DEPARTMENT OF HEALTH

Protecting , Maintaining and Improvingthe Health of All Minnesotans

Electronically Delivered

July 5, 2018

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

Subject: Karlstad Healthcare Center Inc. - IDR CMS Certification Number (CCN) 245468 Project # S5468028

Dear Mr. Ahlf:

This is in response to your letter of November 10, 2017, in regard to your request of an informal dispute resolution (IDR) for the federal deficiencies at tag F250 and F309 issued pursuant to the survey event RQUD11, completed on October 20, 2017.

The information presented with your letter, the CMS 2567 dated October 20, 2017 and corresponding Plan of Correction, as well as survey documents and discussion with representatives of L&C staff have been carefully considered and the following determination has been made:

F250 S/S-G §483.40(d)

The facility must provide medically-related social services to attain or maintain the highest Practicable physical, mental and psychosocial well-being of each resident.

Summary of the facility's reason for IDR of this tag: The provider disputes actual psychosocial harm was received by the resident. The provider asserts the resident's displacement was not related to their actions, but was instead related to the resident's behaviors which the provider had tried to address, without success.

Summary of facts: R5 was admitted to the facility in 2013, following hospitalization for a back injury and a failed attempt for independent living in an apartment. R5 had frequent falls and was determined to be unsafe to live alone due to ongoing medical needs. R5's admission diagnosis included: bipolar disorder, adjustment disorder with mixed anxiety, major depression, narcotic dependence, post-traumatic stress disorder, poorly controlled insulin dependent diabetic, kidney failure requiring hemodialysis, chronic back pain, peripheral vascular disease, and skin ulcers at various stages of healing. Although R5 was assessed to be cognitively intact, R5 was appointed a guardian in 2016, due to incapacitated mental impairment with inability to make appropriate decisions for health care. In addition, when admitted to the facility, R5 exhibited behaviors including: screaming, cursing, non-compliance with cares and services, threatening others and crying. The provider had implemented a number of interventions aimed at managing/modifying R5's behaviors: including taking R5 to her room when screaming or threatening; restricting cell phone use; increased social service visits; a behavior program for dialysis; a behavior contract with risk vs. benefit; and assigning a one to one if R5's screaming behaviors persisted. Progress notes indicate behavioral interventions were used by the staff for identified behaviors and were modified several times during R5's stay in the facility. R5 however, remained chronically non-compliant and resistant to changing behaviors.

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R5 refused to comply with a diabetic diet leading to uncontrolled diabetes control, and failed to adhere to dialysis diet/fluid restrictions related to chronic water overload, leading to increased dialysis runs during the week. Progress notes revealed evidence of ongoing resident education by staff for diabetic control, adherence to renal diet and fluid intake restrictions. R5 was seen frequently by a psychiatrist for behavioral management, but R5 remained non-compliant with diabetic diet, fluid intake limits and lack of behavior control.

During the October 2017 survey, R5 reported being "extremely upset" alleging the director of nursing had told her she had thirty days to "drastically" improve her behaviors or she would be discharged to a facility 300 miles away. Nursing notes dated 10/4/17, indicated the dialysis transport driver had refused to transport R5 any longer due to the resident's continued and escalating screaming bouts during the ride. There were no other transport drivers willing to transport R5 due to her past history of verbal abuse and screaming. R5's psychiatrist was contacted and recommended R5 be sent to a hospital for evaluation of current behavioral issues. As a result, R5 was sent to an acute care hospital emergency department to be evaluated by the psychiatric team. The psychiatric team determined R5 did not require in-patient treatment. The nursing home was notified, but stated they were unable to take her back due to inability to provide transportation to dialysis. R5's psychiatric unit to assess her ongoing behaviors. The acute care hospital emergency room then transferred R5 to the Mayo Clinic psychiatric services for an evaluation. Mayo Clinic psychiatric services also determined R5 did not require in-patient psychiatric services. Ultimately, R5 was sent back to the nursing home and the social worker was able to secure transportation for her dialysis needs.

Summary of findings: After careful review of the information provided by the facility, by MDH staff, and review of the CMS 2567, the facility did make good faith attempts to coordinate care and meet R5's psychosocial needs.

This is not a valid example of a deficient practice under this regulation and will be removed from the Statement of Deficiencies.

F309 S/S-G §483.25(I) Dialysis.

The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.

Summary of the facility's reason for IDR of this tag: The provider disputes actual harm occurred due to their lack of monitoring fluid intake. The provider asserts R5 has a chronic and extensive history of non-compliance affecting dialysis including the need for fluid monitoring to prevent fluid overload.

Summary of facts: As previously identified, R5's admission diagnosis included: bipolar disorder, adjustment disorder with mixed anxiety, major depression, narcotic dependence, post-traumatic stress disorder, poorly controlled insulin dependent diabetic, kidney failure requiring hemodialysis, chronic back pain, peripheral vascular disease, and skin ulcers at various stages of healing. Although R5 was assessed to be cognitively intact, R5 was appointed a guardian in 2016 due to incapacitated mental impairment with inability to make appropriate decisions for care. In addition, when admitted to the facility, R5 exhibited behaviors including: screaming, cursing, non-compliance with cares and services, threatening others and crying. The provider

Karlstad Healthcare Center Inc July 5, 2018 Page 3

had implemented a number of interventions aimed at managing/modifying R5's behaviors: including taking R5 to her room when screaming or threatening; restricting cell phone use; increased social service visits; a behavior program for dialysis; a behavior contract with risk vs. benefit; and assigning a one to one if R5's screaming behaviors persisted. Progress notes indicate behavioral interventions were used by the staff for identified behaviors and were modified several times during R5's stay in the facility. R5 was chronically non-compliant especially in regards to dialysis diet/fluid restrictions. The dialysis unit reported chronic fluid overload, leading to increased dialysis runs during the week. The survey team identified the provider was not recording R5's fluid intake. Facility staff reported they had attempted to maintain records of R5's fluid intake but due to R5's non-compliance, especially while out of the facility, it was difficult. The staff stated R5 drank large amounts of soda at fast food restaurants while out of the facility, so they had stopped recording any fluid intake measurement. Instead, the facility documented ongoing non-compliance with adhering to fluid restriction and non-compliance with a renal diet. Documentation indicated the facility had made efforts to educate the resident about the risks of her non-compliance. In addition, there were several meetings held with dialysis staff, including the nephrologist, to provide R5 with education regarding the importance of following the renal diet/fluid restrictions. Even though R5 was given education on her kidney disease and the importance of adhering to a renal diet and fluid restriction for her overall health, R5 chose not to be compliant with the recommendations.

Summary of findings: After careful review of the information provided by the facility, by MDH staff, and review of the CMS 2567, although the facility made good faith attempts to educate R5 about the risks of her non-compliance, they provider did not continue to monitor the resident's fluid intake while in the facility.

This is a valid deficiency at this tag however, the scope and severity should be changed to isolated and no actual harm with potential for more than minimal harm that is not immediate jeopardy (D).

The revised Statement of Deficiencies is attached.

This concludes the Minnesota Department of Health informal dispute resolution process.

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

Sincerely,

Gary Nederhoff, Unit Supervisor Licensing and Certification Program Health Regulation Division Telephone: 507-206-2731 Fax: 507-206-2711

cc: Office of Ombudsman for Long-Term Care Maria King, Assistant Program Manager Licensing and Certification File Gary Nederhoff, Bemidji District Office Unit Supervisor

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F 000	INITIAL COMMENT	rs	F 0	000			
F 201 SS=D	survey was comple Minnesota Departm determine compliar CFR Part 483, subp Term Care Facilities The facility's electro will serve as your a the Department's a Because you are en- signature is not req page of the CMS-2: submission of the F verification of comp An investigation of comp Seconducted and was F225, F226. "Revised 2567 as a Resolution." REASONS FOR TF RESIDENT CFR(s): 483.15(c)(((c) Transfer and dis (1) Facility requirem (i) The facility must remain in the facility discharge the resid	onic Plan of Correction (ePOC) llegation of compliance upon cceptance. nrolled in ePOC, your uired at the bottom of the first 567 form. Your electronic POC will be used as bliance. complaint H5468004 was a found to be substantiated at a result of an Informal Dispute RANSFER/DISCHARGE OF 1)(i)(ii) scharge	F 2	201			11/29/17
		and the resident's needs			TITLE		(X6) DATE
	ically Signed				III LL		11/13/2017

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 201		e facility; discharge is appropriate	F 2	201			
	sufficiently so the re services provided b	nt's health has improved esident no longer needs the y the facility; dividuals in the facility is					
	endangered due to status of the reside	the clinical or behavioral					
	otherwise be endar	ngered;					
	appropriate notice, under Medicare or Nonpayment applie submit the necessa payment or after the Medicare or Medica resident refuses to resident who becom admission to a facil resident only allowa or	s failed, after reasonable and to pay for (or to have paid Medicaid) a stay at the facility. s if the resident does not ry paperwork for third party e third party, including aid, denies the claim and the pay for his or her stay. For a nes eligible for Medicaid after ity, the facility may charge a able charges under Medicaid;					
	(F) The facility ceas	ses to operate.					
	resident while the a § 431.230 of this ch exercises his or her discharge notice fro 431.220(a)(3) of thi discharge or transfe or safety of the resi	not transfer or discharge the ppeal is pending, pursuant to hapter, when a resident r right to appeal a transfer or om the facility pursuant to § s chapter, unless the failure to er would endanger the health dent or other individuals in the must document the danger					

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F 201	This REQUIREMEN by: Based on interview facility failed to corr determine if a new needs of the reside physician documen discharge related to needs of 1 of 1 resi emergency room for refused to allow R5 inform R5 of the ref emergency room vi hospital stay. Findings include: R5's cumulative dia indicated R5 was a diagnoses that inclu- bipolar disorder, ad anxiety & depresse disorder, narcotic d behavior disorder, g end stage renal dis back pain, right har amputation, and so personality disorder R5's quarterly Minir 7/6/17, indicated R5 deficits, R5 had ina identified as inatten attention, being eas	Agnoses list dated 10/19/17, dmitted to the facility with uded, but were not limited to: justment disorder with mixed d mood, major depressive ependence, disruptive post-traumatic stress disorder, ease, chronic radicular low nd and right below the knee ciopathic borderline	F 2	201	The preparation of the following plat correction for this deficiency does no constitute and should not be interpre- as an admission nor an agreement be facility of the truth of the facts allege conclusions set forth in the statement deficiencies. The plan of correction prepared for this deficiency was exe- solely because provisions of state and federal law require it. Without waiving foregoing statement, the facility states with respect to: 1. R5 was readmitted to the facility 10/12/17. A new assessment had be completed 10/6/17. Care Conference were held 9/21/17, 10/13/17, and 10. to discuss plan of care with R5 and guardian(s). 2. The facility will permit each reside remain in the facility, and not transfe discharge the resident from the facilita accordance with state guidance. All residents going to ER/ physician app not be denied re-admission unless is deemed a danger to self or others in accordance w/ state guidance. 3. Staff will be re-educated prior to 11/29/17 regarding the Discharge Planning Process Guidelines Policy has the purpose to begin planning and provide for a safe transition plan for residents upon admission to facility. Discharge plan may include remaining the senior living community, returning the community or other facility include but not limited to another nursing ho	ot eted by the d or nt of cuted nd mg the es on een ces /26/17 dent to er or ity in ot will s which nd mg in ig to Jing	

Facility ID: 00830

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F 201	symptoms present down, depressed, of having to little energy self-or that you are a family member do did not have any sy (hallucinations or d have verbal behavio others (threatening at others) 1-3 days R5 required extens for bed mobility and extensive assistand personal hygiene a unit using a wheelc	age 3 ad the following mood 2-6 days a week: Feeling or hopeless, feeling tired or gy, and feeling bad about a failure or have let yourself or own. The MDS indicated R5 rmptoms of psychosis elusions) however, R5 did or symptoms directed at others, screaming or cursing a week. The MDS indicated ive assistance of two persons d toilet use, and required ce of one person for dressing, nd locomotion on and off the hair. R5 was unable to totally dependent on two staff	F 201 ALF. 4. Executive Director (ED) or Design will audit all resident discharges and/o transfers for discharge reason, physic documentation supporting the discharg and resident and/or family involvement with discharge process. The data collected will be reviewed at the Month QAPI and Quarterly QA meeting. At the time the committee will make the decision/recommendation regarding at follow-up studies. Completion Date 11/29/17		d/or ysician harge, nent onthly At that		
	R5's medical record included a document identified as Order Appointing Guardian dated and signed by a judge on 5/26/16, which indicated R5 was incapacitated from mental impairment to the extent lacking sufficient understanding or capacity to make or communicate responsible decisions concerning personal needs for medical care, nutrition, clothing, shelter or safety. The judge appointed R5 two guardians.						
	stated she was extr and stated the facil "nut house" last we come back to the fa sent to a local eme	d on 10/17/17, at 2:00 p.m. and remely upset. R5 began to cry ity had tried sending her to a ek and would not allow her to acility. R5 stated she had been rgency room from dialysis, and g home refused to allow R5 to					

Facility ID: 00830

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	come back to the nursing home, R5 ended up going all the way to a hospital in Rochester, Minnesota (322 miles). R5 stated a social worker from the hospital in Rochester had called the director of nursing (DON) at Karlstad Healthcare Center and made the nursing home allow R5 to come back to the facility. R5 stated she was distressed and felt panicked when she was not allowed to return back to her home at the nursing home after going to the emergency room at Sanford Fargo, ND, and stated she had to stay in the emergency room over two days before they transferred her to another emergency room at Mayo Medical Center in Rochester Minnesota. R5 stated she did not understand why she was shipped all the way to Rochester.					
	room dismissal sun R5 arrived in the er and stayed in the er 10/8/17. The dismis was brought to the psychiatric evaluation disruptive behavior resided. The crisis and determined R5 and verbally abusive aggressive towards was not suicidal, ar herself or others, an hospital admission. indicated the Karlst to take R5 back wh	ord Medical Center emergency nmary dated 10/8/17, indicated nergency room on 10/6/17, mergency room two days until ssal summary indicated R5 emergency room for on because of increasingly in the care center where R5 team completed an evaluation while being loud, disruptive, te towards staff, R5 was not s others, was non-threatening, nd did not pose a threat to nd R5 did not meet criteria for The dismissal summary ad Healthcare Center refused ten the physician discharged d emergency room. The c indicated R5 was then				

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	dismissal summary was assessed in the was found not in ne psychiatric care bee more behaviorally b indicated the Karlst not agree to accept therefore, R5 had to just to continue dial summary indicated psychiatry was cons was employed to ou behaviors and R5 d R5's medical record discharge notice be when the decision w facility. The DON was inter 10:14 a.m. and con to return to the nurs evaluated in the em Medical Center Far from Mayo Medical stated she was uns transportation to dia When the DON was that the transportation ongoing transportation any documentation	 Clinic Medicine 9 Hospital dated 10/12/17, indicated R5 e emergency department and ed of hospital admission for cause R5's outbursts were based. The dismissal summary ad Healthcare Center would R5 back into the facility, b be admitted to their hospital ysis treatments. The dismissal that while in the hospital, sulted and a behavior plan utline expected respectful divery well with this. d lacked any evidence of a sing provided to the resident was made not readmit to the firmed she had not allowed R5 sing home after being the gency room at Sanford go, ND on 10/6/17, and again Center on 10/8/17. The DON ure if R5 would have alysis while at the facility. Is asked to provide evidence on services to R5, the DON is company had not provided which identified R5 was on services. The DON 					

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		AND HUMAN SERVICES			FORM	: 07/05/2018 APPROVED . 0938-0391
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F 201 F 225 SS=D	the community of K provided transportaneeded. Review of the Karls Resident Admission the following: "The discharge or transfereason, but not limit A: Persons who be extent that they are themselves, or staf B: Persons whose a days. C: Persons whome t adequately in confor of care due to chan family interference. The policy had not residents return to the emergency room vi INVESTIGATE/REF ALLEGATIONS/INE CFR(s): 483.12(a)(483.12(a) The facilit (3) Not employ or ow who-	s an ambulance service for carlstad that could have attion on an emergency basis, if that Healthcare Center in Policy dated 6/9/11, revealed facility reserved the right to er residents for the following ted to these only: come mentally disturbed to the dangerous to other residents, f members. accounts are not paid in 60 he facility is unable to care for ormance with the medical plan iges in their condition or due to included directives for the facility following an sit or hospital stay. PORT DIVIDUALS 3)(4)(c)(1)-(4) ity must- therwise engage individuals	F 20			11/29/17
	(II) Have had a find	ing entered into the State				

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F 225	Continued From pa	age 7	F 2	25			
		concerning abuse, neglect, atment of residents or f their property; or					
	or her professional body as a result of	hary action in effect against his license by a state licensure a finding of abuse, neglect, atment of residents or f resident property.			\bigcirc		
	licensing authorities actions by a court of	ate nurse aide registry or s any knowledge it has of of law against an employee, te unfitness for service as a facility staff.		NS			
		allegations of abuse, neglect, treatment, the facility must:					
	abuse, neglect, exp including injuries of misappropriation of reported immediate after the allegation cause the allegation serious bodily injury the events that cau abuse and do not re the administrator of officials (including t adult protective ser for jurisdiction in low	alleged violations involving ploitation or mistreatment, if unknown source and if resident property, are ely, but not later than 2 hours is made, if the events that in involve abuse or result in y, or not later than 24 hours if se the allegation do not involve esult in serious bodily injury, to if the facility and to other to the State Survey Agency and vices where state law provides ing-term care facilities) in that law through established					
	(2) Have evidence thoroughly investigation	that all alleged violations are ated.					

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	(3) Prevent further exploitation, or misi investigation is in p						
	administrator or his representative and with State law, inclu Agency, within 5 we if the alleged violati corrective action m This REQUIREMEI by: Based on observat review, the facility f investigation and en were reported to the investigation for 1 of adult (VA) reports r allegations of finant thoroughly investigat VA reports reviewed include all informati investigation which reported to the Stat days for 1 of 3 resid Findings include: R5's medical record 10/17/17, and the p revealed R5 had re been rough with he identified the staff r progress note indic	to other officials in accordance uding to the State Survey orking days of the incident, and on is verified appropriate			The preparation of the following plan correction for this deficiency does no constitute and should not be interpret as an admission nor an agreement b facility of the truth of the facts alleged conclusions set forth in the statemen deficiencies. The plan of correction prepared for this deficiency was exect solely because provisions of state an federal law require it. Without waivin foregoing statement, the facility state with respect to: 1. R5 has been reported to MDH ar thoroughly investigated for potential abuse/mistreatment on 7/25/17 (and re-submission on 11/10/17) and 10/2 (which had included statements from aides that provided cares on the day question). R41 had been reported to MDH and to local law enforcement of 8/9/17 for allegations of financial exploitation. Law enforcement closer case on 8/11/17. This facility receive email confirmation on 9/15/17, that th information had been reviewed and it	t ted by the d or it of cuted nd ng the es nd with c3/17 n the in o n d this ed ne	

Facility ID: 00830

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KARLST	AD HEALTHCARE CE	ENTER INC			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 PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETIO DATE
F 225	immediately contact morning cares to R the director of nurs cursory investigatio perpetrator who de with cares or transf note indicated the e of the allegation, he indication the State notified of the alleg The DON was inter a.m. during which s allegation R5 made her on 10/16/17, wa investigating the all the past R5 had ma abuse and after tall the DON stated it to complete the invest R5 had not been tra- investigation did no aides that did provi 10/16/17, interview and interviewing ot care received by th DON confirmed sho before reporting to needed to use com a history of confabu- she didn't know wh not.	age 9 ed staff member) were sted and asked who provided is. The progress note indicated ing (DON) had completed a on and interviewed the alleged nied providing or assisting R5 fers on 10/16/17. The progress executive director was notified owever, there was no e agency (SA) had been ation of abuse by R5. eviewed on 10/19/17, at 9:49 she was asked why the e about staff being rough with asn't reported to the SA prior to legation. The DON stated in ade false accusations of staff king to the alleged perpetrator, pok only 10 minutes to tigation enough to ascertain eated roughly. However, the ot include interviewing the de care to R5 the morning of ing R5 for pertinent details, her residents regarding the e alleged perpetrator. The e had investigated the incident the SA because she felt we imon sense, and since R5 had ulating stories, the DON stated ether to believe R5's report or	F 2.	25	 been determined that no further activation was necessary. 2. Executive Director, DNS or as designee is immediately notified perfacility policy and procedure of incidetermine if additional reporting to law enforcement or other agencies required. All incidents are reviewed daily IDT meetings to assure staff. followed proper reporting and momprocedures. 3. VA Policy will be updated to inditat results of the investigation will submitted within 5 business days. will be re-educated prior to 11/29/1 regarding the policy and procedure reporting all injuries and allegation completion of an incident report, ir of the investigation, immediate not of Administrator and DNS and the notification of the Common Entry Fand/or MDH. 4. Executive Director and DNS reincident reports daily to assure proreporting and monitoring procedur followed. The incident reports will reviewed/discussed at the Monthly and Quarterly QA meeting. At this the QA committee will make the decision/recommendation regardir follow-up studies. Completion Date: 11/29/17 	signed er dents to MDH, s are of at itoring clude be Staff 7 e of s, itiation ification Point eview all per es are cQAPI time	

If continuation sheet Page 10 of 79

TATEMENT	OF DEFICIENCIES	K MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DA). 0938-039 TE SURVEY MPLETED
				NG		С
		245468	B. WING _			/20/2017
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COE	E	
KARLST	AD HEALTHCARE CE	ENTER INC		304 WASHINGTON AVENUE WEST KARLSTAD, MN 56732		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETIO DATE
F 225	System immediate	age 10 via the on-line Reporting ly (as soon as possible)." th the DON on 10/19/2017, at	F 22	25		
	9:49 a.m. she confi allegation of abuse to the SA. The DOI abuse had not bee	irmed she investigated R5's prior to reporting the incident N confirmed R5's allegation of n reported to the SA at point rt of rough treatment.				
	victim of financial e identified R42 was 7/6/17, and had dia not limited to malig mets to the bone, p disorder, hypertens palliative care. The son who received f in the amount of 3, another check was 7/7/17, for 5,000.00 for non-sufficient fu the SA was notified exploitation on 8/9/ Sheriff's Office rece from the Minnesota Center. The investi exploitation had no the alleged perpetr included any intervi	d 8/9/17, alleged R42 was the exploitation. The VA report admitted to the facility on ignoses that included, but were nant neoplasm of prostate with bain, weakness, anxiety sion, constipation, and alleged perpetrator was R42's unds from R42's bank account 000.00 dollars on 7/5/17, and drafted on R42's account on 0 dollars which was returned inds. The VA report indicated I of the alleged financial 17, and the Kittson County eived the report on 8/11/17, a Adult Abuse Reporting gation for this alleged financial t included any interviews with ator (R41's son) and had not iews with R41, and it was f the 3 000 00 dollars R41's				
	the alleged perpetr included any intervi- never determined in son received was u who drafted the cho	ator (R41's son) and had not				

Facility ID: 00830

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		AND HUMAN SERVICES				FORM	: 07/05/2018 APPROVED : 0938-0391	
-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	CON	E SURVEY IPLETED	
		245468	B. WING	i		C 10/20/2017		
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	•		
KARLST	AD HEALTHCARE CE	ENTER INC			304 WASHINGTON AVENUE WEST KARLSTAD, 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 APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 225	Continued From pa	age 11	F 2	22	5			
	was interviewed an was not complete a had not been interv determined if the 3 received was used Additionally, the fac drafted the check th non-sufficient funds dollars, and the rea Review of the VA re 7/25/17, indicated F (NA)-F had told her was acting like a bi NA-F who was the been suspended per The follow up invest dated 7/28/17, indic	12:30 p.m. the Administrator of confirmed the investigation as R41, and the son of R41 viewed, and it was never ,000.00 dollars R41's son for the benefit of R41. cility had not determined who hat was returned for is in the amount of 5,000.00 ason the check was drafted. eport submitted to the SA on R5 reported nursing assistant r to shut up and told R5 she tch. The VA report indicated alleged perpetrator (AP) had ending investigation.						
	and stated the AP r to her when they w The follow up invest following: -Multiple staff mem stated they had new harshly/meanly/or w of the resident. -The AP was interv anything mean to a name. -The AP denied ever resident she later re	made inappropriate comments ere in her room alone together. stigation further indicated the bers were interviewed and all ver heard the AP speak with foul language to or in front iewed and denied having said resident or calling a resident a er making a statement to a egretted.						
		port also indicated staff had uld come across as being			acility ID: 00830 If continue		Page 12 of 7	

If continuation sheet Page 12 of 79

	RS FOR MEDICARE	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DA	D. 0938-039 TE SURVEY MPLETED
		245468	B. WING		10	C)/ 20/2017
NAME OF	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE	, ZIP CODE	
KARLST	AD HEALTHCARE CE	INTER INC		304 WASHINGTON AVENUE V KARLSTAD, MN 56732	VEST	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETIO DATE
F 225	acted like she want boss, but with R5, y she would run you long history of dem time and care from on a typical 8 hour clean her glasses 1 glasses were not di indicated following suspension was lift provide care to R5 education would be her non-verbal bod resident care plan. following policy and conduct at Karlstad given to the AP. The DON's investig it was noted they giv VA investigative rep indicated. Review of revealed four nursii practical nurse wer employees describe snappy or harsh. Th also left out of the i to the SA: -NA-A stated "I hav They bicker back a once 'I have had er -NA-G stated "at th	aff member stated the AP aff member stated the AP red to show R5 who was the you had to be kinda firm, or over, it's a fine line. R5 had a anding excessive amounts of her caregivers. For example, shift R5 would request staff to 5 or more times. Normally her irty or soiled. The report this investigation, the AP's ed and was instructed not to per R5's request. Additional e done with the AP regarding y language and following the A final written warning for not d procedure and standards of I Senior Living would also be gative notes were reviewed and reatly differed from what the port submitted to the SA had of the investigative notes ng assistants and one licensed e interviewed and all five ed the AP as being short or he following interviews were nvestigative report submitted e noticed her short with [R5]. nd forth. I heard [AP] tell [R5]	F 2	25		

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	07/05/2018 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				COM	E SURVEY PLETED
		245468	B. WING	i			20/2017
NAME OF	PROVIDER OR SUPPLIER			:	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
KARLST	AD HEALTHCARE CE	NTER INC			304 WASHINGTON AVENUE WEST KARLSTAD, MN 56732		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 225	make comments lik Cathy' (to R5), or 'if describe what she r "kinda short temper -NA-C stated " [AP] sometimes not real like [AP] wants to sl R5, you have to be over, it's a fine line. was soaked, and sh didn't respond at all telling her anything. -LPN-A and LPN-B snappy, kinda short "not right now" whe something. -NA-H stated she h in front of any resid the AP tell R5 she v her to shut up. NA-I herself in a harsh w The AP does tell R5 counseled AP that s rather say "we will h NA-H had also heal off" when R5 was a another. NA-H stated described the AP as On 10/19/17 at 2:34 interviewed and wa aforementioned stat included in the follo to the SA and the D	e 'that's not my job, ask I have to'." When asked to meant by short the NA stated red". can be harsh with staff and ly nice with [R5]. "Kinda mean, how [R5] who is boss, but with kinda firm, or she will run you I told her one day a resident he walked right by me and . She doesn't like anyone " stated that [AP] can be with residents. She will say n a resident asks for ad never heard the AP swear ent and she has never heard vas acting like a bitch or tell H stated the AP presented ray to residents sometimes. 5 "no" sometimes and I have she shouldn't say that, but have to see if I have the time". rd the AP tell R5 to "knock it sking for one thing after ed that another resident	F 2	225			

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		AND HUMAN SERVICES				FORM	: 07/05/2018 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED C	
		245468	B. WING	ì			20/2017
NAME OF I	PROVIDER OR SUPPLIER	•			STREET ADDRESS, CITY, STATE, ZIP CODE		
KARLST	AD HEALTHCARE CE				304 WASHINGTON AVENUE WEST KARLSTAD, 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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 225 F 226 SS=D	The DON was aske constituted verbally DON stated "Yes", of my grandmother not included all of the follow up investigat all of the NA/LPN in resident interaction verbal abuse. The I terminate this empl allow her to. The Dor return to work after completed and the chose not too. The Karlstad Senio revised November Administrator would internal investigatio incident. The invest with staff, residents environmental revise review, and behavio VA policy failed to in investigation needed within 5 business d DEVELOP/IMPLME POLICIES CFR(s): 483.12(b)(483.12 (b) The facility mus written policies and (1) Prohibit and pre	and your acting like a bitch. and your acting like a bitch. a busive behavior, and the I wouldn't want her taking care . The DON confirmed she had he employee interviews in the ion report to the SA and with herviews together, the AP's s suggested a pattern of DON stated she wanted to oyee but corporate would not ON stated the AP was able to the investigation was suspension was lifted, but r Living VA policy dated as 2016, indicated the DON or d immediately institute an in of the reported allegation or tigation may include interviews by and witnesses, ew, resident health status or and medication review. The indicate the results of the ed to be submitted to the SA ays. ENT ABUSE/NEGLECT, ETC 1)-(3), 483.95(c)(1)-(3) t develop and implement procedures that: event abuse, neglect, and lents and misappropriation of	F	225			11/29/17 Page 15 of 79

Facility ID: 00830

If continuation sheet Page 15 of 79

		AND HUMAN SERVICES			F	ORM	07/05/2018 APPROVED 0938-0391	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			.E CONSTRUCTION (X	COM	SURVEY PLETED	
		245468	B. WING			C 10/20/2017		
NAME OF F	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE					
KARLST	AD HEALTHCARE CE		304 WASHINGTON AVENUE WEST KARLSTAD, MN 56732					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 226	Continued From pa resident property,	ige 15	F 2	226				
	(2) Establish policie investigate any suc	es and procedures to hallegations, and						
	(3) Include training §483.95,	as required at paragraph						
	the freedom from a requirements in § 4	and exploitation. In addition to buse, neglect, and exploitation 83.12, facilities must also heir staff that at a minimum				ŕ		
		constitute abuse, neglect, isappropriation of resident h at § 483.12.						
		or reporting incidents of abuse, n, or the misappropriation of						
	prevention.	anagement and resident abuse						
	Based on observat review, the facility f Adult (VA) policy ha written for reporting State agency prior f residents (R5) vulne reviewed; failed to a was implemented a of financial exploita investigated for 1 o reviewed; and failed	tion, interview, and document ailed to ensure the Vulnerable ad been implemented as a allegations of abuse to the to investigation for 1 of 3 erable adult (VA) reports ensure the facilities VA policy as written to ensure allegations tion had been thoroughly f 3 residents (R42) VA reports d to ensure the facility VA ented as written to include all			The preparation of the following plan correction for this deficiency does not constitute and should not be interpret as an admission nor an agreement by facility of the truth of the facts alleged conclusions set forth in the statement deficiencies. The plan of correction prepared for this deficiency was exect solely because provisions of state an federal law require it. Without waiving foregoing statement, the facility states with respect to:	t ted y the d or t of cuted d g the		

Facility ID: 00830

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY PLETED
		245468	B. WING _	·····		C 2 0/2017
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF	CODE	
KARLST	AD HEALTHCARE CE			304 WASHINGTON AVENUE WES KARLSTAD, MN 56732	Т	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIC DATE
F 226	information learned was reported to the business days for 1 reviewed. Findings include: The Karlstad Senio revised November nursing (DON) or A immediately institut the reported allegat investigation may in residents, and with residents, and with resident health stat medication review. the results of the in submitted to the SA The Karlstad Senio revised November deemed reportable submitted to MDH	by the internal investigation State agency within 5 of 3 residents (R5) VA reports r Living VA policy dated as 2016, indicated the director of dministrator would e an internal investigation of tion or incident. The nclude interviews with staff, esses, environmental review, us review, and behavior and The VA policy failed to indicate vestigation needed to be within 5 business days. r Living VA policy dated as 2016, indicated "All incidents under MN statute are <i>v</i> ia the on-line Reporting	F 2:	 R5 has been reported thoroughly investigated fo abuse/mistreatment on 7/ re-submission on 11/10/17 R41 had been reported to local law enforcement on allegations of financial exp enforcement closed this of This facility received emai on 9/15/17, that the inform reviewed and it has been no further action was need 2. Executive Director, DI designee are notified per procedure of incidents to additional reporting to MD enforcement or other age required. All incidents are IDT to assure staff follower reporting and monitoring p 3. VA Policy will be updat include that results of the be submitted within 5 bus will be re-educated prior to regording the policy and p reporting all injuries and a 	r potential 25/17 (and with 7) and 10/23/17. MDH and to 8/9/17 for bloitation. Law ase on 8/11/17. I confirmation nation had been determined that essary. NS or assigned facility policy and determine if H, law ncies are e reviewed at ed proper brocedures. ted/changed to investigation will iness days. Staff to 11/29/17, procedure of llegations,	
	R5's medical record 10/17/17, and the p revealed R5 had re been rough with he identified the staff r progress note indic making "faulty alleg	y (as soon as possible)." d was reviewed initially on progress note dated 10/16/17, ported a staff member had r during morning cares, and nember by name. The ated R5 had a long history of jations", day shift staff ed staff member) were		 completion of an incident of the investigation, notific Administrator and DNS ar notification of the Commo and/or MDH 4. Executive Director an incident reports to assure and monitoring procedure The incident reports will b reviewed/discussed at the and Quarterly QA meeting 	ation of the n Entry Point d DNS review all proper reporting s are followed. e Monthly QAPI	

Facility ID: 00830

If continuation sheet Page 17 of 79

STATEMEN	OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DA). 0938-039 TE SURVEY MPLETED	
		245468	B. WING _		C 10/20/2017		
NAME OF	PROVIDER OR SUPPLIER	I	L	STREET ADDRESS, CITY, STATE, ZIP CODE		20/2011	
	AD HEALTHCARE CE	ENTER INC		304 WASHINGTON AVENUE WEST KARLSTAD, MN 56732			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 226	the DON had comp and interviewed the denied providing or transfers on 10/16/ indicated the execu- the allegation, how the State agency (S allegation of abuse The DON was inter a.m. during which s allegation R5 made her on 10/16/17, wa investigating the all the past, R5 had m abuse and after tall the DON stated it to complete the invest R5 had not been tra- investigation did no aides that did provi 10/16/17, interview and interviewing ot care received by th DON confirmed she allegation of abuse because she felt we sense, and since R confabulating storie know whether to be The VA report date victim of financial e identified R42 was 7/6/17, and had dia	obleted a cursory investigation e alleged perpetrator who r assisting R5 with cares or 17. The progress note utive director was notified of ever, there was no indication SA) had been notified of the by R5. rviewed on 10/19/17, at 9:49 she was asked why the e about staff being rough with asn't reported to the SA prior to legation. The DON stated in lade false accusations of staff king to the alleged perpetrator, ook only 10 minutes to tigation enough to ascertain eated roughly. However, the ot include interviewing the de care to R5 the morning of ing R5 for pertinent details, her residents regarding the e alleged perpetrator. The e had investigated R5's before reporting to the SA e needed to use common	F 22	follow-up studies. Completion Date: 11/29/17			

If continuation sheet Page 18 of 79

STATEMENT	OF DEFICIENCIES	K MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /		(X3) DA	D. 0938-039 TE SURVEY MPLETED		
		245468	A. BUILDI B. WING	ING		С		
	PROVIDER OR SUPPLIER	243400	D. WING	STREET ADDRESS, CITY, STATE,)/20/2017		
	AD HEALTHCARE CE	ENTER INC		304 WASHINGTON AVENUE W KARLSTAD, MN 56732				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		TION SHOULD BE	(X5) COMPLETION DATE		
F 226	disorder, hypertens palliative care. The son who received fi in the amount of 3, another check was 7/7/17, for 5,000.00 for non-sufficient fu the SA was notified exploitation on 8/9/ Sherriff's Office rec from the Minnesota Center. The investi exploitation had nor the alleged perpetra included any intervi never determined if son received was u who drafted the che non-sufficient funds dollars.	inge 18 ision, constipation, and alleged perpetrator was R42's unds from R42's bank account 000.00 dollars on 7/5/17, and drafted on R42's account on 0 dollars which was returned inds. The VA report indicated 17, and the Kittson County reived the report on 8/11/17, a Adult Abuse Reporting gation for this alleged financial t included any interviews with ator (R41's son) and had not rews with R41, and it was f the 3,000.00 dollars R41's ised for the benefit of R41 or eck that was returned for a in the amount of 5,000.00 12:30 p.m. the Administrator d confirmed the investigation	F 2					
	was not complete as R41, and the son of R41 had not been interviewed, and it was never determined if the 3,000.00 dollars R41's son received was used for the benefit of R41. Additionally, the facility had not determined who drafted the check that was returned for non-sufficient funds in the amount of 5,000.00 dollars, and the reason the check was drafted.							
	7/25/17, indicated F (NA)-F had told her was acting like a bi	eport submitted to the SA on R5 reported nursing assistant r to shut up and told R5 she tch. The VA report indicated alleged perpetrator (AP) had						

CENTE	RS FOR MEDICARE	AND HUMAN SERVICES			OMB NC	APPROVEI 0. 0938-039	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		TE SURVEY MPLETED	
		245468	B. WING			C / 20/2017	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2			
KARLST	AD HEALTHCARE CE			304 WASHINGTON AVENUE WE KARLSTAD, MN 56732	ST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE	
F 226	Continued From page 19 been suspended pending investigation.			226			
	dated 7/28/17, indic and stated the AP r to her when they we The follow up invest following: -Multiple staff mem stated they had new harshly/meanly/or w of the resident. -The AP was intervi- anything mean to a name. -The AP denied ever resident she later re The VA report also the AP could come Another staff mem she wanted to show with R5, you had to run you over, it's a of demanding exce care from her care typical 8 hour shift I her glasses 15 or m glasses were not di indicated following suspension was lift provide care to R5 education would be her non-verbal body resident care plan. following policy and	tigation submitted to the SA cated R5 had been interviewed nade inappropriate comments ere in her room alone together. tigation further indicated the bers were interviewed and all ver heard the AP speak with foul language to or in front iewed and denied having said resident or calling a resident a er making a statement to a egretted. indicated staff had reported across as being "short". ber stated the AP acted like v R5 who was the boss, but be kinda firm, or she would fine line. R5 had a long history ssive amounts of time and givers. For example, on a R5 would request staff to clean hore times. Normally her inty or soiled. The report this investigation, the AP's ed and was instructed not to per R5's request. Additional e done with the AP regarding y language and following the A final written warning for not I procedure and standards of I Senior Living would also be					

