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.

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 psychiatrist, medical doctor and interdisciplinary team requested that R5 be transferred to an inpatient 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(l) 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

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

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

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F 000	INITIAL COMMENTS On 10/16/17, through 10/20/17, a recertification survey was completed by surveyors from the Minnesota Department of Health (MDH) to determine compliance with requirements at 42 CFR Part 483, subpart B, requirements for Long Term Care Facilities. The facility's electronic Plan of Correction (ePOC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. An investigation of complaint H5468004 was conducted and was found to be substantiated at F225, F226. "Revised 2567 as a result of an Informal Dispute Resolution."	F 000		
F 201 SS=D	REASONS FOR TRANSFER/DISCHARGE OF RESIDENT CFR(s): 483.15(c)(1)(i)(ii) (c) Transfer and discharge (1) Facility requirements (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs	F 201		11/29/17

REVISED

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

Electronically 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.

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F 201	Continued From page 1 cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger	F 201		

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F 201	Continued From page 2 that failure to transfer or discharge would pose. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to complete an assessment to determine if a new plan of care would meet the needs of the resident and failed to obtain physician documentation supporting the facility's discharge related to the inability to meet the needs of 1 of 1 resident (R5) who was sent to the emergency room for evaluation and the facility refused to allow R5 to return to the facilty or inform R5 of the refusal for return resulting in two emergency room visits and an unnecessary hospital stay. Findings include: R5's cumulative diagnoses list dated 10/19/17, indicated R5 was admitted to the facility with diagnoses that included, but were not limited to: bipolar disorder, adjustment disorder with mixed anxiety & depressed mood, major depressive disorder, narcotic dependence, disruptive behavior disorder, post-traumatic stress disorder, end stage renal disease, chronic radicular low back pain, right hand and right below the knee amputation, and sociopathic borderline personality disorder. R5's quarterly Minimum Data Set (MDS) dated 7/6/17, indicated R5 had no cognitive or memory deficits, R5 had inappropriate behavior symptoms identified as inattention (trouble focusing attention, being easily distractible, or had difficulty keeping track of what was being said). The MDS	F 201	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because provisions of state and federal law require it. Without waiving the foregoing statement, the facility states with respect to: 1. R5 was readmitted to the facility on 10/12/17. A new assessment had been completed 10/6/17. Care Conferences were held 9/21/17, 10/13/17, and 10/26/17 to discuss plan of care with R5 and guardian(s). 2. The facility will permit each resident to remain in the facility, and not transfer or discharge the resident from the facility in accordance with state guidance. All residents going to ER/ physician appt will 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 which has the purpose to begin planning and provide for a safe transition plan for residents upon admission to facility. Discharge plan may include remaining in the senior living community, returning to the community or other facility including but not limited to another nursing home or	

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F 201	Continued From page 3 also indicated R5 had the following mood symptoms present 2-6 days a week: Feeling down, depressed, or hopeless, feeling tired or having to little energy, and feeling bad about self-or that you are a failure or have let yourself or a family member down. The MDS indicated R5 did not have any symptoms of psychosis (hallucinations or delusions) however, R5 did have verbal behavior symptoms directed at others (threatening others, screaming or cursing at others) 1-3 days a week. The MDS indicated R5 required extensive assistance of two persons for bed mobility and toilet use, and required extensive assistance of one person for dressing, personal hygiene and locomotion on and off the unit using a wheelchair. R5 was unable to ambulate, and was totally dependent on two staff during transfers. 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. R5 was interviewed on 10/17/17, at 2:00 p.m. and stated she was extremely upset. R5 began to cry and stated the facility had tried sending her to a "nut house" last week and would not allow her to come back to the facility. R5 stated she had been sent to a local emergency room from dialysis, and because the nursing home refused to allow R5 to	F 201	ALF. 4. Executive Director (ED) or Designee will audit all resident discharges and/or transfers for discharge reason, physician documentation supporting the discharge, and resident and/or family involvement with discharge process. The data collected will be reviewed at the Monthly QAPI and Quarterly QA meeting. At that time the committee will make the decision/recommendation regarding any follow-up studies. Completion Date 11/29/17 REVISED	

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F 201	Continued From page 4 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. Review of the Sanford Medical Center emergency room dismissal summary dated 10/8/17, indicated R5 arrived in the emergency room on 10/6/17, and stayed in the emergency room two days until 10/8/17. The dismissal summary indicated R5 was brought to the emergency room for psychiatric evaluation because of increasingly disruptive behavior in the care center where R5 resided. The crisis team completed an evaluation and determined R5 while being loud, disruptive, and verbally abusive towards staff, R5 was not aggressive towards others, was non-threatening, was not suicidal, and did not pose a threat to herself or others, and R5 did not meet criteria for hospital admission. The dismissal summary indicated the Karlstad Healthcare Center refused to take R5 back when the physician discharged R5 from the Sanford emergency room. The dismissal summary indicated R5 was then transferred to the emergency room at Mayo Medical Center in Rochester, MN for psychiatric	F 201		

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F 201	Continued From page 5 evaluation. Review of the Mayo Clinic Medicine 9 Hospital dismissal summary dated 10/12/17, indicated R5 was assessed in the emergency department and was found not in need of hospital admission for psychiatric care because R5's outbursts were more behaviorally based. The dismissal summary indicated the Karlstad Healthcare Center would not agree to accept R5 back into the facility, therefore, R5 had to be admitted to their hospital just to continue dialysis treatments. The dismissal summary indicated that while in the hospital, psychiatry was consulted and a behavior plan was employed to outline expected respectful behaviors and R5 did very well with this. R5's medical record lacked any evidence of a discharge notice being provided to the resident when the decision was made not readmit to the facility. The DON was interviewed on 10/19/2017, at 10:14 a.m. and confirmed she had not allowed R5 to return to the nursing home after being evaluated in the emergency room at Sanford Medical Center Fargo, ND on 10/6/17, and again from Mayo Medical Center on 10/8/17. The DON stated she was unsure if R5 would have transportation to dialysis while at the facility. When the DON was asked to provide evidence that the transportation service had refused ongoing transportation services to R5, the DON stated the transport company had not provided any documentation which identified R5 was denied transportation services. The DON	F 201		

