstad Healthcare Center is a 1-story building without a basement and constructed at 2 different times. The original building was constructed in 1974, was determined to be of Type II(222) construction. In 1983 an addition was constructed south of the original building, which was determined to be of Type II (000) construction and is not separated from the original building with a 2-hour fire barrier so the construction type is Type II (000). Attached to the original building at the south west corner and separated with a	K 000		

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K 000	Continued From page 2 2-hour fire barrier is a connecting link to an assisted living building. The facility has a capacity of 46 beds and had a census of 30 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K 000		
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces	K 321		5/25/25

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K 321	Continued From page 3 (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain hazardous storage rooms per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.1.3 and 7.2.1.8.1. These deficient finding could have an isolated impact on the residents within the facility. Findings include: On 04/17/2025, between 12:30pm and 3:30pm, it was revealed by observation that patient room 124 that has been converted into a storage room did not have a self-closing device. An interview with the Facility Administrator verified these deficient findings at the time of discovery.	K 321	Karlstad Senior Living denies it violated any federal or state regulations. Accordingly, this plan of correction does 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. In Continuing compliance with K321 Hazardous Areas- Closures This deficiency was corrected by installing a door encloser on room 124 and did an audit on all other hazardous areas to ensure compliance. The facility maintenance director will follow Tels program to ensure all other doors are inspected and meet regulatory standards A comprehensive life-safety audit is	

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K 321	Continued From page 4	K 321	conducted annually by Accura Resource Center. The cited findings will be inspected during this review. A written report will be sent to Administration after the review.	
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on documentation review and staff interview, the facility failed to test and inspect the	K 324	In Continuing compliance with K-324 Cooking Facilities	5/25/25

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K 324	Continued From page 5 kitchen hood ventilation and fire suppression system per NFPA 101 (2012 edition), Life Safety Code, section 9.2.3 and NFPA 96 (2011 edition), Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, section 11.2.1. This deficient finding could have an isolated impact on the residents within the facility. Findings Include: On 04/17/2025, between 12:30pm and 3:30pm, it was revealed by a review of available documentation that inspection documentation for the kitchen hood ventilation and fire suppression system was not available. The facility could not provide completed test/inspection documentation for both of the semi-annual kitchen hood suppression system inspections for the last 12 months. An interview with the Facility Administrator verified these deficient findings at the time of discovery.	K 324	This deficiency was corrected by the maintenance Director obtaining the proper documentation for the kitchen hood suppression system Inspection. The maintenance director will follow the Tels program to ensure all hood inspections are completed with documentation. A comprehensive life-safety audit is conducted annually by Accura Resource Center. The cited findings will be inspected during this review. A written report will be sent to Administration after the review.	
K 345 SS=E	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by:	K 345		5/25/25

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K 345	Continued From page 6 Based on a review of available documentation and staff interview, the facility failed to maintain the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, section 9.6.1.3, and NFPA 72 (2010 edition), National Fire Alarm and Signaling Code section 14.2.1.2.2. These deficient findings could have a patterned impact on the residents within the facility. Findings include: On 04/17/2025, between 12:30pm and 3:30pm, it was revealed by a review of available documentation that the annual fire alarm inspection report produced by Johnson Controls dated 04/05/2022 that the facility could not provide documentation that a sensitivity testing had been conducted. An interview with the Facility Administrator verified these deficient findings at the time of discovery.	K 345	In Continuing compliance with K-345 Fire Alarm Testing and Maintenance This deficiency was corrected by the maintenance Director obtaining the proper documentation for the sensitivity testing being completed. The maintenance director will follow the Tels program to ensure all smoke sensitivity inspections are completed with documentation. A comprehensive life-safety audit is conducted annually by Accura Resource Center. The cited findings will be inspected during this review. A written report will be sent to Administration after the review.	
K 346 SS=F	Fire Alarm System - Out of Service CFR(s): NFPA 101 Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility did not properly implement a fire watch	K 346	In Continuing compliance with K-346 Fire Alarm System - Out of Service	5/25/25

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K 346	Continued From page 7 protocol for when the fire alarm system is out of service for more than 4 hours in a 24-hour period, according to NFPA 101 2012 edition, Life Safety Code, section 9.6.1.6. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 04/17/2025, between 12:30pm and 3:30pm, it was revealed that the facility's fire watch policy did not identify the Authority Having Jurisdiction (AHJ) in the fire alarm system policy. An interview with the Facility Administrator verified these deficient findings at the time of discovery	K 346	This deficiency was corrected by identifiying the AHJ In the fire alarm system policy and to contact them in case of the system being down. A comprehensive life-safety audit is conducted annually by Accura Resource Center. The cited findings will be inspected during this review. A written report will be sent to Administration after the review.	
K 354 SS=D	Sprinkler System - Out of Service CFR(s): NFPA 101 Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) This REQUIREMENT is not met as evidenced by: Based on document review and staff interview,	K 354	In Continuing compliance with K-354	5/25/25