		AND HUMAN SERVICES			FORM	: 07/05/2018 APPROVED . 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	CON	E SURVEY IPLETED C
		245468	B. WING _			20/2017
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	
KARLST	AD HEALTHCARE CE	ENTER INC		304 WASHINGTON AVENUE WEST KARLSTAD, MN 56732		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 226	Continued From pa	ige 20	F 22	26		
	it was noted they gives a state of the series of the serie	e end of the day [AP] can be staff and residents). She has seen her roll her eyes when a o do something, and then we 'that's not my job, ask i I have to'." When asked to meant by short the NA stated red". I can be harsh with staff and ly nice with [R5]. "Kinda mean, how [R5] who is boss, but with kinda firm, or she will run you I told her one day a resident he walked right by me and I. She doesn't like anyone " stated that [AP] can be t with residents. She will say in a resident asks for				Page 21 of 79

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	MENT OF HEALTH					FORM): 07/05/2018 / APPROVED). 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/			IPLE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		24	45468	B. WING _		10	C / 20/2017
NAME OF F	PROVIDER OR SUPPLIER			<u> </u>	STREET ADDRESS, CITY, STATE		
KARLST	AD HEALTHCARE CE	ENTER INC			304 WASHINGTON AVENUE W KARLSTAD, MN 56732	/EST	
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENC REGULATORY OR L		EDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLETION DATE
F 226	Continued From pa	age 21		F 22	26		
	-NA-H stated she h in front of any resid the AP tell R5 she w her to shut up. NA- herself in a harsh w The AP does tell R counseled AP that rather say "we will NA-H had heard th when R5 was askir NA-H stated that a AP as "kinda pushy	lent and she h was acting like H stated the A vay to resident 5 "no" sometir she shouldn't have to see if he AP tell R5 to ng for one thin nother residen	as never heard a bitch or tell P presented ts sometimes. nes and I have say that, but I have the time". o "knock it off" g after another.			560	
	On 10/19/17 at 2:3 interviewed and as aforementioned sta included in the follo to the SA and the D statements were po was told to shut up The DON was aske constituted verbally DON stated "Yes", of my grandmother not included all of t follow up investigat all of the NA/LPN in resident interaction verbal abuse. The terminate this emp allow her to. The D return to work after completed and the	ked why all of aff interviews h ow-up investig OON stated sh ertinent to R5 and your actined if the above abusive beha I wouldn't war The DON co he employee i ion report to the therviews toge s suggested a DON stated sh oyee but corp ON stated the the investigat	the nad not been ation submitted e didn't think the reporting she ng like a bitch. e statements avior, and the nt her taking care onfirmed she had interviews in the he SA and with ether, the AP's a pattern of he wanted to orate would not e AP was able to tion was				
F 279 SS=D	chose not too. DEVELOP COMPF CFR(s): 483.20(d);	REHENSIVE		F 27	79		11/29/17
	567(02-99) Previous Versions		Event ID: RQUD	011	Facility ID: 00830	If continuation shee	t Page 22 of 7

STATEMENT	OF DEFICIENCIES	KMEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT	0938-039 E SURVEY PLETED
AND PLAN (JF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING _			C
		245468	B. WING				0 20/2017
NAME OF	PROVIDER OR SUPPLIER	•			TREET ADDRESS, CITY, STATE, ZIP CODE	-	
KARLST	AD HEALTHCARE CE	INTER INC			04 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 PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 279	Continued From pa	ige 22	F 2	79			
	assessments comp months in the resid results of the asses	nust maintain all resident bleted within the previous 15 ent's active record and use the ssments to develop, review dent's comprehensive care					
	(1) The facility mus comprehensive per each resident, cons set forth at §483.10 includes measurab to meet a resident's and psychosocial n comprehensive ass	t develop and implement a rson-centered care plan for sistent with the resident rights 0(c)(2) and §483.10(c)(3), that le objectives and timeframes s medical, nursing, and mental eeds that are identified in the sessment. The comprehensive cribe the following -			RENIS		
	or maintain the resi physical, mental, ar	t are to be furnished to attain ident's highest practicable nd psychosocial well-being as 3.24, §483.25 or §483.40; and					
	under §483.24, §48 provided due to the	at would otherwise be required 33.25 or §483.40 but are not e resident's exercise of rights uding the right to refuse 83.10(c)(6).					
	rehabilitative servic provide as a result	services or specialized es the nursing facility will of PASARR If a facility disagrees with the					

If continuation sheet Page 23 of 79

				FORM	07/05/2018 APPROVED 0938-0391		
OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			`́сом	E SURVEY PLETED		
	245468	B. WING			20/2017		
ROVIDER OR SUPPLIER		· [STREET ADDRESS, CITY, STATE, ZIP CODE	•			
AD HEALTHCARE CE		304 WASHINGTON AVENUE WEST KARLSTAD, MN 56732					
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL	D BE	(X5) COMPLETION DATE		
findings of the PAS, rationale in the resident (iv) In consultation we resident's represen (A) The resident's ge desired outcomes. (B) The resident's ge future discharge. Far whether the resider community was asses local contact agence entities, for this pur (C) Discharge plans plan, as appropriate requirements set for section. This REQUIREMENT by: Based on interview facility failed to deve identification of the (antiseizure medical side effects for 1 of for unnecessary medical Findings include: R35's care plan fail Carbamazepine (m and partial complex	ARR, it must indicate its dent's medical record. with the resident and the tative (s)- goals for admission and preference and potential for acilities must document nt's desire to return to the sessed and any referrals to ies and/or other appropriate pose. s in the comprehensive care a, in accordance with the orth in paragraph (c) of this NT is not met as evidenced <i>A</i> , and document review, the elop a care plan to include the use of Carbamazepine ation), monitoring needs or 5 residents (R35) reviewed edications.	F 2	79 The preparation of the following p correction for this deficiency does constitute and should not be interp as an admission nor an agreement facility of the truth of the facts alle conclusions set forth in the statern deficiencies. The plan of correction prepared for this deficiency was e solely because provisions of state federal law require it. Without was foregoing statement, the facility st with respect to: 1. R35 had a care plan review w changes made for the medication Carbamazepine for resident beha	not preted at by the ged or hent of on xecuted and tving the ates ith viors.			
	S FOR MEDICARE OF DEFICIENCIES F CORRECTION PROVIDER OR SUPPLIER AD HEALTHCARE CE SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From pa findings of the PAS rationale in the resi (iv)In consultation v resident's represen (A) The resident's g desired outcomes. (B) The resident's g future discharge. Fa whether the resider community was ass local contact agence entities, for this pur (C) Discharge plane plan, as appropriate requirements set for section. This REQUIREMEN by: Based on interview facility failed to devi identification of the (antiseizure medica side effects for 1 of for unnecessary me Findings include: R35's care plan fail Carbamazepine (m and partial complex	F CORRECTION IDENTIFICATION NUMBER: 245468 PROVIDER OR SUPPLIER AD HEALTHCARE CENTER INC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 23 findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to develop a care plan to include the identification of the use of Carbamazepine (antiseizure medication), monitoring needs or side effects for 1 of 5 residents (R35) reviewed for unnecessary medications.	AS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULT A. BUILDI PROVIDER OR SUPPLIER 245468 B. WING AD HEALTHCARE CENTER INC ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID Continued From page 23 findings of the PASARR, it must indicate its rationale in the resident's medical record. F 2 (iv) In consultation with the resident and the resident's representative (s)- F 2 (A) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to develop a care plan to include the identification of the use of Carbamazepine (antiseizure medication), monitoring needs or side effects for 1 of 5 residents (R35) reviewed for unnecessary medications. Findings include: R35's care plan failed to address the use of Carbamazepine (medication for both generalized and partial complex seizure disorders), it's side	MENT OF HEALTH AND HUMAN SERVICES SFOR MEDICARE & MEDICAID SERVICES OF DEFICIENCIES OF DEFICIENCIES CONRECTION (X1) PROVIDER/SUPPLERICLIA DENTIFICATION NUMBER: 245468 B. WING SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY ON LSC IDENTIFIYING INFORMATION) (Red) DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY ON LSC IDENTIFIYING INFORMATION) (N) The resident's proference and potential for future discharge. Facilities must document whether the resident's collect or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. Findings include: Findings include:	MENT OF HEALTH AND HUMAN SERVICES FORM SF COR MEDICARE & MEDICAID SERVICES OMB NO. OF DEFICIENCIES OMB NO. OF DEFICIENCIES OMB NO. POMECTION 245468 B WING STREET ADDRESS, CITY, STATE, ZIP CODE 304 WASHINGTON AVENUE WEST KARLSTAD, MN 56732 SUMMARY STATEMENT OF DEFICIENCIES ID IEACT DEFICIENCY MUST BE PRECEDED BY FULL ID REQULTORY ON US BE PRECEDED BY FULL ID RECULTORY ON US BE PR		

Facility ID: 00830

If continuation sheet Page 24 of 79

TATEMEN	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				X3) DATE COMF	0938-039 SURVEY PLETED
245468		B. WING _		C 10/20/2017			
NAME OF	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
KARLST	AD HEALTHCARE CE	ENTER INC			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 PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETIC DATE
F 279	R35's diagnosis re diagnoses of Alzhe disorder, hypothyro undifferentiated scl behavioral disturba disabilities. R35's five day MDS as severely impaire behaviors and rece antidepressant, an medications. R35's Medication F 10/6/17, indicated I 300 milligrams (mg The MRR further ic 300 mg medication R35's Medication A 10/2017, indicated 300 milligrams in th R35's care plan, pr psychoactive medic Risperdal, Celexa, care plan lacked id identification of sei monitoring, or inter On 10/2/17, at 9:05 recently returned fr	port dated 10/20/17, indicated imer's disease, anxiety bidism Parkinson's disease, hizophrenia, dementia with ances, and profound intellectual S, dated 9/18/17, identifies R35 ed, exhibits verbal and physical eived antipsychotic, tianxiety and antibiotic Review Report (MRR), dated R35 received Carbamazepine b) in the evening for seizures. dentified R35's Carbamazepine b- start date as 12/14/16. Administration Record, dated R35 received Carbamazepine b- start date as 12/14/16.	F 27	79	Carbamazepine is being utilized for behaviors, checking routine levels is clinically indicated. 2. All residents will be reviewed thr chart review for seizure history, to er that they are care planned appropria along w/ being identified on the MDS that monitoring needs have been identified and implemented. 3. Staff education will be completed 11/29/17 regarding the need to addre the use of medications and if side ef or behaviors warrant monitoring. 4. Audits of care plans will be comp by DNS or designee with all new admissions and for any resident hav medication order changes for the following 3 months to ensure that all psychoactive or anti-seizure medicat would be identified properly on the M care plan, and the monitoring needs identified and implemented. The dat collected will be reviewed at the Mor QAPI and Quarterly QA meeting. At time the committee will make the decision/recommendation regarding follow-up studies. Completion Date: 11/29/17	rough hsure ttely 5, and d by ess fects pleted ring tion ADS, ta hthly t hat	

ND PLAN OF CORRECTION IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED			
		B. WING			C 10/20/2017		
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE 304 WASHINGTON AVENUE WEST KARLSTAD, MN 56732			
(X4) ID PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE	
F 279	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		F 27	9			

If continuation sheet Page 26 of 79

		& MEDICAID SERVICES				<u>). 0938-039</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		TE SURVEY MPLETED
245468		B. WING _		10	C)/ 20/2017	
NAME OF I	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP C	ODE	
KARLST	AD HEALTHCARE CE	INTER INC		304 WASHINGTON AVENUE WEST KARLSTAD, MN 56732		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIOI DATE
F 279		applicable with appropriate for use, and gradual dose	F 27	79		
F 280 SS=D	RIGHT TO PARTIC CARE-REVISE CP	IPATE PLANNING	F 28	30		11/29/17
	and implementation	participate in the development n of his or her person-centered ing but not limited to:		6		
	including the right to be included in the p request meetings a	cipate in the planning process, o identify individuals or roles to planning process, the right to and the right to request son-centered plan of care.				
	expected goals and amount, frequency,	icipate in establishing the d outcomes of care, the type, , and duration of care, and any d to the effectiveness of the				
	(iv) The right to rec included in the plan	eive the services and/or items of care.				
		the care plan, including the gnificant changes to the plan				
	right to participate i	nall inform the resident of the n his or her treatment and sident in this right. The nust				
	(i) Facilitate the inclusion (i) Facilitate the inclusion (ii) (ii) (iii) (iii	lusion of the resident and/or titve.				

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DEPARTMENT OF HEALTH AND HUMAN SERVICES						FORM	APPROVED
CENTERS FOR MEDICARE & MEDICAID SERVICES							0938-0391
-	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
		A. DOILDI			С		
		245468	B. WING				20/2017
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
KARLST	AD HEALTHCARE CE	NTER INC			04 WASHINGTON AVENUE WEST		
				ĸ	ARLSTAD, MN 56732		
(X4) ID PREFIX		TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL	ID PREFIX	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	-	CROSS-REFERENCED TO THE APPROP DEFICIENCY)		DATE
	1		ı				
F 280	Continued From pa	ae 27	F 2	20			
1 200	Continued i rom pa	ge zi	Γ 2	.00			
	(ii) Include an asses	ssment of the resident's					
	strengths and need						
	(iii) Incorporato the	resident's personal and					
		s in developing goals of care.					
	483.21						
	(b) Comprehensive	Care Plans					
	(2) A comprehensiv	e care plan must be-			, CV		
	(i) Developed within the comprehensive	7 days after completion of assessment.					
	(ii) Prepared by an includes but is not l	interdisciplinary team, that imited to					
	(A) The attending p	hysician.					
	(B) A registered nur resident.	se with responsibility for the			*		
	(C) A nurse aide wit resident.	th responsibility for the					
	(D) A member of fo	od and nutrition services staff.					
	the resident and the An explanation must medical record if the and their resident re not practicable for t resident's care plan						
		te staff or professionals in mined by the resident's needs					

If continuation sheet Page 28 of 79

		AND HUMAN SERVICES				FORM	07/05/2018 APPROVED 0938-0391
			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C	
		245468	B. WING				_ 20/2017
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
KARLST	AD HEALTHCARE CE				4 WASHINGTON AVENUE WEST ARLSTAD, 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	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 280	Continued From pa or as requested by	-	F 2	80			
	team after each ass comprehensive and assessments. This REQUIREMEN by: Based on interview facility failed to ens revised to include fl and ongoing monito (R5) resident in the and failed to revise behavior/mood sym medications for 2 o reviewed for unnec Findings include: R5's cumulative dia indicated R5 was a diagnoses that inclue end stage renal dis bipolar disorder, dis post-traumatic stres borderline personal On 10/20/17, at 9:2 the end of the breat have four cups of fl	NT is not met as evidenced y, and document review, the ure the written care plan was uid restriction interventions oring of fluid intake for 1 of 1 sample reviewed for dialysis, the care plan to include target optoms for psychotropic f 5 residents (R6, R30) essary medications. Agnoses list dated 10/19/17, dmitted to the facility with uded, but were not limited to: ease requiring hemodialysis, sruptive behavior disorder, ss disorder, and sociopathic			The preparation of the following plat correction for this deficiency does no constitute and should not be interpre- as an admission nor an agreement be facility of the truth of the facts allege conclusions set forth in the statement deficiencies. The plan of correction prepared for this deficiency was exe solely because provisions of state and federal law require it. Without waiving foregoing statement, the facility state with respect to: 1. R5 did not have a physician order fluid restriction due to an extensive he of non-compliance. R5 has had a car plan review to include fluid restriction interventions and monitoring of fluid intake. R6 and R30 have had care p reviews with updates to include target behavior/mood symptoms for psychotropic medications. 2. Residents receiving dialysis will their care plans reviewed for fluid restrictions and ongoing monitoring of fluid intake. Residents that received psychotropic medication will have car plans reviewed for target behavior/m	ot eted by the d or nt of cuted nd mg the es er for nistory are n blan et have of l are	
	of the fluids provide serve her the corre	er breakfast tray. R5 drank all ed. R5 stated the facility did not ct amount of fluids according R5 stated she herself tracked			symptoms. 3. Staff education will be completed 11/15/17 regarding target behavior/ r monitoring care plan need, and the r	mood	

Facility ID: 00830

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
							С	
			B. WING			10/	20/2017	
NAME OF I	PROVIDER OR SUPPLIER				SS, CITY, STATE, ZIP CODE			
KARLSTAD HEALTHCARE CENTER INC				KARLSTAD, N	ON AVENUE WEST IN 56732			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH	VIDER'S PLAN OF CORRECT CORRECTIVE ACTION SHOL REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE	
F 280	Continued From pa	ae 29	F 2	80				
	showed the surveyor written down for ear no totals which ider consumed in a day look complete. R5 a was not correct and restriction was 32 o dialysis unit had no fluid intake log beca recordings. R5 state with fluid managem to keep going into t Review of R5's und revealed there was however, when R5's reviewed, a progress indicated a dialysis	consumed each day and or a notebook with numbers ch day. However, there were ntified how much fluid was and many of the days didn't also stated the fluid calculation d she did not know if her fluid or 36 ounces. R5 stated the t even looked at her personal ause they did not believe her ed she was trying to do better tent because she didn't want he hospital for fluid overload.		4. DNS of on any new current res psychotrop following 3 proper car will be revi Quarterly 0 committee decision/re follow-up s	fluid intake monitoring with residents eiving dialysis. DNS or designee will complete audi any new residents/ new orders for rent residents on dialysis or with chotropic medication ordered for the owing 3 months and, to ensure that per care planning. The data collecte be reviewed at the Monthly QAPI an arterly QA meeting. At that time the nmittee will make the cision/recommendation regarding any ow-up studies. mpletion Date: 11/29/17			
	on 10/13/17, reveal identified, and the of her own fluid restrict total intake to be dis nursing and to docu care plan had not id cc's of fluid was allo medication pass an non-compliant with plan also failed to id minimize fluid cons instead of water, of	e plan for dialysis last revised ed no fluid restriction was care plan stated R5 "monitors ctions." The care plan directed stributed between dietary and ument non-compliance. The dentified a plan for how many otted for each meal and id had not identified R5 was fluid restrictions. The care dentify interventions to umption like offering ice chips fering a popsicle rather than rd candy or lemon drops for outh.						

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		AND HUMAN SERVICES				FORM	07/05/2018 APPROVED 0938-0391	
	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245468	B. WING			C 10/20/2017		
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
KARLST	AD HEALTHCARE CE				304 WASHINGTON AVENUE WEST KARLSTAD, MN 56732			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 280	Continued From pa	ge 30	F 2	280				
		5's medical record revealed nd R5's fluid balance had not and monitored.						
	on 10/20/17, 9:50 a intake was not mor	hurse (LPN)-A was interviewed u.m. and stated R5's fluid hitored by the facility, and there where R5 was with fluid			SF			
	10/20/17, at 10:32 a restrictions during w plan had not identif not delineated how	sing (DON) was interviewed on a.m. regarding R5's fluid which she confirmed R5's care ied R5's fluid restriction, had many fluids R5 would receive now much fluid R5 received bass by nursing.			REN			
	R6's care plan was target/mood sympto	not revised to include oms						
		port dated 10/20/17, included depressive disorder, anxiety oaffective disorder.						
	8/1/17, identified Red days during the ass	um Data Set (MDS) dated 6 had verbal behaviors 1-3 sessment period and took ntidepressant medications.						
	dated 8/3/17, indica calling out to staff w transferring rather t	mptom Care Area Assessment ated R6's behaviors included when she needed assistance than using her call light. The behavioral symptoms would						
FORM CMS 20	67(02-99) Previous Versions	Obsolete Event ID: ROUD1		Б.	acility ID: 00830 If continuat		Page 31 of 79	

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ATEMENT	OF DEFICIENCIES OF CORRECTION	KMEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				
		B. WING	B. WING					
AME OF F	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CO	DE			
ARLST	AD HEALTHCARE CE	INTER INC		304 WASHINGTON AVENUE WEST KARLSTAD, MN 56732				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE		
F 280	Continued From pa	ige 31	F 28	0				
	not be care planned noted on the CAA.	d, no further analysis was						
	R6's physician orde 10/20/17 included:	ers provided by the facility on						
	-Benzotropine Mes of Parkinson's dise	ylate (used to treat symptom ase or involuntary movements of certain psychiatric drugs)			\bigcirc			
	milligram (mg) at b date of 7/26/16.	edtime for behaviors. Start						
	the morning for dep -Trazodone (antide	essant medication) 15 mg in pression. Start date of 7/26/16. pressant medication) 50 mg at depressive disorder. Start date						
		rs did not include an tion.						
	on 10/20/17, indica	ted and provided by the facility ted R6 used antianxiety I to anxiety and antidepressant						
	medications related 11/14/16). The asso instruction to give a by the physician. The	d to depression (last revised ociated interventions included anti-anxiety medication ordered he care plan lacked target						
	symptoms identified	od symptoms including d on the CAA.						
	seated in her reclin R6 fell asleep multi interview and was o	4 p.m. R6 was observed er in her room, watching TV. ple times during the resident difficult to keep awake. Her ssions were flat with little						
	On 10/17/17, at 8:5 ambulate down the	i9 a.m. R6 was observed to hallway using her walker, her appropriate, had slightly more						

DEPARTMENT OF HEALTH AND HUMAN SERVICES					Pi		APPROVED
CENTERS FOR MEDICARE & MEDICAID SERVICES					OI		0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ECONSTRUCTION		E SURVEY PLETED
		A. BUILDII	NG_		С		
		245468	B. WING _				
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
KARLST	AD HEALTHCARE CE	NTER INC			4 WASHINGTON AVENUE WEST		
				K	ARLSTAD, MN 56732	<u>. </u>	
(X4) ID PREFIX	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL	ID PREFIX	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION
TAG	REGULATORY OR LS	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	₹IATE	DATE
			1				
F 280	Continued From pa	ge 32	F 28	80			
		7 p.m. licensed social worker					
		s's care plan and verified the oms for depression were not					
	identified. LSW exp	lained R6 had depression and					
		and down days and R6 ve symptoms by not doing her					
		generally would not come out					
	of her room on thos	e days. LSW stated when R6					
		ned like she was more eived things more negatively					
	than what they were						
		-					
		5 a.m. assistant director of rified the lack of target mood					
		are plan and stated the target					
		ould have been identified on					
	the care plan.						
		s not revised to include target					
	behaviors/mood syr	nptoms.					
		Sheet dated 10/20/17, of dementia without					
		nce, anxiety disorder, and					
	major depressive di						
	R30's annual Minim	um Data Set (MDS) dated					
	8/4/17, indicated R3	30 had severe cognitive					
		d verbal behaviors directed to three days during the					
		and there had not been a					
	-	s since the previous					
	assessment.						

If continuation sheet Page 33 of 79
STATEMENT	OF DEFICIENCIES	K MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /		(X3) DA). 0938-039 TE SURVEY MPLETED	
				NG	00	C	
		245468	B. WING _		10	/20/2017	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 304 WASHINGTON AVENUE WEST KARLSTAD, MN 56732			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC	ULD BE	(X5) COMPLETIO DATE	
F 280	R30's Behavioral C R30 had the potent being resistive to ca behavioral symptor the care plan. The verbal behaviors id R30's physician orc (antidepressant) 20 major depressive d 5/22/17, and mirtaz major depressive d behaviors for anxie on the physician orc 12/29/16, included of bed and directed area and offer nour orders did not ident depression. R30's care plan prii facility on 10/20/17, antidepressant and to depression, anxi The care plan indic sadness, anxiety, a by ineffective copin on 12/21/16. R30's Progress Nor 7/17/17-10/16/17, r of care, medication and hitting staff. Th	A dated 8/7/17, indicated ial for behavioral problems by ares and indicated the ns would not be addressed on CAA lacked indication of the entified on the MDS. ders included Celexa) milligrams every morning for isorder with a start date of capine 15 mg every bedtime for isorder. R30's target ty to be monitored indicated ders, and were dated restlessness and crawling out I staff to bring R30 to quiet rishment. The physician's tify target mood symptoms for nted and provided by the , indicated R30 received antianxiety medication related ety, and appetite stimulation. ated R30 had feelings of and depression characterized g and fearfulness last revised tes reviewed from eflected behaviors of refusals and meals, agitation, hollering ie care plan was also not esistive to care that was	F 2				

If continuation sheet Page 34 of 79

		AND HUMAN SERVICES					
		& MEDICAID SERVICES				0938-0391	
-	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	IPLE CONSTRUCTION	(-)	E SURVEY PLETED	
/			A. BUILDIN	NG	(
		245468	B. WING _			20/2017	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
KADI CT	AD HEALTHCARE CE			304 WASHINGTON AVENUE WEST			
KARLOI	AD REALINCARE CE			KARLSTAD, MN 56732			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG		(MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE		COMPLETION DATE	
iAd			IAG	DEFICIENCY)			
			1				
F 280	Continued From pa	ae 34	F 28	30			
		3 • •					
	On 10/16/17, at 5:1	3 p.m. R30 was observed					
		awake. R30's mood was					
		d and was unable to articulate					
		name. At 6:20 p.m. director					
		eported she refused dinner e she refused, staff did not					
		0 would become very easily					
	agitated if asked to						
	0.40/17/17.404						
		8 a.m. R30 was observed					
		area in her pajamas. R30 was round. When asked how she					
		iled without verbally					
	responding.						
	resting in bed with l	0 a.m. R30 was observed					
		vas resting calmly in bed with					
	her eyes open.	vas resting carriy in bed with					
		ng assistant (NA)-A entered					
		ted R30 with morning cares.					
		ues during the cares, R30 was					
		and followed cues without					
		havioral or mood symptoms. 0 did better with older NA's					
		e someone she would wave					
		eported R30's behaviors					
	included pushing st	aff away, refusing care, and					
		sporadic and usually did not					
		h redirection. NA-A stated staff					
		ions such as toileting, offer nd/or re-approaching at a later					
	time.	no, or re-approaching at a later					
	0= 10/10/17 =+ 0.4						
1	On 10/19/17, at 9:4	5 a.m. the ADON confirmed					

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CENTE		AND HUMAN SERVICES	1			1 APPROVEI). 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245468	B. WING	C 10/20/20		
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
KARLST	AD HEALTHCARE CE			304 WASHINGTON AVENUE WEST KARLSTAD, MN 56732		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
F 280	the care plan did no behaviors/moods a have a process in p analysis and/or eva mediations. On 10/20/17, at 9:3 hit, pinch, scratch, a interventions includ member, getting me later time, and nails -At 9:37 a.m. licens stated R30 hit staff refused medication aides across the ro R30 exhibited the b re-approach and us -At 12:58 a.m. NA-B once in a while whe tired and this was d expressions. NA-B NA's or shake her f something and staff doing and help her and telling her what attempt to try again Facility policy Perso Guideline last revis plan must be review quarterly, with a sig as needed. The pol person centered ca towards: preventing	 at identify all of R30's and stated the facility did not blace to ensure ongoing alluation of psychotropic at a.m. NA-C stated R30 would and refuse meals. NA-C stated led getting a different staff ore help, re-approaching at a swere kept short. bed practical nurse (LPN)-A during cares, refused cares, s, and had thrown her hearing om. LPN-A explained when behaviors they would se different staff members. B stated R30 had behaviors en she was mad, angry, or lisplayed by her facial stated R30 would tap on the ist when she didn't like f were to stop what they are calm down by sitting with her t you are doing step by step or 	F 2			

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	07/05/2018 APPROVED 0938-0391
-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED C
		245468	B. WING			0 20/2017
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	
KARLST	AD HEALTHCARE CE	NTER INC			04 WASHINGTON AVENUE WEST ARLSTAD, MN 56732	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	medication class if diagnosis/indication	et behaviors, al interventions, psychoactive applicable with appropriate of for use, and gradual dose	F 2	280		
F 282 SS=D	reductions/pharmad SERVICES BY QU CARE PLAN CFR(s): 483.21(b)(ALIFIED PERSONS/PER	F 2	82		11/29/17
		ive Care Plans led or arranged by the facility, omprehensive care plan,			S	
	care.	qualified persons in ch resident's written plan of NT is not met as evidenced				
	Based on observat review, the facility fa plan related to the r skin impairment for wound which was n treated. In addition, and monitor behavi psychotropic medic plan for 1 of 5 resid	tion, interview, and document ailed to implement the care eporting of newly identified 1 of 3 residents (R37) with a not reported, assessed or the facilty failed to document ors related to the use of ation as directed by the care ents (R1) reviewed for			The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because provisions of state and	
	unnecessary medic Findings include:	ations.			federal law require it. Without waiving the foregoing statement, the facility states with respect to: 1. R37 has had his skin impairment assessed and treated. R1 has had behaviors monitored and documented.	
	had chronic kidney check body for brea	ised on 8/17/16, indicated R37 disease and directed staff to aks in skin and treat promptly cal practitioner. The			2. All current residents will have a head to toe body assessment for injury or wounds by 11/29/17. All current residents will be audited for psychotropic medication	

Facility ID: 00830

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TATEMEN	T OF DEFICIENCIES OF CORRECTION	KANDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	COM	E SURVEY PLETED
		245468	B. WING		C 10/20/2017	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP		
KARLST	AD HEALTHCARE CE	ENTER INC		304 WASHINGTON AVENUE WEST KARLSTAD, MN 56732	Γ	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIC DATE
F 282	directed staff to per and to report abnor practitioner. The sk directed staff to use and transfers to pre hands against surfa R37's medical reco skin impairment or directed by the card On 10/18/17, at 7:5 seated in wheelcha covered. The right the knee and the le yellow/reddish thin upper calf just belo the wound was not entered the room fi surveyor reported t wound on the outsi previously aware of the injury a week a the wheelchair. The wound to the nurse On 10/19/17, at 3:4 nursing (ADON) sta R37's left leg woun wheelchair back to periphery was now to a darker red and ADON cleaned, me wound. R37 stated	apy care plan dated 11/1/16, rform daily skin inspections rmalities to the nurse/medical kin care plan dated 11/1/16, e caution during bed mobility event striking arms, legs, and aces that may cause injury. ord did not reflect any areas of daily skin inspections as e plan. 64 a.m. R37 was observed air, lower extremities were not leg was amputated just below eff leg had a dime sized light scab on the outside of the w the knee. The skin around red. Nursing assistant (NA)-D irst and NA-E shortly after. The o both NA's and to R37 the de of the leg. NA's were not f the wound. R37 stated he got go when he transferred into e NAs failed to report the	F 28	 use and proper documental behavior along with non-pl alternatives tried prior to pluse. 3. Staff education will be 11/29/17 regarding the near monitor and document any injury or behavior. 4. DNS or designee will a weekly x1 month, then 1 refor 2 months regarding the documentation of skin injut target behavior monitoring medication administration. collected will be reviewed QAPI and Quarterly QA metime the committee will madecision/recommendation follow-up studies. Completion Date 11/29/17 	narmacologic rn medication completed by ed to report, r resident skin audit 5 residents esident weekly proper ry, resident and PRN The data at the Monthly eeting. At that ake the	

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		AND HUMAN SERVICES				FORM	: 07/05/2018 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		245468	B. WING	à			C 2 0/2017
	PROVIDER OR SUPPLIER AD HEALTHCARE CE		STREET ADDRESS, CITY, STATE, ZIP CODE 304 WASHINGTON AVENUE WEST KARLSTAD, MN 56732				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 282	wheelchair when tranot told anybody ab figured it would just NAs should report of the nurse. Followin comprehensive skii for R37's wound. R37's Incident prog indicated maintena which caused wour protein powder add be monitored and of R1's care plan was monitoring/docume interventions and o R1's care plan, prin had feelings of une to anxiety, depress disorder. Target be depression and any and directed staff to visits, ensure safety doll, and engage in directed to record t interventions used, R1's Medication Ad dated 10/2017, indi 7.5 mg at bedtime in mg orally as neede	ansferring. R37 stated he had bout the wound because he t heal. The ADON stated the changes in skin condition to g this assessment, a n assessment was completed gress noted dated 10/20/17, nce would pad on wheelchair nd, dietary informed and led to the diet plan, wound to education provided to staff. not followed for enting of target behaviors, utcomes. At date 10/20/17, indicated R1 asiness and sadness related ion and episodic mood haviors identified for kiety was explosive behaviors o redirect, provide one to one y, divert attention, offer baby conversations. Staff was also he number of occurrences, and outcomes.	F				

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		AND HUMAN SERVICES			FORM	: 07/05/2018 1 APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DAT COM	TE SURVEY MPLETED
		245468	B. WING			C / 20/2017
NAME OF I	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZI		
KARIST	AD HEALTHCARE CE			304 WASHINGTON AVENUE WES	ST	
KANLU				KARLSTAD, MN 56732		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 282	Continued From pa	ige 39	F 2	82		
	-8/27/17 at 3:30 p.r -9/8/17 at 12:00 a.r -9/20/17 at 12:15 a -9/21/17 at 12:00 p	n. .m.				
	Interventions, and o shift, daily. The mo 10/17, were all blar behaviors, non-pha	the explosive behavior, butcomes for monitoring every nitoring forms for 8/17, 9/17, and did not identify armacological interventions or ays R1 utilized as needed				
	nurse (LPN)-A state document on the M behaviors and not j Ativan. The LPN co	7:20 a.m. licensed practical ed staff were supposed to IAR when R1 had any ust when she received the onfirmed the aforementioned ns were blank and should ed, as directed.				
	behaviors occurred needed Ativan. The awake for a couple followed by exhaus days when she und stated R1 received month, several time periods of looking f staff were suppose behaviors on the M attempted and the the MAR's with the	DON stated the ns were to be completed when l, not just when R1 received as ADON stated R1 would be of days looking for her baby tion and sleeping. R1 had controllably cried. The ADON as needed Ativan once this es in September due to or her baby. The ADON stated d to be documenting the AR along with interventions outcomes. During review of ADON for 10/17, 9/17, and nfirmed they were void of any				
L	67(02-99) Previous Versions			Facility ID: 00830	If continuation sheet	<u> </u>

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		AND HUMAN SERVICES				FORM	07/05/2018 APPROVED 0938-0391
-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				СОМ	E SURVEY PLETED
		245468	B. WING			C 10/20/2017	
NAME OF	PROVIDER OR SUPPLIER	·		S	STREET ADDRESS, CITY, STATE, ZIP CODE		
KARLST	AD HEALTHCARE CE	ENTER INC		3 			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
	Continued From page 40 behavioral documentation and stated the staff should have been documenting the behaviors. In addition, the ADON stated the facility did not have an accurate reflection of R1's behaviors in order to determine if the continued use of the medication was necessary or if an increase or decrease should be initiated.		F 2	282			
	resident MDS asse monitoring of psych should have been of accurately reflect th personal needs. Th expectation that mo identification of targ documentation of th interventions be do currently being don the facilty knew on that the resident ca monitoring was ser	6 p.m. the DON confirmed assments, care plans and noactive and other medications completed in order to he residents medical and he DON confirmed it was her ponitoring of medications, the get behaviors and he use of non-pharmacological cumented which was not he. In addition, the DON stated the second day of the survey are plans and other areas of iously lacking identified I should not have been.			RENSE		
	the facility would m communicate conc behaviors and prov	idelines, dated 11/16, indicated onitor behaviors to erns in resident mood and /or ride documentation of evidence ns and modifications to the					
	revised 11/2016, in develop and impler	Centered Care Plan Guideline, dicated the facility must ment a baseline care plan for included instructions needed to					

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		AND HUMAN SERVICES				FORM	07/05/2018 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	COM	E SURVEY IPLETED
		245468	B. WING	<u></u> ډ			C 20/2017
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
KARLST	AD HEALTHCARE CE	INTER INC			304 WASHINGTON AVENUE WEST KARLSTAD, MN 56732		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282		-	F 2	282			
F 309 SS=D	resident that meet p quality of care and the services that ar maintain the reside mental and psychol PROVIDE CARE/S WELL BEING CFR(s): 483.24, 48 483.24 Quality of life Quality of life is a fu applies to all care a residents. Each res facility must provide services to attain on practicable physica well-being, consiste comprehensive ass 483.25 Quality of ca Quality of care is a applies to all treatm facility residents. Ba assessment of a re that residents recei accordance with pro practice, the compr care plan, and the r but not limited to th (k) Pain Management Consistent with profithe comprehensive	ERVICES FOR HIGHEST 3.25(k)(l) e undamental principle that und services provided to facility sident must receive and the e the necessary care and r maintain the highest l, mental, and psychosocial ent with the resident's sessment and plan of care. are fundamental principle that nent and care provided to ased on the comprehensive sident, the facility must ensure ve treatment and care in ofessional standards of rehensive person-centered residents' choices, including e following:	FS	309			11/29/17

Facility ID: 00830

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CENTE	RS FOR MEDICARE	AND HUMAN SERVICES	T		FORM OMB NO.	07/05/2018 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		245468	B. WING _			20/2017
NAME OF I	PROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
KARLST	AD HEALTHCARE CE			304 WASHINGTON AVENUE WEST KARLSTAD, MN 56732		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 309	residents who requiservices, consisten of practice, the com- care plan, and the re- preferences. This REQUIREMEN by: Based on observation review, the facility for restriction was more hospitalizations for resident (R5) review based on observation review the facility facility facility facility impaired skin integro observed who was complications from Findings include: R5's cumulative dia indicated R5 was and diagnoses that inclu- bipolar disorder, and anxiety and depression disorder, narcotic di- behavior disorder, pend stage renal dis back pain, right har amputation, and so personality disorder R5's medical recording and the stage renal distant and the stage renal distant and the stage and stage renal distant and so personality disorder and the stage renal distant and so personality disorder and the stage renal distant and so personality disorder and the stage renal distant and so personality disorder and the stage renal distant and so personality disorder and the stage renal distant and so personality disorder and the stage renal distant and so personality disorder and the stage renal distant and so personality disorder and the stage renal distant and so personality disorder and the stage renal distant and so personality disorder and the stage renal distant and so personality disorder and the stage renal distant and so personality disorder and the stage renal distant and so personality disorder and the stage renal distant and so personality disorder and the stage renal distant and so personality disorder and the stage renal distant and so personality disorder and the stage renal distant and so personality disorder and the stage renal distant and so personality disorder and the stage renal distant and so personality disorder and the stage renal distant and so personality disorder and the stage renal distant and so personality disorder and the stage renal distant and so personality disorder and the stage renal distant and so personality disorder and the stage renal distant and so personality disorder and the sta	cility must ensure that ire dialysis receive such t with professional standards prehensive person-centered residents' goals and NT is not met as evidenced tion, interview, and document ailed to ensure dialysis fluid itored to minimize fluid overload for 1 of 1 wed for dialysis. In addition, on, interview, and document ailed to identify and monitor rity for 1 of 1 resident (R37) at risk for developing serious impaired skin integrity.	F 30	 The preparation of the following correction for this deficiency doe constitute and should not be inter as an admission nor an agreem facility of the truth of the facts al conclusions set forth in the state deficiencies. The plan of correct prepared for this deficiency was solely because provisions of state federal law require it. Without we foregoing statement, the facility with respect to: Fluid intake monitoring was implemented on R5. R37 impai integrity was identified, monitore received treatment. All resident care plans will be reviewed to insure that each incompassion should be and person-centered care of the It will also describe the services be furnished to attain or maintai resident's highest practicable, monitories and the dialysis center will be not results. All current residents will full body assessment completed evaluate skin integrity 	es not erpreted ent by the leged or ement of tion executed te and vaiving the states red skin d and e ludes a ffective e resident. that are to n the iental and ysis conitored otified w/ I have a to	