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F 201	Continued From page 6 confirmed there was an ambulance service for the community of Karlstad that could have provided transportation on an emergency basis, if needed. Review of the Karlstad Healthcare Center Resident Admission Policy dated 6/9/11, revealed the following: "The facility reserved the right to discharge or transfer residents for the following reason, but not limited to these only: A: Persons who become mentally disturbed to the extent that they are dangerous to other residents, themselves, or staff members. B: Persons whose accounts are not paid in 60 days. C: Persons whom the facility is unable to care for adequately in conformance with the medical plan of care due to changes in their condition or due to family interference. The policy had not included directives for residents return to the facility following an emergency room visit or hospital stay.	F 201		
F 225 SS=D	INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS CFR(s): 483.12(a)(3)(4)(c)(1)-(4) 483.12(a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State	F 225		11/29/17

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F 225	Continued From page 7	F 225		

nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or

(iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property.

(4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff.

(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:

(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.

(2) Have evidence that all alleged violations are thoroughly investigated.

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F 225	Continued From page 8 (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to conduct a thorough investigation and ensure allegations of abuse were reported to the State agency prior to investigation for 1 of 3 resident (R5) vulnerable adult (VA) reports reviewed and failed to ensure allegations of financial exploitation had been thoroughly investigated for 1 of 3 residents (R41) VA reports reviewed. Lastly, the facility failed to include all information learned by the internal investigation which substantiated abuse had been reported to the State agency within 5 business days for 1 of 3 resident (R5) VA reports reviewed. Findings include: 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	F 225	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because provisions of state and federal law require it. Without waiving the foregoing statement, the facility states with respect to: 1. R5 has been reported to MDH and thoroughly investigated for potential abuse/mistreatment on 7/25/17 (and with re-submission on 11/10/17) and 10/23/17 (which had included statements from the aides that provided cares on the day in question). R41 had been reported to MDH and to local law enforcement on 8/9/17 for allegations of financial exploitation. Law enforcement closed this case on 8/11/17. This facility received email confirmation on 9/15/17, that the information had been reviewed and it has	

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F 225	Continued From page 9 (including the named staff member) were immediately contacted and asked who provided morning cares to R5. The progress note indicated the director of nursing (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 indicated the executive director was notified of the allegation, however, there was no indication the State agency (SA) had been notified of the allegation of abuse by R5. The DON was interviewed on 10/19/17, at 9:49 a.m. during which she was asked why the allegation R5 made about staff being rough with her on 10/16/17, wasn't reported to the SA prior to investigating the allegation. The DON stated in the past R5 had made false accusations of staff abuse and after talking to the alleged perpetrator, the DON stated it took only 10 minutes to complete the investigation enough to ascertain R5 had not been treated roughly. However, the investigation did not include interviewing the aides that did provide care to R5 the morning of 10/16/17, interviewing R5 for pertinent details, and interviewing other residents regarding the care received by the alleged perpetrator. The DON confirmed she had investigated the incident before reporting to the SA because she felt we needed to use common sense, and since R5 had a history of confabulating stories, the DON stated she didn't know whether to believe R5's report or not. The Karlstad Senior Living VA policy dated as revised November 2016, indicated "All incidents deemed reportable under MN statute are	F 225	been determined that no further action was necessary. 2. Executive Director, DNS or assigned designee is immediately notified per facility policy and procedure of incidents to determine if additional reporting to MDH, law enforcement or other agencies are required. All incidents are reviewed at daily IDT meetings to assure staff followed proper reporting and monitoring procedures. 3. VA Policy will be updated to include that results of the investigation will be submitted within 5 business days. Staff 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, initiation of the investigation, immediate notification of Administrator and DNS and the notification of the Common Entry Point and/or MDH. 4. Executive Director and DNS review all incident reports daily to assure proper reporting and monitoring procedures are followed. The incident reports will be reviewed/discussed at the Monthly QAPI and Quarterly QA meeting. At this time the QA committee will make the decision/recommendation regarding any follow-up studies. Completion Date: 11/29/17	

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	245468	A. BUILDING _____ B. WING _____	C 10/20/2017

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F 225	Continued From page 10 submitted to MDH via the on-line Reporting System immediately (as soon as possible)." During interview with the DON on 10/19/2017, at 9:49 a.m. she confirmed she investigated R5's allegation of abuse prior to reporting the incident to the SA. The DON confirmed R5's allegation of abuse had not been reported to the SA at point following R5's report of rough treatment. The VA report dated 8/9/17, alleged R42 was the victim of financial exploitation. The VA report identified R42 was admitted to the facility on 7/6/17, and had diagnoses that included, but were not limited to malignant neoplasm of prostate with mets to the bone, pain, weakness, anxiety disorder, hypertension, constipation, and palliative care. The alleged perpetrator was R42's son who received funds from R42's bank account in the amount of 3,000.00 dollars on 7/5/17, and another check was drafted on R42's account on 7/7/17, for 5,000.00 dollars which was returned for non-sufficient funds. The VA report indicated the SA was notified of the alleged financial exploitation on 8/9/17, and the Kittson County Sheriff's Office received the report on 8/11/17, from the Minnesota Adult Abuse Reporting Center. The investigation for this alleged financial exploitation had not included any interviews with the alleged perpetrator (R41's son) and had not included any interviews with R41, and it was never determined if the 3,000.00 dollars R41's son received was used for the benefit of R41 or who drafted the check that was returned for non-sufficient funds in the amount of 5,000.00 dollars.	F 225		

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F 225	Continued From page 11 On 10/20/2017, at 12:30 p.m. the Administrator was interviewed and confirmed the investigation 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. 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	F 225		

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F 225	Continued From page 12	F 225		

"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 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

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F 225	Continued From page 13	F 225		

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 "kinda short tempered".