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K 354	Continued From page 8 the facility did not properly implement a fire watch protocol for when the fire alarm system is out of service for more than 10 hours in a 24-hour period, according to NFPA 101 2012 edition, Life Safety Code, section 19.3.5.1, 9.7.5, and NFPA 25 2017 edition, Installation, Test and Maintenance of Water Based System, section 15.5.2. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 04/17/2025, between 12:30pm and 3:30pm,it was revealed by documentation review that the facility failed to provide an out of service policy that indicated that the facility would contact the State Fire Marshals Office (Authority having jurisdiction) in the event on a fire sprinkler system outage lasting longer than ten (10) hours in a 24-hour period. An interview with the Facility Administrator verified these deficient findings at the time of discovery.	K 354	Sprinkler System - Out of Service This deficiency was corrected by identifying the AHJ In the fire sprinkler system policy and to contact them in case of the system being down. A comprehensive life-safety audit is conducted annually by Accura Resource Center. The cited findings will be inspected during this review. A written report will be sent to Administration after the review.	
K 355 SS=D	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain access to portable fire extinguishers per NFPA 101 (2012 edition), Life	K 355	In Continuing compliance with K-355 Portable Fire Extinguishers	5/25/25

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K 355	Continued From page 9 Safety Code, section 9.7.4.1, and NFPA 10 (2010 edition), Standard for Portable Fire Extinguishers, section 7.3.1.1.1. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 04/17/2025, between 12:30pm and 3:30pm, it was revealed by documentation review that the fire extinguishers annual inspection documentation did not have name of contractor and/or name of technician. An interview with the Facility Administrator verified these deficient findings at the time of discovery.	K 355	This deficiency was corrected by the Maintenance Director acquiring Documentation that has the contractors and technician's name. The maintenance director will follow the Tels program to ensure all Fire Extinguishers inspections are completed with documentation. A comprehensive life-safety audit is conducted annually by Accura Resource Center. The cited findings will be inspected during this review. A written report will be sent to Administration after the review.	
K 521 SS=F	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect fire dampers per NFPA 101 (2012 edition), Life Safety Code, section 8.5.5.4.2, and NFPA 105 (2010 edition), Standard for Smoke Door Assemblies and Other Opening Protectives, section 6.5.2,	K 521	In Continuing compliance with K-521 HVAC This deficiency was corrected by the Maintenance Director acquiring the proper documentation for fire damper inspections	5/25/25

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 521	Continued From page 10 6.5.11, and 6.5.12. This deficient finding could have a widespread impact on the residents within the facility. Findings include: 1) On 04/17/2025, between 12:30pm and 3:30pm, it was revealed by a review of available documentation that the facility could not provide a fire damper inspection report indicating location and/or provide a location map of dampers. 2) On 04/17/2025, between 12:30pm and 3:30pm, it was revealed by a review of available documentation that the facility could not provide a fire damper inspection report indicating repairs of dampers.. An interview with the Facility Administrator verified these deficient findings at the time of discovery.	K 521	and a map of locations of the fire dampers The maintenance director will follow the Tels program to ensure all Fire Damper inspections are completed with documentation. A comprehensive life-safety audit is conducted annually by Accura Resource Center. The cited findings will be inspected during this review. A written report will be sent to Administration after the review.	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC)	K 761		6/15/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245468	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/17/2025**

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K 761	Continued From page 11 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect fire doors per NFPA 101 (2012 edition), Life Safety Code section 8.3.3.1, and NFPA 80 (2010 edition), Standard for Fire Doors and Other Opening Protectives, section 5.2.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 04/17/2025, between 12:30pm and 3:30pm, it was revealed by review of available documentation the required annual door repair / inspection documentation was not available at the time of the survey. An interview with the Facility Administrator verified these deficient findings at the time of discovery.	K 761	In Continuing compliance with K-761 Maintenance, Inspection & Testing Doors This deficiency was corrected by the Maintenance Director by having a third party out to label missing labels on fire Doors and frames by June 15th 2025 The maintenance director will follow the Tels program to ensure all Door inspections are completed with documentation. A comprehensive life-safety audit is conducted annually by Accura Resource Center. The cited findings will be inspected during this review. A written report will be sent to Administration after the review.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised	K 918		5/25/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245468	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/17/2025**

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K 918	Continued From page 12 under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to install and maintain generators per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, 6.4.1.1.16.2 and 6.4.1.1.17, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, sections 8.4.9, 8.4.9.1, 8.4.9.2 and 8.4.9.5.1. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 04/17/2025, between 12:30pm and 3:30pm, it was revealed by a review of available	K 918	In Continuing compliance with K-918 Electrical Systems - Essential Electric Stystem This deficiency was corrected by the Maintenance Director acquiring the proper documentation for the 36 month (4)hour load bank test. The maintenance director will follow the Tels program to ensure all Generator inspections are completed with documentation. A comprehensive life-safety audit is	

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	245468	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/17/2025**

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K 918	Continued From page 13 documentation of the emergency generator maintenance and testing that the facility could not provide documentation that a 36 month four (4) hour load bank test had been performed. An interview with the Facility Administrator verified these deficient findings at the time of discovery.	K 918	conducted annually by Accura Resource Center. The cited findings will be inspected during this review. A written report will be sent to Administration after the review.	