Facility ID: 00830

	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DAT COM	. 0938-039 TE SURVEY MPLETED
		245468	B. WING			C / 20/2017
NAME OF	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP		
KARLST	AD HEALTHCARE CE	INTER INC		304 WASHINGTON AVENUE WEST KARLSTAD, MN 56732	r	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
F 309	indicated R5 was ir impairment to the e understanding or ca communicate respo- personal needs for clothing, shelter or R5 two guardians. R5's quarterly Minir 7/6/17, indicated R3 deficits, R5 had ina- identified as inatter attention, being eas keeping track of wh also indicated R5 h symptoms present down, depressed, of having to little ener self-or that you are a family member do did not have any sy (hallucinations or d have verbal behavi others (threatening at others) 1-3 days R5 required extens for bed mobility and extensive assistand personal hygiene a unit using a wheeld ambulate, and was during transfers.	capacitated from mental extent lacking sufficient	F 30	9 to 11/29/17 regarding the r accurate care plans being person-centered and must services provided for their mental and psychosocial m Protocols with regard to co with dialysis have been rev 4. DNS or designee will a admission care plans for th months and 2 resident cha with regard to care plannin month. The data collected reviewed at the Monthly Q. Quarterly QA meeting. At committee will make the decision/recommendation follow-up studies. Completion Date 11/29/17	effectively t include physical, needs. ommunication vised. audit all new ne following 2 anges in needs ng weekly x2 will be API and that time the	

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				0.0938-039	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		TE SURVEY MPLETED	
		245468	B. WING _		10	C / 20/2017	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
KARLST	AD HEALTHCARE CE	ENTER INC		304 WASHINGTON AVENUE WEST KARLSTAD, MN 56732			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHC CROSS-REFERENCED TO THE APPP DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE	
F 309	fluids provided. R5 her the correct and dialysis diet. R5 sta much fluid she cons the surveyor a note down for each day. which identified how a day and many of complete. R5 also s not correct and she restriction was 32 c stated the dialysis u personal fluid intake believe her recordir to do better with flu did not want to kee fluid overload. Review of R5's und revealed there was however, when R5' reviewed a progres indicated a dialysis R5 should have no servings (960 cc) o Review of R5's care on 10/13/17, reveal identified, and the c her own fluid restric total intake to be dii nursing and to door care plan had not ic cc's of fluid was to	ast tray. R5 drank all of the stated the facility did not serve punt of fluids according to her ated she herself tracked how sumed each day and showed abook with numbers written However, there were no totals w much fluid was consumed in the days did not look stated the fluid calculation was a did not know if her fluid or 36 ounces per day. R5 unit had not even looked at her e log because they did not ngs. R5 stated she was trying id management because she p going into the hospital for	F 3(

Facility ID: 00830

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STATEMEN	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED
		245468	B. WING		C
NAME OF	PROVIDER OR SUPPLIER	2+3+00	D: 11110 _	STREET ADDRESS, CITY, STATE, ZIP CC	10/20/2017
	AD HEALTHCARE CE	ENTER INC		304 WASHINGTON AVENUE WEST KARLSTAD, MN 56732	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETION
F 309	Continued From pa	age 45	F 30	99	
	offering ice chips ir popsicle rather that	nimize fluid consumption like istead of water, offering a n juice, offering hard candy or mptoms of dry mouth.			
		5's medical record revealed and R5's fluid balance had not and monitored.			
	on 10/20/17, 9:50 a intake was not mor	nurse (LPN)-A was interviewed a.m. and stated R5's fluid nitored by the facility, and there where R5 was in regards to		ENS.	
	nurse manager wa fluid intake and mo manager stated R5 of fluid daily, and R dialysis nurse state her dry weight, and fluids between dialy dialysis nurse state record and monitor got close to daily to educated regarding non-compliance wi choices after being dialysis nurse state with the fluid restric month R5 had bee intake amounts. Th	59 a.m. the dialysis registered s interviewed regarding R5's nitoring. The dialysis nurse 5's fluid restriction was 1000 cc 55 was fluid overloaded. The ed R5 was 8-12 kilograms over 1 was gaining large amounts of ysis treatments (3-5 kg). The ed she expected the facility to r R5's fluid intake so when R5 otal of fluid intake, R5 could be g the risks and benefits of th fluid restrictions, and make provided the education. The ed R5 could be non-compliant ction, however, in the last n really trying to decrease fluid he dialysis registered nurse 5 had been hospitalized at least			

		AND HUMAN SERVICES				FORM	07/05/2018 APPROVED 0938-0391
-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	COM	E SURVEY IPLETED C
		245468	B. WING				20/2017
NAME OF I	PROVIDER OR SUPPLIER		•	ę	STREET ADDRESS, CITY, STATE, ZIP CODE		
KARLST	AD HEALTHCARE CE	INTER INC			304 WASHINGTON AVENUE WEST KARLSTAD, MN 56732		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 309	Continued From pa	ige 46	F3	309			
	R5 had been hospit twice in the last six 9/6/17. The Altru ho dated 9/8/17, indica hospital on 9/6/17, fluid overload, chro failure, and end sta dismissal summary compliant with fluid required hospitaliza runs were impleme fluid. The dismissal also been hospitaliza Altru hospital on 9/8 The hospitalization hospitalization 6/24 from the facility but Review of R5's dial 10/16/17, revealed (11-22 pounds) ove weight), and had no during any dialysis The director of nurs 10/20/17, at 10:32 a restrictions during w as still not monito fact R5 had been h on 4/4/14, and 9/6// dialysis unit asked intake. The DON st with fluid restriction	records for R5's /17- 6/28/17, were requested					

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STATEMEN	F OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	IPLE CONSTRUCTION	(X3) DA	D. 0938-039 TE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	IG	CO	MPLETED
		245468	B. WING _		10	C / 20/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
KARLST	AD HEALTHCARE CI	ENTER INC		304 WASHINGTON AVENUE WEST KARLSTAD, MN 56732		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETIOI DATE
F 309	DON confirmed a j because R5 was ir impairment to the e understanding or c communicate resp personal needs for clothing, shelter or did not respond wh capacity to make re decisions concerni R37 was at risk for complication and th report, and treat a R37's Diagnosis R diagnoses of diabe right below the kne vascular disease, o (infections of the b muscle weakness, (CKD) stage 3. R37's quarterly ME R37 had no cogniti independent with a he required superv R37's cognition ca indicated R37 had alteration in though in memory, judger	udge appointed R5 a guardian icapacitated from mental extent lacking sufficient apacity to make or onsible decisions concerning medical care, nutrition, safety. In addition, The DON hen asked if R5 had the mental esponsible and reasonable ng medical care. impaired skin integrity he facility failed to identify, current wound. eport dated 10/20/17, included tes type II, complete traumatic e amputation, peripheral chronic multifocal osteomyelitis one), edema, hypertension, and chronic kidney disease	F 30			

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F DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE CONSTRUCTION	(X3) DAT	<u>. 0938-039[.] E SURVEY</u>
CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG		IPLETED
	245468	B. WING			C 20/2017
OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STAT		
HEALTHCARE CE	ENTER INC		304 WASHINGTON AVENUE KARLSTAD, MN 56732	WEST	
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFI) TAG	((EACH CORRECTIVE CROSS-REFERENCED	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
nticoagulant thera irected daily skin i bnormalities to the he skin care plan se caution during revent striking arn urfaces that may o lursing Assistant C ay was on Monda (37's Comprehens /13/17, indicated F everely limited or wn weight and/or hair or wheelchair with friction and sho xtremities showed eripheral vascular ensation to lower indicated staff woul (37's medical reco kin impairment or nonitoring as direct on 10/18/17, at 7:5 eated in wheelchair vere not covered. ust below the knee	apy care plan dated 11/1/16, nspections and to report e nurse/medical practitioner. dated 11/1/16, directed staff to bed mobility and transfers to ns, legs, and hands against cause injury. R37's undated Care Plan indicated R37's bath ys. sive Skin Assessment dated R37's ability to walk was non-existent or could not bear must be assisted in/out of . R37 had a potential problem ear injuries, his lower d signs and symptoms of disease, and had loss of extremities. The assessment ld inspect skin daily. and did not reflect any current evidence of daily skin ted by the care plan. 54 a.m. R37 was observed air, and the lower extremities The right leg was amputated and the left leg had a dime	F 3	09		
	DVIDER OR SUPPLIER DVIDER OR SUPPLIER DEFICIENCIES DVIDER OR SUPPLIER DEFICIENCY SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From particles irected daily skin i bnormalities to the he skin care plan se caution during revent striking arm urfaces that may of lursing Assistant Of ay was on Monda Comprehense (13/17, indicated F everely limited or wn weight and/or hair or wheelchair rith friction and sho xtremities showed eripheral vascular ensation to lower adicated staff woul Continued Staff woul Continued From particles (13/17, indicated F everely limited or wn weight and/or hair or wheelchair rith friction and sho xtremities showed eripheral vascular ensation to lower adicated staff woul Contonitoring as direct Deficience and the showed is below the kneet ized light yellow/ref	EDEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245468 DVIDER OR SUPPLIER HEALTHCARE CENTER INC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 48 nticoagulant therapy care plan dated 11/1/16, irected daily skin inspections and to report bnormalities to the nurse/medical practitioner. he skin care plan dated 11/1/16, directed staff to se caution during bed mobility and transfers to revent striking arms, legs, and hands against urfaces that may cause injury. R37's undated lursing Assistant Care Plan indicated R37's bath ay was on Mondays. 837's Comprehensive Skin Assessment dated /13/17, indicated R37's ability to walk was everely limited or non-existent or could not bear win weight and/or must be assisted in/out of hair or wheelchair. R37 had a potential problem ith friction and shear injuries, his lower xtremities showed signs and symptoms of eripheral vascular disease, and had loss of ensation to lower extremities. The assessment idicated staff would inspect skin daily. 837's medical record did not reflect any current kin impairment or evidence of daily skin nonitoring as directed by the care plan. 0n 10/18/17, at 7:54 a.m. R37 was observed eated in wheelchair, and the lower extremities rere not covered. The right leg was amputated ist below the knee and the left leg had a dime ized light yellow/reddish thin scab on the outside	EDEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULT A. BUILDI 245468 B. WING OVIDER OR SUPPLIER 245468 PHEALTHCARE CENTER INC ID REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFID REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 48 nticoagulant therapy care plan dated 11/1/16, irrected daily skin inspections and to report bnormalities to the nurse/medical practitioner. he skin care plan dated 11/1/16, directed staff to se caution during bed mobility and transfers to revent striking arms, legs, and hands against urfaces that may cause injury. R37's undated lursing Assistant Care Plan indicated R37's bath ay was on Mondays. F 3 837's Comprehensive Skin Assessment dated /13/17, indicated R37's ability to walk was everely limited or non-existent or could not bear wn weight and/or must be assisted in/out of hair or wheelchair. R37 had a potential problem ith friction and shear injuries, his lower xtremities showed signs and symptoms of eripheral vascular disease, and had loss of ensation to lower extremities. The assessment idicated staff would inspect skin daily. 837's medical record did not reflect any current kin impairment or evidence of daily skin nonitoring as directed by the care plan. Nn 10/18/17, at 7:54 a.m. R37 was observed eated in wheelchair, and the lower extremities rere not covered. The right leg was amputated ist below the knee and the left leg had a dime ized light yellow/reddish thin scab on the outside	EDEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION DOWNEER 245468 BUILDING DVIDER OR SUPPLIER 245468 B. WING DVIDER OR SUPPLIER STREET ADDRESS, CITY, STAT 304 WASHINGTON AVENUE KARLSTAD, MN 56732 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX PROVIDER'S PLAN (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 48 ID ID ID CROSS-REFERENCED DEFICI F 309 Continued From page 48 F 309 Infaces that may cause injury. R37's undated lursing Assistant Care Plan indicated R37's bath ay was on Mondays. F 309 37'S Comprehensive Skin Assessment dated /13/17, indicated R37's ability to walk was everely limited or non-existent or could not bear wn weight and/or must be assisted in/out of hair or wheelchair. R37 had a potential problem ith friction and shear injuries, his lower xtremities showed signs and symptoms of eripheral vascular disease, and had loss of ensation to lower extremities. The assessment idicated staff would inspect skin daily. 87's medical record did not reflect any current kin impairment or evidence of daily skin nonitoring as directed by the care plan. Din 10/18/17, at 7:54 a.m. R37 was observed eated in wheelchair, and the lower extremities rere not covered. The right leg was amputated ist below the knee and the left leg had a dime	TOEFICIENCIES (N1) PROVIETRIVERULA (X2) MULTIPLE CONSTRUCTION (X3) DAT 2007 245468 B. WING 10/ 2010ER OR SUPPLIER 245468 B. WING 10/ 2010ER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES State1 AdDRESS, CITY, STATE, ZIP CODE 304 WASHINGTON AVENUE WEST KARLSTAD, MN 56732 SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ATTOMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION ID (EACH CORRECTIVE ATTOMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION ID (EACH CORRECTIVE ATTOMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION ID (EACH CORRECTIVE ATTOMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION ID (EACH CORRECTIVE ATTOMENT OF DEFICIENCY BLAN OF CORRECTION ID ID PROVIDER'S PLAN OF CORRECTION ID (EACH CORRECTIVE ATTOMENT OF DEFICIENCY BLAN OF CORRECTION ID ID PROVIDER'S PLAN OF CORNECTION ID (EACH CORRECTIVE ATTOMENT OR LISC IDENTIFYING IMFORMATION ID ID PROVIDER'S PLAN OF CORNECTION ID (Introduction at some plan dated 111/116, directed staff to secaution during bed

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TATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DA). 0938-039 TE SURVEY MPLETED
		245468			10	C / 20/2017
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 304 WASHINGTON AVENUE WEST KARLSTAD, MN 56732		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE
F 309	transferred into the report the wound to -at 12:58 p.m. NA-f was looked at durin resident contact an reported to the nurs On 10/19/17, at 3:4 nursing (ADON) sta R37's left leg woun his wheelchair back wound. The wound the scab had chang appeared to be thic measured, and dre he had received the when he bumped it transferring. R37 st about the wound be heal. The ADON st reported the chang nurse. Following th comprehensive skii for R37's wound. R37's Comprehens 10/19/2017, indicat area of concern to was dry with no dra centimeters (cm) x was 0.5 cm around he bumped it on the investigating the ar	jury a week ago when he wheelchair. The NAs failed to o the nurse, as directed. B stated the resident's skin ag daily cares or with each d areas of concern were se as soon as possible. 5 p.m. the assistant director of ated she was not informed of d. The ADON assisted R37 in to his room to assess the periphery was now red and ged to a darker red and eker. The ADON cleansed, ssed the wound. R37 stated e wound over a week ago on his wheelchair when tated he had not told anybody ecause he figured it would just ated the NAs should have e in skin condition to the is assessment, a n assessment was completed sive Skin Assessment dated ed R37 was found to have an left leg, near the knee which inage. Area measured 1.5 1.0 cm and surrounding skin scab like area. R37 reported	F 3			

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		AND HUMAN SERVICES			FORM	: 07/05/2018 APPROVED . 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	`´CON	E SURVEY IPLETED
		245468	B. WING _			20/2017
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	-	
KARLST	AD HEALTHCARE CE	INTER INC		304 WASHINGTON AVENUE WEST KARLSTAD, MN 56732		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 309	Continued From pa	ige 50	F 30	09		
	indicated maintenal part which caused to informed and prote diet plan, and the w the 24 hour clipboa Administration Rec provided to staff. On 10/20/2017, at 9 had put the new wo and provided educa reporting skin conc	ord, and education would be 9:51 a.m. ADON explained she bund interventions into place ation to the NAs about erns to the nurse timely. The E reported she had forgotten to				
	revised 11/2016, ind develop and implement each resident that i provide effective and resident that meet p quality of care and the services that an	Centered Care Plan Guideline, dicated the facility must nent a baseline care plan for ncluded instructions needed to nd person-centered care of the professional standards of the care plan must describe e to be furnished to attain or nt's highest practicable, social well-being.				
F 329 SS=D	A skin care policy w received. DRUG REGIMEN I UNNECESSARY D CFR(s): 483.45(d)(RUGS	F 32	29		11/29/17
		sary Drugs-General. Ig regimen must be free from				

Facility ID: 00830

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		AND HUMAN SERVICES				FORM	07/05/2018 APPROVED 0938-0391
-	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	COM	E SURVEY IPLETED C
		245468	B. WING				20/2017
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
KARLST	AD HEALTHCARE CE	INTER INC			804 WASHINGTON AVENUE WEST KARLSTAD, MN 56732		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 329	Continued From pa	ge 51	F 3	29			
		. An unnecessary drug is any					
	(1) In excessive do therapy); or	se (including duplicate drug					
	(2) For excessive d	uration; or					
	(3) Without adequa	te monitoring; or					
	(4) Without adequa	te indications for its use; or			C		
		of adverse consequences dose should be reduced or					
		ns of the reasons stated in hrough (5) of this section.					
	483.45(e) Psychotre Based on a compre- resident, the facility	hensive assessment of a					
	drugs are not given medication is neces	have not used psychotropic these drugs unless the ssary to treat a specific used and documented in the					
	gradual dose reduct interventions, unless an effort to disconti This REQUIREMENT by:	NT is not met as evidenced			The properation of the following of		
		tion, interview, and document ailed to obtain clear indication			The preparation of the following pl correction for this deficiency does r		

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					FORM /	07/05/2018 APPROVED 0938-0391
OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				COMF	E SURVEY PLETED
	245468	B. WING	ì			_ 20/2017
ROVIDER OR SUPPLIER			:	STREET ADDRESS, CITY, STATE, ZIP CODE		
D HEALTHCARE CE	NTER INC					
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION DATE
for the use of an an to monitor for effect (R35) reviewed for addition, failed to id behaviors/mood sym medications for 2 of failed to attempt tap gradual dose reduc medications for medications for medications for medications for medications for medications for use of antiseizur used for seizures of result could not momedication. R35's Diagnosis Rediagnoses of Alzhei disorder, hypothyro undifferentiated sch behavioral disturbat disabilities. R35's five day MDS as severely impaire ohysical behaviors antidepressant, ant medications. R35's Medication R	tiseizure medication in order tiveness for 1 of 5 residents unnecessary medications. In entify and analyze target mptoms for antidepressant f 5 residents (R6,R30) and bering of antidepressant and a tion of an antipsychotic edications for 1 of 5 residents unnecessary medications. d to obtain a clear indication re medication that could be r for behavior control and as a nitor for effectiveness of the eport dated 10/20/17, indicated mer's disease, anxiety idism Parkinson's disease, nizophrenia, dementia with nces, and profound intellectual 6 dated 9/18/17, identified R35 d, exhibited verbal and and received antipsychotic, ianxiety and antibiotic	F	329	 constitute and should not be interpreas an admission nor an agreement facility of the truth of the facts allege conclusions set forth in the stateme deficiencies. The plan of correction prepared for this deficiency was exercise solely because provisions of state a federal law require it. Without waivif foregoing statement, the facility stat with respect to: 1. R35 had a care plan review with changes made for the medication Carbamazepine for resident behavior along with interventions for behavior R35 has not had a history of seizure Pharmacy consultants state that wh Carbamazepine is being utilized for behaviors, checking routine levels is clinically indicated. R6 and R30 hav care plan reviews with updates to in target behavior/mood symptoms for psychotropic medications. R6 has b reviewed by consulting pharmacist for gradual dose reduction (GDR) of an antipsychotic on 11/13/17. 2. All residents will be reviewed th chart review for clear indication for medication use, to ensure that they care planned appropriately along with implemented for effectiveness. All residents have been reviewed for tabehaviors/mood symptoms with psychotropic medication use and G 3. Staff education will be complete 11/29/17 regarding: the need to additional complete to additional	by the ed or ent of ecuted ing the tes n ors rs. es. en sn't ve had include for n rough are / being nitoring arget DR's. ed by dress	
	S FOR MEDICARE OF DEFICIENCIES CORRECTION ROVIDER OR SUPPLIER D HEALTHCARE CE SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From pa for the use of an an to monitor for effect (R35) reviewed for addition, failed to id behaviors/mood syn medications for 2 o failed to attempt tap gradual dose reduce medications for me (R6) reviewed for u Findings include: R35 the facilty failer for use of antiseizur used for seizures o result could not mo medication. R35's Diagnosis Rediagnoses of Alzheid disorder, hypothyro undifferentiated sch behavioral disturband disabilities. R35's five day MDS as severely impaire ohysical behaviors antidepressant, ant medications. R35's Medication R	CORRECTION IDENTIFICATION NUMBER: 245468 IDENTIFICATION NUMBER: 245468 NOVIDER OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 52 for the use of an antiseizure medication in order to monitor for effectiveness for 1 of 5 residents (R35) reviewed for unnecessary medications. In addition, failed to identify and analyze target behaviors/mood symptoms for antidepressant medications for 2 of 5 residents (R6,R30) and failed to attempt tapering of antidepressant and a gradual dose reduction of an antipsychotic medications for medications for 1 of 5 residents (R6) reviewed for unnecessary medications. Findings include: R35 the facilty failed to obtain a clear indication for use of antiseizure medication that could be used for seizures or for behavior control and as a result could not monitor for effectiveness of the medication. R35's Diagnosis Report dated 10/20/17, indicated diagnoses of Alzheimer's disease, anxiety disorder, hypothyroidism Parkinson's disease, undifferentiated schizophrenia, dementia with behavioral disturbances, and profound intellectual disabilities. R35's five day MDS dated 9/18/17, identified R35 as severely impaired, exhibited verbal and ohysical behaviors and received antipsychotic, antidepressant, antianxiety and antibiotic	S FOR MEDICARE & MEDICAID SERVICES SF DEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MU A BUILT 245468 B. WING IOVIDER OR SUPPLIER 245468 B. WING D HEALTHCARE CENTER INC ID RECONTINUE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREF TAC Continued From page 52 for the use of an antiseizure medication in order to monitor for effectiveness for 1 of 5 residents (R35) reviewed for unnecessary medications. In addition, failed to identify and analyze target behaviors/mood symptoms for antidepressant medications for 2 of 5 residents (R6,R30) and ailed to attempt tapering of antidepressant and a gradual dose reduction of an antipsychotic medications for medications for 1 of 5 residents (R6) reviewed for unnecessary medications. Findings include: R35 the facility failed to obtain a clear indication for use of antiseizure medication that could be used for seizures or for behavior control and as a result could not monitor for effectiveness of the medication. R35's Diagnosis Report dated 10/20/17, indicated disgnoses of Alzheimer's disease, anxiety disorder, hypothyroidism Parkinson's disease, undifferentiated schizophrenia, dementia with behavioral disturbances, and profound intellectual disabilities. R35's five day MDS dated 9/18/17, identified R35 as severely impaired, exhibited verbal and ohysical behaviors and received antipsychotic, antidepressant, antianxiety and antibiotic medications.	S FOR MEDICARE & MEDICAID SERVICES SF DEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIP A. BUILDING 245468 B. WING	ALENT OF HEALTH AND HUMAN SERVICES ON S FOR MEDICARE & MEDICAID SERVICES ON S FOR MEDICARE & MEDICAID SERVICES ON OVIDER OR SUPPLIER 245468 D HEALTHCARE CENTER INC STREET ADDRESS, CITY, STATE, ZIP CODE SUMMARY STATEMENT OF DEFICIENCES B. WING EACH DEFICIENCY WIST BE PRECEDED BY FULL STREET ADDRESS, CITY, STATE, ZIP CODE SUMMARY STATEMENT OF DEFICIENCY B. WING Continued From page 52 Continued From page 52 F 329 Continued From page 52 F 329 Constitute and should not be interprised for this deciations. In addition, failed to identify and analyze target behavior. Conductions for 1 of 5 residents F 329 Findings include: F 329 Constitute and should not be interprise ant ada gradual dose reduction for medications. In addition, failed t	JENT OF HEALTH AND HUMAN SERVICES FORM S FOR MEDICARE & MEDICALS ESTICES OMB NO. IP DEFICIENCIES OMB NO. SPORT MEDICARE & MEDICALD SERVICES OMB NO. IP DEFICIENCIES OMB NO. IP DEFICIENCY STREET ADDRESS, CITY, STATE, JP CODE IP DEFICIENCY STREET ADDRESS, CITY, STATE, JP CODE SUMMARY STATEMENT OF DEFICIENCIES IP PROVIDER'S PLAN OF CORRECTION IP CALTHCARE CENTER INC IP PROVIDER'S PLAN OF CORRECTION Continued From page 52 IP S29 Continued From page 52 F 329 Continued From page 52 F 329 Continued From page 52 F S 329 Continued from macications for 1 of 5 residents Forewised for init deficiency was executed solely because provisions of state and fadditon, failed to identify and analyze target and antiscipant of a state and fadditon, failed to identify antion of an antipsychotic medication for medications for 1 of 5 residents R35 the facility failed to obtain a clear indication or use of antiseizure medication for medications for 1 of 5 residents Staf fadiculutaris reset ore brown orhorid ant acl

Facility ID: 00830

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STATEMENT	OF DEFICIENCIES F CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION	COM	E SURVEY PLETED
		245468	B. WING _				C 2 0/2017
NAME OF I	PROVIDER OR SUPPLIER	• •		STREE	T ADDRESS, CITY, STATE, ZIP CODE	-	
KARLST	AD HEALTHCARE CE	ENTER INC			ASHINGTON AVENUE WEST STAD, MN 56732		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIC DATE
F 329	300 milligrams (mg start date 12/14/16 Administration Rec indicated R35 rece milligrams in the ev October 2015, MAI R35 had resided in twice daily for beha R35's care plan, pr psychoactive media Risperdal, Celexa, care plan failed to in medication and had for either seizures On 10/2/17, at 9:05 nursing (ADON) sta identified the need carbamazepine. The aware of R35 exhibits stated R35's last car was conducted on (therapeutic referent ADON stated she wa anti-seizure medication, the monitoring needs, The ADON stated the MDS staff and discoresident health car	g) in the evening for seizures, a. R35's Medication cord (MAR) dated 10/17, ived carbamazepine 300 vening for seizures. R35's R from a previous facility where included carbamazepine 200 mg aviors. rint date 10/20/17, identified cation use of Zyprexa, Klonopin, and Buspar. The identify the use of seizure d not identified interventions	F 32	or l reg mo use 4. by adr me foll me foll me foll or o cor on on ens hav app not will Qu cor deo foll	behaviors warrant monitoring, jarding target behavior/ mood onitoring with psychotropic med e and; the process and need for Audits of care plans will be co DNS or designee with all new missions and for any resident f edication order changes for the owing 3 months to ensure that edication would be identified pre- e MDS, care plan, and the mor- eds identified and implemented designee will complete audits of mpletion of Monthly Behavior F all residents that have physicia 2 residents per week for 3 mo sure that proper care planning ve been attempted, or that the oropriate physician documenta t attempt a GDR. The data co l be reviewed at the Monthly Q arterly QA meeting. At that tim mmittee will make the cision/recommendation regard ow-up studies. mpletion Date 11/29/17	or GDR's. completed naving all operly on itoring d. DNS on the Reviews an orders on ths, to GDR's re is tion to lected API and ne the	
	On 10/20/17, at 1:1	16 p.m. the director of nursing					

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		AND HUMAN SERVICES				FORM	: 07/05/2018 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DAT CON	E SURVEY IPLETED C
		245468	B. WING				20/2017
NAME OF I	PROVIDER OR SUPPLIER		<u> </u>	ę	STREET ADDRESS, CITY, STATE, ZIP CODE		
KARLST	AD HEALTHCARE CE	ENTER INC			304 WASHINGTON AVENUE WEST KARLSTAD, MN 56732		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 329	medications should accurately on the M monitoring needs in The DON stated the plans were seriouslineeds, which was g R6's medication reg analyzed target mo antidepressant use tapering or had phy use. In addition, ha reduction or had a p going antipsychotic R6's Diagnosis Reg diagnoses of major disorder, and schize R6's annual MDS d moderate cognitive symptoms of delirit no depressive symp indicated R6 had phy behaviors 1-3 days and received antips medications. R6's physician order facility on 10/20/17 -Latuda (atypical ar used to treat bipola evening for schizoa 7/26/16.	A35's use of anti-seizure I have been identified ADS, care plan, and the dentified and implemented. ey had identified resident care ly lacking identified residents' going to be addressed. gimen had not identified or od symptoms for and had not attempted vsician justification for ongoing d not attempted a dose physician justification for on e medication.	F 3	329			

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TATEMENT	OF DEFICIENCIES OF CORRECTION	KANDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DA	D. 0938-039 TE SURVEY MPLETED
		245468	B. WING _		10	C)/ 20/2017
NAME OF I	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CO	DE	
KARLST	AD HEALTHCARE CE	ENTER INC		304 WASHINGTON AVENUE WEST KARLSTAD, MN 56732		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 329	-Trazodone (antide bedtime for major of 4/21/17. However, clear indication for antidepressant me comprehensive ass	bression. Start date of 7/26/16. pressant medication) 50 mg at depressive disorder. Start date the medical record lacked any adding an addition dication and did not reflect a sessment of depressive of current medications at the	F 32	29	\bigcirc	
	R6's care plan prov 10/20/17, and last r received psychotro schizoaffective disc Interventions direct pharmacy, medical reduction when clin gradual dose reduc behavior managem medication use. Th received antianxiet related to anxiety a directed to adminis ordered, to attempt interventions of rec go to her room awa observe the effectiv However, the care	ted staff to consult with practitioner to consider dose nically appropriate, follow stion protocols, and develop a nent program with alternative to be plan also indicated R6 y/antidepressant medications nd depression. Interventions ter antianxiety medication as a non-pharmacological lirection, diversion, have her ay from other residents, and to veness of the interventions. plan failed to identify R6's et mood symptoms of		RENS		
	7/12/17, and 8/1/17 symptoms for antid medications. Additi	navior Evaluations dated 7, also lacked identified mood lepressant/antianxiety onally, the behavior evaluation ne target behaviors for				

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ND PLAN (OF DEFICIENCIES	KEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DA	0. 0938-039 TE SURVEY MPLETED
		245468	B. WING		10	C / 20/2017
NAME OF	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CO	DDE	
KARLST	AD HEALTHCARE CE	ENTER INC		304 WASHINGTON AVENUE WEST KARLSTAD, MN 56732		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		SHOULD BE	(X5) COMPLETIO DATE
F 329	Continued From pa	age 56	F 3	329		
	lacked an indication	Furthermore, the evaluation n or rationale to continue the chotic and antidepressant				
	were reviewed from through October 20 but not received). T behavior of sexual/ antipsychotic use. sexual/negative cor record was docume made a sexually ba TV with a male res	ministration Records (TARS) in January-March and June 017 (April and May requested The TARs identified the target (negative comments for the The only incident of mments identified in R6's ented on 9/24/17, when R6 ased comment while watching ident. The TARs had not s for antidepressant use.				
	dated 6/19/17, indic	provider consult referral note cated R6 was excessively he appointment and reported				

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STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			MB NO. 0 (X3) DATE S COMPL	SURVEY LETED
		245468	B. WING			0/2017
	PROVIDER OR SUPPLIER		30	REET ADDRESS, CITY, STATE, ZIP CODE 4 WASHINGTON AVENUE WEST ARLSTAD, MN 56732		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 329	and schizoaffective psychiatric medicat notes lacked a reas the psychotropic m On 10/16/17, at 5:4 seated in her reclin R6 fell asleep multi interview and was o overall facial expres emotion in respons On 10/18/17, at 7:1 awake sitting up in occasionally felt do didn't feel like doing sometimes felt anx would report tightne breath, and felt resi know what the staff down, depressed, o stated she went to that helped with her explained she ofter On 10/20/17, at 9:0 sleeping in a chair i 12:58 p.m. NA-B st only every once in a down when she did On 10/20/17, at 9:3 (LPN)-A stated R6 varied, sometimes	disorder were stable with no ion changes. The physician son or justification to continue edications at the same doses. 4 p.m. R6 was observed er in her room watching TV. ple times during the resident difficult to keep awake. Her ssions were flat with little es to questions. 2 a.m. R6 was observed the recliner. R6 explained she wn or depressed and she g anything. She stated she ious and overwhelmed and ess in her chest, short of tless. R6 stated she didn't did for her when she felt or anxious. However, R6 a psych doctor and thought r mood symptoms. R6	F 329			

		AND HUMAN SERVICES			FORM	: 07/05/201 APPROVE . 0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	CON	TE SURVEY MPLETED C
		245468	B. WING			/20/2017
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	-	
KARLST	AD HEALTHCARE CE			304 WASHINGTON AVENUE WEST		
_		-		KARLSTAD, MN 56732		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION) CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 329	she would holler at directed at staff. LF one to one visits, a talk to which perks Trazodone was for most of the night. On 10/18/17, at 1:5 (LSW) verified the symptoms identified antidepressant/anti target behavior of s been identified for t On 10/19/17, at 9:4 nursing (ADON) co have a process in p analysis and/or eva mediations. ADON symptoms should b monitored, and eva On 10/20/17, at 1:4 the consulting phar 10/23/17, at 1:35 p and confirmed he f	staff and use profanities PN-A indicated staff provided nd called her friend for her to her up. LPN-A thought the sleep because R6 was up 57 p.m. licensed social worker re were no target/mood				
	behaviors/mood sy effectiveness, and behaviors/mood sy care plan with corre	acility staff to identify target mptoms, to monitor for would also expect the target mptoms to be identified on the esponding interventions. egimen had not identified or bod symptoms for				

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		AND HUMAN SERVICES				FORM	07/05/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DAT COM	E SURVEY PLETED
		245468	B. WING				C 20/2017
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 304 WASHINGTON AVENUE WEST KARLSTAD, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 329	Continued From pa antidepressant use	-	F3	329	9		
	included diagnoses	Sheet dated 10/20/17, of dementia without nce, anxiety disorder, and isorder.					
	had severe cognitive behaviors directed days during the asses not been a change previous assessment depressive symptot	dated 8/4/17, indicated R30 re impairment and had verbal towards others one to three sessment period and there had in behaviors since the ent. The MDS identified ms of difficulty with sleep and ng little energy and trouble			RENISE		
	milligrams every me disorder with a star mirtazapine 15 mg	ders included Celexa 20 orning for major depressive t date of 5/22/17, and every bedtime for major r (last dose change 4/11/17).					
	facility on 10/20/17, antianxiety medicat anxiety, and appetin feelings of sadness characterized by in fearfulness last rev plan directed staff t non-pharmacologic for effectiveness, p oil message, diversi	nted and provided by the indicated antidepressant and ion use related to depression, te stimulation. R30 had s, anxiety, and depression effective coping and ised on 12/21/16. The care o attempt ral interventions and observe rovide nourishment, essential ion, word finds, liked to look at o bring to a quiet area at night					

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		AND HUMAN SERVICES			FORM	: 07/05/201 APPROVE . 0938-039	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED C		
		245468	B. WING			20/2017	
NAME OF I	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE			
KARLST	AD HEALTHCARE CE	ENTER INC	304 WASHINGTON AVENUE WEST KARLSTAD, MN 56732				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT	LD BE	(X5) COMPLETIO DATE	
F 329	consult with pharm. consider dosage rea appropriate, observe effectiveness, and get ready for bed a R30's physician order indicated target belarestless, crawling of bring R30 to a quie The physician order document the effect used. The physician target mood sympto were reviewed for the revealed one docume when R30 was rest on 9/1/17. R30's progress numeration included refusals of agitation, resistive the identified on the car R30's Mood and Bas 8/4/17, lacked identified on the car R30's Mood and Bas	The plan also directed staff to acy/medical practitioner to eductions when clinically ve/document side effects and do not just take to room and s this would cause anxiety. ders dated 12/29/16, and TAR haviors for anxiety were but of bed and directed staff to et area and offer nourishment. For also directed staff to et area and offer nourishment. For anxiety medication for depression. The TARs the last three months and mented episode on 9/1/17, these and crawling out of bed For anxiety notes mot and mood symptoms which f medication, cares and meals, to cares, and hitting out at se symptoms were not re plan. The anxiety medication. The tage of the medication dated tified mood symptoms for fanxiety medication. The tage of the medication. The tage of the medication. The tage of the medication.	F 3				

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		AND HUMAN SERVICES				FORM	APPROVED
		& MEDICAID SERVICES					0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
			A. BOILDI	ina			C
		245468	B. WING				20/2017
NAME OF F	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
KARLST	AD HEALTHCARE CE			-	04 WASHINGTON AVENUE WEST		
_				K	KARLSTAD, MN 56732		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 329	Continued From pa	ge 61	F 3	29			
	calmly lying in bed a pleasant, she smile words including her stated R30 had refu once R30 refused, s R30 would become too many questions On 10/17/17, at 9:1 seated in the lobby calm and looking ar only smiled without On 10/18/17, at 7:1 resting in bed with r -At 7:53 a.m. R30's awake. -At 8:24 a.m. NA-A assisted R30 with n verbal cues during t calm, cooperative, a evidence of any bet NA-A explained R30 and if she did not lik them away. NA-A si included pushing st her behaviors were have a problem with would use intervent something to eat, a time.	8 a.m. R30 was observed area in her pajamas. R30 was round. When questioned, R30 verbally responding. 0 a.m. R30 was observed her eyes closed. s remained in bed, calmly entered the room and norning cares. NA-A gave the cares, which R30 was and followed cues without havioral or mood symptoms. 0 did better with older NA's ke someone she would wave tated R30's behaviors aff away, refusing care and sporadic and usually did not h redirection. NA-A stated staff ions such as toileting, offer nd/or re-approaching at a later					
		1 a.m. NA-C reported R30 cratch, and refuse meals.					