-NA-C stated " [AP] can be harsh with staff and sometimes not really nice with [R5]. "Kinda mean, like [AP] wants to show [R5] who is boss, but with R5, you have to be kinda firm, or she will run you over, it's a fine line. I told her one day a resident was soaked, and she walked right by me and didn't respond at all. She doesn't like anyone telling her anything."

-LPN-A and LPN-B stated that [AP] can be snappy, kinda short with residents. She will say "not right now" when a resident asks for something.

-NA-H stated she had never heard the AP swear in front of any resident and she has never heard the AP tell R5 she was acting like a bitch or tell her to shut up. NA-H stated the AP presented herself in a harsh way to residents sometimes. The AP does tell R5 "no" sometimes and I have counseled AP that she shouldn't say that, but rather say "we will have to see if I have the time". NA-H had also heard the AP tell R5 to "knock it off" when R5 was asking for one thing after another. NA-H stated that another resident described the AP as "kinda pushy".

On 10/19/17 at 2:34 p.m. the DON was interviewed and was asked why all of the aforementioned staff interviews had not been included in the follow-up investigation submitted to the SA and the DON stated she didn't think the statements were pertinent to R5 reporting she

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F 225	Continued From page 14 was told to shut up and your acting like a bitch. The DON was asked if the above statements constituted verbally abusive behavior, and the DON stated "Yes", I wouldn't want her taking care of my grandmother. The DON confirmed she had not included all of the employee interviews in the follow up investigation report to the SA and with all of the NA/LPN interviews together, the AP's resident interactions suggested a pattern of verbal abuse. The DON stated she wanted to terminate this employee but corporate would not allow her to. The DON stated the AP was able to return to work after the investigation was completed and the suspension was lifted, but chose not too. The Karlstad Senior Living VA policy dated as revised November 2016, indicated the DON or Administrator would immediately institute an internal investigation of the reported allegation or incident. The investigation may include interviews with staff, residents, and witnesses, environmental review, resident health status review, and behavior and medication review. The VA policy failed to indicate the results of the investigation needed to be submitted to the SA within 5 business days.	F 225		
F 226 SS=D	DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES CFR(s): 483.12(b)(1)-(3), 483.95(c)(1)-(3) 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of	F 226		11/29/17

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F 226	Continued From page 15 resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the Vulnerable Adult (VA) policy had been implemented as written for reporting allegations of abuse to the State agency prior to investigation for 1 of 3 residents (R5) vulnerable adult (VA) reports reviewed; failed to ensure the facilities VA policy was implemented as written to ensure allegations of financial exploitation had been thoroughly investigated for 1 of 3 residents (R42) VA reports reviewed; and failed to ensure the facility VA policy was implemented as written to include all	F 226	 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because provisions of state and federal law require it. Without waiving the foregoing statement, the facility states with respect to:	

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F 226	Continued From page 16 information learned by the internal investigation was reported to the State agency within 5 business days for 1 of 3 residents (R5) VA reports reviewed. Findings include: The Karlstad Senior Living VA policy dated as revised November 2016, indicated the director of nursing (DON) or Administrator would immediately institute an internal investigation of the reported allegation or incident. The investigation may include interviews with staff, residents, and witnesses, environmental review, resident health status review, and behavior and medication review. The VA policy failed to indicate the results of the investigation needed to be submitted to the SA within 5 business days. The Karlstad Senior Living VA policy dated as revised November 2016, indicated "All incidents deemed reportable under MN statute are submitted to MDH via the on-line Reporting System immediately (as soon as possible)." 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	F 226	1. R5 has been reported to MDH and thoroughly investigated for potential abuse/mistreatment on 7/25/17 (and with re-submission on 11/10/17) and 10/23/17. R41 had been reported to MDH and to local law enforcement on 8/9/17 for allegations of financial exploitation. Law enforcement closed this case on 8/11/17. This facility received email confirmation on 9/15/17, that the information had been reviewed and it has been determined that no further action was necessary. 2. Executive Director, DNS or assigned designee are notified per facility policy and procedure of incidents to determine if additional reporting to MDH, law enforcement or other agencies are required. All incidents are reviewed at IDT to assure staff followed proper reporting and monitoring procedures. 3. VA Policy will be updated/changed to include that results of the investigation will be submitted within 5 business days. Staff 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, initiation of the investigation, notification of Administrator and DNS and the notification of the Common Entry Point and/or MDH. . 4. Executive Director and DNS review all incident reports to assure proper reporting and monitoring procedures are followed. The incident reports will be reviewed/discussed at the Monthly QAPI and Quarterly QA meeting. At this time the QA committee will make the decision/recommendation regarding any	

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F 226	Continued From page 17 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 indicated the executive director was notified of the allegation, however, there was no indication the State agency (SA) had been notified of the allegation of abuse by R5. The DON was interviewed on 10/19/17, at 9:49 a.m. during which she was asked why the allegation R5 made about staff being rough with her on 10/16/17, wasn't reported to the SA prior to investigating the allegation. The DON stated in the past, R5 had made false accusations of staff abuse and after talking to the alleged perpetrator, the DON stated it took only 10 minutes to complete the investigation enough to ascertain R5 had not been treated roughly. However, the investigation did not include interviewing the aides that did provide care to R5 the morning of 10/16/17, interviewing R5 for pertinent details, and interviewing other residents regarding the care received by the alleged perpetrator. The DON confirmed she had investigated R5's allegation of abuse before reporting to the SA because she felt we needed to use common sense, and since R5 had a history of confabulating stories, the DON stated she didn't know whether to believe R5's report or not. The VA report dated 8/9/17, alleged R42 was the victim of financial exploitation. The VA report identified R42 was admitted to the facility on 7/6/17, and had diagnoses that included, but were not limited to malignant neoplasm of prostate with mets to the bone, pain, weakness, anxiety	F 226	follow-up studies. Completion Date: 11/29/17 REVISED	