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	<u> SFOR MEDICARE</u> OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MI II T	TIPLE CONSTRUCTION). 0938-039 TE SURVEY
-	OF CORRECTION	IDENTIFICATION NUMBER:		NG		MPLETED
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		245468	B. WING _			/20/2017
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC	DE	
KARLST	AD HEALTHCARE CE	ENTER INC		304 WASHINGTON AVENUE WEST KARLSTAD, MN 56732		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 329	Continued From pa	age 62	F 32	29		
	different staff mem	entions included getting a ber, getting more help, a later time, and nails were				
	-At 9:37 a.m. licensed practical nurse (LPN)-A reported R30 hit staff during cares, refused cares, refused medications, and would throw objects across the room. LPN-A explained when R30 exhibited the behaviors they would re-approach and use different staff members.			S		
	behaviors once in a angry, or tired whic facial expressions. the NA's or shake h something and staf doing and help her	B explained R30 had a while when she was mad, h was was displayed by her NA-B stated R30 would tap on her fist when she did not like if were to stop what they were calm down by sitting with her t you are doing step by step or h later.		REN		
	there was no evalu moods and the car R30's behaviors/mo facility did not have ongoing analysis an psychotropic media mood symptoms sh	15 a.m. the ADON verified ation of R30's behaviors or e plan did not identify all of oods. ADON explained the e a process in place to ensure nd/or evaluation of ations and confirmed target nould have been identified on itored, and evaluated for				
	revised 5/15/2003 i	ntipsychotic Medication last included; ng would be ongoing to indicate				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		TE SURVEY MPLETED C
		245468	B. WING _		10)/20/2017
NAME OF I	PROVIDER OR SUPPLIER	·	·	STREET ADDRESS, CITY, STATE, ZIP CODE		
KARLST	AD HEALTHCARE CE	ENTER INC		304 WASHINGTON AVENUE WEST KARLSTAD, MN 56732		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHC CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
F 329	utilization and conti psychoactive media to their use, and co- least every six mor Facility policy Mood Guidelines last revit - The facility suppo- underlying cause of appropriate treatme and/or behavioral in psychopharmacolo utilized to meet the -Efforts to reduce of psychopharmacolo ongoing for the clinin -A mood and behave completed for all re- quarterly, annually, status and prior to of psychoactive me for the medication a related to the use of indicated the evalue appropriate use of documentation of or rationale for contine -The nurse and/or to specific target behave the care plan is upo- has been appropriate	edication y care team will evaluate the inued need for the cation and pursue alternatives onsider medication reduction at oths. d and Behavior Documentation ised 11/16, indicated: rts the goal of determining the f behavioral symptoms so the ent of environmental, medical, nterventions as well as gical medication can be needs of the resident. dosage or discontinue gical medications would be ical situation. vior evaluation will be esidents on admission, with significant change in the use of, and/or dose change edication to evaluate the need and determine target behavior of the medication. The policy ation included assessment, medications, and lose reductions or provides ued use of medication regimen the social worker to define the avior/symptoms and to verify dated to ensure the problem ately identified.	F 32			11/20/17
F 428 SS=D	DRUG REGIMEN I IRREGULAR, ACT		F 42	28		11/29/17

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		AND HUMAN SERVICES				FORM	APPROVED
	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPL	E CONSTRUCTION		0938-0391 SURVEY
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	NG_			PLETED
		245468	B. WING _				C 2 0/2017
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
KARLST	AD HEALTHCARE CE	NTER INC			04 WASHINGTON AVENUE WEST ARLSTAD, MN 56732		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
	Continued From pa c) Drug Regimen R (1) The drug regime reviewed at least or pharmacist. (3) A psychotropic of brain activities asso and behavior. Thes limited to, drugs in t (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-depressant; (iii) Anti-depressant; (iii) Anti-depressant; (iii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. (4) The pharmacist to the attending phy facility's medical dir and these reports m (i) Irregularities includ drug that meets the (d) of this section for (ii) Any irregularities during this review m separate, written re attending physician director and directo minimum, the reside and the irregularity for (iii) The attending p	ge 64 eview en of each resident must be nee a month by a licensed drug is any drug that affects beciated with mental processes be drugs include, but are not the following categories: d must report any irregularities visician and the ector and director of nursing,	TAG	28		RIATE	DATE
		and should be a second se					

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		AND HUMAN SERVICES	-				APPROVE[0938-039 ⁻
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (>	COMF	SURVEY PLETED
		245468	B. WING			C 10/2) 20/2017
NAME OF I	PROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
KARLST	AD HEALTHCARE CE				04 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 PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 428	physician should do the resident's media (5) The facility mus and procedures for review that include, frames for the differ steps the pharmaci identifies an irregula to protect the reside This REQUIREMEN by: Based on interview facility failed to ens identified the lack o symptoms for the u medications for 2 o failed to identify the dose reduction/dos physician justification reduction for 1 of 5 unnecessary medic Findings include; R6's medication reg analyzed target mo antidepressant use tapering or had phy use. In addition, had	boument his or her rationale in cal record. t develop and maintain policies the monthly drug regimen but are not limited to, time rent steps in the process and st must take when he or she arity that requires urgent action ent. NT is not met as evidenced v and document review, the ure the consultant pharmacist of target behaviors/mood se of psychotropic f 5 residents (R6, R30) and e taper and/or lack of a on for not attempting a dose residents (R6) reviewed for cations.	F 4	-28	The preparation of the following plar correction for this deficiency does no constitute and should not be interpre as an admission nor an agreement b facility of the truth of the facts alleged conclusions set forth in the statemen deficiencies. The plan of correction prepared for this deficiency was exect solely because provisions of state an federal law require it. Without waivin foregoing statement, the facility state with respect to: 1. R6 and R30 have had consulting pharmacist reviews regarding psychotropic medications. R6's care has been reviewed with individualized target mood symptoms of depression /anxiety have been added. 2. All residents have been reviewed GDR's w/ regards to psychotropic medication and care plans have been audited for appropriate target mood symptoms/behaviors.	ot sted by the d or nt of cuted nd ng the es plan d n d for	
		port dated 10/20/17, included depressive disorder, anxiety oaffective disorder.			 Staff education will be completed 11/29/17 regarding the Monthly Mood Behavior Program. DNS or designee will complete a 	d and	

Facility ID: 00830

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		AND HUMAN SERVICES				FORM	07/05/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATI COM	E SURVEY PLETED
		245468	B. WING				C 20/2017
	PROVIDER OR SUPPLIER			30	TREET ADDRESS, CITY, STATE, ZIP CODE 04 WASHINGTON AVENUE WEST (ARLSTAD, MN 56732		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 428	moderate cognitive symptoms of deliriu no depressive symp indicated R6 had po behaviors 1-3 days and received antips medications. R6's physician order facility on 10/20/17 -Latuda (atypical ar used to treat bipola evening for schizoa 7/26/16. -Lexapro (antidepre- the morning for dep -Trazodone (antide bedtime for major of 4/21/17. However, clear indication for antidepressant med comprehensive ass symptoms, efficacy time and any other anxiety/depression R6's care plan prov 10/20/17, and last r received psychotrop schizoaffective disc Interventions direct pharmacy, medical	lated 8/1/17, indicated R6 had impairment, no signs and im, delusions, hallucinations, ptoms. The MDS also roblems with sleep, had verbal during the assessment period sychotic and antidepressant ers printed and provided by the included the following orders: nti-antipsychotic medication r depression) 80 mg in the effective disorder. Start date of essant medication) 15 mg in pression. Start date of 7/26/16. pressant medication) 50 mg at depressive disorder. Start date the medical record lacked any adding an addition dication and did not reflect a sessment of depressive of current medications at the episodes of between 3/22/17, and 4/22/17.	F 4	.28	on the completion of Monthly Beha Reviews on all residents that have physician orders on 2 residents per for 3 months, to ensure that proper planning GDR's have been attempt documentation to not attempt a GL The data collected will be reviewed Monthly QAPI and Quarterly QA ma At that time the committee will make decision/recommendation regarding follow-up studies. Completion date 11/29/17	r week care ted, or OR. at the seting. te the	

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TATEMEN	OF DEFICIENCIES	A MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DA	0. 0938-039 TE SURVEY MPLETED
		245468	B. WING _		10	C / 20/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	
KARLST	AD HEALTHCARE CE	ENTER INC		304 WASHINGTON AVENUE WEST KARLSTAD, MN 56732		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPP DEFICIENCY)	JLD BE	(X5) COMPLETIC DATE
F 428	gradual dose reduce behavior managem medication use. The received antianxiet related to anxiety a directed to administ ordered, to attempt interventions of record go to her room awa observe the effective However, the care individualized target depression and or R6's Mood and Bel 7/12/17, and 8/1/17 symptoms for antion medications. Additi had not analyzed the antipsychotic use. lacked an indication use of both antipsy medications. R6's Treatment Ad were reviewed from through October 20 but not received). The behavior of sexual/ antipsychotic use. sexual/negative co- record was docum- made a sexually ba TV with a male rest	ction protocols, and develop a nent program with alternative to ne plan also indicated R6 y/antidepressant medications and depression. Interventions ther antianxiety medication as t non-pharmacological direction, diversion, have her ay from other residents, and to veness of the interventions. plan failed to identify R6's et mood symptoms of	F 42			

Facility ID: 00830

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TATEMENT	OF DEFICIENCIES F CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DA	<u>). 0938-039</u> TE SURVEY MPLETED C	
		245468	B. WING _		10)/20/2017	
NAME OF F	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, Z			
KARLST	AD HEALTHCARE CE	ENTER INC		304 WASHINGTON AVENUE WE KARLSTAD, MN 56732	ST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE	
F 428	Continued From pa	age 68	F 42	28			
	somnolent during the complaints of mild anxiety and really we than anything. The of mental illness are the history, and the with recurrent depri- indicated there was quantifiable docum symptoms to determ recommend change physician did not re- medication change daytime napping.	cated R6 was excessively he appointment and reported depression and occasional wanted help with sleep more physician identified the history and R6 was unable to describe history was more consistent ression. The physician also is not enough history or mentation of behaviors or mood mine definitive diagnoses or es to medication dosages. The ecommend any psychiatric as and recommended no	e				
	and 9/12/17, indica and schizoaffective psychiatric medicat notes lacked a reas	t notes dated, 6/20/17, 7/12/17 ated R6's depression, anxiety, e disorder were stable with no tion changes. The physician son or justification to continue redications at the same doses.					
	February through C and revealed the co identified the lack c symptoms or recon reduction for the ar	ledication Reviews from October 2017, were reviewed onsulting pharmacist had not of target behaviors/mood nmended a gradual dose ntipsychotic medication or a antidepressant medications.					
	seated in her reclin R6 fell asleep multi	14 p.m. R6 was observed her in her room watching TV. iple times during the resident difficult to keep awake. Her					
		AND HUMAN SERVICES				FORM	APPROVED 0938-0391
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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245468	B. WING				C 20/2017
NAME OF F	PROVIDER OR SUPPLIER	-	-	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	AD HEALTHCARE CE			3	04 WASHINGTON AVENUE WEST		
KARLOI	AD HEALINGARE CE			K	ARLSTAD, MN 56732		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 428	emotion in respons On 10/18/17, at 7: awake sitting up in occasionally felt doo didn't feel like doing sometimes felt anxi would report tightne breath, and felt rest know what the staff down, depressed, o stated she went to a that helped with her explained she often On 10/20/17, at 9:0 sleeping in a chair i 12:58 p.m. NA-B st only every once in a down when she did On 10/20/17, at 9:3 (LPN)-A stated R6 varied, sometimes refused cares and v she would holler at directed at staff. LP one to one visits, ar talk to which perks	12 a.m. R6 was observed the recliner. R6 explained she wn or depressed and she g anything. She stated she ious and overwhelmed and ess in her chest, short of tless. R6 stated she didn't did for her when she felt or anxious. However, R6 a psych doctor and thought r mood symptoms. R6	F 4	428			
		7 p.m. licensed social worker re were no target/mood					

Facility ID: 00830

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		AND HUMAN SERVICES				FORM	07/05/2018 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	COM	E SURVEY PLETED C
		245468	B. WING	i			0 20/2017
NAME OF F	ROVIDER OR SUPPLIER	L			STREET ADDRESS, CITY, STATE, ZIP CODE		
KARLST	AD HEALTHCARE CE	INTER INC			304 WASHINGTON AVENUE WEST		
					KARLSTAD, 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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 428	target behavior of s been identified for t On 10/19/17, at 9:4 nursing (ADON) co have a process in p analysis and/or eva mediations. ADON symptoms should b monitored, and eva On 10/20/17, at 1:4 the consulting phar 10/23/17, at 1:35 p. and confirmed he h reduction, had not I and expected the fa behaviors/mood syn effectiveness, and v behaviors/mood syn care plan with correct R30's medication re analyzed target mo antidepressant use R30's facility Face 3 included diagnoses	d for the use of the anxiety medication however, a sexual/negative comments had the antipsychotic medication. 5 a.m. the assistant director of nfirmed the facility did not blace to ensure ongoing iluation of psychotropic also indicated target mood be identified on the care plan, iluated for efficacy. 5 p.m. attempted to contact macist (CP) for interview. On .m. CP returned the phone call had not recommended a dose ooked for target behaviors, acility staff to identify target mptoms, to monitor for would also expect the target mptoms to be identified on the esponding interventions. egimen had not identified or od symptoms for Sheet dated 10/20/17, a of dementia without nce, anxiety disorder, and	F 4	428			
	R30's annual MDS	dated 8/4/17, indicated R30			acility ID: 00830		

TATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DA). 0938-039 TE SURVEY MPLETED
		245468	B. WING		10	C / 20/2017
NAME OF F	PROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, 2		
KARLST	AD HEALTHCARE CE	INTER INC		304 WASHINGTON AVENUE WE KARLSTAD, MN 56732	EST	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 428	behaviors directed days during the ass not been a change previous assessme depressive symptor feeling tired or havi concentrating. R30's physician ord milligrams every me disorder with a star mirtazapine 15 mg depressive disorde R30's care plan prin facility on 10/20/17, antianxiety medicat anxiety, and appetin feelings of sadness characterized by in- fearfulness last rev plan directed staff t non-pharmacologic for effectiveness, p oil message, divers newspapers, and to if anxious in room. consult with pharma consider dosage re appropriate, observe	ve impairment and had verbal towards others one to three sessment period and there had in behaviors since the ent. The MDS identified ms of difficulty with sleep and ng little energy and trouble ders included Celexa 20 orning for major depressive t date of 5/22/17, and every bedtime for major r (last dose change 4/11/17). Inted and provided by the , indicated antidepressant and tion use related to depression, te stimulation. R30 had s, anxiety, and depression effective coping and ised on 12/21/16. The care				
		ders dated 12/29/16, and TAR naviors for anxiety were				

		AND HUMAN SERVICES				FORM	: 07/05/201 APPROVE . 0938-039	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	CON	E SURVEY IPLETED C	
		245468	B. WING			10/20/2017		
NAME OF F	PROVIDER OR SUPPLIER			ę	STREET ADDRESS, CITY, STATE, ZIP CODE			
KARLST	AD HEALTHCARE CE	ENTER INC			304 WASHINGTON AVENUE WEST KARLSTAD, MN 56732			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETIO DATE	
F 428	restless, crawling of bring R30 to a quie The physician orde document the effect used. The physicia target mood sympti- were reviewed for t revealed one docut when R30 was rest on 9/1/17. R30's progress nur reviewed from 7/17 identified behavior included refusals o agitation, resistive is staff. However, the identified on the ca R30's Mood and B6 8/4/17, lacked iden antidepressant/anti Review of R30's ph 6/20/17, through 7/ and anxiety were s R30's Pharmacist February through 0 the consulting phar lack of target behavior On 10/16/17, at 5:1	but of bed and directed staff to but of bed and offer nourishment. Frs also directed staff to ctiveness of the medication n's orders did not identify oms for depression. The TARs the last three months and mented episode on 9/1/17, tless and crawling out of bed rsing progress notes were 7/17, through 10/16/17, and and mood symptoms which f medication, cares and meals, to cares, and hitting out at se symptoms were not re plan. ehavior Evaluation dated tified mood symptoms for ianxiety medication. hysician visit notes from (11/17, indicated depression table. Medication Reviews from October 2017, were reviewed; macist had not identified the viors/mood symptoms.	F	128				
		3 a.m. R30 was observed awake. R30's mood was						

		AND HUMAN SERVICES				FORM	07/05/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DAT CON	E SURVEY IPLETED
		245468	B. WING				C 20/2017
	PROVIDER OR SUPPLIER			3	STREET ADDRESS, CITY, STATE, ZIP CODE 304 WASHINGTON AVENUE WEST KARLSTAD, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 428	pleasant, she smile words including her stated R30 had refu once R30 refused, R30 would become too many questions On 10/17/17, at 9:1 seated in the lobby calm and looking at only smiled without On 10/18/17, at 7:1 resting in bed with I -At 7:53 a.m. R30's awake. -At 8:24 a.m. NA-A assisted R30 with r verbal cues during calm, cooperative, a evidence of any bel NA-A explained R3 and if she did not lift them away. NA-A s included pushing st her behaviors were have a problem witt would use intervent something to eat, a time. On 10/20/17, at 9:3 liked to hit, pinch, s NA-C stated intervent different staff memil	 and was unable to articulate r name. At 6:20 p.m. the DON used dinner and explained staff did not persist because every easily agitated if asked s. 8 a.m. R30 was observed area in her pajamas. R30 was round. When questioned, R30 verbally responding. 0 a.m. R30 was observed 	F 4	128			

		AND HUMAN SERVICES				FORM	07/05/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT CON	E SURVEY PLETED
		245468	B. WING			C 10/20/2017	
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	•	
KARLST	AD HEALTHCARE CE	INTER INC			04 WASHINGTON AVENUE WEST (ARLSTAD, MN 56732		
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F 428	Continued From pa kept short.	ige 74	F 4	28			
	cares, refused care would throw objects explained when R3	A reported R30 hit staff during es, refused medications, and s across the room. LPN-A 0 exhibited the behaviors they and use different staff					
	behaviors once in a angry, or tired whic facial expressions. the NA's or shake h something and staf doing and help her	B explained R30 had a while when she was mad, h was was displayed by her NA-B stated R30 would tap on her fist when she did not like f were to stop what they were calm down by sitting with her t you are doing step by step or later.			RENS		
	there was no evalua moods and the care R30's behaviors/mo facility did not have ongoing analysis ar psychotropic media mood symptoms sh	5 a.m. the ADON verified ation of R30's behaviors or e plan did not identify all of bods. ADON explained the a process in place to ensure nd/or evaluation of tions and confirmed target hould have been identified on tored, and evaluated for					
	the consulting phar 10/23/17, at 1:35 p. and confirmed he h	5 p.m. attempted to contact macist (CP) for interview. On m. CP returned the phone call ad not looked for target ected the facility staff to					

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				1 APPROVE). 0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		TE SURVEY
		245468	B. WING		10	C / 20/2017
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
KARLST	AD HEALTHCARE CE	ENTER INC		304 WASHINGTON AVENUE WEST KARLSTAD, MN 56732		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIOI DATE
F 428	Continued From pa	age 75	F 4	28		
	monitor for effective the target behavior	aviors/mood symptoms, to eness, and would also expect s/mood symptoms to be are plan with corresponding				
	Facility policy for Antipsychotic Medication last revised 5/15/2003 included; -behavior monitoring would be ongoing to indicate the effect of the medication -the interdisciplinary care team will evaluate the utilization and continued need for the psychoactive medication and pursue alternatives to their use, and consider medication reduction at least every six months.					
	Guidelines last revi - The facility support underlying cause of appropriate treatmost and/or behavioral in psychopharmacolor utilized to meet the	d and Behavior Documentation ised 11/16 included: orts the goal of determining the f behavioral symptoms so the ent of environmental, medical, nterventions as well as ogical medication can be e needs of the resident. dosage or discontinue				

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STATEMENT OF DERCIENCIES (XI) PROVIDERSUPPLIER/LIA (XI) PROVIDERSUPPLIER/LIA (XI) PROVIDERSUPPLIER/LIA (XI) PROVIDERSUPPLIER/LIA (XI) PROVIDERSUPPLIER/LIA (XII) PROVIDERSUPPLIER/LIA (XIII) PROVIDERSUPPLIER/LIA (XIIII) PROVIDERSUPPLIER/LIA (XIIIIIIII) PROVIDERSUPPLIER/LIA (XIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII			I AND HUMAN SERVICES E & MEDICAID SERVICES			FORM): 07/05/2018 /I APPROVED). 0938-0391
245468 B. WING 10/20/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, 217 10/20/2017 KARLSTAD HEALTHCARE CENTER INC STREET ADDRESS, CITY, STATE, 217 Common State Providers Plance 20/20/2017 PRETX SUMMARY STATEMENT OF DEFICIENCIES STREET ADDRESS, CITY, STATE, 217 Common State Providers Plance Consections Common State Plance Consections Common State Providers Plance Consections Common State Providers Plance Consections Common State Providers Plance Consections Common State Plance Consections	-					COMPLETED	
304 WASHINGTON AVENUE WEST KARLSTAD, MN 56732 CMAIL STAD, MN 56732 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION) ID PREFIX TAG D PREFIX FAG D CACH CORPECTIVE (EACH CORPECTIVE ACTION SHOULD BE DEFICIENCY) O COME (EACH DEFICIENCY) F 428 Continued From page 76 -The nurse and/or the social worker to define the specific target behavior/symptoms and to verify the care plan is updated to ensure the problem has been appropriately identified. F 428 F 441 F 441 F 441 INFECTION CONTROL, PREVENT SPREAD, LINENS CFR(s): 483.80(a)(1)(2)(4)(e)(f) F 441 F 441 11/29/17 (a) Infection prevention and control program (IPCP) that must include, at a minimum, the following elements: F 441 F 441 (1) A system for preventing, identifying, reporting, investigating, and control ing residents, staff, voluncers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment implementation is Phase 2); F 441 III/29/17 (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: () A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the tacility; (i) When and to whom possible incidents of communicable diseases or infections should be reported; (i) When and to whom possible incidents of communicable diseases or infections should be			245468	B. WING _		10	
Prefrix Tag IEACH DEFICIENCY MISTER PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX Tag CEACH CORRECTVE ACTIONS HOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 428 Continued From page 76 - The nurse and/or the social worker to define the specific target behavior/symptoms and to verify the care plan is updated to ensure the problem has been appropriately identified. F 428 F 441 INFECTION CONTROL, PREVENT SPREAD, UNENS CFR(s): 483.80(a)(1)(2)(4)(e)(f) F 441 (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: F 441 (1) A system for prevention; 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 \$483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (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) When and to whom possible incidents of communicable disease or infections should be					304 WASHINGTON AVENUE WEST	E	
 The nurse and/or the social worker to define the specific target behavior/symptoms and to verify the care plan is updated to ensure the problem has been appropriately identified. F 441 INFECTION CONTROL, PREVENT SPREAD, LINENS CFR(s): 483.80(a)(1)(2)(4)(e)(f) (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: (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 \$483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (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; 	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	((EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP	OULD BE	COMPLETION
(iii) Standard and transmission-based precautions	F 441	-The nurse and/or the specific target behas the care plan is upon has been appropriated INFECTION CONTLINENS CFR(s): 483.80(a)((a) Infection prevent The facility must estimated control programs a minimum, the foll (1) A system for previous to a specific target of the program and control programs are providing services to arrangement based conducted accordinaccepted national services to a specific the program, where the program, where the program, where the programs are the programs of the program to be fore the program to be fore the program. The providing services to a specific the program to the program to be fore the program. The program is provided to: (b) A system of survex possible communicable distribution is provided to: (c) When and to whe communicable distribution to the program to be fore the program to be fore the program. The program is provided to the program to be fore the program. The program is provided to the program to be fore the program. The program is provided to the program to be fore the program. The program is provided to the program to be fore the program. The program is provided to the program to be fore the program. The program is provided to the program to be fore the program. The program is provided to the program to be fore the program. The program is provided to the program to be fore the program. The program is provided to the program to be fore the program. The program is provided to the program to be fore the program. The program is provided to the program to be fore the program. The program is provided to the program to be fore the program. The program is provided to the program to be provided to the program. The provided to the program to be provided to the program to be provided to the program. The provided to the program to be provided to the provided t	the social worker to define the avior/symptoms and to verify dated to ensure the problem ately identified. "ROL, PREVENT SPREAD, 1)(2)(4)(e)(f) ntion and control program. stablish an infection prevention m (IPCP) that must include, at lowing elements: eventing, identifying, reporting, controlling infections and eases for all residents, staff, , and other individuals under a contractual d upon the facility assessment ng to §483.70(e) and following standards (facility assessment Phase 2); ds, policies, and procedures nich must include, but are not veillance designed to identify cable diseases or infections read to other persons in the		28		11/29/17
		(iii) Standard and tr	ransmission-based precautions				

		AND HUMAN SERVICES			PRINTED: (FORM A OMB NO. (PPROVED
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE COMPI	SURVEY LETED
		245468	B. WING _		C 10/2	0/2017
NAME OF I	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
KARLST	AD HEALTHCARE CE	ENTER INC		304 WASHINGTON AVENUE WEST KARLSTAD, MN 56732		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 441	Continued From pa	-	F 44	41		
	to be followed to pr	event 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. 					
	must prohibit emplo disease or infected	ces under which the facility byees with a communicable skin lesions from direct nts or their food, if direct it the disease; and				
		ene procedures to be followed direct resident contact.				
		cording incidents identified IPCP and the corrective e facility.				
		nel must handle, store, port linens so as to prevent the				
	annual review of its program, as neces This REQUIREME	The facility will conduct an PCP and update their sary. NT is not met as evidenced				
	review, the facility f surveillance progra trends of resident in	tion, interview, and document ailed to develop an ongoing m to analyze patterns and nfections not treated with an the potential to affect all 36		The preparation of the following correction for this deficiency does constitute and should not be inter as an admission nor an agreeme facility of the truth of the facts alle	not preted nt by the	

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE		MB NO. 0938-0391 (X3) DATE SURVEY COMPLETED	
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	ING _			C
		245468	B. WING _				20/2017
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE 4 WASHINGTON AVENUE WEST		
KARLST	AD HEALTHCARE CE	NTER INC			ARLSTAD, MN 56732		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	control logs were re- nursing (DON). The which identified the identified, name of t which the resident r symptoms were new if a culture was com- organisms, and the prescribed by the pl did not contain the t illnesses which were antibiotic. On 10/19/17, at 1:3 infection control pre- infections with prese tracked. She stated established a system were not treated with facility failed to follo The facility's Survei indicated surveilland identify and report e Collecting, docume	0 p.m. the facility infection eviewed with the director of e logs were a tracking form date symptoms were the resident, room number in resided, if the identified w or ongoing, type of infection, npleted, the name of the type of antibiotic or treatment hysician. However, the logs tracking or trending of any e not being treated with an 0 p.m. the DON, also the eventionist, confirmed only cribed antibiotics were d the facilty had not m to track infections which th antibiotics and verified the w their surveillance policy. Ilance policy, revised 11/16, ce was implemented to evidence of infection. nting, and analyzing data ne infection preventionist or	F 44	41	 conclusions set forth in the statemed deficiencies. The plan of correction prepared for this deficiency was exisolely because provisions of state a federal law require it. Without waiv foregoing statement, the facility stat with respect to: All illnesses which are/are not be treated by antibiotics are being tract and reviewed for any trending. DNS or designee will daily revies physician orders and the 24 hour resheet for residents exhibiting signs symptoms of illness. Any illness will logged onto a spread sheet to analy trending. Staff education has been comp prior to 11/29/17 with regards to the for accurate and concise document of resident symptoms and disease prevention. DNS or designee will complete of the 24 hour report for accuracy or resident symptoms of illness 4x per x1 month, then weekly x2 months. data collected will be reviewed at th Monthly QAPI and Quarterly QA me At that time the committee will mak decision/recommendation regarding follow-up studies. 	and ecuted and ing the tes being ked ew all eport or ill be yze for bleted e need tation audits of r week The beeting. e the	

DEPARTMENT OF HEALT	H AND	HUMAN	SERVI	CES
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DEPARTMENT OF HEALT			ID CERTIFI	CATION A	CENTERS FOR MI AND TRANSMITTAL	EDICARE & MEDI	CAID SERVICES D: RQUD
					TE SURVEY AGENCY		Facility ID: 00830
1. MEDICARE/MEDICAID PROVIDI (L1) 245468 2.STATE VENDOR OR MEDICAID NO (L2) 012028600 (L2)		 NAME AND ADDRESS OF FACILITY (L3) KARLSTAD HEALTHCARE CENTER (L4) 304 WASHINGTON AVENUE WEST (L5) KARLSTAD, MN 				 TYPE OF ACTION Initial Termination Validation 	 Recertification CHOW Complaint
 5. EFFECTIVE DATE CHANGE OF (L9) 6. DATE OF SURVEY 12/0 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other 	07/2017 (L34)	 PROVIDER/SU 11 Hospital 22 SNF/NF/Dual 33 SNF/NF/Distinct 44 SNF 	JPPLIER CATEGO 05 HHA 06 PRTF 07 X-Ray 08 OPT/SP	DRY 09 ESRD 10 NF 11 ICF/IID 12 RHC	<u>02</u> (L7) 13 PTIP 22 CLIA 14 CORF 15 ASC 16 HOSPICE	7. On-Site Visit 8. Full Survey After C FISCAL YEAR ENDING 12/31	
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12. Total Facility Beds 13. Total Certified Beds 14. LTC CERTIFIED BED BREAKDOD 18 SNF 18/19 SNF 46	46 (L18) 46 (L17)	Complian 1. B. Not in Co		gram	And/Or Approved Waivers Of Th 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SNF 5. Life Safety Code * Code: A 15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	6. Scope of Ser 7. Medical Dire	vices Limit ector
(L37) (L38)	(L39)	(L42)	(L43)				
 16. STATE SURVEY AGENCY REM See Attached Remarks 17. SURVEYOR SIGNATURE 	ARKS (IF APPLICABL	E SHOW LTC CANC	ELLATION DATE	E):	18. STATE SURVEY AGENCY A	APPROVAL	Date:
<u>Theresa Gullingsrud, H</u>	FE-NE II		12/26/2017	(L19)	Joanne Simon, Enforce	ment Specialist	12/29/2017 (L20)
	PART II - TO BE	COMPLETED	BY HCFA R	EGIONAI	L OFFICE OR SINGLE ST.	ATE AGENCY	
 DETERMINATION OF ELIGIBIL X 1. Facility is Eligible to 2. Facility is not Eligible 	Participate		MPLIANCE WITH IGHTS ACT:	I CIVIL	 1. Statement of Finar 2. Ownership/Contro 3. Both of the Above 	l Interest Disclosure Stmt (H	
22. ORIGINAL DATE	23. LTC AGREEM	ENT	24. LTC AGREEN	MENT	26. TERMINATION ACTION:	(L30)
OF PARTICIPATION 04/01/1987	BEGINNING	DATE	ENDING DA	ГЕ	VOLUNTARY 00 01-Merger, Closure	05-Fail to N	<u>ГАRY</u> leet Health/Safety
(L24) 25. LTC EXTENSION DATE:	(L41) 27. ALTERNATI A. Suspension	VE SANCTIONS n of Admissions:	(L25)		02-Dissatisfaction W/ Reimburseme 03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	<u>OTHER</u>	feet Agreement Status Change
(L27)	B. Rescind Sus	pension Date:	(L44) (L45)			00-Active	
28. TERMINATION DATE:	29	. INTERMEDIARY	CARRIER NO.		30. REMARKS		
		03001					
	(L28)			(L31)			
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION 12/27/2017	OF APPROVAL I	DATE			

(L33)

DETERMINATION APPROVAL

(L32)

CCN: 24-5468

On October 20, 2017, a standard survey was completed at Karlstad Healthcare Center. The most serious deficiencies were cited at a S/S of G at F250 & F309. This is a no opportunity to correct (NOTC), therefore this Department is imposing the Category 1 remedy of State Monitoring, effective November 8, 2017, and Mandatory DPNA, effective January 20, 2018.

We are also recommending the following enforcement actions to the CMS RO for imposition:

- CMP for the deficiency cited at F250.
- CMP for the deficiency cited at F309

We also reported that this survey found a deficiency at F201. Per guidance we are forwarded this to CMS for enforcement for all scope and severity levels.

As a result of the revisit findings, we have discontinued the Category 1 remedy of State Monitoring as of December 10, 2017.

Furthermore, we are recommended to the CMS RO the following actions:

- CMP for the deficiency cited at F250 be imposed
- CMP for the deficiency cited at F309 be imposed
- NATCEP loss pending DPNA and/or CMS enforcement of CMPs for deficiency cited at F201.



Protecting, Maintaining and Improvingthe Health of All Minnesotans

CMS Certification Number (CCN): 245468

December 26, 2017

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

Dear Mr. Ahlf:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective December 10, 2017 the above facility is recommended 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.

Please contact me if you have any questions.

Sincerely,

Joanne Simon, Enforcement Specialist Minnesota Department of Health Licensing and Certification Program Program Assurance Unit Health Regulation Division Telephone: 651-201-4161 Fax: 651-215-9697 Email: joanne.simon@state.mn.us

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered December 26, 2017

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

RE: Project Number S5468028 and H5468004 Dear Mr. Ahlf:

On November 3, 2017, we informed you that the following enforcement remedy was being imposed:

• State Monitoring effective November 8, 2017. (42 CFR 488.422)

Also on November 3, 2017, we recommended the enforcement remedy listed below to the CMS Region V Office for imposition

- Civil money penalty of for the deficiency cited at F250 (42 CFR 488.430 through 488.444)
- Civil money penalty of for the deficiency cited at F309 (42 CFR 488.430 through 488.444)

This was based on the deficiencies cited by this Department for a standard survey completed on October 20, 2017 that included an investigation of complaint number H5468004. The most serious deficiency was found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On December 7, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on December 11, 2017 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 October 20, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 10, 2017. We have determined, based on our visit, that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on October 20, 2017, as of December 10, 2017.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective December 10, 2017.

In addition, this Department recommended to the CMS Region V Office the following actions:

- Civil money penalty of for the deficiency cited at F250 be imposed (42 CFR 488.430 through 488.444)
- Civil money penalty of for the deficiency cited at F309 be imposed (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

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.

Sincerely,

Joanne Simon, Enforcement Specialist Minnesota Department of Health Licensing and Certification Program Program Assurance Unit Health Regulation Division Telephone: 651-201-4161 Fax: 651-215-9697 Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

	CARE/MEDICAID CERTIFICATION		ID: RQUD
PAR1 1. MEDICARE/MEDICAID PROVIDER NO. (L1) 245468 2.STATE VENDOR OR MEDICAID NO. (L2) 012028600 5. EFFECTIVE DATE CHANGE OF OWNERSHIP	 I - TO BE COMPLETED BY THE STA 3. NAME AND ADDRESS OF FACILITY (L3) KARLSTAD HEALTHCARE CENTH (L4) 304 WASHINGTON AVENUE WEST (L5) KARLSTAD, MN 7. PROVIDER/SUPPLIER CATEGORY 	ER INC	Facility ID: 00830 4. TYPE OF ACTION: 2 (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other
(L9) 10/20/2017 (L34) 6. DATE OF SURVEY 10/20/2017 (L10) 8. ACCREDITATION STATUS: (L10) 0 Unaccredited 1 TJC 2 AOA 3 Other	01 Hospital05 HHA09 ESRD02 SNF/NF/Dual06 PRTF10 NF03 SNF/NF/Distinct07 X-Ray11 ICF/IIE04 SNF08 OPT/SP12 RHC	13 PTIP 22 CLIA 14 CORF 15 ASC 16 HOSPICE	8. Full Survey After Complaint FISCAL YEAR ENDING DATE: (L35) 12/31
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds 46 (L18)	10.THE FACILITY IS CERTIFIED AS: A. In Compliance With Program Requirements Compliance Based On: 1. Acceptable POC X B. Not in Compliance with Program	And/Or Approved Waivers Of The 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SNF) 5. Life Safety Code	 6. Scope of Services Limit 7. Medical Director 8. Patient Room Size 9. Beds/Room
14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 19 SNF 46 (L37) (L38) (L39)	ICF IID (L42) (L43)	* Code: B * 15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L12) (L15)
16. STATE SURVEY AGENCY REMARKS (IF APPLICAE See Attached Remarks			
17. SURVEYOR SIGNATURE <u>Debra Vincent, HFE- NE II</u>	Date : 11/21/2017 (L19)	18. STATE SURVEY AGENCY A	
Image: Marginal system I	E COMPLETED BY HCFA REGIONA 20. COMPLIANCE WITH CIVIL RIGHTS ACT:	21. 1. Statement of Finance	cial Solvency (HCFA-2572) Interest Disclosure Stmt (HCFA-1513)
22. ORIGINAL DATE 23. LTC AGREE OF PARTICIPATION BEGINNIN 04/01/1987 (L24) (L41)		26. TERMINATION ACTION: VOLUNTARY 00 01-Merger, Closure 02-Dissatisfaction W/ Reimbursement	05-Fail to Meet Health/Safety
A. Suspensi	IVE SANCTIONS on of Admissions: (L44) uspension Date:	03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	OTHER 07-Provider Status Change 00-Active
28. TERMINATION DATE:	(L45) 29. INTERMEDIARY/CARRIER NO. 03001 (L31)	30. REMARKS	
31. RO RECEIPT OF CMS-1539 (L32)	22. DETERMINATION OF APPROVAL DATE (L33)	DETERMINATION APPRO	DVAL

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

C&T REMARKS - CMS 1539 FORM

STATE AGENCY REMARKS

CCN: 24-5468

On October 20, 2017, a standard survey was completed at Karlstad Healthcare Center. The most serious deficiencies were cited at a S/S of G at F250 & F309. This is a no opportunity to correct (NOTC), therefore this Department is imposing the Category 1 remedy of State Monitoring, effective November 8, 2017, and Mandatory DPNA, effective January 20, 2018.

We are also recommending the following enforcement actions to the CMS RO for imposition:

- CMP for the deficiency cited at F250.
- CMP for the deficiency cited at F309

We also report that this survey found a deficiency at F201. Per our guidance we are forwarding this to CMS for enforcement for all scope and severity levels.



Electronically delivered

November 3, 2017

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

RE: Project Number S5468028 & H5468004

Dear Mr. Ahlf:

On October 20, 2017, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. In addition, at the time of the October 20, 2017 standard survey the Minnesota Department of Health, Office of Health Facility Complaints completed an investigation of complaint number H5468004. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

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

<u>No Opportunity to Correct</u> - the facility will have remedies imposed immediately after a determination of noncompliance has been made;

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);

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

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 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 Bemidji Survey Team Licensing and Certification Program Health Regulation Division Minnesota Department of Health 705 5th Street Northwest, Suite A Bemidji, Minnesota 56601-2933 Email: Iyla.burkman@state.mn.us Phone: (218) 308-2104 Fax: (218) 308-2122

NO OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

For all surveys completed after September 1, 2016, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when one or more of the following circumstances exist:

- Immediate jeopardy (IJ) (scope and severity levels J, K, and L) is identified on the current survey; OR
- Deficiencies of Substandard Quality of Care (SQC) that are not IJ are identified on the current survey; OR
- Any G level deficiency is identified on the current survey in 42 CFR 483.13, Resident Behavior and Facility Practices, 42 CFR 483.15, Quality of Life, or 42 CFR 483.25 Quality of Care; <u>OR</u>
- Deficiencies of actual harm or above (level G or above) on the current survey as well as having deficiencies of actual harm or above on the previous standard health or Life Safety Code (LSC) survey OR deficiencies of actual harm or above on any type of survey between the current survey and the last standard survey. These surveys must be separated by a period of compliance (i.e., from different noncompliance cycles).; OR
- A facility is classified as a Special Focus Facility (SFF) <u>AND</u> has a deficiency citation at level "F" or higher on its current health survey or "G" or higher for the current LSC survey.

Note: the "current" survey is whatever Health and/or LSC survey is currently being performed, i.e., standard, revisit, or complaint.

Your facility meets one or more criteria and remedies will be imposed immediately. Therefore, this Department is imposing the following remedy:

- State Monitoring effective November 8, 2017. (42 CFR 488.422)
- Mandatory Denial of payment for new Medicare and Medicaid admissions effective January 20, 2018. (42 CFR 488.417 (b))

The Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

• Civil money penalty for the deficiency cited at F250. (42 CFR 488.430 through 488.444)

• Civil money penalty for the deficiency cited at F309. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding our recommendations, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

• 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 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 their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit 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 we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. 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 January 20, 2018 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by April 20, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: <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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services Departmental Appeals Board, MS 6132 Director, Civil Remedies Division 330 Independence Avenue, S.W. Cohen Building – Room G-644 Washington, D.C. 20201 (202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Acting Branch Manager by phone at (312)353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

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

Feel free to contact me if you have questions.

Sincerely,

motor

Kate JohnsTon, Program Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health kate.johnston@state.mn.us Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

		AND HUMAN SERVICES				APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	I		<u>)MB NO</u>	. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY IPLETED
		245468	B. WING _		10/	20/2017
NAME OF F	PROVIDER OR SUPPLIER		· [STREET ADDRESS, CITY, STATE, ZIP CODE	-	
KARLST	AD HEALTHCARE CE			304 WASHINGTON AVENUE WEST KARLSTAD, MN 56732		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	rs	F 00	00		
	survey was comple Minnesota Departm determine compliar	ugh 10/20/17, a recertification ted by surveyors from the nent of Health (MDH) to nce with requirements at 42 part B, requirements for Long s.				
		onic Plan of Correction (ePOC) llegation of compliance upon cceptance.				
	signature is not req page of the CMS-2	nrolled in ePOC, your uired at the bottom of the first 567 form. Your electronic POC will be used as bliance.				
F 201 SS=D	conducted and was F225, F226, and F2	RANSFER/DISCHARGE OF	F 20)1		11/29/17
	(c) Transfer and dis (1) Facility requirem					
	remain in the facility	permit each resident to y, and not transfer or ent from the facility unless-				
		discharge is necessary for the and the resident's needs e facility;				
	(B) The transfer or	discharge is appropriate				
		DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE		(X6) DATE
Electron	ically Signed					11/13/2017

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.

PRINTED: 11/21/2017

CENTERS	SEOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES			RINTED: 11/21/2017 FORM APPROVED MB NO. 0938-0391
	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245468	B. WING		10/20/2017
NAME OF PRO	OVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	
KARLSTAD	D HEALTHCARE CE	NTER INC	_	04 WASHINGTON AVENUE WEST (ARLSTAD, MN 56732	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLÉTION
bu su su (0 e e st (1 o o (1 e e st (1 o o (1 e e st (1 o o (1 e e st (1 o o (1 e e st (1 o o (1 e e st (1 o o (1 e e st (1) o (1) e e st (1) o (1) e e st (1) o (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) e (1) (1) e (1) e (1) (1) (1) (1) (1) (1) (1) (1) (1) (1)	sufficiently so the re- services provided b C) The safety of in- endangered due to status of the residen D) The health of in otherwise be endand E) The resident ha uppropriate notice, under Medicare or I Jonpayment applie submit the necessa payment or after the Medicare or Medicare esident refuses to esident who becom admission to a facil esident only allowa or F) The facility ceas ii) The facility may esident while the a 3 431.230 of this ch exercises his or her lischarge notice from 31.220(a)(3) of this charge or transfe acility. The facility hat failure to transfe This REQUIREMEN	nt's health has improved esident no longer needs the by the facility; dividuals in the facility is the clinical or behavioral nt; dividuals in the facility would ngered; s failed, after reasonable and to pay for (or to have paid Medicaid) a stay at the facility. s if the resident does not ary paperwork for third party e third party, including aid, denies the claim and the pay for his or her stay. For a nes eligible for Medicaid after ity, the facility may charge a able charges under Medicaid;	F 201	The preparation of the following pl	an of

Facility ID: 00830

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CENTE	-	I AND HUMAN SERVICES <u>& MEDICAID SERVICES</u>	1			APPROVE 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	()	E SURVEY IPLETED
		245468	B. WING _		10/	20/2017
NAME OF	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, 2	ZIP CODE	
KARLST	AD HEALTHCARE CE	ENTER INC		304 WASHINGTON AVENUE WE KARLSTAD, MN 56732	ST	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 201	determine if a new needs of the reside physician document discharge related to needs of 1 of 1 resi emergency room for refused to allow R5 inform R5 of the re- emergency room vi- hospital stay. Findings include: R5's cumulative dia indicated R5 was a diagnoses that inclu- bipolar disorder, ad anxiety & depresse disorder, narcotic di behavior disorder, p end stage renal dis back pain, right har amputation, and so personality disorde R5's quarterly Minin 7/6/17, indicated R5 deficits, R5 had ina identified as inatter attention, being eas keeping track of wi- also indicated R5 has symptoms present	Applete an assessment to plan of care would meet the ent and failed to obtain natation supporting the facility's to the inability to meet the ident (R5) who was sent to the prevaluation and the facility to return to the facility or fusal for return resulting in two isits and an unnecessary agnoses list dated 10/19/17, idmitted to the facility with uded, but were not limited to: ljustment disorder with mixed ad mood, major depressive lependence, disruptive post-traumatic stress disorder, iease, chronic radicular low and and right below the knee beiopathic borderline	F 20	 correction for this deficiencies constitute and should not as an admission nor an facility of the truth of the conclusions set forth in the deficiencies. The plan of prepared for this deficiencies solely because provision federal law require it. We foregoing statement, the with respect to: R5 was readmitted to 10/12/17. A new assess completed 10/6/17. Car were held 9/21/17, 10/13 to discuss plan of care we guardian(s). The facility will permitremain in the facility, and discharge the resident fraccordance with state gresidents going to ER/p not be denied re-admiss deemed a danger to self accordance w/ state guita. Staff will be re-educ 11/29/17 regarding the E Planning Process Guide has the purpose to begin provide for a safe transitiresidents upon admissic Discharge plan may incl the senior living commute community or other but not limited to anothe ALF. 	at be interpreted agreement by the facts alleged or the statement of of correction ney was executed as of state and vithout waiving the e facility states to the facility on sment had been re Conferences 3/17, and 10/26/17 with R5 and hit each resident to d not transfer or rom the facility in uidance. All hysician appt will sion unless is f or others in dance. ated prior to Discharge lines Policy which n planning and tion plan for on to facility. ude remaining in nity, returning to facility including r nursing home or ED) or Designee	

Facility ID: 00830

TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION		E SURVEY	
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	IG	CON	IPLETED	
		245468	B. WING _		10/	20/2017	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
KARLST	AD HEALTHCARE CE	ENTER INC	304 WASHINGTON AVENUE WEST KARLSTAD, MN 56732				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE	
F 201	a family member de did not have any sy (hallucinations or d have verbal behavi others (threatening at others) 1-3 days R5 required extens for bed mobility and extensive assistand personal hygiene a unit using a wheeld	age 3 a failure or have let yourself or own. The MDS indicated R5 ymptoms of psychosis elusions) however, R5 did or symptoms directed at others, screaming or cursing a week. The MDS indicated vive assistance of two persons d toilet use, and required ce of one person for dressing, nd locomotion on and off the chair. R5 was unable to totally dependent on two staff	F 201 documentation supporting the disc and resident and/or family involven with discharge process. The data collected will be reviewed at the Mo QAPI and Quarterly QA meeting. A time the committee will make the decision/recommendation regardin follow-up studies. Completion Date 11/29/17		Monthly At that		
	identified as Order and signed by a juc indicated R5 was in impairment to the e understanding or c communicate respo personal needs for	d included a document Appointing Guardian dated dge on 5/26/16, which ncapacitated from mental extent lacking sufficient apacity to make or onsible decisions concerning medical care, nutrition, safety. The judge appointed					
	stated she was ext and stated the facil "nut house" last we come back to the fa sent to a local eme because the nursin come back to the n going all the way to Minnesota (322 mil	d on 10/17/17, at 2:00 p.m. and remely upset. R5 began to cry ity had tried sending her to a tek and would not allow her to acility. R5 stated she had been rgency room from dialysis, and ug home refused to allow R5 to pursing home, R5 ended up a hospital in Rochester, les). R5 stated a social worker Rochester had called the					

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		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	: 11/21/2017 APPROVED . 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DAT	E SURVEY IPLETED
		245468	B. WING	i		10/	20/2017
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
KARLST	AD HEALTHCARE CE	INTER INC		-	304 WASHINGTON AVENUE WEST KARLSTAD, MN 56732		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 201	Center and made the come back to the far distressed and felt allowed to return back home after going to Sanford Fargo, ND the emergency root transferred her to a Mayo Medical Cent stated she did not us shipped all the way Review of the Sanfer room dismissal sum R5 arrived in the er and stayed in the er and stayed in the er and stayed in the er and stayed in the er sychiatric evaluati disruptive behavior resided. The crisis and determined R5 and verbally abusiv aggressive towards was not suicidal, ar herself or others, al hospital admission. indicated the Karlst to take R5 back wh R5 from the Sanfor dismissal summary transferred to the e Medical Center in F evaluation.	(DON) at Karlstad Healthcare he nursing home allow R5 to acility. R5 stated she was panicked when she was not ack to her home at the nursing to the emergency room at b, and stated she had to stay in m over two days before they another emergency room at ter in Rochester Minnesota. R5 understand why she was	F 2	201			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	11/21/2017 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		E SURVEY PLETED
		245468	B. WING			10/2	20/2017
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
KARLST	AD HEALTHCARE CE	NTER INC			804 WASHINGTON AVENUE WEST (ARLSTAD, MN 56732		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 201	dismissal summary was assessed in the was found not in ne psychiatric care bee more behaviorally b indicated the Karlst not agree to accept therefore, R5 had to just to continue dial summary indicated psychiatry was cons was employed to ou behaviors and R5 d R5's medical record discharge notice be when the decision w facility. The DON was inter 10:14 a.m. and con to return to the nurs evaluated in the em Medical Center Far- from Mayo Medical stated she was uns transportation to dia When the DON was that the transportat stated the transport any documentation denied transportation confirmed there wa the community of K	ge 5 dated 10/12/17, indicated R5 e emergency department and red of hospital admission for cause R5's outbursts were pased. The dismissal summary ad Healthcare Center would R5 back into the facility, b be admitted to their hospital ysis treatments. The dismissal that while in the hospital, sulted and a behavior plan utline expected respectful lid very well with this. d lacked any evidence of a sing provided to the resident vas made not readmit to the viewed on 10/19/2017, at firmed she had not allowed R5 sing home after being hergency room at Sanford go, ND on 10/6/17, and again Center on 10/8/17. The DON ure if R5 would have alysis while at the facility. s asked to provide evidence on services to R5, the DON c company had not provided which identified R5 was on services. The DON s an ambulance service for arlstad that could have tion on an emergency basis, if	F	201			

		AND HUMAN SERVICES			FORM	APPROVED 0938-0391
STATEMENT	F OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE	E SURVEY IPLETED
		245468	B. WING _		10/:	20/2017
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
KARLST	AD HEALTHCARE CE			304 WASHINGTON AVENUE WEST KARLSTAD, MN 56732		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 201	Continued From pa	ge 6	F 20)1		
F 225 SS=D	Resident Admission the following: "The f discharge or transfe reason, but not limit A: Persons who bed extent that they are themselves, or staff B: Persons whose a days. C: Persons whom the adequately in confo of care due to chan family interference. The policy had not i residents return to t emergency room vis INVESTIGATE/REF ALLEGATIONS/INE CFR(s): 483.12(a)(3 483.12(a) The facilit (3) Not employ or of who- (i) Have been found exploitation, misapp mistreatment by a c (ii) Have had a findi nurse aide registry of	come mentally disturbed to the e dangerous to other residents, f members. accounts are not paid in 60 the facility is unable to care for ormance with the medical plan ages in their condition or due to included directives for the facility following an isit or hospital stay. PORT DIVIDUALS 3)(4)(c)(1)-(4) ity must- therwise engage individuals d guilty of abuse, neglect, propriation of property, or court of law; ing entered into the State concerning abuse, neglect, atment of residents or	F 22	25		11/29/17

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PRINTED: 11/21/2017

		AND HUMAN SERVICES				FORM	: 11/21/2017 APPROVED . 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY IPLETED
		245468	B. WING			10/:	20/2017
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
KARLST	AD HEALTHCARE CE	INTER INC			04 WASHINGTON AVENUE WEST (ARLSTAD, MN 56732		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 225	 (iii) Have a disciplin or her professional body as a result of a exploitation, mistrea misappropriation of (4) Report to the St licensing authorities actions by a court of which would indicat nurse aide or other (c) In response to a exploitation, or mist (1) Ensure that all a abuse, neglect, exp including injuries of misappropriation of reported immediate after the allegation cause the allegation serious bodily injury the events that caus abuse and do not re the administrator of officials (including to adult protective serion for jurisdiction in lor accordance with Sta procedures. (2) Have evidence to thoroughly investigation 	ary action in effect against his license by a state licensure a finding of abuse, neglect, atment of residents or resident property. ate nurse aide registry or s any knowledge it has of of law against an employee, te unfitness for service as a facility staff. allegations of abuse, neglect, treatment, the facility must: alleged violations involving ploitation or mistreatment, funknown source and resident property, are aly, but not later than 2 hours is made, if the events that n involve abuse or result in <i>y</i> , or not later than 24 hours if se the allegation do not involve esult in serious bodily injury, to f the facility and to other o the State Survey Agency and vices where state law provides ng-term care facilities) in ate law through established that all alleged violations are ated. potential abuse, neglect, treatment while the		225			

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	: 11/21/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		E SURVEY IPLETED
		245468	B. WING		10/:	20/2017
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP		
KARLST	AD HEALTHCARE CE	NTER INC		304 WASHINGTON AVENUE WEST KARLSTAD, MN 56732		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 225	Continued From pa	ge 8	F 2	25		
	administrator or his representative and with State law, inclu Agency, within 5 wo if the alleged violatic corrective action m This REQUIREMEN by: Based on observat review, the facility fa investigation and er were reported to the investigation for 1 of adult (VA) reports re allegations of finance thoroughly investigat VA reports reviewed include all informati investigation which reported to the Stat days for 1 of 3 reside Findings include: R5's medical record 10/17/17, and the p revealed R5 had re been rough with he identified the staff m progress note indica making "faulty alleg (including the name immediately contac morning cares to R	to other officials in accordance iding to the State Survey orking days of the incident, and on is verified appropriate		The preparation of the follo correction for this deficience constitute and should not be as an admission nor an ag facility of the truth of the fa- conclusions set forth in the deficiencies. The plan of co prepared for this deficiency solely because provisions of federal law require it. With foregoing statement, the fa- with respect to: 1. R5 has been reported thoroughly investigated for abuse/mistreatment on 7/2 re-submission on 11/10/17 (which had included statem aides that provided cares of question). R41 had been r MDH and to local law enfor 8/9/17 for allegations of fin- exploitation. Law enforcem case on 8/11/17. This facil email confirmation on 9/15 information had been revie been determined that no fu- was necessary. 2. Executive Director, DN designee is immediately no	ey does not be interpreted reement by the cts alleged or estatement of correction / was executed of state and rout waiving the acility states to MDH and potential 25/17 (and with) and 10/23/17 nents from the on the day in reported to reement on ancial nent closed this ity received /17, that the wed and it has inther action	

Facility ID: 00830

TATEMEN	OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(3) DATE	0938-039 SURVEY PLETED
		245468	B. WING			10/2	20/2017
NAME OF	PROVIDER OR SUPPLIER		<u> </u>	S	TREET ADDRESS, CITY, STATE, ZIP CODE	10/2	.0/2011
KARLST	AD HEALTHCARE CE	ENTER INC			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 PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETIO DATE
F 225	cursory investigatic perpetrator who de with cares or transf note indicated the e of the allegation, he indication the State notified of the alleg The DON was inter a.m. during which s allegation R5 made her on 10/16/17, w investigating the all the past R5 had ma abuse and after tal the DON stated it to complete the inves R5 had not been tr investigation did no aides that did provi 10/16/17, interview and interviewing ot care received by th DON confirmed sh before reporting to needed to use com a history of confabr she didn't know wh not.	age 9 on and interviewed the alleged enied providing or assisting R5 fers on 10/16/17. The progress executive director was notified owever, there was no e agency (SA) had been pation of abuse by R5. rviewed on 10/19/17, at 9:49 she was asked why the e about staff being rough with asn't reported to the SA prior to legation. The DON stated in ade false accusations of staff king to the alleged perpetrator, ook only 10 minutes to tigation enough to ascertain eated roughly. However, the ot include interviewing the ide care to R5 the morning of ring R5 for pertinent details, her residents regarding the e alleged perpetrator. The e had investigated the incident the SA because she felt we amon sense, and since R5 had ulating stories, the DON stated bether to believe R5's report or or Living VA policy dated as 2016, indicated "All incidents e under MN statute are via the on-line Reporting ly (as soon as possible)."	F 2.	25	 facility policy and procedure of incider determine if additional reporting to MI law enforcement or other agencies ar required. All incidents are reviewed a daily IDT meetings to assure staff followed proper reporting and monitor procedures. 3. VA Policy will be updated to include that results of the investigation will be submitted within 5 business days. State will be re-educated prior to 11/29/17 regarding the policy and procedure of reporting all injuries and allegations, completion of an incident report, initia of the investigation, immediate notific of Administrator and DNS and the notification of the Common Entry Poin and/or MDH. 4. Executive Director and DNS revise incident reports daily to assure prope reporting and monitoring procedures followed. The incident reports will be reviewed/discussed at the Monthly Qu and Quarterly QA meeting. At this tim the QA committee will make the decision/recommendation regarding a follow-up studies. Completion Date: 11/29/17 	DH, re at ring de e aff f ation cation nt ew all er are API ne	

TATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) D	O. 0938-039 ATE SURVEY OMPLETED
				NG		
		245468	B. WING _			0/20/2017
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S 304 WASHINGTON AVENI		
(ARLST/	AD HEALTHCARE CE	INTER INC		KARLSTAD, MN 56732		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTI CROSS-REFERENCI	AN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETIC DATE
F 225	9:49 a.m. she confi allegation of abuse to the SA. The DON abuse had not been following R5's repo The VA report dated victim of financial e identified R42 was 7/6/17, and had dia not limited to maligi mets to the bone, p disorder, hypertens palliative care. The son who received fi in the amount of 3, another check was 7/7/17, for 5,000.00 for non-sufficient fut the SA was notified exploitation on 8/9/ Sheriff's Office rece from the Minnesota Center. The investi exploitation had not the alleged perpetra included any intervi never determined if son received was u who drafted the che non-sufficient funds dollars.	ge 10 th the DON on 10/19/2017, at rmed she investigated R5's prior to reporting the incident N confirmed R5's allegation of n reported to the SA at point rt of rough treatment. d 8/9/17, alleged R42 was the xploitation. The VA report admitted to the facility on gnoses that included, but were nant neoplasm of prostate with ain, weakness, anxiety ion, constipation, and alleged perpetrator was R42's unds from R42's bank account 000.00 dollars on 7/5/17, and drafted on R42's account on 0 dollars which was returned nds. The VA report indicated of the alleged financial 17, and the Kittson County eived the report on 8/11/17, Adult Abuse Reporting gation for this alleged financial t included any interviews with ator (R41's son) and had not ews with R41, and it was the 3,000.00 dollars R41's sed for the benefit of R41 or eck that was returned for a in the amount of 5,000.00	F 22	25		
	was interviewed an	12:30 p.m. the Administrator d confirmed the investigation is R41, and the son of R41				

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DEPAR ⁻ CENTE		PRINTED: 11/21/2017 FORM APPROVED OMB NO. 0938-0391							
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		245468	B. WING			10/20/2017			
NAME OF PROVIDER OR SUPPLIER			•	S	STREET ADDRESS, CITY, STATE, ZIP CODE	-			
KARLSTAD HEALTHCARE CENTER INC				304 WASHINGTON AVENUE WEST KARLSTAD, MN 56732					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE		
F 225	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 11 had not been interviewed, and it was never determined if the 3,000.00 dollars R41's son received was used for the benefit of R41. Additionally, the facility had not determined who drafted the check that was returned for non-sufficient funds in the amount of 5,000.00 dollars, and the reason the check was drafted. Review of the VA report submitted to the SA on 7/25/17, indicated R5 reported nursing assistant (NA)-F had told her to shut up and told R5 she was acting like a bitch. The VA report indicated NA-F who was the alleged perpetrator (AP) had been suspended pending investigation. The follow up investigation submitted to the SA dated 7/28/17, indicated R5 had been interviewed and stated the AP made inappropriate comments to her when they were in her room alone together. The follow up investigation further indicated the following: -Multiple staff members were interviewed and all stated they had never heard the AP speak harshly/meanly/or with foul language to or in front of the resident. -The AP was interviewed and denied having said anything mean to a resident or calling a resident a name. -The AP denied ever making a statement to a resident she later regretted. However, the VA report also indicated staff had reported the AP could come across as being "short". Another staff member stated the AP acted like she wanted to show R5 who was the boss, but with R5, you had to be kinda firm, or she would run you over, it's a fine line. R5 had a			225					

Facility ID: 00830

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		AND HUMAN SERVICES			FORM	: 11/21/2017 APPROVED . 0938-0391	
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				IPLE CONSTRUCTION	(X3) DAT	(X3) DATE SURVEY COMPLETED	
245468		B. WING _		10/	10/20/2017		
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
KARLST	AD HEALTHCARE CE	NTER INC		304 WASHINGTON AVENUE WEST KARLSTAD, MN 56732			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 225	AD HEALTHCARE CENTER INC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 12 long history of demanding excessive amounts of time and care from her caregivers. For example, on a typical 8 hour shift R5 would request staff to clean her glasses 15 or more times. Normally her glasses were not dirty or soiled. The report indicated following this investigation, the AP's suspension was lifted and was instructed not to provide care to R5 per R5's request. Additional education would be done with the AP regarding her non-verbal body language and following the resident care plan. A final written warning for not following policy and procedure and standards of conduct at Karlstad Senior Living would also be given to the AP. The DON's investigative notes were reviewed and it was noted they greatly differed from what the VA investigative report submitted to the SA had indicated. Review of the investigative notes revealed four nursing assistants and one licensed practical nurse were interviewed and all five employees described the AP as being short or snappy or harsh. The following interviews were also left out of the investigative report submitted to the SA: -NA-A stated "I have noticed her short with [R5]. They bicker back and forth. I heard [AP] tell [R5] once 'I have had enough of you'." -NA-G stated "at the end of the day [AP] can be short with people (staff and residents). She has an attitude. I have seen her roll her eyes when a resident asks her to do something, and then make comments like 'that's not my job, ask Cathy' (to R5), or 'if I have to'." When asked to describe what she meant by short the NA stated		F 22				

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		AND HUMAN SERVICES				FORM	: 11/21/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245468	B. WING	i		10/:	20/2017
NAME OF	PROVIDER OR SUPPLIER	•	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
KARLST	AD HEALTHCARE CE	INTER INC			04 WASHINGTON AVENUE WEST (ARLSTAD, MN 56732		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 225	Continued From pa	ige 13	F	225			
	sometimes not real like [AP] wants to s R5, you have to be over, it's a fine line. was soaked, and sl didn't respond at al telling her anything. -LPN-A and LPN-B snappy, kinda shor "not right now" whe something. -NA-H stated she h in front of any resid the AP tell R5 she w her to shut up. NA- herself in a harsh w The AP does tell R5 counseled AP that se rather say "we will h NA-H had also hea off" when R5 was a another. NA-H stated described the AP ac On 10/19/17 at 2:34 interviewed and wa aforementioned station included in the follo to the SA and the D statements were per was told to shut up The DON was aske constituted verbally	stated that [AP] can be t with residents. She will say n a resident asks for ad never heard the AP swear ent and she has never heard was acting like a bitch or tell H stated the AP presented vay to residents sometimes. 5 "no" sometimes and I have she shouldn't say that, but nave to see if I have the time". rd the AP tell R5 to "knock it isking for one thing after ed that another resident					

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY
				NG	001	
		245468	B. WING _		10/	20/2017
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 304 WASHINGTON AVENUE WEST		
NANLOI	AD HEALINGARE CE				1	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE
F 225	not included all of the follow up investigat all of the NA/LPN in resident interaction verbal abuse. The I terminate this empl allow her to. The D return to work after	ge 14 . The DON confirmed she had he employee interviews in the ion report to the SA and with heterviews together, the AP's s suggested a pattern of DON stated she wanted to oyee but corporate would not ON stated the AP was able to the investigation was suspension was lifted, but	F 22	25		
F 226 SS=D	revised November 3 Administrator would internal investigatio incident. The invest with staff, residents environmental revise review, and behavio VA policy failed to in investigation neede within 5 business d DEVELOP/IMPLME POLICIES	ew, resident health status or and medication review. The indicate the results of the ind to be submitted to the SA	F 22	26		11/29/17
	written policies and (1) Prohibit and pre	vent abuse, neglect, and lents and misappropriation of				

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM /	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	E SURVEY PLETED
		245468	B. WING			10/2	20/2017
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
KARI ST	AD HEALTHCARE CE			3	04 WASHINGTON AVENUE WEST		
KAILOI				k	(ARLSTAD, MN 56732		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 226	Continued From pa	ge 15	F 2	226			
	(3) Include training §483.95,	as required at paragraph					
	the freedom from a requirements in § 4	and exploitation. In addition to buse, neglect, and exploitation 83.12, facilities must also heir staff that at a minimum					
		constitute abuse, neglect, sappropriation of resident n at § 483.12.					
		or reporting incidents of abuse, n, or the misappropriation of					
	prevention.	nagement and resident abuse					
	Based on observat review, the facility fa Adult (VA) policy ha written for reporting State agency prior t residents (R5) vulne reviewed; failed to e was implemented a of financial exploitat investigated for 1 of reviewed; and failed policy was impleme information learned was reported to the	ion, interview, and document ailed to ensure the Vulnerable allegations of abuse to the to investigation for 1 of 3 erable adult (VA) reports ensure the facilities VA policy s written to ensure allegations tion had been thoroughly f 3 residents (R42) VA reports d to ensure the facility VA ented as written to include all by the internal investigation State agency within 5 of 3 residents (R5) VA reports			The preparation of the following pla correction for this deficiency does not constitute and should not be interpre- as an admission nor an agreement of facility of the truth of the facts allege conclusions set forth in the statement deficiencies. The plan of correction prepared for this deficiency was exe solely because provisions of state and federal law require it. Without waiving foregoing statement, the facility state with respect to: 1. R5 has been reported to MDH at thoroughly investigated for potential abuse/mistreatment on 7/25/17 (and re-submission on 11/10/17) and 10/2	ot eted by the ed or nt of ecuted nd ng the es and d with	

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PRINTED: 11/21/2017

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO.	0938-039	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	· · ·	E SURVEY PLETED	
		245468	B. WING		10/2	20/2017	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE		
KARLST	AD HEALTHCARE CE	ENTER INC		304 WASHINGTON AVENUE WEST KARLSTAD, MN 56732			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE	
F 226	Continued From pa	age 16	F 226	6			
	Findings include:			R41 had been reported to M local law enforcement on 8/ allegations of financial explo enforcement closed this cas This facility received email of	9/17 for bitation. Law se on 8/11/17.		
	revised November nursing (DON) or A immediately institut the reported allegat investigation may in residents, and with resident health stat medication review. the results of the in	ar Living VA policy dated as 2016, indicated the director of administrator would te an internal investigation of tion or incident. The include interviews with staff, esses, environmental review, rus review, and behavior and The VA policy failed to indicate vestigation needed to be A within 5 business days.		on 9/15/17, that the informa reviewed and it has been de no further action was neces 2. Executive Director, DNS designee are notified per fa procedure of incidents to de additional reporting to MDH enforcement or other agend required. All incidents are r IDT to assure staff followed reporting and monitoring pro 3. VA Policy will be update include that results of the in	tion had been etermined that sary. 5 or assigned cility policy and etermine if , law sies are eviewed at proper pocedures. d/changed to		
	revised November deemed reportable submitted to MDH System immediatel	r Living VA policy dated as 2016, indicated "All incidents under MN statute are via the on-line Reporting y (as soon as possible)."		be submitted within 5 busine will be re-educated prior to regarding the policy and pro- reporting all injuries and alle completion of an incident re of the investigation, notificat Administrator and DNS and	11/29/17, becedure of egations, port, initiation tion of		
	R5's medical record was reviewed initially on 10/17/17, and the progress note dated 10/16/17, revealed R5 had reported a staff member had been rough with her during morning cares, and identified the staff member by name. The progress note indicated R5 had a long history of making "faulty allegations", day shift staff (including the named staff member) were immediately contacted and asked who provided morning cares to R5. The progress note indicated the DON had completed a cursory investigation and interviewed the alleged perpetrator who denied providing or assisting R5 with cares or transfers on 10/16/17. The progress note			 notification of the Common and/or MDH 4. Executive Director and incident reports to assure pr and monitoring procedures The incident reports will be reviewed/discussed at the N and Quarterly QA meeting. the QA committee will make decision/recommendation re follow-up studies. Completion Date: 11/29/17 	DNS review all roper reporting are followed. Monthly QAPI At this time the		

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		AND HUMAN SERVICES				FORM	: 11/21/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245468	B. WING			10/:	20/2017
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
KARLST	AD HEALTHCARE CE	INTER INC		-	04 WASHINGTON AVENUE WEST ARLSTAD, MN 56732		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 226	indicated the execut the allegation, howe the State agency (S allegation of abuse The DON was inter a.m. during which s allegation R5 made her on 10/16/17, wa investigating the all the past, R5 had m abuse and after talk the DON stated it to complete the invest R5 had not been tre investigation did no aides that did provid 10/16/17, interviewi and interviewing oth care received by the DON confirmed she allegation of abuse because she felt we sense, and since R confabulating storie know whether to be The VA report dated victim of financial e identified R42 was 7/6/17, and had dia not limited to malign mets to the bone, p disorder, hypertens palliative care. The son who received fu	tive director was notified of ever, there was no indication SA) had been notified of the by R5. viewed on 10/19/17, at 9:49 she was asked why the e about staff being rough with asn't reported to the SA prior to legation. The DON stated in ade false accusations of staff king to the alleged perpetrator, bok only 10 minutes to tigation enough to ascertain eated roughly. However, the ot include interviewing the de care to R5 the morning of ing R5 for pertinent details, her residents regarding the e alleged perpetrator. The e had investigated R5's before reporting to the SA e needed to use common	F 2	226			

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		I AND HUMAN SERVICES E & MEDICAID SERVICES			FORM	D: 11/21/2017 APPROVED D: 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	(X3) DA	TE SURVEY MPLETED
		245468	B. WING _		10	/20/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		
KARLST	AD HEALTHCARE CE	INTER INC		304 WASHINGTON AVENUE WEST KARLSTAD, MN 56732		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 226	another check was 7/7/17, for 5,000.00 for non-sufficient fu the SA was notified exploitation on 8/9/ Sherriff's Office rec from the Minnesota Center. The investig exploitation had not the alleged perpetra included any intervi never determined if son received was u who drafted the chec non-sufficient funds dollars. On 10/20/2017, at 7 was interviewed an was not complete a had not been interv determined if the 3, received was used Additionally, the fac drafted the check th non-sufficient funds dollars, and the rea Review of the VA re 7/25/17, indicated F (NA)-F had told her was acting like a bit NA-F who was the fact been suspended per	age 18 drafted on R42's account on 0 dollars which was returned ands. The VA report indicated 4 of the alleged financial (17, and the Kittson County beived the report on 8/11/17, a Adult Abuse Reporting igation for this alleged financial t included any interviews with ator (R41's son) and had not iews with R41, and it was f the 3,000.00 dollars R41's used for the benefit of R41 or eck that was returned for s in the amount of 5,000.00 12:30 p.m. the Administrator ad confirmed the investigation as R41, and the son of R41 viewed, and it was never ,000.00 dollars R41's son for the benefit of R41. cility had not determined who hat was returned for s in the amount of 5,000.00 ason the check was drafted. eport submitted to the SA on R5 reported nursing assistant r to shut up and told R5 she itch. The VA report indicated alleged perpetrator (AP) had ending investigation.	F 22			

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		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	: 11/21/2017 APPROVED . 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATI	E SURVEY IPLETED
		245468	B. WING	<u>ـــــ</u> د		10/	20/2017
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
KARLST	AD HEALTHCARE CE	INTER INC			304 WASHINGTON AVENUE WEST KARLSTAD, MN 56732		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 226	dated 7/28/17, indic and stated the AP r to her when they we The follow up invest following: -Multiple staff mem stated they had new harshly/meanly/or w of the resident. -The AP was intervit anything mean to a name. -The AP denied ever resident she later re The VA report also the AP could come Another staff memb she wanted to show with R5, you had to run you over, it's a of demanding exce care from her care typical 8 hour shift I her glasses 15 or m glasses were not di indicated following suspension was lift provide care to R5 education would be her non-verbal body resident care plan. following policy and conduct at Karlstad given to the AP.	cated R5 had been interviewed made inappropriate comments ere in her room alone together. stigation further indicated the abers were interviewed and all ver heard the AP speak with foul language to or in front riewed and denied having said a resident or calling a resident a er making a statement to a		226			

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		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	11/21/2017 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245468	B. WING			10/:	20/2017
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
KARLST	AD HEALTHCARE CE	INTER INC			04 WASHINGTON AVENUE WEST (ARLSTAD, MN 56732		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 226	VA investigative rep indicated. Review of revealed four nursin practical nurse were employees describes snappy or harsh. Th also left out of the in to the SA: -NA-A stated "I have They bicker back all once 'I have had er -NA-G stated "at the short with people (s an attitude. I have so resident asks her to make comments lik Cathy' (to R5), or 'if describe what she r "kinda short temper -NA-C stated " [AP] sometimes not real like [AP] wants to so R5, you have to be over, it's a fine line. was soaked, and sh didn't respond at all telling her anything. -LPN-A and LPN-B snappy, kinda short "not right now" whe something. -NA-H stated she h in front of any resid	bort submitted to the SA had of the investigative notes ing assistants and one licensed e interviewed and all five ed the AP as being short or he following interviews were investigative report submitted re noticed her short with [R5]. Ind forth. I heard [AP] tell [R5] hough of you'." e end of the day [AP] can be staff and residents). She has seen her roll her eyes when a to do something, and then ke 'that's not my job, ask f I have to'." When asked to meant by short the NA stated red".] can be harsh with staff and lly nice with [R5]. "Kinda mean, how [R5] who is boss, but with kinda firm, or she will run you . I told her one day a resident he walked right by me and I. She doesn't like anyone	F 2	226			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	11/21/2017 APPROVED 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245468	B. WING			10/2	20/2017
NAME OF PF	ROVIDER OR SUPPLIER				IREET ADDRESS, CITY, STATE, ZIP CODE		
KARLSTA	D HEALTHCARE CE	NTER INC			04 WASHINGTON AVENUE WEST ARLSTAD, MN 56732		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 250 SS=G	herself in a harsh w The AP does tell RE counseled AP that s rather say "we will h NA-H had heard th when R5 was askin NA-H stated that an AP as "kinda pushy On 10/19/17 at 2:34 interviewed and ask aforementioned sta included in the follor to the SA and the D statements were per was told to shut up The DON was aske constituted verbally DON stated "Yes", I of my grandmother. not included all of th follow up investigati all of the NA/LPN in resident interactions verbal abuse. The D terminate this emple allow her to. The DO return to work after completed and the chose not too. PROVISION OF ME SERVICE CFR(s): 483.40(d) (d) The facility must	H stated the AP presented ray to residents sometimes. 5 "no" sometimes and I have she shouldn't say that, but have to see if I have the time". e AP tell R5 to "knock it off" g for one thing after another. hother resident described the ".	F 2				11/29/17