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F 226	Continued From page 18 disorder, hypertension, constipation, and palliative care. The alleged perpetrator was R42's son who received funds from R42's bank account in the amount of 3,000.00 dollars on 7/5/17, and another check was drafted on R42's account on 7/7/17, for 5,000.00 dollars which was returned for non-sufficient funds. The VA report indicated the SA was notified of the alleged financial exploitation on 8/9/17, and the Kittson County Sherriff's Office received the report on 8/11/17, from the Minnesota Adult Abuse Reporting Center. The investigation for this alleged financial exploitation had not included any interviews with the alleged perpetrator (R41's son) and had not included any interviews with R41, and it was never determined if the 3,000.00 dollars R41's son received was used for the benefit of R41 or who drafted the check that was returned for non-sufficient funds in the amount of 5,000.00 dollars. On 10/20/2017, at 12:30 p.m. the Administrator was interviewed and confirmed the investigation 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. 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	F 226		

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F 226	Continued From page 19 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. 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 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.	F 226		

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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 "kinda short tempered".

-NA-C stated " [AP] can be harsh with staff and sometimes not really nice with [R5]. "Kinda mean, like [AP] wants to show [R5] who is boss, but with R5, you have to be kinda firm, or she will run you over, it's a fine line. I told her one day a resident was soaked, and she walked right by me and didn't respond at all. She doesn't like anyone telling her anything."

-LPN-A and LPN-B stated that [AP] can be snappy, kinda short with residents. She will say "not right now" when a resident asks for something.

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F 226	Continued From page 21 -NA-H stated she had never heard the AP swear in front of any resident and she has never heard the AP tell R5 she was acting like a bitch or tell her to shut up. NA-H stated the AP presented herself in a harsh way to residents sometimes. The AP does tell R5 "no" sometimes and I have counseled AP that she shouldn't say that, but rather say "we will have to see if I have the time". NA-H had heard the AP tell R5 to "knock it off" when R5 was asking for one thing after another. NA-H stated that another resident described the AP as "kinda pushy". On 10/19/17 at 2:34 p.m. the DON was interviewed and asked why all of the aforementioned staff interviews had not been included in the follow-up investigation submitted to the SA and the DON stated she didn't think the statements were pertinent to R5 reporting she was told to shut up and your acting like a bitch. The DON was asked if the above statements constituted verbally abusive behavior, and the DON stated "Yes", I wouldn't want her taking care of my grandmother. The DON confirmed she had not included all of the employee interviews in the follow up investigation report to the SA and with all of the NA/LPN interviews together, the AP's resident interactions suggested a pattern of verbal abuse. The DON stated she wanted to terminate this employee but corporate would not allow her to. The DON stated the AP was able to return to work after the investigation was completed and the suspension was lifted, but chose not too.	F 226		
F 279 SS=D	DEVELOP COMPREHENSIVE CARE PLANS CFR(s): 483.20(d);483.21(b)(1)	F 279		11/29/17

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F 279	Continued From page 22 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the	F 279		

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F 279	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. 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 effects and monitoring needs.	F 279	 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because provisions of state and federal law require it. Without waiving the foregoing statement, the facility states with respect to: 1. R35 had a care plan review with changes made for the medication Carbamazepine for resident behaviors. R35 has not had a history of seizures. Pharmacy consultants state that when	

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F 279	Continued From page 24 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, identifies R35 as severely impaired, exhibits verbal and physical behaviors and received antipsychotic, antidepressant, antianxiety and antibiotic medications. 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. R35's Medication Administration Record, dated 10/2017, indicated R35 received Carbamazepine 300 milligrams in the evening for seizures. R35's care plan, print date 10/20/17, identified psychoactive medication use for Zyprexa, Risperdal, Celexa, Klonopin, and Buspar. The care plan lacked identification of a focus identification of seizure medication use, monitoring, or interventions. On 10/2/17, at 9:05 a.m. the ADON stated, R35 recently returned from a short hospital stay, and her Carbamazepine was not a new medication and staff should have identified the need for	F 279	Carbamazepine is being utilized for behaviors, checking routine levels isn't clinically indicated. 2. All residents will be reviewed through chart review for seizure history, to ensure that they are care planned appropriately along w/ being identified on the MDS, and that monitoring needs have been identified and implemented. 3. Staff education will be completed by 11/29/17 regarding the need to address the use of medications and if side effects or behaviors warrant monitoring. 4. Audits of care plans will be completed by DNS or designee with all new admissions and for any resident having medication order changes for the following 3 months to ensure that all psychoactive or anti-seizure medication would be identified properly on the MDS, care plan, and the monitoring needs identified and implemented. The data collected will be reviewed at the Monthly QAPI and Quarterly QA meeting. At that time the committee will make the decision/recommendation regarding any follow-up studies. Completion Date: 11/29/17	

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F 279	Continued From page 25 monitoring R35's use of Carbamazepine. The ADON stated she was not aware of R35 exhibiting any seizure activity and verified R35's last Carbamazepine laboratory test on 12/8/16, indicated a result of 4.3 mg (therapeutic reference range is 4-12 mg.) The ADON stated she would expect the use of an anti-seizure medication to be monitored and the care plan should reflect identification of the anti-seizure medication use, potential for seizures, monitoring needs, and identified interventions. The ADON stated the facility had a change in their MDS staff and have had resident health care areas/resident needs which had had slipped through the cracks and recognized the care plans were not reflecting resident needs. On 10/20/17, at 1:16 p.m. the director or nursing (DON) confirmed the use of psychoactive and anti-seizure medications should be identified accurately on the MDS, care plans, and the monitoring needs identified and implemented. The DON further stated that on the second day of the survey they had identified the care plans were seriously lacking the identification of residents needs, which needed to be addressed. Facility policy Person Centered Care Plan Guideline last revised 11/16, indicated the care plan must be reviewed and revised annually, quarterly, with a significant change in status and as needed. The policy also included, the overall person centered care plan should be orientated towards: preventing avoidable declines, and managing risk factors. The policy also directed staff to include target behaviors, non-pharmacological interventions, psychoactive	F 279		