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY PLETED
		245468			10/	20/2017
NAME OF I	PROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP C		
KARLST	AD HEALTHCARE CE			304 WASHINGTON AVENUE WEST KARLSTAD, MN 56732		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE
F 250	practicable physica well-being of each in This REQUIREMEN by: Based on observation review, the facility fi (R5) was provided to to ensure individual identified mental her non-compliance with services, and increas symptoms. R5 expending harm related to the displaced from her functioning, and the behavioral problem systematically addr Findings include: R5's cumulative dia indicated R5 was a diagnoses that inclu- bipolar disorder, ad anxiety and depress disorder, narcotic d behavior disorder, p end stage renal dis back pain, right har amputation, and so personality disorder R5's quarterly Minin 7/6/17, indicated R5	I, mental and psychosocial resident. NT is not met as evidenced tion, interview, and document ailed to ensure 1 of 1 resident the necessary social services lized needs were met for ealth needs, issues with th necessary care and ased inappropriate behavior erienced actual psychosocial ongoing worry of being home, a decline in physical e onset of increased mood and s that had not been essed by the facility.	F 25	The preparation of the follow correction for this deficiency constitute and should not be as an admission nor an agree facility of the truth of the face conclusions set forth in the se deficiencies. The plan of co- prepared for this deficiency solely because provisions of federal law require it. Without foregoing statement, the face with respect to: 1. R5 had a Care Plan rev 10/16/17 w/ changes made Social Service (SS) has met 10/24/17 and 10/26/17. R5 Psychotherapist appointment with pending weekly appoint thereafter. R5 had Psychiat appointments scheduled for 10/31/17 and 11/14/17. Ber plan received from Mayo on started constructing persona behavioral care plan 10/19/- hospitalized 10/6-12/17 and 11/2/17. R5 expired 11/3/17 2. All residents will be review health needs, issues w/ non with necessary care and ser increased inappropriate beh symptoms. 3. Care plans and assignm	a does not interpreted eement by the ts alleged or statement of rrection was executed f state and out waiving the dility states iew completed on 10/18/17. t with R5 on: had of on 10/26/17, ments rist 10/12/17, havioral care 10/19/17. SS alized facility 17. R5 10/30- c. ewed quarterly ge, through of or mental -compliance vices, and avior	

Facility ID: 00830

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STATEMENT	TOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	0938-039 SURVEY PLETED
		245468	B. WING			10/20/2017	
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	10/2	20/2017
	AD HEALTHCARE CE			3	304 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 250	also indicated R5 h symptoms present down, depressed, o having to little energy self-or that you are a family member do did not have any sy (hallucinations or d have verbal behavio others (threatening at others) 1-3 days R5 required extens for bed mobility and extensive assistant personal hygiene a unit using a wheeld ambulate, and was during transfers. R5 was interviewed stated she was extr director of nursing of previous week that drastically improve would be discharge south from where s nursing home. R5 k facility had tried ser week and would no the facility. R5 state emergency room a Fargo, ND from dia home refused to all nursing home, she a hospital in Roche R5 stated a social w	age 23 hat was being said). The MDS ad the following mood 2-6 days a week: feeling or hopeless, feeling tired or gy, and feeling bad about a failure or have let yourself or own. The MDS indicated R5 mptoms of psychosis elusions), however, R5 did or symptoms directed at others, screaming or cursing a week. The MDS indicated ive assistance of two persons d toilet use, and required ce of one person for dressing, nd locomotion on and off the thair. R5 was unable to totally dependent on two staff d on 10/17/17, at 2:00 p.m. and remely upset because the (DON) had told her the she had one month to her behavior or else she ed to a facility over 300 miles the was currently living in the began to cry and stated the nding her to a "nut house" last at allow her to come back to be she had been sent to the t Sanford Medical Center in lysis, and because the nursing low R5 to come back to the ended up going all the way to ster Minnesota (322 miles). worker from the hospital in ed the DON at Karlstad	F 2	250	health needs/ non-compliance issu increased behavior symptoms will I reviewed and updated as needed b 11/29/17. SS and nursing staff will re-educated to care plan changes a need for providing individualized ca 11/29/17. An individual's Care Plan developed in cooperation with resid responsible party and the facility ca team that includes the optimal freq of SS and other supportive visits. 4. Audits will be completed by DN designee with all new admissions f following 3 months to ensure that in health and individualized needs will met. The data collected will be rev at the Monthly QAPI and Quarterly meeting. At that time the committee make the decision/recommendatio regarding any follow-up studies. Completion Date: 11/29/17	be be and the are by n will be dent/ are uency IS or or the nental I be iewed QA ee will	

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		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM): 11/21/2017 1 APPROVED . 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DAT	TE SURVEY MPLETED
		245468	B. WING	i		10/	/20/2017
NAME OF	PROVIDER OR SUPPLIER	<u>.</u>		S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
KARLST	AD HEALTHCARE CE	INTER INC		-	304 WASHINGTON AVENUE WEST KARLSTAD, MN 56732		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 250	Healthcare Center allow R5 to come b she was frustrated, that she may be dis behavior did not im continued crying thi stated, "I make a bi so people laugh at R5 explained she h throughout every da that she would beca- leave to another fac DON she had to "di behavior in order to that since returning isolated because fa to want to talk with asked what type of over the next 30 da screaming loudly w needed assistance screamed loudly, si because she was a could get assistance Registered nurse (f 10/18/17, at 8:35 a. many times a day, stated she could no screamed every da tracked how often t antecedent to the b screamed loudly wi immediately, and h care and assistance	and made the nursing home pack to the facility. R5 stated , anxious, and felt panicked scharged from the facility if her prove in the next 30 days. R5 roughout the interview and ig goof of myself like a retard me, instead being mad at me." had increased anxiety ay and cried daily with worry ome homeless or have to cility since being told by the rastically improve" her o stay in the facility. R5 stated to the facility she had felt acility staff no longer seemed her or visit. When R5 was behavior needed to improve ays, R5 stated she had been when she needed something or . When R5 was asked why she he stated she screamed anxious and frustrated and ce in a timelier manner. RN)-A was interviewed on .m. and stated R5 screamed if it was a bad day. RN-A ot quantify how many times R5 ay because the facility had not the behavior occurred or the behavior. RN-A stated R5 hen she wanted something ad anxiety about not getting	F 2	250			

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		AND HUMAN SERVICES				FORM	: 11/21/2017 APPROVED
STATEMENT	RS FOR MEDICARE	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	0938-0391 E SURVEY PLETED
		245468	B. WING _			10/2	20/2017
NAME OF	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
KARLST	AD HEALTHCARE CE	INTER INC			4 WASHINGTON AVENUE WEST ARLSTAD, MN 56732		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 250	a.m. during which s told she had 30 day order to keep living was because the tra transported R5 to d verbally notified the longer transport R5 screaming, and ma driver's driving abilit DON stated because transport company the facility had no c a different nursing h transportation to dia asked to provide ev service had refused services to R5, the company had not p which identified R5 services. R5's medical record identified as Order a and signed by a jud indicated R5 was in impairment to the e understanding or ca communicate respond personal needs for clothing, shelter or s R5 two guardians. The progress notes 10/1/17 - 10/18/17, was learned regard	she stated the reason R5 was ys to change her behavior in at Karlstad Healthcare Center ansport company which lialysis three times a week had a facility that they would no of due to behavior of yelling, king false allegations of the ty, behavior, and conduct. The se there was only one available in the Karlstad area shoice but to attempt to find R5 nome to live at where R5 had alysis. When the DON was vidence the transportation DON stated the transport rovided any document Appointing Guardian dated lige on 5/26/16, which hecapacitated from mental extent lacking sufficient	F 25	50			

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		AND HUMAN SERVICES				FORM	11/21/2017 APPROVED 0938-0391	
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		PLE CONSTRUCTION		E SURVEY PLETED	
		245468	B. WING	i		10/20/2017		
NAME OF	PROVIDER OR SUPPLIER	•	•		STREET ADDRESS, CITY, STATE, ZIP CODE			
KARLST	AD HEALTHCARE CE				304 WASHINGTON AVENUE WEST			
					KARLSTAD, 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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 250	-On 10/4/17, R5 rei transport service an tried to kill her. The was too upset to ea the van driver to the service because R5 driven onto the sho feet. -On 10/5/17, R&L t nursing home staff escalating and R&L could continue to tr -On 10/6/17, R5 wa at Sanford Fargo, N Sanford Thief River in the emergency re- inpatient stay. The Fargo, ND attempte Karlstad Healthcare refused to allow R5 -On 10/8/17, R5 w room at Mayo Med evaluation. -On 10/9/17, R&L any further transpo -On 10/9/17, indica R5 to return to the transportation refus to dialysis. -On 10/11/17, indic (LSW) at the Mayo R5's insurance pro- transportation need provider got R&L to services for the mo -On 10/12/17, indic to Karlstad Healthco 5:30 p.m. (six days	turned to the facility via R&L nd stated the transport driver e progress note indicated R5 at supper, and wanted to report e owner of the transport 5 indicated the van driver had oulder of the road for many ransport reported to the that R5's behavior was doesn't know how long they ransport R5 to dialysis. as sent to the emergency room ND after having dialysis at r Falls, MN. R5 was evaluated oom and was not admitted for emergency room at Sanford ed to discharge R5 back to be Center, however, they is back into the facility. vas sent to the emergency ical Center for psychiatric transport refused to provide rtation services. ted the DON refused to allow facility because R&L sed to provide further transport ated the licensed social worker Medical Center contacted vider to assist with dialysis ds for R5. R5's insurance o agree to provide transport		250				

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PRINTED: 11/21/2017 FORM APPROVED

	-	AND HUMAN SERVICES				FORM	APPROVED
		& MEDICAID SERVICES					0938-0391
	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ID PLAN OF CORRECTION IDENTIFICATION NUMBER:						E SURVEY IPLETED
		045460	B. WING				
		245468	B. WING			10/:	20/2017
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
KARLST	AD HEALTHCARE CE	NTER INC			04 WASHINGTON AVENUE WEST (ARLSTAD, MN 56732		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTIO	N	(X5)
PRÉFIX TAG	(EACH DEFICIENCY REGULATORY OR L	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI> TAG	x	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)		COMPLETION DATE
F 250	Continued From pa	ge 27	F 2	50			
	4/1/17, through 8/24 progress notes had 4/1/17, and 5/9/17, R5 had inappropria A General progress "Behaviors are not a However, the behave 8/24/17, indicated F behaviors over the hollering, screaming clean her glasses 1 requesting oxygen f times per shift, and 1-2 millimeters (mm times per shift, and 1-2 millimeters (mm times per shift. The identified possible of declining physical h included staff attem as possible. From 8/24/17 - 10/1 behavior progress r increased inapprop screaming, yelling, assistance with carr aforementioned inc notes that identified inappropriate behav R5 had been comp determine causal fa behaviors, and inter inappropriate behav or implemented.	rease in behavioral progress					

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PRINTED: 11/21/2017

		AND HUMAN SERVICES				FORM	: 11/21/2017 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245468	B. WING			10/:	20/2017
NAME OF	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
KARLST	AD HEALTHCARE CE				4 WASHINGTON AVENUE WEST ARLSTAD, MN 56732		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 250	10/19/17, from 8:30 on 10/20/17, from 8 which R5 was not h cursing. It was note being dropped off b 10/17/17, at 1:15 p. hug and expressed transportation provi the hug to R5 and t facility the following Review of the Mayo dismissal summary was assessed in th was found not in ne psychiatric services more behaviorally b indicated the Karlst not agree to accept therefore R5 had to that she could rece dismissal summary psychiatry was con- was employed to ou behaviors and R5 of R5's care plan date following: R5's diagnoses with contribute to R5's v striking out at staff crying. R5 has no c planned intervention -Administer medica	 a.m. to 3:30 p.m. and again a:30 a.m9:30 a.m. during beard yelling, screaming, or by R&L transportation on m. R5 gave the van driver a words of thanks for the ided. The van driver returned cold R5 he would be at the day for transport to dialysis. 	F 25	50			

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DA	0. 0938-039 TE SURVEY MPLETED		
		245468	B. WING		10	/20/2017		
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD				
KARLST	AD HEALTHCARE CE	INTER INC		304 WASHINGTON AVENUE WEST KARLSTAD, MN 56732				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SF CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETIC DATE		
F 250	effects or ineffective Pharmacy review m medications are to building for appoint -Allow opportunity f feelings/concerns. -Remove from com manner and explain to redirect. -R5 needs as much and support to main and control over he -Crying: intervention talking about church 1:1 visits. -Verbal Aggression remove from comm manner and explain to redirect. Invite to escort her to activit Non-pharmacologic leave alone in safe remove from comm country music, offe weather permitting, -Observe/document and symptoms of d hopelessness, anxi anorexia, verbalizin repetitive anxious of tearfulness. -Observe/record tai document per facilit times when doing a Staff may go in alor	medical practitioner to side eness of medication. nonthly or as needed. No be sent with R5 when out of ments. or R5 to express her mon areas and leave in safe n you will return when unable n encouragement, assistance, ntain as much independence er environment as possible. ons included diversion with h/hymns, country music and : interventions included non areas, leave in a safe n you will return when unable activities of choice. Offer to ies, if desired. cal interventions included to environment and reapproach, non areas, discuss hymn or r coloring books, take outside	F 2	50				

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	RS FOR MEDICARE OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	(X3) DA	<u>). 0938-039</u> TE SURVEY
ND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G	CO	MPLETED
		245468	B. WING		10)/20/2017
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE	
KARLST	AD HEALTHCARE CI	ENTER INC		304 WASHINGTON AVENUE WEST KARLSTAD, MN 56732		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETIC DATE
F 250	Continued From pa	age 30 d 10/13/17, failed to identify	F 25	o		
	R5's screaming/ye repeatedly asking thad already been r washing glasses, a light repeatedly and she had put it on). any therapeutic co- the licensed social inappropriate beha frequency of those offered in an attem frustration before to repeatedly yelling a had not identified t transportation prov- trial basis for the m inappropriate beha plan did not identified developed to assiss maintaining approp- transportation to an the behavioral plan Center and found th hospitalized there, home care plan, no interventions imple	Iling behavior or behavior of for assistance with tasks that recently completed (i.e. adjusting fan, putting on the call d when answered denying that The care plan had not included nversation interventions with worker (LSW) to work through vior symptoms and the LSW services would be upt to calm R5's anxiety and behavior escalated to and screaming. R5's care plan he issues with R&L riding transport for R5 only on a nonth of October due to R5's vior during transport. The care y behavioral interventions t R5 with being successful with priate behavior during nd from dialysis. Additionally, n used while at Mayo Medical to be successful while R5 was was not added to R5's nursing or were the behavioral mented.				
	interviewed and as the facility that had also had a care pla interventions and g and behavior symp	3 a.m. the facility LSW was ked if she had any residents in high psychosocial needs, and an developed with appropriate goals which addressed mood otoms. The LSW stated she did ents with high psychosocial wed incorrections				

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	11/21/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245468	B. WING			10/2	20/2017
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
KARLST	AD HEALTHCARE CE	NTER INC			804 WASHINGTON AVENUE WEST (ARLSTAD, MN 56732		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 250 F 279 SS=D	interventions and g symptom's and inag been developed or indicated she was r behavioral plan hac hospitalized at May confirmed the beha Medical Center hac R5 returned to Karl 10/12/17. DEVELOP COMPF CFR(s): 483.20(d);4 483.20 (d) Use. A facility n assessments comp months in the resid results of the asses and revise the resic plan. 483.21 (b) Comprehensive forth at §483.10 includes measurabl to meet a resident's and psychosocial n comprehensive ass care plan must des (i) The services tha	Seessed and care plan oals to address the mood opropriate behavior had not implemented. The LSW not aware a successful I been developed for R5 while o Medical Center. The LSW vioral plan developed by Mayo I not been implemented after stad Healthcare Center REHENSIVE CARE PLANS 483.21(b)(1) nust maintain all resident bleted within the previous 15 ent's active record and use the sements to develop, review bent's comprehensive care Care Plans t develop and implement a son-centered care plan for sistent with the resident rights (c)(2) and §483.10(c)(3), that le objectives and timeframes a medical, nursing, and mental eeds that are identified in the sessment. The comprehensive		250			11/29/17

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		AND HUMAN SERVICES			-	APPROVEI 0938-039
-	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	TIPLE CONSTRUCTION		E SURVEY PLETED
		245468	B. WING _		10/2	20/2017
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
KARLST	AD HEALTHCARE CE	INTER INC		304 WASHINGTON AVENUE WEST KARLSTAD, MN 56732		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRC DEFICIENCY)	LD BE	(X5) COMPLETIO DATE
F 279	Continued From pa	ige 32	F 2	79		
		nd psychosocial well-being as 3.24, §483.25 or §483.40; and				
	under §483.24, §48 provided due to the	at would otherwise be required 33.25 or §483.40 but are not resident's exercise of rights uding the right to refuse 83.10(c)(6).				
	rehabilitative servic provide as a result recommendations. findings of the PAS	services or specialized es the nursing facility will of PASARR If a facility disagrees with the ARR, it must indicate its dent's medical record.				
	(iv)In consultation v resident's represen	vith the resident and the tative (s)-				
	(A) The resident's g desired outcomes.	goals for admission and				
	future discharge. F whether the resider community was as	preference and potential for acilities must document nt's desire to return to the sessed and any referrals to ties and/or other appropriate pose.				
	plan, as appropriate requirements set for section. This REQUIREMEN	s in the comprehensive care e, in accordance with the orth in paragraph (c) of this NT is not met as evidenced				
	facility failed to dev identification of the	v, and document review, the elop a care plan to include the use of Carbamazepine ation), monitoring needs or		The preparation of the following correction for this deficiency does constitute and should not be inter as an admission nor an agreeme	s not preted	

Facility ID: 00830

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STATEMENT	OF DEFICIENCIES	KMEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE (CONSTRUCTION	(X3) DATE	0938-039
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G		COMI	PLETED
		245468	B. WING _			10/2	20/2017
NAME OF I	PROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE		
KARLST	AD HEALTHCARE CI	ENTER INC		304 KAI			
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETIO DATE
F 279	Continued From pa	age 33	F 27	9			
	side effects for 1 o for unnecessary m	f 5 residents (R35) reviewed edications.			acility of the truth of the facts alleg conclusions set forth in the statem deficiencies. The plan of correctio prepared for this deficiency was exp	ent of n	
	Findings include:		f f	solely because provisions of state ederal law require it. Without wai oregoing statement, the facility sta	and ving the		
	R35's care plan fai Carbamazepine (m and partial comple effects and monito		((with respect to: 1. R35 had a care plan review wi changes made for the medication Carbamazepine for resident behav R35 has not had a history of seizu	viors. res.		
	diagnoses of Alzhe disorder, hypothyrc undifferentiated sc	port dated 10/20/17, indicated eimer's disease, anxiety bidism Parkinson's disease, hizophrenia, dementia with ances, and profound intellectual			Pharmacy consultants state that w Carbamazepine is being utilized for behaviors, checking routine levels clinically indicated. 2. All residents will be reviewed t chart review for seizure history, to that they are care planned appropria along w/ being identified on the MI	r isn't hrough ensure riately	
	as severely impaire behaviors and rece	S, dated 9/18/17, identifies R35 ed, exhibits verbal and physical eived antipsychotic, tianxiety and antibiotic		i 3 t 2	 that monitoring needs have been dentified and implemented. 3. Staff education will be completed to add the use of medications and if side or behaviors warrant monitoring. 4. Audits of care plans will be completed by DNS or designee with all new 	dress effects	
	R35's Medication Review Report (MRR), dated 10/6/17, indicated R35 received Carbamazepine 300 milligrams (mg) in the evening for seizures. The MRR further identified R35's Carbamazepine 300 mg medication- start date as 12/14/16.			a r f V V	admissions and for any resident had medication order changes for the following 3 months to ensure that a psychoactive or anti-seizure medic would be identified properly on the care plan, and the monitoring need dentified and implemented. The c	all cation MDS, ds	
	10/2017, indicated	Administration Record, dated R35 received Carbamazepine he evening for seizures.		c c t	collected will be reviewed at the M QAPI and Quarterly QA meeting. time the committee will make the decision/recommendation regardir	onthly At that	

Facility ID: 00830

		AND HUMAN SERVICES				FORM	11/21/2017 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION		E SURVEY PLETED
		245468	B. WING			10/:	20/2017
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
KARLST	AD HEALTHCARE CE	INTER INC			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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 279	psychoactive media Risperdal, Celexa, care plan lacked id identification of seiz monitoring, or inter On 10/2/17, at 9:05 recently returned fr her Carbamazepine and staff should ha monitoring R35's us ADON stated she w exhibiting any seizu last Carbamazepine indicated a result o reference range is she would expect th medication to be m should reflect ident medication use, po needs, and identifies stated the facility ha and have had resid needs which had ha and recognized the resident needs. On 10/20/17, at 1:1 (DON) confirmed th anti-seizure medica accurately on the M monitoring needs in The DON further st the survey they had	int date 10/20/17, identified cation use for Zyprexa, Klonopin, and Buspar. The entification of a focus zure medication use,	F 2	279	follow-up studies. Completion Date: 11/29/17		

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		AND HUMAN SERVICES				FORM	11/21/2017 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245468	B. WING			10/2	20/2017
NAME OF F	PROVIDER OR SUPPLIER	-		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
KARLST	AD HEALTHCARE CE				04 WASHINGTON AVENUE WEST (ARLSTAD, MN 56732		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 279	Continued From pa needs, which need	ge 35 ed to be addressed.	F 2	279			
F 280 SS=D	Guideline last revis plan must be review quarterly, with a sig as needed. The pol person centered ca towards: preventing managing risk facto staff to include targ non-pharmacologic medication class if diagnosis/indication reductions/pharmac RIGHT TO PARTIC CARE-REVISE CP	al interventions, psychoactive applicable with appropriate of for use, and gradual dose cy reviews. CIPATE PLANNING	F 2	280			11/29/17
	and implementation plan of care, include (i) The right to parti- including the right to be included in the p- request meetings a revisions to the per (ii) The right to part expected goals and amount, frequency, other factors related plan of care.	Participate in the development of his or her person-centered ing but not limited to: cipate in the planning process, o identify individuals or roles to planning process, the right to nd the right to request son-centered plan of care. icipate in establishing the d outcomes of care, the type, and duration of care, and any d to the effectiveness of the eive the services and/or items					

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		AND HUMAN SERVICES				FORM	APPROVED 0938-0391	
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL7	TIPI	LE CONSTRUCTION		E SURVEY	
-	OF CORRECTION	IDENTIFICATION NUMBER:					PLETED	
		245468	B. WING _			10/:	20/2017	
NAME OF F	PROVIDER OR SUPPLIER		<u> </u>	S	STREET ADDRESS, CITY, STATE, ZIP CODE			
KARLST	AD HEALTHCARE CE			-	304 WASHINGTON AVENUE WEST			
			KARLSTAD, MN 56732					
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION	
TAG		SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROP DEFICIENCY)		DATE	
	1		 /					
F 280	Continued From pa	uge 36	F 2	20				
	included in the plan	-	• -	00				
		the care plan, including the gnificant changes to the plan						
	of care.	grimeant changes to the plan						
	(c)(3) The facility sh	hall inform the resident of the						
	right to participate in	n his or her treatment and						
	shall support the re- planning process m	sident in this right. The nust						
	(i) Facilitate the incl resident representa	lusion of the resident and/or ative.						
	(ii) Include an asses strengths and need	ssment of the resident's ls.						
		resident's personal and s in developing goals of care.						
	483.21							
	(b) Comprehensive	Care Plans						
	(2) A comprehensiv	ve care plan must be-						
	(i) Developed withir the comprehensive	n 7 days after completion of assessment.						
	(ii) Prepared by an i includes but is not l	interdisciplinary team, that limited to						
	(A) The attending p	hysician.						
	(B) A registered nur resident.	rse with responsibility for the						
	(C) A nurse aide wit resident.	th responsibility for the						
	1		1				1	

Facility ID: 00830

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PRINTED: 11/21/2017

		AND HUMAN SERVICES		F	ITED: 11/21/2017 ORM APPROVED NO. 0938-0391		
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION (X3	(X3) DATE SURVEY COMPLETED		
		245468	B. WING		10/20/2017		
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
KARLST	AD HEALTHCARE CE	INTER INC		304 WASHINGTON AVENUE WEST KARLSTAD, MN 56732			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE		
F 280	Continued From pa	ige 37	F 280				
	(D) A member of fo	od and nutrition services staff.					
	the resident and the An explanation mus medical record if th and their resident re	racticable, the participation of e resident's representative(s). st be included in a resident's e participation of the resident epresentative is determined the development of the n.					
		te staff or professionals in mined by the resident's needs the resident.					
	team after each ass comprehensive and assessments.	revised by the interdisciplinary sessment, including both the d quarterly review NT is not met as evidenced					
	facility failed to ens revised to include fl and ongoing monito (R5) resident in the and failed to revise behavior/mood sym medications for 2 o	w, and document review, the ure the written care plan was luid restriction interventions oring of fluid intake for 1 of 1 sample reviewed for dialysis, the care plan to include target optoms for psychotropic f 5 residents (R6, R30) essary medications.		The preparation of the following plan correction for this deficiency does not constitute and should not be interprete as an admission nor an agreement by facility of the truth of the facts alleged conclusions set forth in the statement deficiencies. The plan of correction prepared for this deficiency was execu- solely because provisions of state and federal law require it. Without waiving	ed the or of uted i		
	Findings include:			foregoing statement, the facility states with respect to: 1. R5 did not have a physician order fluid restriction due to an extensive his	for		
	indicated R5 was a diagnoses that inclu	agnoses list dated 10/19/17, dmitted to the facility with uded, but were not limited to: ease requiring hemodialysis,		of non-compliance. R5 has had a car plan review to include fluid restriction interventions and monitoring of fluid intake. R6 and R30 have had care pla	e		

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				X3) DATE	0938-039 SURVEY PLETED
		245468	B. WING _			10/2	20/2017
NAME OF	PROVIDER OR SUPPLIER	-		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
KARLST	AD HEALTHCARE CE				4 WASHINGTON AVENUE WEST ARLSTAD, MN 56732		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETIC DATE
F 280	bipolar disorder, dis post-traumatic stree borderline personal On 10/20/17, at 9:2 the end of the brea have four cups of fl 240 cubic centimete 960 cc of fluid on h of the fluids provide serve her the corre to her dialysis diet. how much fluid she showed the survey written down for ea no totals which ider consumed in a day look complete. R5 a was not correct and restriction was 32 c dialysis unit had no fluid intake log beca recordings. R5 stat with fluid managem to keep going into t	Supplies behavior disorder, se disorder, and sociopathic lity disorder. 22 a.m. R5 was observed at kfast meal and was noted to uid each which held at least ers (cc) per cup for a total of er breakfast tray. R5 drank all ed. R5 stated the facility did not ct amount of fluids according R5 stated she herself tracked e consumed each day and or a notebook with numbers ch day. However, there were ntified how much fluid was and many of the days didn't also stated the fluid calculation d she did not know if her fluid or 36 ounces. R5 stated the t even looked at her personal ause they did not believe her ed she was trying to do better nent because she didn't want he hospital for fluid overload. ated physician orders no fluid restriction ordered, s medical record was as note dated 8/23/17, nurse notified the facility that more than four 8 ounce	F 28	80	reviews with updates to include target behavior/mood symptoms for psychotropic medications. 2. Residents receiving dialysis will I their care plans reviewed for fluid restrictions and ongoing monitoring of fluid intake. Residents that received psychotropic medication will have ca plans reviewed for target behavior/m symptoms. 3. Staff education will be completed 11/15/17 regarding target behavior/r monitoring care plan need, and the r for fluid intake monitoring with reside receiving dialysis. 4. DNS or designee will complete a on any new residents/ new orders fo current residents on dialysis or with psychotropic medication ordered for following 3 months and, to ensure th proper care planning. The data colle will be reviewed at the Monthly QAPI Quarterly QA meeting. At that time t committee will make the decision/recommendation regarding follow-up studies. Completion Date: 11/29/17	have of are nood d mood heed ents audits r the at ected I and the	

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		AND HUMAN SERVICES				FORM	: 11/21/2017 APPROVED . 0938-0391	
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245468	B. WING			10/	/20/2017	
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	•		
KARLST	AD HEALTHCARE CE				804 WASHINGTON AVENUE WEST (ARLSTAD, MN 56732			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIJ TAG	x	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 280	her own fluid restrict total intake to be dis nursing and to docu care plan had not ic cc's of fluid was allo medication pass an non-compliant with plan also failed to ic minimize fluid cons instead of water, of juice, or offering ha symptoms of dry m Further review of R intake monitoring a been documented a Licensed practical r on 10/20/17, 9:50 a intake was not mon was no way to tell w balance. The director of nurs 10/20/17, at 10:32 a restrictions during w plan had not identifi not delineated how during meals, and r during medication p R6's care plan was target/mood symptor	 are plan stated R5 "monitors of the care plan directed stributed between dietary and ument non-compliance. The dentified a plan for how many of the for each meal and ind had not identified R5 was fluid restrictions. The care dentify interventions to umption like offering ice chips fering a popsicle rather than rd candy or lemon drops for outh. 5's medical record revealed nd R5's fluid balance had not and monitored. hurse (LPN)-A was interviewed and stated R5's fluid balance had not and monitored. sing (DON) was interviewed on a.m. regarding R5's fluid restriction, had many fluids R5 would receive now much fluid R5 received bass by nursing. not revised to include base of the care is a state of the care of the	F 2	80				
	R6's Diagnosis Rep	port dated 10/20/17, included						

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		AND HUMAN SERVICES				FORM	: 11/21/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245468	B. WING			10/:	20/2017
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
KARLST	AD HEALTHCARE CE	NTER INC			04 WASHINGTON AVENUE WEST CARLSTAD, MN 56732		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 280	disorder, and schize R6's annual Minimu 8/1/17, identified R6 days during the ass antipsychotic and a R6's Behavioral syd dated 8/3/17, indica calling out to staff w transferring rather t CAA indicated the b not be care planned noted on the CAA. R6's physician orde 10/20/17 included: -Benzotropine Mesy of Parkinson's disea due to side effects of milligram (mg) at be date of 7/26/16. -Lexapro (antidepre the morning for dep -Trazodone (antidepre the morning for dep -Trazodone (antidepre the morning for dep anti-anxiety medica R6's care plan print on 10/20/17, indicated medications related 11/14/16). The asso instruction to give a by the physician. Th	depressive disorder, anxiety oaffective disorder. um Data Set (MDS) dated 5 had verbal behaviors 1-3 sessment period and took ntidepressant medications. mptom Care Area Assessment ated R6's behaviors included when she needed assistance han using her call light. The behavioral symptoms would d, no further analysis was ers provided by the facility on ylate (used to treat symptom ase or involuntary movements of certain psychiatric drugs) edtime for behaviors. Start essant medication) 15 mg in pression. Start date of 7/26/16. pressant medication) 50 mg at lepressive disorder. Start date rs did not include an	F 2	280			

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		AND HUMAN SERVICES					FORM	11/21/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		(X3) DATE	E SURVEY PLETED
		245468	B. WING	i			10/2	20/2017
NAME OF F	PROVIDER OR SUPPLIER		-		STREET ADDRESS, CITY, STATE, ZIP CC	DE		
KARLST	AD HEALTHCARE CE				304 WASHINGTON AVENUE WEST KARLSTAD, MN 56732			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD) BE	(X5) COMPLETION DATE
F 280	seated in her reclin R6 fell asleep multi interview and was of overall facial expres- emotion in respons On 10/17/17, at 8:5 ambulate down the mood was light and emotion when conv On 10/18/17, at 1:5 (LSW) reviewed R6 target/mood sympto- identified. LSW exp anxiety and had up displayed depressiv- hair or makeup and of her room on thos was anxious it seer impulsive and perce- than what they were On 10/19/17, at 9:4 nursing (ADON) ve symptoms on the c mood symptoms sh the care plan.	 d on the CAA. 4 p.m. R6 was observed er in her room, watching TV. ple times during the resident difficult to keep awake. Her ssions were flat with little es to questions. 9 a.m. R6 was observed to hallway using her walker, her appropriate, had slightly more rersing. 7 p.m. licensed social worker by sort depression were not blained R6 had depression and and down days and R6 ve symptoms by not doing her I generally would not come out se days. LSW stated when R6 ned like she was more eived things more negatively e. 5 a.m. assistant director of rified the lack of target mood are plan and stated the target hould have been identified on 	F	280				
		Sheet dated 10/20/17, of dementia without						

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		I AND HUMAN SERVICES E & MEDICAID SERVICES			FORM	11/21/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE	E SURVEY PLETED
		245468	B. WING		10/:	20/2017
NAME OF F	PROVIDER OR SUPPLIER	•	S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
KARLST	AD HEALTHCARE CE	INTER INC		804 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 280		age 42 Ince, anxiety disorder, and	F 280			
	major depressive d					
	8/4/17, indicated R3 impairment and had towards others one assessment period	num Data Set (MDS) dated 30 had severe cognitive d verbal behaviors directed to three days during the and there had not been a s since the previous				
	R30 had the potent being resistive to ca behavioral symptor the care plan. The	CAA dated 8/7/17, indicated tial for behavioral problems by ares and indicated the ms would not be addressed on CAA lacked indication of the entified on the MDS.				
	(antidepressant) 20 major depressive d 5/22/17, and mirtaz major depressive d behaviors for anxie on the physician or 12/29/16, included of bed and directed area and offer nour	ders included Celexa o milligrams every morning for lisorder with a start date of capine 15 mg every bedtime for lisorder. R30's target sty to be monitored indicated ders, and were dated restlessness and crawling out d staff to bring R30 to quiet rishment. The physician's tify target mood symptoms for				
	facility on 10/20/17, antidepressant and	nted and provided by the , indicated R30 received I antianxiety medication related ety, and appetite stimulation.				