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F 279	Continued From page 26 medication class if applicable with appropriate diagnosis/indication for use, and gradual dose reductions/pharmacy reviews.	F 279		
F 280 SS=D	RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP CFR(s): 483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative.	F 280	REVISED	11/29/17

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F 280	Continued From page 27 (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs	F 280		

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F 280	Continued From page 28 or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to ensure the written care plan was revised to include fluid restriction interventions and ongoing monitoring of fluid intake for 1 of 1 (R5) resident in the sample reviewed for dialysis, and failed to revise the care plan to include target behavior/mood symptoms for psychotropic medications for 2 of 5 residents (R6, R30) reviewed for unnecessary medications. Findings include: R5's cumulative diagnoses list dated 10/19/17, indicated R5 was admitted to the facility with diagnoses that included, but were not limited to: end stage renal disease requiring hemodialysis, bipolar disorder, disruptive behavior disorder, post-traumatic stress disorder, and sociopathic borderline personality disorder. On 10/20/17, at 9:22 a.m. R5 was observed at the end of the breakfast meal and was noted to have four cups of fluid each which held at least 240 cubic centimeters (cc) per cup for a total of 960 cc of fluid on her breakfast tray. R5 drank all of the fluids provided. R5 stated the facility did not serve her the correct amount of fluids according to her dialysis diet. R5 stated she herself tracked	F 280	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because provisions of state and federal law require it. Without waiving the foregoing statement, the facility states with respect to: 1. R5 did not have a physician order for fluid restriction due to an extensive history of non-compliance. R5 has had a care plan review to include fluid restriction interventions and monitoring of fluid intake. R6 and R30 have had care plan reviews with updates to include target behavior/mood symptoms for psychotropic medications. 2. Residents receiving dialysis will have their care plans reviewed for fluid restrictions and ongoing monitoring of fluid intake. Residents that received psychotropic medication will have care plans reviewed for target behavior/mood symptoms. 3. Staff education will be completed 11/15/17 regarding target behavior/ mood monitoring care plan need, and the need	

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F 280	Continued From page 29 how much fluid she consumed each day and showed the surveyor a notebook with numbers written down for each day. However, there were no totals which identified how much fluid was consumed in a day and many of the days didn't look complete. R5 also stated the fluid calculation was not correct and she did not know if her fluid restriction was 32 or 36 ounces. R5 stated the dialysis unit had not even looked at her personal fluid intake log because they did not believe her recordings. R5 stated she was trying to do better with fluid management because she didn't want to keep going into the hospital for fluid overload. Review of R5's undated physician orders revealed there was no fluid restriction ordered, however, when R5's medical record was reviewed, a progress note dated 8/23/17, indicated a dialysis nurse notified the facility that R5 should have no more than four 8 ounce servings (960 cc) of fluid daily. Review of R5's care plan for dialysis last revised on 10/13/17, revealed no fluid restriction was identified, and the care plan stated R5 "monitors her own fluid restrictions." The care plan directed total intake to be distributed between dietary and nursing and to document non-compliance. The care plan had not identified a plan for how many cc's of fluid was allotted for each meal and medication pass and had not identified R5 was non-compliant with fluid restrictions. The care plan also failed to identify interventions to minimize fluid consumption like offering ice chips instead of water, offering a popsicle rather than juice, or offering hard candy or lemon drops for symptoms of dry mouth.	F 280	for fluid intake monitoring with residents receiving dialysis. 4. DNS or designee will complete audits on any new residents/ new orders for current residents on dialysis or with psychotropic medication ordered for the following 3 months and, to ensure that proper care planning. The data collected will be reviewed at the Monthly QAPI and Quarterly QA meeting. At that time the committee will make the decision/recommendation regarding any follow-up studies. Completion Date: 11/29/17	

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F 280	Continued From page 30	F 280		

Further review of R5's medical record revealed intake monitoring and R5's fluid balance had not been documented and monitored.

Licensed practical nurse (LPN)-A was interviewed on 10/20/17, 9:50 a.m. and stated R5's fluid intake was not monitored by the facility, and there was no way to tell where R5 was with fluid balance.

The director of nursing (DON) was interviewed on 10/20/17, at 10:32 a.m. regarding R5's fluid restrictions during which she confirmed R5's care plan had not identified R5's fluid restriction, had not delineated how many fluids R5 would receive during meals, and how much fluid R5 received during medication pass by nursing.

R6's care plan was not revised to include target/mood symptoms

R6's Diagnosis Report dated 10/20/17, included diagnoses of major depressive disorder, anxiety disorder, and schizoaffective disorder.

R6's annual Minimum Data Set (MDS) dated 8/1/17, identified R6 had verbal behaviors 1-3 days during the assessment period and took antipsychotic and antidepressant medications.