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	11/21/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATI	E SURVEY PLETED
		245468	B. WING _			10/2	20/2017
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
KARLST	AD HEALTHCARE CE	NTER INC			4 WASHINGTON AVENUE WEST ARLSTAD, MN 56732		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 280	sadness, anxiety, a by ineffective copins on 12/21/16. R30's Progress Not 7/17/17-10/16/17, ro of care, medication and hitting staff. Th revised to include ra identified on the CA On 10/16/17, at 5:1 calmly lying in bed a pleasant; she smile words including her of nursing (DON) re and explained once persist because R3 agitated if asked too On 10/17/17, at 9:1 seated in the lobby calm and looking ar was doing, R30 sm responding. On 10/18/17, at 7:1 resting in bed with f -At 7:53 a.m. R30 w her eyes open. -At 8:24 a.m. nursin the room and assist	 ated R30 had feelings of nd depression characterized g and fearfulness last revised tes reviewed from eflected behaviors of refusals and meals, agitation, hollering e care plan was also not esistive to care that was vA. 3 p.m. R30 was observed awake. R30's mood was d and was unable to articulate mame. At 6:20 p.m. director eported she refused dinner e she refused, staff did not 0 would become very easily o many questions. 8 a.m. R30 was observed area in her pajamas. R30 was round. When asked how she iled without verbally 0 a.m. R30 was observed her eyes closed. was resting calmly in bed with ng assistant (NA)-A entered ted R30 with morning cares. 	F 28	80	DEFICIENCY)		
	NA-A gave verbal c	ues during the cares, R30 was and followed cues without					

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		AND HUMAN SERVICES				FORM	: 11/21/2017 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245468	B. WING			10/:	20/2017
NAME OF	PROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
KARLST	AD HEALTHCARE CE	INTER INC		-	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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 280	evidence of any bel NA-A explained R3 and if she didn't like them away. NA-A re included pushing st her behaviors were have a problem witi would use intervent something to eat, a time. On 10/19/17, at 9:4 the care plan did no behaviors/moods a have a process in p analysis and/or eva mediations. On 10/20/17, at 9:3 hit, pinch, scratch, a interventions includ member, getting me later time, and nails -At 9:37 a.m. licens stated R30 hit staff refused medication aides across the ro R30 exhibited the b re-approach and us -At 12:58 a.m. NA-F once in a while whe tired and this was d expressions. NA-B NA's or shake her f	havioral or mood symptoms. 0 did better with older NA's e someone she would wave eported R30's behaviors taff away, refusing care, and e sporadic and usually did not h redirection. NA-A stated staff tions such as toileting, offer and/or re-approaching at a later 45 a.m. the ADON confirmed bit identify all of R30's and stated the facility did not blace to ensure ongoing aluation of psychotropic 81 a.m. NA-C stated R30 would and refuse meals. NA-C stated led getting a different staff ore help, re-approaching at a		280			

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	11/21/2017 APPROVED 0938-0391		
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE	E SURVEY PLETED		
		245468	B. WING _		10/2	20/2017		
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
KARLST	AD HEALTHCARE CE	NTER INC	304 WASHINGTON AVENUE WEST KARLSTAD, MN 56732					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE		
F 280 F 282 SS=D	and telling her what attempt to try again Facility policy Perso Guideline last revise plan must be review quarterly, with a sig as needed. The pol person centered ca towards: preventing managing risk facto staff to include targe non-pharmacologic medication class if diagnosis/indication reductions/pharmaco SERVICES BY QU/ CARE PLAN CFR(s): 483.21(b)(3) (b)(3) Comprehensi The services provid as outlined by the c must-	calm down by sitting with her you are doing step by step or later. In Centered Care Plan ed 11/16, indicated the care wed and revised annually, nificant change in status and icy also included, the overall re plan should be orientated avoidable declines, and ors. The policy also directed et behaviors, al interventions, psychoactive applicable with appropriate for use, and gradual dose cy reviews. ALIFIED PERSONS/PER 3)(ii) ive Care Plans led or arranged by the facility, omprehensive care plan,	F 28	0		11/29/17		
	care. This REQUIREMEN by: Based on observat review, the facility fa plan related to the r skin impairment for wound which was n	NT is not met as evidenced ion, interview, and document ailed to implement the care eporting of newly identified 1 of 3 residents (R37) with a ot reported, assessed or		The preparation of the following pla correction for this deficiency does no constitute and should not be interpre- as an admission nor an agreement facility of the truth of the facts allege	ot eted by the ed or			
	treated. In addition,	the facilty failed to document		conclusions set forth in the stateme	nt of			

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STATEMEN	OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	OMB NO. (X3) DATE COMF	
		245468	B. WING		10/2	20/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
KARLST	AD HEALTHCARE CE	ENTER INC		304 WASHINGTON AVENUE WEST KARLSTAD, MN 56732		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 282	and monitor behavi psychotropic medic plan for 1 of 5 resid unnecessary medic Findings include: R37's care plan rev had chronic kidney check body for brea as ordered by med anticoagulant thera directed staff to per and to report abnor practitioner. The sk directed staff to use and transfers to pre hands against surfa R37's medical reco skin impairment or directed by the care On 10/18/17, at 7:5 seated in wheelcha covered. The right the knee and the le yellow/reddish thin upper calf just belo the wound was not entered the room fi surveyor reported t wound on the outsi previously aware of	vised on 8/17/16, indicated R37 disease and directed staff to aks in skin and treat promptly ical practitioner. The py care plan dated 11/1/16, form daily skin inspections malities to the nurse/medical sin care plan dated 11/1/16, e caution during bed mobility event striking arms, legs, and aces that may cause injury.	F 282	 deficiencies. The plan of correcting prepared for this deficiency was essolely because provisions of state federal law require it. Without was foregoing statement, the facility swith respect to: R37 has had his skin impairing assessed and treated. R1 has had behaviors monitored and docume All current residents will have to toe body assessment for injury wounds by 11/29/17. All current rewill be audited for psychotropic muse and proper documentation or behavior along with non-pharmace alternatives tried prior to prn med use. Staff education will be completed to remonitor and document any resided injury or behavior. DNS or designee will audit 5 weekly x1 month, then 1 resident for 2 months regarding the prope documentation of skin injury, resistarget behavior monitoring and Pl medication administration. The data collected will be reviewed at the NQAPI and Quarterly QA meeting. time the committee will make the decision/recommendation regard follow-up studies. 	executed e and iving the tates nent ad ented. a head or residents edication ologic ication eted by port, ent skin residents weekly r dent RN ata <i>N</i> ata <i>N</i> At that	

		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	: 11/21/2017 APPROVED 0938-0391
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KARLST	AD HEALTHCARE CE	INTER INC		-	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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 282		e NAs failed to report the	F 2	282			
	nursing (ADON) sta R37's left leg wound wheelchair back to periphery was now to a darker red and ADON cleaned, me wound. R37 stated over a week ago will wheelchair when tra not told anybody ab figured it would just NAs should report of the nurse. Following	45 p.m. assistant director of ated she was not informed of id. ADON assisted R37 in his his room. The wound red and the scab had changed appeared to be thicker. The easured, and dressed the he had received the wound hen he bumped it on his ansferring. R37 stated he had bout the wound because he t heal. The ADON stated the changes in skin condition to g this assessment, a n assessment was completed					
	indicated maintena which caused wour protein powder add	gress noted dated 10/20/17, ince would pad on wheelchair nd, dietary informed and ded to the diet plan, wound to education provided to staff.					
	R1's care plan was monitoring/docume interventions and o	enting of target behaviors,					
	had feelings of une to anxiety, depressi disorder. Target be	nt date 10/20/17, indicated R1 easiness and sadness related ion and episodic mood haviors identified for xiety was explosive behaviors					

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		AND HUMAN SERVICES				FORM	: 11/21/2017 APPROVED . 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245468	B. WING			10/	20/2017
NAME OF I	PROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
KARLST	AD HEALTHCARE CE	INTER INC			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 PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 282	and directed staff to visits, ensure safety doll, and engage in directed to record to interventions used, R1's Medication Ad dated 10/2017, indi 7.5 mg at bedtime to mg orally as needed disorder. The MAR needed Ativan 1 mg -8/27/17 at 3:30 p.r -9/8/17 at 12:00 a.r -9/20/17 at 12:15 a -9/21/17 at 12:00 p. The MAR identified Interventions, and of shift, daily. The mo 10/17, were all blar behaviors, non-pha outcomes for the da Ativan. On 10/18/2017, at 7 nurse (LPN)-A stated document on the M behaviors and not j Ativan. The LPN co documentation form have been complet -At 7:29: a.m. the A	 b redirect, provide one to one y, divert attention, offer baby conversations. Staff was also he number of occurrences, and outcomes. Iministration Record (MAR), icated R1 received Remeron for depression and Ativan 1 of for anxiety/explosive indicated R1 received as g on: m. m. m. m. iministration for solve behavior, outcomes for monitoring every nitoring forms for 8/17, 9/17, he and did not identify armacological interventions or ays R1 utilized as needed 7:20 a.m. licensed practical ed staff were supposed to IAR when R1 had any fust when she received the onfirmed the aforementioned ns were blank and should ted, as directed. 	F 2	282			

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	-	AND HUMAN SERVICES				FORM	: 11/21/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	E SURVEY IPLETED
		245468	B. WING	i		10/:	20/2017
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
KARLST	AD HEALTHCARE CE			-	304 WASHINGTON AVENUE WEST KARLSTAD, MN 56732		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 282	behaviors occurred needed Ativan. The awake for a couple followed by exhaus days when she unc stated R1 received month, several time periods of looking fi staff were suppose behaviors on the M attempted and the of the MAR's with the 8/17, the ADON cou- behavioral docume should have been of addition, the ADON an accurate reflecti to determine if the of medication was need decrease should be On 10/20/17, at 1:1 resident MDS asse monitoring of psych should have been of accurately reflect th personal needs. Th expectation that mo identification of targ documentation of th interventions be do currently being don the facilty knew on that the resident ca monitoring was ser	 , not just when R1 received as ADON stated R1 would be of days looking for her baby tion and sleeping. R1 had ontrollably cried. The ADON as needed Ativan once this es in September due to or her baby. The ADON stated d to be documenting the AR along with interventions outcomes. During review of ADON for 10/17, 9/17, and nfirmed they were void of any ntation and stated the staff documenting the behaviors. In stated the facility did not have on of R1's behaviors in order continued use of the cessary or if an increase or e initiated. 6 p.m. the DON confirmed asments, care plans and loactive and other medications completed in order to be residents medical and le DON confirmed it was her onitoring of medications, the 	F	282			

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STATEMENT	OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DAT	<u>. 0938-039</u> E SURVEY IPLETED
		245468	B. WING		10/	20/2017
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
KARLST	AD HEALTHCARE CE	ENTER INC		304 WASHINGTON AVENUE WEST KARLSTAD, MN 56732		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 282	Documentation Gu the facility would m communicate conc behaviors and prov for practice decisio resident plan of car The facility Person	Mood and Behavior idelines, dated 11/16, indicated onitor behaviors to erns in resident mood and /or ride documentation of evidence ns and modifications to the re. Centered Care Plan Guideline,	F 28	2		
F 309 SS=G	revised 11/2016, in develop and impler each resident that is provide effective ar resident that meet quality of care and the services that ar maintain the reside mental and psycho	dicated the facility must ment a baseline care plan for included instructions needed to nd person-centered care of the professional standards of the care plan must describe re to be furnished to attain or ent's highest practicable, social well-being. ERVICES FOR HIGHEST	F 30	9		11/29/17
	applies to all care a residents. Each re facility must provide services to attain o practicable physica well-being, consiste	fe undamental principle that and services provided to facility sident must receive and the e the necessary care and r maintain the highest I, mental, and psychosocial ent with the resident's sessment and plan of care.				
	applies to all treatm facility residents. B	are fundamental principle that nent and care provided to ased on the comprehensive esident, the facility must ensure				

Facility ID: 00830

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	11/21/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE	E SURVEY PLETED
		245468	B. WING	i		10/2	20/2017
NAME OF F	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
KARLST	AD HEALTHCARE CE	NTER INC					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	accordance with pro- practice, the compri- care plan, and the re- but not limited to the (k) Pain Management The facility must en- provided to residen consistent with profi- the comprehensive and the residents' get (I) Dialysis. The face residents who requi- services, consistent of practice, the com- care plan, and the re- preferences. This REQUIREMENT by: Based on observati- review, the facility fa- resident (R5) review occurred as a resul- monitoring R5's flui- hospitalizations for based on observati- review the facility fa- impaired skin integr- observed who was	ve treatment and care in ofessional standards of ehensive person-centered residents' choices, including e following: ent. sure that pain management is ts who require such services, essional standards of practice, person-centered care plan, goals and preferences. cility must ensure that ire dialysis receive such t with professional standards oprehensive person-centered residents' goals and NT is not met as evidenced cion, interview, and document ailed to ensure dialysis fluid	F	309	The preparation of the following pla correction for this deficiency does no constitute and should not be interpre as an admission nor an agreement facility of the truth of the facts allege conclusions set forth in the stateme deficiencies. The plan of correction prepared for this deficiency was exe solely because provisions of state a federal law require it. Without waivi foregoing statement, the facility stat with respect to: 1. Fluid intake monitoring was implemented on R5. R37 impaired	ot eted by the ed or nt of ecuted ng the es skin	
	Findings include:				integrity was identified, monitored at received treatment.All resident care plans will be reviewed to insure that each include		

Event ID:RQUD11

Facility ID: 00830

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		E & MEDICAID SERVICES					0938-039	
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED	
		245468	B. WING _			10/2	20/2017	
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
KARLST	AD HEALTHCARE CI	ENTER INC			04 WASHINGTON AVENUE WEST ARLSTAD, MN 56732			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIC DATE	
F 309	R5's cumulative dia indicated R5 was a diagnoses that incl bipolar disorder, ac anxiety and depress disorder, narcotic of behavior disorder, end stage renal dis back pain, right ha amputation, and so personality disorder R5's medical recor- identified as Order and signed by a jud indicated R5 was in impairment to the e understanding or of communicate resp personal needs for clothing, shelter or R5 two guardians. R5's quarterly Mini 7/6/17, indicated R deficits, R5 had ina identified as inatter attention, being ea keeping track of wi also indicated R5 h symptoms present down, depressed, having to little ener self-or that you are a family member d	agnoses list dated 10/19/17, admitted to the facility with luded, but were not limited to: djustment disorder with mixed seed mood, major depressive dependence, disruptive post-traumatic stress disorder, sease, chronic radicular low nd and right below the knee pociopathic borderline	F 3	09	baseline care plan that includes instructions needed to provide effect and person-centered care of the re It will also describe the services that be furnished to attain or maintain the resident's highest practicable, men- psychosocial well-being. All dialysis residents will have fluid intake mon and the dialysis center will be notified results. All current residents will have full body assessment completed to evaluate skin integrity 3. Staff education will be completed to 11/29/17 regarding the need for accurate care plans being effective person-centered and must include services provided for their physical, mental and psychosocial needs. Protocols with regard to communica with dialysis have been revised. 4. DNS or designee will audit all m admission care plans for the follow months and 2 resident changes in m with regard to care planning weekly month. The data collected will be reviewed at the Monthly QAPI and Quarterly QA meeting. At that time committee will make the decision/recommendation regarding follow-up studies. Completion Date 11/29/17	sident. at are to ne tal and s itored ed w/ ave a ed prior ly , ation needs r x2 e the		

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		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	: 11/21/2017 APPROVED . 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245468	B. WING	ì		10/	/20/2017
NAME OF	PROVIDER OR SUPPLIER	•	-	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
KARLST	AD HEALTHCARE CE	INTER INC			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 CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRC DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 309	have verbal behavio others (threatening at others) 1-3 days R5 required extens for bed mobility and extensive assistand personal hygiene a unit using a wheeld ambulate, and was during transfers. On 10/20/17, at 9:2 the end of the brea have four cups of fl centimeters (cc) pe fluid on her breakfa fluids provided. R5 her the correct and dialysis diet. R5 sta much fluid she cons the surveyor a note down for each day. which identified how a day and many of complete. R5 also s not correct and she restriction was 32 o stated the dialysis u personal fluid intake believe her recordir to do better with flu did not want to kee fluid overload. Review of R5's und revealed there was	age 53 or symptoms directed at others, screaming or cursing a week. The MDS indicated sive assistance of two persons d toilet use, and required ce of one person for dressing, and locomotion on and off the chair. R5 was unable to totally dependent on two staff 22 a.m. R5 was observed at kfast meal and was noted to luid each which held 240 cubic er cup for a total of 960 cc of ast tray. R5 drank all of the stated the facility did not serve ount of fluids according to her ated she herself tracked how sumed each day and showed abook with numbers written . However, there were no totals w much fluid was consumed in the days did not look stated the fluid calculation was e did not know if her fluid or 36 ounces per day. R5 unit had not even looked at her e log because they did not ngs. R5 stated she was trying iid management because she p going into the hospital for	F	309			

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		I AND HUMAN SERVICES E & MEDICAID SERVICES			FORM	: 11/21/2017 APPROVED . 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245468	B. WING		10/	20/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
KARLST	AD HEALTHCARE CE	INTER INC		304 WASHINGTON AVENUE WEST KARLSTAD, MN 56732		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 309	reviewed a progress indicated a dialysis R5 should have no servings (960 cc) o Review of R5's care on 10/13/17, reveal identified, and the c her own fluid restrict total intake to be dia nursing and to docu care plan had not ic cc's of fluid was to l medication pass an fluid restrictions. Th interventions to mir offering ice chips in popsicle rather than lemon drops for syn Further review of R intake monitoring a been documented a Licensed practical r on 10/20/17, 9:50 a intake was not mon was no way to tell v fluid balance. On 10/20/17, at 9:5 nurse manager was fluid intake and mo manager stated R5	e plan for dialysis last revised led no fluid restriction was care plan stated R5 "monitors ctions." The care plan directed stributed between dietary and ument non-compliance. The dentified a plan for how many be allotted for each meal and nd R5's noncompliance with ne care plan had not included nimize fluid consumption like nstead of water, offering a n juice, offering hard candy or mptoms of dry mouth.	F 30			

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		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	: 11/21/2017 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245468	B. WING _			10/;	20/2017
NAME OF	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
KARLST	TAD HEALTHCARE CE	INTER INC			04 WASHINGTON AVENUE WEST ARLSTAD, MN 56732		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	dialysis nurse state her dry weight, and fluids between dialy dialysis nurse state record and monitor got close to daily to educated regarding non-compliance wit choices after being dialysis nurse state with the fluid restric month R5 had beer intake amounts. Th manager stated R5 twice in the previou overload on 6/24/17 Review of R5's hos R5 had been hospit twice in the last six 9/6/17. The Altru ho dated 9/8/17, indica hospital on 9/6/17, fluid overload, chro failure, and end sta dismissal summary compliant with fluid required hospitaliza runs were impleme fluid. The dismissal also been hospitaliz Altru hospital on 9/8 The hospitalion 6/24 from the facility but	ad R5 was 8-12 kilograms over I was gaining large amounts of ysis treatments (3-5 kg). The ed she expected the facility to R5's fluid intake, R5 could be g the risks and benefits of th fluid restrictions, and make provided the education. The ed R5 could be non-compliant ction, however, in the last n really trying to decrease fluid he dialysis registered nurse to had been hospitalized at least is 6 months for fluid volume 7, and 9/6/17. Spitalization records revealed talized with fluid overload months on 6/24/17, and ospital dismissal summary ated R5 was admitted to the with a diagnoses that included: onic hypoxemic respiratory age renal failure. The y indicated R5 had not been I intake restrictions, and ation where daily hemodialysis ented to remove the excess I summary indicated R5 had zed on R5 discharged from 8/17. records for R5's k/17- 6/28/17, were requested	F 3(09			

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		AND HUMAN SERVICES				FORM	: 11/21/2017 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •			(X3) DATE	E SURVEY PLETED
		245468	B. WING			10/:	20/2017
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
KARLST	AD HEALTHCARE CE	NTER INC			04 WASHINGTON AVENUE WEST ARLSTAD, MN 56732		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	10/16/17, revealed (11-22 pounds) over weight), and had not during any dialysis The director of nurs 10/20/17, at 10:32 a restrictions during v was still not monito fact R5 had been h on 4/4/14, and 9/6/- dialysis unit asked t intake. The DON st with fluid restriction monitor her own flu DON confirmed a ju because R5 was im- impairment to the e understanding or ca communicate respon- personal needs for clothing, shelter or did not respond who capacity to make re- decisions concernin R37 was at risk for complication and th report, and treat a ca R37's Diagnosis Re- diagnoses of diabel- right below the knew vascular disease, c (infections of the bo	R5 was routinely 5-10 kg or her target weight (dry ot reached her dry weight goal treatments in October 2017. sing (DON) was interviewed on a.m. regarding R5's fluid which she confirmed the facility ring her fluid intake despite the ospitalized for fluid overload 17, and on 8/23/17, the the facility to monitor fluid ated R5 was non-compliant s, however, she wanted to id restrictions and intake. The udge appointed R5 a guardian capacitated from mental extent lacking sufficient apacity to make or onsible decisions concerning medical care, nutrition, safety. In addition, The DON en asked if R5 had the mental esponsible and reasonable ng medical care.	F 3	809			

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		I AND HUMAN SERVICES E & MEDICAID SERVICES			FORM	: 11/21/2017 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE	E SURVEY IPLETED
		245468	B. WING		10/;	20/2017
NAME OF F	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
KARLST	AD HEALTHCARE CE	INTER INC	-	804 WASHINGTON AVENUE WEST KARLSTAD, MN 56732		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	Continued From pa (CKD) stage 3.	ıge 57	F 309			
	R37 had no cognitiv	S dated 8/25/17, indicated ve impairment and was ctivities of daily living except ision with eating.				
	indicated R37 had a alteration in though in memory, judgem CKD care plan revi- to check body for b promptly as ordered anticoagulant thera directed daily skin i abnormalities to the The skin care plan use caution during prevent striking arm surfaces that may o	re plan last revised on 8/15/16, cognitive loss/dementia or it process evidenced by deficits nent, and decision making. The sed on 8/17/16, directed staff preaks in skin and treat d by medical practitioner. The apy care plan dated 11/1/16, inspections and to report e nurse/medical practitioner. dated 11/1/16, directed staff to bed mobility and transfers to ns, legs, and hands against cause injury. R37's undated Care Plan indicated R37's bath ys.				
	9/13/17, indicated F severely limited or r own weight and/or chair or wheelchair with friction and she extremities showed peripheral vascular sensation to lower	sive Skin Assessment dated R37's ability to walk was non-existent or could not bear must be assisted in/out of . R37 had a potential problem ear injuries, his lower d signs and symptoms of disease, and had loss of extremities. The assessment Id inspect skin daily.				

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		AND HUMAN SERVICES				FORM	: 11/21/2017 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATI	E SURVEY IPLETED
		245468	B. WING			10/:	20/2017
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
KARLST	AD HEALTHCARE CE	NTER INC			04 WASHINGTON AVENUE WEST (ARLSTAD, MN 56732		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 309	R37's medical reco skin impairment or monitoring as direc On 10/18/17, at 7:5 seated in wheelcha were not covered. T just below the knee sized light yellow/re of the upper calf jus around the wound w (NA)-D entered the after. The surveyor R37 the wound on the were not previously stated he got the in transferred into the report the wound to -at 12:58 p.m. NA-E was looked at durin resident contact an reported to the nurs On 10/19/17, at 3:4 nursing (ADON) sta R37's left leg wound his wheelchair back wound. The wound the scab had chang appeared to be thic measured, and dres he had received the when he bumped it transferring. R37 st about the wound be	ge 58 rd did not reflect any current evidence of daily skin ted by the care plan. 4 a.m. R37 was observed ir, and the lower extremities The right leg was amputated and the left leg had a dime eddish thin scab on the outside st below the knee. The skin was not red. Nursing assistant room first and NA-E shortly reported to both NAs and to the outside of the leg. NAs aware of the wound. R37 jury a week ago when he wheelchair. The NAs failed to the nurse, as directed. 8 stated the resident's skin og daily cares or with each d areas of concern were se as soon as possible. 5 p.m. the assistant director of ated she was not informed of d. The ADON assisted R37 in to his room to assess the periphery was now red and ged to a darker red and ker. The ADON cleansed, ssed the wound. R37 stated wound over a week ago on his wheelchair when ated he had not told anybody ecause he figured it would just ated the NAs should have		809			

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CENTERS FOR MEDICARE & MEDICAID SERVICES O		. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		E SURVEY IPLETED
245468 B. WING	10/	20/2017
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	-	
KARLSTAD HEALTHCARE CENTER INC 304 WASHINGTON AVENUE WEST KARLSTAD, MN 56732		
(X4) IDSUMMARY STATEMENT OF DEFICIENCIESIDPROVIDER'S PLAN OF CORRECTIOPREFIX(EACH DEFICIENCY MUST BE PRECEDED BY FULLPREFIX(EACH CORRECTIVE ACTION SHOULDTAGREGULATORY OR LSC IDENTIFYING INFORMATION)TAGCROSS-REFERENCED TO THE APPROPDEFICIENCY)DEFICIENCY)CROSS-REFERENCED TO THE APPROP) BE	(X5) COMPLETION DATE
F 309 Continued From page 59 F 309 reported the change in skin condition to the nurse. Following this assessment, a comprehensive skin assessment was completed for R37's wound. F 309 R37's Comprehensive Skin Assessment dated 10/19/2017, indicated R37 was found to have an area of concern to left leg, near the knee which was 0,5 cm around scab like area. R37 reported he bumped it on the wheelchair. After investigating the area and wheelchair, the area on the wheelchair where R37 had bumped his leg was identified. R37's Incident Progress Note dated 10/20/17, indicated maintenance would pad the wheelchair part which caused the wound, dietary was informed and protein powder was added to the diet plan, and the wound would be monitored on the 24 hour clipboard and Medication Administration Record, and education would be provided to staff. On 10/20/2017, at 9:51 a.m. ADON explained she had put the new wound interventions into place and provide ducation to the NAs about reporting skin concerns to the nurse timely. The ADON stated, NA-E reported she had forgotten to report R37's wound to the nurse. The facility Person Centered Care Plan Guideline, revised 11/2016, indicated the facility must develop and implement a baseline care plan for each resident that included instructions needed to		

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPR CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0930							APPROVED
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION	0	(X3) DAT	E SURVEY
AND PLAN O	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG		COM	PLETED
		245468	B. WING _			10/2	20/2017
NAME OF F	PROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, Z	IP CODE	•	
KARLST	AD HEALTHCARE CE	NTER INC		304 WASHINGTON AVENUE WES KARLSTAD, MN 56732	ST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ACTION SHOULD BE COMPLET TO THE APPROPRIATE DATE		
F 309 F 329 SS=D	resident that meet p quality of care and t the services that are maintain the resider mental and psychos A skin care policy w received. DRUG REGIMEN IS UNNECESSARY D CFR(s): 483.45(d)(d 483.45(d) Unneces Each resident's dru unnecessary drugs drug when used (1) In excessive dos therapy); or (2) For excessive d (3) Without adequa (4) Without adequa (5) In the presence which indicate the c discontinued; or (6) Any combination paragraphs (d)(1) the 483.45(e) Psychotre	d person-centered care of the professional standards of the care plan must describe e to be furnished to attain or nt's highest practicable, social well-being. vas requested and not S FREE FROM RUGS e)(1)-(2) sary Drugs-General. g regimen must be free from . An unnecessary drug is any se (including duplicate drug uration; or te monitoring; or te indications for its use; or of adverse consequences dose should be reduced or hs of the reasons stated in hrough (5) of this section.	F 3	09	Y)		11/29/17
		hensive assessment of a					

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		AND HUMAN SERVICES			FORM	11/21/2017 APPROVED 0938-0391		
-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	· · /	E SURVEY PLETED		
		245468	B. WING _		10/2	10/20/2017		
NAME OF	PROVIDER OR SUPPLIER	L	STREET ADDRESS, CITY, STATE, ZIP CODE					
KARLST	AD HEALTHCARE CE	INTER INC		304 WASHINGTON AVENUE WEST KARLSTAD, MN 56732				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE		
F 329	Continued From pa	lge 61	F 32	29				
	drugs are not given medication is neces	have not used psychotropic a these drugs unless the ssary to treat a specific osed and documented in the						
	gradual dose reduct interventions, unlest an effort to disconti This REQUIREMEN by: Based on observation	NT is not met as evidenced tion, interview, and document		The preparation of the followir				
	for the use of an ar to monitor for effect (R35) reviewed for addition, failed to id behaviors/mood sy medications for 2 o failed to attempt tag gradual dose reduct medications for medications for medicatio	ailed to obtain clear indication ntiseizure medication in order tiveness for 1 of 5 residents unnecessary medications. In lentify and analyze target mptoms for antidepressant f 5 residents (R6,R30) and bering of antidepressant and a stion of an antipsychotic edications for 1 of 5 residents unnecessary medications.		correction for this deficiency do constitute and should not be in as an admission nor an agreen facility of the truth of the facts a conclusions set forth in the stat deficiencies. The plan of corre prepared for this deficiency wa solely because provisions of st federal law require it. Without foregoing statement, the facility with respect to:	terpreted nent by the alleged or tement of ection s executed ate and waiving the			
	for use of antiseizu used for seizures o	d to obtain a clear indication re medication that could be r for behavior control and as a nitor for effectiveness of the		1. R35 had a care plan review changes made for the medicat Carbamazepine for resident be along with interventions for beh R35 has not had a history of se Pharmacy consultants state the Carbamazepine is being utilize behaviors, checking routine lev clinically indicated. R6 and R3 care plan reviews with updates target behavior/mood symptom	ion haviors haviors. bizures. at when d for rels isn't 0 have had to include			

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	OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	IPLI			0938-039 SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:				. ,	PLETED
		245468	B. WING _			10/2	20/2017
NAME OF I	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
KARLST	AD HEALTHCARE CE	ENTER INC			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 PROVIDER'S PLAN OF CORRECTIO PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROP DEFICIENCY)				(X5) COMPLETIO DATE
F 329	Continued From pa	age 62	F 32	29			
	diagnoses of Alzhe disorder, hypothyrc undifferentiated sol behavioral disturba disabilities. R35's five day MDS as severely impaire physical behaviors antidepressant, an medications. R35's Medication F 10/6/17, indicated I 300 milligrams (mg start date 12/14/16 Administration Rec indicated R35 rece milligrams in the ev October 2015, MAI R35 had resided in twice daily for beha R35's care plan, pr psychoactive media Risperdal, Celexa, care plan failed to i	simer's disease, anxiety pidism Parkinson's disease, hizophrenia, dementia with ances, and profound intellectual S dated 9/18/17, identified R35 ed, exhibited verbal and and received antipsychotic, tianxiety and antibiotic Review Report (MRR) dated R35 received carbamazepine g) in the evening for seizures, 5. R35's Medication cord (MAR) dated 10/17, sived carbamazepine 300 vening for seizures. R35's R from a previous facility where included carbamazepine 200 mg aviors.			reviewed by consulting pharmacist for gradual dose reduction (GDR) of an antipsychotic on 11/13/17. 2. All residents will be reviewed thr chart review for clear indication for medication use, to ensure that they a care planned appropriately along w/ identified on the MDS, and that mon needs have been identified and implemented for effectiveness. All residents have been reviewed for tar behaviors/mood symptoms with psychotropic medication use and GE 3. Staff education will be completed 11/29/17 regarding: the need to add the use of medications and if side eff or behaviors warrant monitoring, regarding target behavior/ mood monitoring with psychotropic medicat use and; the process and need for G 4. Audits of care plans will be completed by DNS or designee with all new admissions and for any resident hav medication order changes for the following 3 months to ensure that all medication would be identified proper the MDS, care plan, and the monitor needs identified and implemented. If or designee will complete audits on to completion of Monthly Behavior Rev on all residents that have physician of on 2 residents per week for 3 month ensure that proper care planning GE	rough are being itoring rget DR's. d by fress fects ation GDR's. pleted ring erly on ring DNS the riews orders is, to DR's	
	nursing (ADON) sta identified the need carbamazepine. Th	5 a.m. the assistant director of ated staff should have for monitoring R35's use of ne ADON verified she was not piting any seizure activity and			have been attempted, or that there is appropriate physician documentation not attempt a GDR. The data collec will be reviewed at the Monthly QAP Quarterly QA meeting. At that time t committee will make the	n to ted I and	

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TATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		TE SURVEY MPLETED		
		245468	B. WING		10/20/2017			
NAME OF I	PROVIDER OR SUPPLIER	_ 10 100		STREET ADDRESS, CITY, STATE, Z		0/20/2017		
KARLST	AD HEALTHCARE CE			304 WASHINGTON AVENUE WE KARLSTAD, MN 56732				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETIC DATE		
F 329	stated R35's last ca was conducted on (therapeutic referen ADON stated she w anti-seizure medica care plan should ha the medication, the monitoring needs, a The ADON stated t MDS staff and disc resident health care	age 63 arbamazepine laboratory test 12/8/16, with results of 4.3 mg nce range is 4-12 mg.). The vould expect the use of an ation be monitored and the ave also reflected the use of potential for seizures, and identified interventions. he facilty had a change in their overed there had been e areas that had slipped and not identified on the care	F 32	29 decision/recommendatio follow-up studies. Completion Date 11/29/1				
	(DON) confirmed F medications should accurately on the M monitoring needs in The DON stated th plans were serious needs, which was g R6's medication reg analyzed target mo antidepressant use tapering or had phy use. In addition, ha	and had not attempted vsician justification for ongoing d not attempted a dose physician justification for on						
		port dated 10/20/17, included depressive disorder, anxiety oaffective disorder.						
	R6's Diagnosis Rep diagnoses of major disorder, and schiz R6's annual MDS c	port dated 10/20/17, included depressive disorder, anxiety						

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	OF DEFICIENCIES	KANNERS KANNERS	· · /		ISTRUCTION	(X3) DA). 0938-039 TE SURVEY MPLETED	
		245468	B. WING			10/20/2017		
NAME OF I	PROVIDER OR SUPPLIER	1		STREET	ADDRESS, CITY, STATE, ZIP CODE			
KARLST	AD HEALTHCARE C	ENTER INC			ASHINGTON AVENUE WEST STAD, MN 56732			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETIC DATE	
F 329	no depressive sym indicated R6 had p behaviors 1-3 days	age 64 um, delusions, hallucinations, ptoms. The MDS also roblems with sleep, had verbal during the assessment period sychotic and antidepressant	FS	29				
	facility on 10/20/17 -Latuda (atypical a used to treat bipola evening for schizoa 7/26/16. -Lexapro (antidepre the morning for dej -Trazodone (antide bedtime for major of 4/21/17. However, clear indication for antidepressant me comprehensive as symptoms, efficacy time and any other	dication and did not reflect a sessment of depressive of current medications at the						
	10/20/17, and last received psychotro schizoaffective disc Interventions direc pharmacy, medica reduction when clir gradual dose reduc behavior managen medication use. Th	vided by the facility on revised 11/14/16, indicated R6 pic medication related to order-bipolar type. ted staff to consult with I practitioner to consider dose nically appropriate, follow ction protocols, and develop a nent program with alternative to be plan also indicated R6 y/antidepressant medications						

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		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	: 11/21/2017 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245468	B. WING _			10/:	20/2017
NAME OF !	PROVIDER OR SUPPLIER		<u> </u>	ST	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
KARLST	AD HEALTHCARE CE	INTER INC			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 PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 329	related to anxiety a directed to adminision ordered, to attempt interventions of red go to her room awa observe the effective However, the care p individualized targe depression and or a R6's Mood and Ber 7/12/17, and 8/1/17 symptoms for antid medications. Additional had not analyzed the antipsychotic use. F lacked an indication use of both antipsyce medications. R6's Treatment Adr were reviewed from through October 20 but not received). T behavior of sexual/ antipsychotic use. T sexual/negative con record was docume made a sexually ba TV with a male resi identified symptoms R6's mental health dated 6/19/17, indic somnolent during the	and depression. Interventions ther antianxiety medication as t non-pharmacological lirection, diversion, have her ay from other residents, and to veness of the interventions. plan failed to identify R6's et mood symptoms of	F 32	29			

Facility ID: 00830

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		AND HUMAN SERVICES				FORM	11/21/2017 APPROVED 0938-0391			
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED			
		245468	B. WING			10/:	20/2017			
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE					
KARLST	AD HEALTHCARE CE		304 WASHINGTON AVENUE WEST KARLSTAD, MN 56732							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE			
F 329	than anything. The of mental illness an the history, and the with recurrent depre- indicated there was quantifiable docume symptoms to detern recommend change physician did not re medication changes daytime napping. R6's physician visit and 9/12/17, indicat and schizoaffective psychiatric medicat notes lacked a reas the psychotropic me On 10/16/17, at 5:4 seated in her recline R6 fell asleep multi interview and was co overall facial exprese emotion in respons On 10/18/17, at 7:1 awake sitting up in occasionally felt door didn't feel like doing sometimes felt anxi- would report tightne breath, and felt rest know what the staff	vanted help with sleep more physician identified the history ad R6 was unable to describe history was more consistent ession. The physician also a not enough history or entation of behaviors or mood mine definitive diagnoses or es to medication dosages. The ecommend any psychiatric s and recommended no notes dated, 6/20/17, 7/12/17, ted R6's depression, anxiety, disorder were stable with no ion changes. The physician son or justification to continue edications at the same doses.	F 3	29						

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		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	: 11/21/2017 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245468	B. WING			10/;	20/2017
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
KARLST	AD HEALTHCARE CE	INTER INC			04 WASHINGTON AVENUE WEST ARLSTAD, MN 56732		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				(X5) COMPLETION DATE
F 329	stated she went to a that helped with hele explained she ofter On 10/20/17, at 9:0 sleeping in a chair i 12:58 p.m. NA-B st only every once in a down when she did On 10/20/17, at 9:3 (LPN)-A stated R6 varied, sometimes refused cares and v she would holler at directed at staff. LP one to one visits, at talk to which perks Trazodone was for most of the night. On 10/18/17, at 1:5 (LSW) verified then symptoms identified antidepressant/anti target behavior of s been identified for t On 10/19/17, at 9:4 nursing (ADON) co have a process in p analysis and/or eva mediations. ADON	 a psych doctor and thought r mood symptoms. R6 n felt tired. 04 a.m. R6 was observed in the main lobby area. At tated R6's mood was down a while and seemed to act in't have anything to do. 87 a.m. licensed practical nurse sometimes felt anxious and it she was quiet and sometimes when she got in those moods, staff and use profanities PN-A indicated staff provided nd called her friend for her to her up. LPN-A thought the sleep because R6 was up 67 p.m. licensed social worker re were no target/mood d for the use of the fanxiety medication however, a sexual/negative comments had the antipsychotic medication. 45 a.m. the assistant director of onfirmed the facility did not blace to ensure ongoing aluation of psychotropic also indicated target mood be identified on the care plan, 		29			

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			AND HUMAN SERVICES						APPROVED
Г			& MEDICAID SERVICES				OMB NO. 0938-0391		
		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	()		E SURVEY PLETED
			245468	B. WING	i			10/2	20/2017
Ì	NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
	KARLST/	AD HEALTHCARE CE	NTER INC	304 WASHINGTON AVENUE WEST KARLSTAD, MN 56732					
	(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	ILD B		(X5) COMPLETION DATE
	F 329	Continued From pa	ge 68	F:	329	9			
		the consulting pharm 10/23/17, at 1:35 p. and confirmed he h reduction, had not le and expected the fa behaviors/mood syn effectiveness, and w behaviors/mood syn care plan with correct R30's medication re analyzed target mod antidepressant use. R30's facility Face S included diagnoses behavioral disturban major depressive di R30's annual MDS had severe cognitiv behaviors directed to days during the ass not been a change	Sheet dated 10/20/17, of dementia without nce, anxiety disorder, and						
		depressive symptor feeling tired or havin concentrating. R30's physician ord milligrams every mo	ns of difficulty with sleep and ng little energy and trouble lers included Celexa 20 prning for major depressive t date of 5/22/17, and						

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		AND HUMAN SERVICES				FORM	: 11/21/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		245468	B. WING	à		10/2	20/2017
NAME OF I	PROVIDER OR SUPPLIER	-		5	STREET ADDRESS, CITY, STATE, ZIP CODE		
KARLST	AD HEALTHCARE CE				304 WASHINGTON AVENUE WEST KARLSTAD, MN 56732		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 329	depressive disorder R30's care plan prin facility on 10/20/17, antianxiety medicat anxiety, and appetit feelings of sadness characterized by ind fearfulness last rev plan directed staff t non-pharmacologic for effectiveness, p oil message, divers newspapers, and to if anxious in room. consult with pharma consider dosage re appropriate, observ effectiveness, and of get ready for bed as R30's physician ord indicated target bef restless, crawling o bring R30 to a quie The physician orde document the effect used. The physician target mood sympto were reviewed for t revealed one docur when R30 was rest on 9/1/17.	every bedtime for major r (last dose change 4/11/17). nted and provided by the indicated antidepressant and ion use related to depression, te stimulation. R30 had s, anxiety, and depression effective coping and ised on 12/21/16. The care	F	329			

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		AND HUMAN SERVICES				FORM	: 11/21/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		PLE CONSTRUCTION	(X3) DATE	E SURVEY IPLETED
		245468	B. WING	à		10/:	20/2017
NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
KARLST	AD HEALTHCARE CE	INTER INC			304 WASHINGTON AVENUE WEST KARLSTAD, MN 56732		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 329	reviewed from 7/17 identified behavior a included refusals of agitation, resistive t staff. However, thes identified on the cal R30's Mood and Be 8/4/17, lacked ident antidepressant/antia Review of R30's ph 6/20/17, through 7/- and anxiety were st On 10/16/17, at 5:1 calmly lying in bed a pleasant, she smile words including her stated R30 had refu once R30 refused, i R30 would become too many questions On 10/17/17, at 9:1 seated in the lobby calm and looking ar only smiled without On 10/18/17, at 7:1 resting in bed with f -At 7:53 a.m. R30's awake. -At 8:24 a.m. NA-A	 717, through 10/16/17, and and mood symptoms which f medication, cares and meals, to cares, and hitting out at se symptoms were not re plan. ehavior Evaluation dated tified mood symptoms for anxiety medication. eysician visit notes from 11/17, indicated depression table. 3 a.m. R30 was observed awake. R30's mood was ed and was unable to articulate r name. At 6:20 p.m. the DON used dinner and explained staff did not persist because e very easily agitated if asked area in her pajamas. R30 was round. When questioned, R30 verbally responding. 0 a.m. R30 was observed 	F	329			