R6's Behavioral symptom Care Area Assessment dated 8/3/17, indicated R6's behaviors included calling out to staff when she needed assistance transferring rather than using her call light. The CAA indicated the behavioral symptoms would

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F 280	Continued From page 31 not be care planned, no further analysis was noted on the CAA. R6's physician orders provided by the facility on 10/20/17 included: -Benzotropine Mesylate (used to treat symptom of Parkinson's disease or involuntary movements due to side effects of certain psychiatric drugs) milligram (mg) at bedtime for behaviors. Start date of 7/26/16. -Lexapro (antidepressant medication) 15 mg in the morning for depression. Start date of 7/26/16. -Trazodone (antidepressant medication) 50 mg at bedtime for major depressive disorder. Start date 4/21/17. The physician orders did not include an anti-anxiety medication. R6's care plan printed and provided by the facility on 10/20/17, indicated R6 used antianxiety medications related to anxiety and antidepressant medications related to depression (last revised 11/14/16). The associated interventions included instruction to give anti-anxiety medication ordered by the physician. The care plan lacked target behaviors/ and mood symptoms including symptoms identified on the CAA. On 10/16/17, at 5:44 p.m. R6 was observed seated in her recliner in her room, watching TV. R6 fell asleep multiple times during the resident interview and was difficult to keep awake. Her overall facial expressions were flat with little emotion in responses to questions. On 10/17/17, at 8:59 a.m. R6 was observed to ambulate down the hallway using her walker, her mood was light and appropriate, had slightly more emotion when conversing.	F 280		

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F 280	Continued From page 32 On 10/18/17, at 1:57 p.m. licensed social worker (LSW) reviewed R6's care plan and verified the target/mood symptoms for depression were not identified. LSW explained R6 had depression and anxiety and had up and down days and R6 displayed depressive symptoms by not doing her hair or makeup and generally would not come out of her room on those days. LSW stated when R6 was anxious it seemed like she was more impulsive and perceived things more negatively than what they were. On 10/19/17, at 9:45 a.m. assistant director of nursing (ADON) verified the lack of target mood symptoms on the care plan and stated the target mood symptoms should have been identified on the care plan. R30's care plan was not revised to include target behaviors/mood symptoms. R30's facility Face Sheet dated 10/20/17, included diagnoses of dementia without behavioral disturbance, anxiety disorder, and major depressive disorder. R30's annual Minimum Data Set (MDS) dated 8/4/17, indicated R30 had severe cognitive impairment and had verbal behaviors directed towards others one to three days during the assessment period and there had not been a change in behaviors since the previous assessment.	F 280	REVISED	

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F 280	Continued From page 33 R30's Behavioral CAA dated 8/7/17, indicated R30 had the potential for behavioral problems by being resistive to cares and indicated the behavioral symptoms would not be addressed on the care plan. The CAA lacked indication of the verbal behaviors identified on the MDS. R30's physician orders included Celexa (antidepressant) 20 milligrams every morning for major depressive disorder with a start date of 5/22/17, and mirtazapine 15 mg every bedtime for major depressive disorder. R30's target behaviors for anxiety to be monitored indicated on the physician orders, and were dated 12/29/16, included restlessness and crawling out of bed and directed staff to bring R30 to quiet area and offer nourishment. The physician's orders did not identify target mood symptoms for depression. R30's care plan printed and provided by the facility on 10/20/17, indicated R30 received antidepressant and antianxiety medication related to depression, anxiety, and appetite stimulation. The care plan indicated R30 had feelings of sadness, anxiety, and depression characterized by ineffective coping and fearfulness last revised on 12/21/16. R30's Progress Notes reviewed from 7/17/17-10/16/17, reflected behaviors of refusals of care, medication and meals, agitation, hollering and hitting staff. The care plan was also not revised to include resistive to care that was identified on the CAA.	F 280		

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F 280	Continued From page 34 On 10/16/17, at 5:13 p.m. R30 was observed calmly lying in bed awake. R30's mood was pleasant; she smiled and was unable to articulate words including her name. At 6:20 p.m. director of nursing (DON) reported she refused dinner and explained once she refused, staff did not persist because R30 would become very easily agitated if asked too many questions. On 10/17/17, at 9:18 a.m. R30 was observed seated in the lobby area in her pajamas. R30 was calm and looking around. When asked how she was doing, R30 smiled without verbally responding. On 10/18/17, at 7:10 a.m. R30 was observed resting in bed with her eyes closed. -At 7:53 a.m. R30 was resting calmly in bed with her eyes open. -At 8:24 a.m. nursing assistant (NA)-A entered the room and assisted R30 with morning cares. NA-A gave verbal cues during the cares, R30 was calm, cooperative, and followed cues without evidence of any behavioral or mood symptoms. NA-A explained R30 did better with older NA's and if she didn't like someone she would wave them away. NA-A reported R30's behaviors included pushing staff away, refusing care, and her behaviors were sporadic and usually did not have a problem with redirection. NA-A stated staff would use interventions such as toileting, offer something to eat, and/or re-approaching at a later time. On 10/19/17, at 9:45 a.m. the ADON confirmed	F 280	REVISED	

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F 280	Continued From page 35 the care plan did not identify all of R30's behaviors/moods and stated the facility did not have a process in place to ensure ongoing analysis and/or evaluation of psychotropic mediations. On 10/20/17, at 9:31 a.m. NA-C stated R30 would hit, pinch, scratch, and refuse meals. NA-C stated interventions included getting a different staff member, getting more help, re-approaching at a later time, and nails were kept short. -At 9:37 a.m. licensed practical nurse (LPN)-A stated R30 hit staff during cares, refused cares, refused medications, and had thrown her hearing aides across the room. LPN-A explained when R30 exhibited the behaviors they would re-approach and use different staff members. -At 12:58 a.m. NA-B stated R30 had behaviors once in a while when she was mad, angry, or tired and this was displayed by her facial expressions. NA-B stated R30 would tap on the NA's or shake her fist when she didn't like something and staff were to stop what they are doing and help her calm down by sitting with her and telling her what you are doing step by step or attempt to try again later. Facility policy Person Centered Care Plan Guideline last revised 11/16, indicated the care plan must be reviewed and revised annually, quarterly, with a significant change in status and as needed. The policy also included, the overall person centered care plan should be orientated towards: preventing avoidable declines, and managing risk factors. The policy also directed	F 280	REVISED	