		AND HUMAN SERVICES			FORM	11/21/2017 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245468	B. WING		10/;	20/2017
NAME OF	PROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
KARLST	AD HEALTHCARE CE	INTER INC		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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 329	verbal cues during calm, cooperative, evidence of any bel NA-A explained R3 and if she did not lil them away. NA-A s included pushing st her behaviors were have a problem wit would use intervent something to eat, a time. On 10/20/17, at 9:3 liked to hit, pinch, s NA-C stated interved different staff member re-approaching at a kept short. -At 9:37 a.m. licens reported R30 hit star refused medication across the room. Ll exhibited the behav and use different staff behaviors once in a angry, or tired whic facial expressions. the NA's or shake h something and staff doing and help her	the cares, which R30 was and followed cues without havioral or mood symptoms. 0 did better with older NA's ke someone she would wave tated R30's behaviors taff away, refusing care and sporadic and usually did not h redirection. NA-A stated staff tions such as toileting, offer and/or re-approaching at a later a later inc, and refuse meals. entions included getting a ber, getting more help, a later time, and nails were sed practical nurse (LPN)-A aff during cares, refused cares, is, and would throw objects PN-A explained when R30 viors they would re-approach taff members. B explained R30 had a while when she was mad, h was was displayed by her NA-B stated R30 would tap on her fist when she did not like if were to stop what they were calm down by sitting with her t you are doing step by step or	F 329			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FO	RM APPROVED		
	<u>DMB NO. 0938-0391</u>		
	DATE SURVEY COMPLETED		
	10/20/2017		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE			
KARLSTAD HEALTHCARE CENTER INC 304 WASHINGTON AVENUE WEST			
KARLSTAD HEALTHCARE CENTER INC KARLSTAD, MN 56732			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION DATE		
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	5/112		
F 329 Continued From page 72 F 329			
F 329 Continued From page 72 F 329			
On 10/19/17, at 9:45 a.m. the ADON verified			
there was no evaluation of R30's behaviors or			
moods and the care plan did not identify all of			
R30's behaviors/moods. ADON explained the			
facility did not have a process in place to ensure			
ongoing analysis and/or evaluation of			
psychotropic mediations and confirmed target			
mood symptoms should have been identified on			
the care plan, monitored, and evaluated for			
efficacy.			
Facility policy for Antipsychotic Medication last			
revised 5/15/2003 included;			
-behavior monitoring would be ongoing to indicate			
the effect of the medication			
-the interdisciplinary care team will evaluate the			
utilization and continued need for the			
psychoactive medication and pursue alternatives			
to their use, and consider medication reduction at			
least every six months.			
Facility radius Maad and Dahaviar Decomposite for			
Facility policy Mood and Behavior Documentation Guidelines last revised 11/16, indicated:			
duidennes last revised 11/10, indicated.			
- The facility supports the goal of determining the			
underlying cause of behavioral symptoms so the			
appropriate treatment of environmental, medical,			
and/or behavioral interventions as well as			
psychopharmacological medication can be			
utilized to meet the needs of the resident.			
-Efforts to reduce dosage or discontinue			
psychopharmacological medications would be			
ongoing for the clinical situation.			
-A mood and behavior evaluation will be			
-A mood and behavior evaluation will be completed for all residents on admission, quarterly, annually, with significant change in			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	11/21/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245468	B. WING			10/;	20/2017
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
KARLST	AD HEALTHCARE CE				04 WASHINGTON AVENUE WEST (ARLSTAD, MN 56732		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 329 F 428 SS=D	of psychoactive me for the medication a related to the use o indicated the evalua appropriate use of r documentation of d rationale for continu- -The nurse and/or t specific target beha the care plan is upo has been appropria DRUG REGIMEN F IRREGULAR, ACT CFR(s): 483.45(c)(c) Drug Regimen R (1) The drug regime reviewed at least or pharmacist. (3) A psychotropic o brain activities asso and behavior. Thes limited to, drugs in t (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-depressant; (iv) Hypnotic. (4) The pharmacist to the attending phy facility's medical dir and these reports n (i) Irregularities inclu-	dication to evaluate the need and determine target behavior f the medication. The policy ation included assessment, medications, and ose reductions or provides ued use of medication regimen he social worker to define the twor/symptoms and to verify lated to ensure the problem tely identified. REVIEW, REPORT ON 1)(3)-(5) eview en of each resident must be noce a month by a licensed drug is any drug that affects ociated with mental processes se drugs include, but are not the following categories:		428			11/29/17

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		AND HUMAN SERVICES		O	FORM APPROV MB NO. 0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED
		245468	B. WING _		10/20/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
KARLST	AD HEALTHCARE CE	INTER INC		304 WASHINGTON AVENUE WEST KARLSTAD, MN 56732	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLÉTIO
F 428	 (ii) Any irregularities during this review in separate, written reattending physician director and director and director and director and the irregularity (iii) The attending president's medical rirregularity has bee action has been take be no change in the physician should do the resident's medication should do the resident's medication for review that include, frames for the differsteps the pharmacii identifies an irregulation for the resident's medications for 2 of failed to identify the dose reduction/dos physician justification 	or an unnecessary drug. Is noted by the pharmacist must be documented on a port that is sent to the and the facility's medical r of nursing and lists, at a ent's name, the relevant drug, the pharmacist identified. hysician must document in the record that the identified n reviewed and what, if any, the to address it. If there is to e medication, the attending bocument his or her rationale in cal record. t develop and maintain policies the monthly drug regimen but are not limited to, time rent steps in the process and st must take when he or she arity that requires urgent action ent. NT is not met as evidenced v and document review, the ure the consultant pharmacist f target behaviors/mood	F 42	The preparation of the following places of the preparation of the following places of the correction for this deficiency does not constitute and should not be interputed as an admission nor an agreement facility of the truth of the facts alleg conclusions set forth in the statemed deficiencies. The plan of correction prepared for this deficiency was existed by because provisions of state at a solely because provision of state at a solely becau	not reted by the ed or ent of n ecuted

Facility ID: 00830

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	11/21/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245468	B. WING			10/2	20/2017
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
KARLST	AD HEALTHCARE CE	NTER INC			04 WASHINGTON AVENUE WEST ARLSTAD, MN 56732		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 428	analyzed target mo antidepressant use tapering or had phy use. In addition, had reduction or had a p going antipsychotic R6's Diagnosis Rep diagnoses of major disorder, and schize R6's annual MDS d moderate cognitive symptoms of deliriu no depressive symp indicated R6 had pr behaviors 1-3 days and received antips medications. R6's physician order facility on 10/20/17 -Latuda (atypical ar used to treat bipola evening for schizoa 7/26/16. -Lexapro (antidepre- the morning for dep -Trazodone (antidep	gimen had not identified or od symptoms for and had not attempted sician justification for ongoing d not attempted a dose obysician justification for on medication. bort dated 10/20/17, included depressive disorder, anxiety oaffective disorder. ated 8/1/17, indicated R6 had impairment, no signs and im, delusions, hallucinations, otoms. The MDS also roblems with sleep, had verbal during the assessment period sychotic and antidepressant ers printed and provided by the included the following orders: nti-antipsychotic medication r depression) 80 mg in the ffective disorder. Start date of essant medication) 15 mg in oression. Start date of 7/26/16. pressant medication) 50 mg at	F 4	428	 R6 and R30 have had consulting pharmacist reviews regarding psychotropic medications. R6's carrhas been reviewed with individualiz target mood symptoms of depression/anxiety have been added. All residents have been reviewed GDR's w/ regards to psychotropic medication and care plans have be audited for appropriate target mood symptoms/behaviors. Staff education will be complete 11/29/17 regarding the Monthly Mod Behavior Program. DNS or designee will complete on the completion of Monthly Behavior Program. DNS or designee will complete on the completion of Monthly Behavior program. DNS or designee that proper planning GDR's have been attempt that there is appropriate physician documentation to not attempt a GD The data collected will be reviewed Monthly QAPI and Quarterly QA me At that time the committee will mak decision/recommendation regarding follow-up studies. Completion date 11/29/17 	e plan ed on ed for en d by od and audits vior week care ed, or R. at the eeting. e the	
	-Latuda (atypical ar used to treat bipola evening for schizoa 7/26/16. -Lexapro (antidepre the morning for dep -Trazodone (antidep bedtime for major d	ati-antipsychotic medication r depression) 80 mg in the ffective disorder. Start date of essant medication) 15 mg in pression. Start date of 7/26/16.					

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				. 0938-039
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		E SURVEY IPLETED
		245468	B. WING _		10/	20/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	-	
KARLST	AD HEALTHCARE CE	NTER INC		304 WASHINGTON AVENUE WEST KARLSTAD, MN 56732		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE
F 428	clear indication for a antidepressant med comprehensive ass symptoms, efficacy time and any other anxiety/depression R6's care plan prov 10/20/17, and last r received psychotrop schizoaffective diso Interventions direct pharmacy, medical reduction when clin gradual dose reduc behavior managem medication use. The received antianxiety related to anxiety and directed to administ ordered, to attempt interventions of red go to her room awa observe the effective However, the care p individualized targe depression and or a R6's Mood and Beh 7/12/17, and 8/1/17 symptoms for antid medications. Addition had not analyzed th antipsychotic use. F lacked an indication	adding an addition dication and did not reflect a ressment of depressive of current medications at the episodes of between 3/22/17, and 4/22/17. ided by the facility on evised 11/14/16, indicated R6 bic medication related to order-bipolar type. ed staff to consult with practitioner to consider dose ically appropriate, follow tion protocols, and develop a ent program with alternative to e plan also indicated R6 n/antidepressant medications and depression. Interventions ter antianxiety medication as non-pharmacological irection, diversion, have her y from other residents, and to reness of the interventions. blan failed to identify R6's t mood symptoms of	F 4	28		

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						FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245468	B. WING _			10/2	20/2017
NAME OF F	PROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE		
KARLST	PLAN OF CORRECTION IDENTIFICATION NUMBER: 245468 IDENTIFICATION NUMBER: Add Control Contect Control Control Contect Control Control Control Control Contro				4 WASHINGTON AVENUE WEST ARLSTAD, MN 56732		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 428	Continued From pa	ge 77	F 42	1 28			
	were reviewed from through October 20 but not received). T behavior of sexual/r antipsychotic use. T sexual/negative cor record was docume made a sexually ba TV with a male resi identified symptoms R6's mental health dated 6/19/17, indic somnolent during th complaints of mild of anxiety and really w than anything. The of mental illness an the history, and the with recurrent depre- indicated there was quantifiable docume symptoms to detern recommend change physician did not re medication changes daytime napping.	a January-March and June 17 (April and May requested the TARs identified the target negative comments for the The only incident of mments identified in R6's ented on 9/24/17, when R6 sed comment while watching dent. The TARs had not is for antidepressant use.					
	and schizoaffective psychiatric medicat notes lacked a reas	disorder were stable with no ion changes. The physician on or justification to continue edications at the same doses.					

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		AND HUMAN SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			-E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
						0011	
		245468	B. WING			10/2	20/2017
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
KARLST	AD HEALTHCARE CE	NTER INC		-	04 WASHINGTON AVENUE WEST (ARLSTAD, MN 56732		
(X4) ID			ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI> TAG	×	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)		COMPLETION DATE
F 428	Continued From pa	.ge 78	F 4	.28		_	
	February through C and revealed the co identified the lack o symptoms or recom reduction for the an	edication Reviews from October 2017, were reviewed onsulting pharmacist had not of target behaviors/mood nmended a gradual dose ntipsychotic medication or a antidepressant medications.					
	seated in her recline R6 fell asleep multi interview and was c	4 p.m. R6 was observed er in her room watching TV. ple times during the resident difficult to keep awake. Her ssions were flat with little es to questions.					
	awake sitting up in occasionally felt dou didn't feel like doing sometimes felt anxi would report tightne breath, and felt rest know what the staff down, depressed, o stated she went to a	12 a.m. R6 was observed the recliner. R6 explained she wn or depressed and she g anything. She stated she ious and overwhelmed and ess in her chest, short of tless. R6 stated she didn't did for her when she felt or anxious. However, R6 a psych doctor and thought r mood symptoms. R6 n felt tired.					
	sleeping in a chair i 12:58 p.m. NA-B st only every once in a	4 a.m. R6 was observed in the main lobby area. At ated R6's mood was down a while and seemed to act n't have anything to do.					

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						FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245468	B. WING			10/:	20/2017
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
KARLST	D PLAN OF CORRECTION IDENTIFICATION NUMBER 245468 AME OF PROVIDER OR SUPPLIER ARLSTAD HEALTHCARE CENTER INC (X4) ID SUMMARY STATEMENT OF DEFICIENCIES				04 WASHINGTON AVENUE WEST (ARLSTAD, MN 56732		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 428	Continued From pa	ge 79	F4	28			
	(LPN)-A stated R6 s varied, sometimes a refused cares and v she would holler at directed at staff. LP one to one visits, ar talk to which perks Trazodone was for most of the night. On 10/18/17, at 1:5	sometimes felt anxious and it she was quiet and sometimes when she got in those moods, staff and use profanities PN-A indicated staff provided nd called her friend for her to her up. LPN-A thought the sleep because R6 was up					
	symptoms identified antidepressant/anti- target behavior of s	d for the use of the anxiety medication however, a exual/negative comments had					
	nursing (ADON) co have a process in p analysis and/or eva mediations. ADON	nfirmed the facility did not place to ensure ongoing iluation of psychotropic also indicated target mood be identified on the care plan,					
	the consulting phar 10/23/17, at 1:35 p. and confirmed he h reduction, had not I and expected the fa behaviors/mood syn effectiveness, and	5 p.m. attempted to contact macist (CP) for interview. On m. CP returned the phone call ad not recommended a dose ooked for target behaviors, acility staff to identify target mptoms, to monitor for would also expect the target mptoms to be identified on the					

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		AND HUMAN SERVICES				FORM	: 11/21/2017 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY IPLETED
		245468	B. WING			10/	20/2017
	PROVIDER OR SUPPLIER AD HEALTHCARE CE			3	TREET ADDRESS, CITY, STATE, ZIP CODE 04 WASHINGTON AVENUE WEST XARLSTAD, MN 56732		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 428		ge 80 esponding interventions.	F 4	28			
	R30's medication re analyzed target mo antidepressant use						
	included diagnoses	Sheet dated 10/20/17, of dementia without nce, anxiety disorder, and isorder.					
	had severe cognitive behaviors directed days during the assess not been a change previous assessment depressive symptometers	dated 8/4/17, indicated R30 re impairment and had verbal towards others one to three sessment period and there had in behaviors since the ent. The MDS identified ms of difficulty with sleep and ng little energy and trouble					
	milligrams every m disorder with a star mirtazapine 15 mg	ders included Celexa 20 orning for major depressive t date of 5/22/17, and every bedtime for major r (last dose change 4/11/17).					
	facility on 10/20/17 antianxiety medical anxiety, and appeti feelings of sadness characterized by in	nted and provided by the indicated antidepressant and ion use related to depression, te stimulation. R30 had s, anxiety, and depression effective coping and ised on 12/21/16. The care					

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		AND HUMAN SERVICES				FORM	: 11/21/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	E SURVEY IPLETED
		245468	B. WING _			10/:	20/2017
NAME OF I	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE	-	
KARLST	AD HEALTHCARE CE	INTER INC			4 WASHINGTON AVENUE WEST ARLSTAD, MN 56732		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 428	plan directed staff tr non-pharmacologic for effectiveness, pro- oil message, divers newspapers, and to if anxious in room. consult with pharma consider dosage re appropriate, observe effectiveness, and of get ready for bed as R30's physician order indicated target beh- restless, crawling o bring R30 to a quiet The physician order document the effec- used. The physician target mood symptor were reviewed for the revealed one document when R30 was rest on 9/1/17. R30's progress numeration included refusals of agitation, resistive the staff. However, these identified on the car R30's Mood and Between the staff.	to attempt cal interventions and observe rovide nourishment, essential sion, word finds, liked to look at o bring to a quiet area at night The plan also directed staff to acy/medical practitioner to eductions when clinically ve/document side effects and do not just take to room and s this would cause anxiety. ders dated 12/29/16, and TAR naviors for anxiety were but of bed and directed staff to t area and offer nourishment. rs also directed staff to etiveness of the medication n's orders did not identify oms for depression. The TARs he last three months and mented episode on 9/1/17, eless and crawling out of bed sting progress notes were 7/17, through 10/16/17, and and mood symptoms which f medication, cares and meals, to cares, and hitting out at se symptoms were not re plan.	F 42	28			

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		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE	E SURVEY IPLETED
		245468	B. WING			10/:	20/2017
NAME OF F	PROVIDER OR SUPPLIER		<u> </u>	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
KARLST	AD HEALTHCARE CE			-	04 WASHINGTON AVENUE WEST (ARLSTAD, MN 56732		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 428	Continued From pa	ıge 82	F4	428			
		nysician visit notes from (11/17, indicated depression table.					
	February through C the consulting phare	Medication Reviews from October 2017, were reviewed; macist had not identified the viors/mood symptoms.					
	calmly lying in bed a pleasant, she smile words including her stated R30 had refu once R30 refused, s	13 a.m. R30 was observed awake. R30's mood was ed and was unable to articulate r name. At 6:20 p.m. the DON used dinner and explained staff did not persist because e very easily agitated if asked s.					
	seated in the lobby calm and looking ar	8 a.m. R30 was observed area in her pajamas. R30 was round. When questioned, R30 verbally responding.					
	resting in bed with h -At 7:53 a.m. R30's awake. -At 8:24 a.m. NA-A assisted R30 with n verbal cues during calm, cooperative, a evidence of any bel	10 a.m. R30 was observed her eyes closed. s remained in bed, calmly entered the room and morning cares. NA-A gave the cares, which R30 was and followed cues without havioral or mood symptoms. 00 did better with older NA's					

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		AND HUMAN SERVICES				FORM	: 11/21/2017 APPROVED . 0938-0391
STATEN	MENT OF DEFICIENCIES AN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245468	B. WING	ì		10/	20/2017
NAME	OF PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
KAR	LSTAD HEALTHCARE C	ENTER INC			304 WASHINGTON AVENUE WEST KARLSTAD, MN 56732		
(X4) PREF TAC	IX (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)	D BE	(X5) COMPLETION DATE
F 4	 them away. NA-A sincluded pushing sincluded pushing sincluded pushing sincluded pushing sincluded pushing to eat, a time. On 10/20/17, at 9:3 liked to hit, pinch, sinch, s	ke someone she would wave stated R30's behaviors taff away, refusing care and e sporadic and usually did not th redirection. NA-A stated staff tions such as toileting, offer and/or re-approaching at a later B1 a.m. NA-C reported R30 scratch, and refuse meals. entions included getting a ber, getting more help, a later time, and nails were A reported R30 hit staff during es, refused medications, and s across the room. LPN-A 80 exhibited the behaviors they and use different staff B explained R30 had a while when she was mad, ch was was displayed by her NA-B stated R30 would tap on her fist when she did not like ff were to stop what they were calm down by sitting with her t you are doing step by step or	F	428			

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		AND HUMAN SERVICES				FORM	11/21/2017 APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245468	B. WING	i		10/20/2017		
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
KARI ST	AD HEALTHCARE CE		304 WASHINGTON AVENUE WEST					
KANLOT					KARLSTAD, 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 SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 428	moods and the care R30's behaviors/mo facility did not have ongoing analysis an psychotropic media mood symptoms sh the care plan, moni efficacy. On 10/20/17, at 1:4 the consulting phar 10/23/17, at 1:35 p and confirmed he h behaviors, and exp identify target behaviors identify target behaviors identified on the ca interventions. Facility policy for An revised 5/15/2003 i -behavior monitorin the effect of the me -the interdisciplinar utilization and conti psychoactive medid to their use, and co least every six mon Facility policy Mood Guidelines last revi - The facility suppo underlying cause o appropriate treatme and/or behavioral in	 e plan did not identify all of bods. ADON explained the a process in place to ensure nd/or evaluation of ations and confirmed target nould have been identified on tored, and evaluated for 5 p.m. attempted to contact macist (CP) for interview. On .m. CP returned the phone call had not looked for target ected the facility staff to viors/mood symptoms, to eness, and would also expect s/mood symptoms to be re plan with corresponding htipsychotic Medication last ncluded; ag would be ongoing to indicate edication y care team will evaluate the nued need for the cation and pursue alternatives insider medication reduction at 	F	428	B			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 11/21/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245468	B. WING			10/:	20/2017
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
KARLST	AD HEALTHCARE CE	NTER INC			04 WASHINGTON AVENUE WEST (ARLSTAD, MN 56732		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 428 F 441 SS=F	utilized to meet the -Efforts to reduce d psychopharmacolog ongoing for the clini -A mood and behav completed for all re quarterly, annually, status and prior to t of psychoactive me for the medication a related tot he use o indicated the evalua appropriate use of r documentation of d rationale for continu. -The nurse and/or t specific target beha the care plan is upo has been appropria INFECTION CONT LINENS CFR(s): 483.80(a)(1) (a) Infection preven The facility must es and control program a minimum, the follow (1) A system for pre- investigating, and c communicable dise volunteers, visitors, providing services u arrangement based conducted accordim	needs of the resident. osage or discontinue gical medications will be ical situation. for evaluation will be sidents on admission, with significant change in he use of, and/or dose change dication to evaluate the need and determine target behavior f the medication. The policy ation includes, assessment, medications, and ose reductions or provides use of medication regimen he social worker to define the twor/symptoms and to verify lated to ensure the problem tely identified. ROL, PREVENT SPREAD, 1)(2)(4)(e)(f) tion and control program. tablish an infection prevention n (IPCP) that must include, at owing elements: eventing, identifying, reporting, ontrolling infections and ases for all residents, staff, and other individuals under a contractual l upon the facility assessment og to §483.70(e) and following tandards (facility assessment		428			11/29/17

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	E CONSTRUCTION	(X3) DATE	0938-0391 E SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING .		COMPLETED	
		245468	B. WING			10/2	20/2017
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE 04 WASHINGTON AVENUE WEST		
KARLST	AD HEALTHCARE CE	NTER INC			CARLSTAD, MN 56732		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	Continued From pa	ge 86	F4	41			
		ds, policies, and procedures hich must include, but are not					
	possible communic	eillance designed to identify able diseases or infections ead to other persons in the					
		om possible incidents of ase or infections should be					
		ansmission-based precautions event spread of infections;					
	(iv) When and how resident; including b	isolation should be used for a out not limited to:					
	depending upon the involved, and (B) A requirement th	uration of the isolation, e infectious agent or organism hat the isolation should be the sible for the resident under the					
	must prohibit emplo disease or infected	ces under which the facility byees with a communicable skin lesions from direct hts or their food, if direct t the disease; and					
		ne procedures to be followed direct resident contact.					
		cording incidents identified PCP and the corrective					

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		AND HUMAN SERVICES				FORM	11/21/2017 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
		245468	B. WING _		10/2	20/2017	
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
KARLST	AD HEALTHCARE CE	ENTER INC			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 PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	process, and transp spread of infection. (f) Annual review.	e facility. nel must handle, store, port linens so as to prevent the The facility will conduct an	F 44	41			
	program, as necess This REQUIREMED by: Based on observa review, the facility f surveillance progra trends of resident in	NT is not met as evidenced tion, interview, and document ailed to develop an ongoing m to analyze patterns and nfections not treated with an the potential to affect all 36			The preparation of the following pla correction for this deficiency does r constitute and should not be interpr as an admission nor an agreement facility of the truth of the facts alleg conclusions set forth in the statement deficiencies. The plan of correction	not reted by the ed or ent of	
	Findings include:	0 p.m. the facility infection			prepared for this deficiency was ex- solely because provisions of state a federal law require it. Without waiv foregoing statement, the facility sta with respect to:	and ing the	
	control logs were re nursing (DON). The which identified the identified, name of which the resident symptoms were ne if a culture was con organisms, and the prescribed by the p did not contain the illnesses which wer antibiotic.	eviewed with the director of e logs were a tracking form date symptoms were the resident, room number in resided, if the identified w or ongoing, type of infection, npleted, the name of the type of antibiotic or treatment hysician. However, the logs tracking or trending of any re not being treated with an			 All illnesses which are/are not be treated by antibiotics are being track and reviewed for any trending. DNS or designee will daily revies physician orders and the 24 hour re- sheet for residents exhibiting signs symptoms of illness. Any illness will logged onto a spread sheet to analy trending. Staff education has been comport prior to 11/29/17 with regards to the for accurate and concise document of resident symptoms and disease prevention. 	ked ew all eport or Il be yze for eleted e need tation	
		30 p.m. the DON, also the eventionist, confirmed only			 DNS or designee will complete of the 24 hour report for accuracy of 		

Facility ID: 00830

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TATEMEN	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	TIPLE CONSTRUCTION	(X3) DAT	. 0938-039 E SURVEY IPLETED
		245468	B. WING _		10/	20/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF		
KARLST	AD HEALTHCARE CE	ENTER INC		304 WASHINGTON AVENUE WES KARLSTAD, MN 56732	T	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIC DATE
F 441	infections with pres tracked. She state established a syste were not treated wi facility failed to follo The facility's Surve indicated surveillar identify and report Collecting, docume	scribed antibiotics were do the facilty had not ern to track infections which ith antibiotics and verified the pow their surveillance policy. illance policy, revised 11/16, noce was implemented to evidence of infection. enting, and analyzing data the infection preventionist or	F 44	41 resident symptoms of illne x1 month, then weekly x2 data collected will be revie Monthly QAPI and Quarte At that time the committee decision/recommendation follow-up studies. Completion Date: 11/29/1	months. The ewed at the rly QA meeting. e will make the regarding any	

Facility ID: 00830

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

F5468026

PRINTED: 11/15/2017 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · · ·		CONSTRUCTION I - MAIN BUILDING 01		E SURVEY PLETED
		245468	B. WING			10/	17/2017
	PROVIDER OR SUPPLIER			304	REET ADDRESS, CITY, STATE, ZIP CODE WASHINGTON AVENUE WEST IRLSTAD, 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 CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
K 000	INITIAL COMMEN	TS	K	000			
	ALLEGATION OF DEPARTMENT'S A SIGNATURE AT TH PAGE OF THE CM USED AS VERIFIC UPON RECEIPT CONSITE REVISIT CONDUCTED TO SUBSTANTIAL CO REGULATIONS HA ACCORDANCE W A Life Safety Code Minnesota Departr time of this survey Main Building was the requirements ff Medicare/Medicaic 483.70(a), Life Saf	MPLIANCE WITH THE AS BEEN ATTAINED IN /ITH YOUR VERIFICATION. Survey was conducted by the nent of Public Safety. At the Karlstad Healthcare Center 01 found not in compliance with					
	Standard 101, Life 19 Existing Health the Health Care Fa PLEASE RETURN CORRECTION FC DEFICIENCIES (K HEALTH CARE FI STATE FIRE MAR	Safety Code (LSC), Chapter Care and the 2012 edition of acilities Code (NFPA 99). I THE PLAN OF OR THE FIRE SAFETY C-TAGS) TO: RE INSPECTIONS SHAL DIVISION STREET, SUITE 145			EPOC		
ABORATOR		DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TITLE		(X6) DATE
	nically Signed						11/13/20

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.

		AND HUMAN SERVICES & MEDICAID SERVICES				FORMA	11/15/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION 6 01 - MAIN BUILDING 01	(X3) DATE COMF	SURVEY PLETED
		245468	B. WING			10/1	7/2017
NAME OF F	PROVIDER OR SUPPLIER			I	STREET ADDRESS, CITY, STATE, ZIP CODE		
KARLST	AD HEALTHCARE CE				304 WASHINGTON AVENUE WEST KARLSTAD, MN 56732		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000	Continued From pa	ige 1	K	000	0		
	By e-mail to: Marian.Whitney@s and Angela.kappenmar						
	DEFICIENCY MUS FOLLOWING INFO		a)				
	1. A description of to correct the defici	what has been, or will be, done iency.					
	2. The actual, or pr	oposed, completion date.					
		r title of the person rection and monitoring to ence of the deficiency.					
	without a basemen times. The original 1974, was determin construction. In 199 south of the original determined to be o and is not separate with a 2-hour fire b is Type II (000). At at the south west c 2-hour fire barrier i assisted living build						
	fire sprinkler syster NFPA 13 Standard Automatic Sprinkle	is protected with an automatic m installed in accordance with for the Installation of r Systems. The facility has a with smoke detection at the				1	

If continuation sheet Page 2 of 9

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 11/15/2017 APPROVED .0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DAT	E SURVEY IPLETED
		245468	B. WING	÷		10/	17/2017
NAME OF I	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
KARLST	AD HEALTHCARE CE	NTER INC			804 WASHINGTON AVENUE WEST (ARLSTAD, MN 56732		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
	with extended space with NFPA 72 "The The fire alarm syster fire department noti have either heat det that are on the fire a divided into 4 smoke minute fire barriers. The facility has a ca census of 36at the t The requirement at NOT MET as evider NFPA 101 Hazardou Hazardous Areas - I 2012 EXISTING Hazardous Areas ar having 1-hour fire re- fire rated doors) or a system in accordance approved automatic option is used, the a other spaces by smo doors in accordance self-closing or autor have nonrated or fie that do not exceed 4 the door. Describe the floor at hazardous areas tha 19.3.2.1 Area Separation N/A a. Boiler and Fuel-Fie	s and in the corridor system ing, installed in accordance National Fire Alarm Code". em is monitored for automatic fication. Hazardous areas tection or smoke detection alarm system. The facility is e zones with at least 30 apacity of 46 beds and had a ime of the survey. 42 CFR, Subpart 483.70(a) is need by: us Areas - Enclosure Enclosure e protected by a fire barrier esistance rating (with 3/4-hour an automatic fire extinguishing ce with 8.7.1. When the fire extinguishing system ureas shall be separated from oke resisting partitions and e with 8.4. Doors shall be natic-closing and permitted to id-applied protective plates 18 inches from the bottom of at are deficient in REMARKS. Automatic Sprinkler		321			12/10/17

IEMENI					D. 0938-039 ATE SURVEY
) PLAN C	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			OMPLETED
		245468	B, WING		0/17/2017
AME OF I	PROVIDER OR SUPPLIER		1	TREET ADDRESS, CITY, STATE, ZIP CODE	
ARLST	AD HEALTHCARE CE			04 WASHINGTON AVENUE WEST ARLSTAD, MN 56732	
(X4) ID PREFIX T A G	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIC DATE
K 321	Continued From page 3 b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms		K 321		
	(exceeding 64 galle f. Combustible Sto (over 50 square fee g. Laboratories (if of Hazard - see K322 This STANDARD Based on observa facility failed to ma	ons) rage Rooms/Spaces et) classified as Severe) is not met as evidenced by: tion and staff interview the aintain a hazardous storage		The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted	
	Code (NFPA 101) s deficient condition enter the corridor r the quick and effici residents and an u and visitors.	e with the 2012 Life Safety section 19.3.2.1.3. This could allow smoke or fire to naking it untenable and affect ent exiting for 8 of the 36 ndetermined amount of staff		as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because provisions of state and federal law require it. Without waiving the	d
	revealed the oxyge clean utility room o have a self closing	/17/2017 observations on storage room inside the f the Heritage wing did not door and did not have the d the maintenance room		 foregoing statement, the facility states with respect to: A door closer has been installed to the maintenance room door across from the boiler room and to the door of the oxyget storage room inside of clean utility room on Heritage wing. Proper signage has 	en l
	across from the bo	pler room contained ge and did not have a self		also been added to the oxygen storage room inside of clean utility room on Heritage wing in accordance with NFPA	

Facility ID: 00830

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	TOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE	0938-039 SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:		01 - MAIN BUILDING 01		PLETED	
		245468	B. WING		10/1	7/2017	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
KARLST	AD HEALTHCARE CE			304 WASHINGTON AVENUE WEST KARLSTAD, MN 56732			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE	
K 351	construction type, a approved automati accordance with N Installation of Sprir In Type I and II cor measures are perr sprinkler protection or local regulations In hospitals, sprink closets of patient s of the closet does sprinkler coverage required by NFPA Sprinkler Systems 19.3.5.1, 19.3.5.2, 19.4.2, 19.3.5.10, 9 This STANDARD Based on observa facility failed to insi accordance with the Safety Code (NFP) 9.7.1.1 and the 20 Standard for the Im This deficient prace extinguishing a fire 36 residents and a staff and visitors. Findings include: At 10:30 am on 10 revealed the electr not have complete	are protected throughout by an c sprinkler system in FPA 13, Standard for the hkler Systems. Instruction, alternative protection nitted to be substituted for in specific areas where state s prohibit sprinklers. Ilers are not required in clothes Ileeping rooms where the area not exceed 6 square feet and covers the closet footprint as 13, Standard for Installation of	K 354	The preparation of the following p correction for this deficiency does constitute and should not be inter as an admission nor an agreement facility of the truth of the facts alle conclusions set forth in the statent deficiencies. The plan of correction prepared for this deficiency was e solely because provisions of state federal law require it. Without wa foregoing statement, the facility st with respect to: 1. Electrical Room in Heritage L been reviewed by a licensed cont and a sprinkler head added accor manufacturer and NFPA regulatio 2. Completion date: 10/27/2017	not preted at by the ged or hent of on xecuted and iving the ates ane has ractor ding to		

Facility ID: 00830

If continuation sheet Page 5 of 9

TEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA			CONSTRUCTION	(X3) DATE	0938-039 SURVEY PLETED
D PLAN O	FCORRECTION	IDENTIFICATION NUMBER:	A, BUILDI	ING 0 '	1 - MAIN BUILDING 01	COM	PLETED
		245468	B. WING			10/*	7/2017
AME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
ARLST	AD HEALTHCARE CE				4 WASHINGTON AVENUE WEST ARLSTAD, MN 56732		
(X4) ID PREFIX T A G	(EACH DEFICIENC)	SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFID REGULATORY OR LSC IDENTIFYING INFORMATION) TAG			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 353	Continued From pa	age 5	К 3	353			
	NFPA 101 Sprinkler System - Maintenance and Testing		К 3	353			10/17/17
	Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked						
	b) Who provided						
	Provide in REMAR any non-required o	KS information on coverage for r partial automatic sprinkler					
	Based on observa facility failed to test system in accordan Code (NFPA 101) a The standard for te sprinkler systems. cause the sprinkle properly and allow could affect all of the	and NFPA 25 is not met as evidenced by: ition and staff interview, the t and maintain the sprinkler ince with the 2012 Life Safety and NFPA 25 section 5.2.1.1.2. esting and maintenance of This deficient condition could r system not to function for the spread of fire. This he 36 residents and an bunt of staff and visitors.			The preparation of the following p correction for this deficiency does constitute and should not be interp as an admission nor an agreemen facility of the truth of the facts alleg conclusions set forth in the statem deficiencies. The plan of correction prepared for this deficiency was ex- solely because provisions of state federal law require it. Without wai foregoing statement, the facility sta- with respect to:	not oreted t by the ged or ent of on kecuted and ving the	
	revealed the sprink	/17/2017 observations kler heads in the kitchen layer of dust and dirt.			 All sprinkler heads in kitchen of from dust and dirt. Completion date: 10/11/2017 	leaned	

Facility ID: 00830

	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MU			ATE SURVE	-039 EY
	OF DEFICIENCIES	IDENTIFICATION NUMBER:	l` '			OMPLETED	
		245468	B, WING			0/17/201	17
NAME OF I	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
KARLST	AD HEALTHCARE CI				4 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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPL	(5) LETIO ATE
K 353	Continued From pa	age 6	КЗ	353			
		lition was confirmed by the for and the Environmental pr.			3. Maintenance Director will complete monthly inspections on all sprinkler hea in accordance with our preventative maintenance program.	st	
	NFPA 101 Subdivis Smoke Barrie	sion of Building Spaces -	КЗ	372		12/10)/17
	Construction 2012 EXISTING Smoke barriers sh fire resistance ratin be permitted to ter Smoke dampers a penetrations in full an approved sprint smoke compartme barrier. 19.3.7.3, 8.6.7.1(1 Describe any mec in REMARKS. This STANDARD Based on observa facility failed to ma barriers as require (NFPA 101) section deficient practice of from one smoke c affecting the exitin	ding Spaces - Smoke Barrier all be constructed to a 1/2-hour ng per 8.5. Smoke barriers shall minate at an atrium wall. re not required in duct y ducted HVAC systems where kler system is installed for ents adjacent to the smoke) hanical smoke control system is not met as evidenced by: ation and staff interview the intain two of four smoke d by the 2012 Life Safety Code n 19.3.7.3, 8.8.7.1 (1). This could allow smoke to transfer ompartment to another g of 18 of the 36 residents and amount of staff and visitors.			The preparation of the following plan or correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged of conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was execut solely because provisions of state and federal law require it. Without waiving the foregoing statement, the facility states	he r f ed	

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Facility ID: 00830

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		& MEDICAID SERVICES			1	. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION 01 - MAIN BUILDING 01		TE SURVEY MPLETED
		245468	B. WING		10	/17/2017
NAME OF 1	PROVIDER OR SUPPLIER	L	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
KARLST	AD HEALTHCARE CE			304 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIO DATE
К 918	following locations. 1. At 10:00 am in t cross corridor doors cable. 2. At 10:10 am in t cross corridor doors 3. At 10:15 am in t of the pipe penetrat a golf ball. This deficient cond Facility Administrate Services Supervise NFPA 101 Electrical Syste Electrical Systems Maintenance and T The generator or of and associated equ service within 10 sec criterion is not met process shall be pr capability for the life Maintenance and te transfer switches a with NFPA 110. Generator sets are	ns in 2 smoke barriers in the he wilderness wing above the s an annular space around a he Heritage wing above the s the top of the 3" pipes. he Heritage wing opposite side tions is a hole about the size of ition was confirmed by the or and the Environmental or. Il Systems - Essential Electric - Essential Electric System	K 372	 All penetrations in smoke bar have been filled with fire barrier s per NFPA guidelines. Completion date: 12/10/2017 Maintenance Director 	ealant	12/10/17
	months for 4 contin under load conditio simulated cold star transfer of all EES competent personn stored energy powe	exercised once every 36 nuous hours. Scheduled test ns include a complete t and automatic or manual loads, and are conducted by nel. Maintenance and testing of er sources (Type 3 EES) are in FPA 111. Main and feeder				

Facility ID: 00830

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-							
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	
245468		245468	B. WING		10/17/2017		
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)			FIX (EACH CORRECTIVE ACTION SHOULD		BE	(X5) COMPLETION DATE
К 918	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		K	PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPE		not reted t by the ged or ent of n kecuted and ving the ates cted and elines.	

Facility ID: 00830

If continuation sheet Page 9 of 9