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F 280	Continued From page 36 staff to include target behaviors, non-pharmacological interventions, psychoactive medication class if applicable with appropriate diagnosis/indication for use, and gradual dose reductions/pharmacy reviews.	F 280		
F 282 SS=D	SERVICES BY QUALIFIED PERSONS/PER CARE PLAN CFR(s): 483.21(b)(3)(ii) (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to implement the care plan related to the reporting of newly identified skin impairment for 1 of 3 residents (R37) with a wound which was not reported, assessed or treated. In addition, the facilty failed to document and monitor behaviors related to the use of psychotropic medication as directed by the care plan for 1 of 5 residents (R1) reviewed for unnecessary medications. Findings include: R37's care plan revised on 8/17/16, indicated R37 had chronic kidney disease and directed staff to check body for breaks in skin and treat promptly as ordered by medical practitioner. The	F 282	REVISED The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because provisions of state and federal law require it. Without waiving the foregoing statement, the facility states with respect to: 1. R37 has had his skin impairment assessed and treated. R1 has had behaviors monitored and documented. 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	11/29/17

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F 282	Continued From page 37 anticoagulant therapy care plan dated 11/1/16, directed staff to perform daily skin inspections and to report abnormalities to the nurse/medical practitioner. The skin care plan dated 11/1/16, directed staff to use caution during bed mobility and transfers to prevent striking arms, legs, and hands against surfaces that may cause injury. R37's medical record did not reflect any areas of skin impairment or daily skin inspections as directed by the care plan. On 10/18/17, at 7:54 a.m. R37 was observed seated in wheelchair, lower extremities were not covered. The right leg was amputated just below the knee and the left leg had a dime sized light yellow/reddish thin scab on the outside of the upper calf just below the knee. The skin around the wound was not red. Nursing assistant (NA)-D entered the room first and NA-E shortly after. The surveyor reported to both NA's and to R37 the wound on the outside of the leg. NA's were not previously aware of the wound. R37 stated he got the injury a week ago when he transferred into the wheelchair. The NAs failed to report the wound to the nurse, as directed. On 10/19/17, at 3:45 p.m. assistant director of nursing (ADON) stated she was not informed of R37's left leg wound. ADON assisted R37 in his wheelchair back to his room. The wound periphery was now red and the scab had changed to a darker red and appeared to be thicker. The ADON cleaned, measured, and dressed the wound. R37 stated he had received the wound over a week ago when he bumped it on his	F 282	use and proper documentation or behavior along with non-pharmacologic alternatives tried prior to prn medication use. 3. Staff education will be completed by 11/29/17 regarding the need to report, monitor and document any resident skin injury or behavior. 4. DNS or designee will audit 5 residents weekly x1 month, then 1 resident weekly for 2 months regarding the proper documentation of skin injury, resident target behavior monitoring and PRN medication administration. The data collected will be reviewed at the Monthly QAPI and Quarterly QA meeting. At that time the committee will make the decision/recommendation regarding any follow-up studies. Completion Date 11/29/17	

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wheelchair when transferring. R37 stated he had not told anybody about the wound because he figured it would just heal. The ADON stated the NAs should report changes in skin condition to the nurse. Following this assessment, a comprehensive skin assessment was completed for R37's wound.

R37's Incident progress noted dated 10/20/17, indicated maintenance would pad on wheelchair which caused wound, dietary informed and protein powder added to the diet plan, wound to be monitored and education provided to staff.

R1's care plan was not followed for monitoring/documenting of target behaviors, interventions and outcomes.

R1's care plan, print date 10/20/17, indicated R1 had feelings of uneasiness and sadness related to anxiety, depression and episodic mood disorder. Target behaviors identified for depression and anxiety was explosive behaviors and directed staff to redirect, provide one to one visits, ensure safety, divert attention, offer baby doll, and engage in conversations. Staff was also directed to record the number of occurrences, interventions used, and outcomes.

R1's Medication Administration Record (MAR), dated 10/2017, indicated R1 received Remeron 7.5 mg at bedtime for depression and Ativan 1 mg orally as needed for anxiety/explosive disorder. The MAR indicated R1 received as needed Ativan 1 mg on:

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F 282	Continued From page 39 -8/27/17 at 3:30 p.m. -9/8/17 at 12:00 a.m. -9/20/17 at 12:15 a.m. -9/21/17 at 12:00 p.m. The MAR identified the explosive behavior, Interventions, and outcomes for monitoring every shift, daily. The monitoring forms for 8/17, 9/17, 10/17, were all blank and did not identify behaviors, non-pharmacological interventions or outcomes for the days R1 utilized as needed Ativan. On 10/18/2017, at 7:20 a.m. licensed practical nurse (LPN)-A stated staff were supposed to document on the MAR when R1 had any behaviors and not just when she received the Ativan. The LPN confirmed the aforementioned documentation forms were blank and should have been completed, as directed. -At 7:29: a.m. the ADON stated the documentation forms were to be completed when behaviors occurred, not just when R1 received as needed Ativan. The ADON stated R1 would be awake for a couple of days looking for her baby followed by exhaustion and sleeping. R1 had days when she uncontrollably cried. The ADON stated R1 received as needed Ativan once this month, several times in September due to periods of looking for her baby. The ADON stated staff were supposed to be documenting the behaviors on the MAR along with interventions attempted and the outcomes. During review of the MAR's with the ADON for 10/17, 9/17, and 8/17, the ADON confirmed they were void of any	F 282		

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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.

On 10/20/17, at 1:16 p.m. the DON confirmed resident MDS assessments, care plans and monitoring of psychoactive and other medications should have been completed in order to accurately reflect the residents medical and personal needs. The DON confirmed it was her expectation that monitoring of medications, the identification of target behaviors and documentation of the use of non-pharmacological interventions be documented which was not currently being done. In addition, the DON stated the facilty knew on the second day of the survey that the resident care plans and other areas of monitoring was seriously lacking identified resident needs and should not have been.

The facility policy, Mood and Behavior Documentation Guidelines, dated 11/16, indicated the facility would monitor behaviors to communicate concerns in resident mood and /or behaviors and provide documentation of evidence for practice decisions and modifications to the resident plan of care.

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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F 282	Continued From page 41 provide effective and person-centered care of the resident that meet professional standards of quality of care and the care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable, mental and psychosocial well-being.	F 282		
F 309 SS=D	PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING CFR(s): 483.24, 483.25(k)(l) 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.	F 309	REVISED	11/29/17

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F 309	Continued From page 42 (l) 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure dialysis fluid restriction was monitored to minimize hospitalizations for fluid overload for 1 of 1 resident (R5) reviewed for dialysis. In addition, based on observation, interview, and document review the facility failed to identify and monitor impaired skin integrity for 1 of 1 resident (R37) observed who was at risk for developing serious complications from impaired skin integrity. Findings include: R5's cumulative diagnoses list dated 10/19/17, indicated R5 was admitted to the facility with diagnoses that included, but were not limited to: bipolar disorder, adjustment disorder with mixed anxiety and depressed mood, major depressive disorder, narcotic dependence, disruptive behavior disorder, post-traumatic stress disorder, end stage renal disease, chronic radicular low back pain, right hand and right below the knee amputation, and sociopathic borderline personality disorder. R5's medical record included a document identified as Order Appointing Guardian dated and signed by a judge on 5/26/16, which	F 309	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because provisions of state and federal law require it. Without waiving the foregoing statement, the facility states with respect to: 1. Fluid intake monitoring was implemented on R5. R37 impaired skin integrity was identified, monitored and received treatment. 2. All resident care plans will be reviewed to insure that each includes a baseline care plan that includes instructions needed to provide effective and person-centered care of the resident. It will also describe the services that are to be furnished to attain or maintain the resident's highest practicable, mental and psychosocial well-being. All dialysis residents will have fluid intake monitored and the dialysis center will be notified w/ results. All current residents will have a full body assessment completed to evaluate skin integrity 3. Staff education will be completed prior	

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F 309	Continued From page 43 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. R5's quarterly Minimum Data Set (MDS) dated 7/6/17, indicated R5 had no cognitive or memory deficits, R5 had inappropriate behavior symptoms identified as inattention (trouble focusing attention, being easily distractible, or had difficulty keeping track of what was being said). The MDS also indicated R5 had the following mood symptoms present 2-6 days a week: Feeling down, depressed, or hopeless, feeling tired or having to little energy, and feeling bad about self-or that you are a failure or have let yourself or a family member down. The MDS indicated R5 did not have any symptoms of psychosis (hallucinations or delusions), however, R5 did have verbal behavior symptoms directed at others (threatening others, screaming or cursing at others) 1-3 days a week. The MDS indicated R5 required extensive assistance of two persons for bed mobility and toilet use, and required extensive assistance of one person for dressing, personal hygiene and locomotion on and off the unit using a wheelchair. R5 was unable to ambulate, and was totally dependent on two staff during transfers. On 10/20/17, at 9:22 a.m. R5 was observed at the end of the breakfast meal and was noted to have four cups of fluid each which held 240 cubic centimeters (cc) per cup for a total of 960 cc of	F 309	to 11/29/17 regarding the need for accurate care plans being effectively person-centered and must include services provided for their physical, mental and psychosocial needs. Protocols with regard to communication with dialysis have been revised. 4. DNS or designee will audit all new admission care plans for the following 2 months and 2 resident changes in needs with regard to care planning weekly x2 month. The data collected will be reviewed at the Monthly QAPI and Quarterly QA meeting. At that time the committee will make the decision/recommendation regarding any follow-up studies. Completion Date 11/29/17	

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fluid on her breakfast tray. R5 drank all of the fluids provided. R5 stated the facility did not serve her the correct amount of fluids according to her dialysis diet. R5 stated she herself tracked how much fluid she consumed each day and showed the surveyor a notebook with numbers written down for each day. However, there were no totals which identified how much fluid was consumed in a day and many of the days did not look complete. R5 also stated the fluid calculation was not correct and she did not know if her fluid restriction was 32 or 36 ounces per day. R5 stated the dialysis unit had not even looked at her personal fluid intake log because they did not believe her recordings. R5 stated she was trying to do better with fluid management because she did not want to keep going into the hospital for fluid overload.

Review of R5's undated physician orders revealed there was no fluid restriction ordered, however, when R5's medical record was reviewed a progress note dated 8/23/17, indicated a dialysis nurse notified the facility that R5 should have no more than four 8 ounce servings (960 cc) of fluid daily.

Review of R5's care plan for dialysis last revised on 10/13/17, revealed no fluid restriction was identified, and the care plan stated R5 "monitors her own fluid restrictions." The care plan directed total intake to be distributed between dietary and nursing and to document non-compliance. The care plan had not identified a plan for how many cc's of fluid was to be allotted for each meal and medication pass and R5's noncompliance with fluid restrictions. The care plan had not included

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F 309	Continued From page 45 interventions to minimize fluid consumption like offering ice chips instead of water, offering a popsicle rather than juice, offering hard candy or lemon drops for symptoms of dry mouth. Further review of R5's medical record revealed intake monitoring and R5's fluid balance had not been documented and monitored. Licensed practical nurse (LPN)-A was interviewed on 10/20/17, 9:50 a.m. and stated R5's fluid intake was not monitored by the facility, and there was no way to tell where R5 was in regards to fluid balance. On 10/20/17, at 9:59 a.m. the dialysis registered nurse manager was interviewed regarding R5's fluid intake and monitoring. The dialysis nurse manager stated R5's fluid restriction was 1000 cc of fluid daily, and R5 was fluid overloaded. The dialysis nurse stated R5 was 8-12 kilograms over her dry weight, and was gaining large amounts of fluids between dialysis treatments (3-5 kg). The dialysis nurse stated she expected the facility to record and monitor R5's fluid intake so when R5 got close to daily total of fluid intake, R5 could be educated regarding the risks and benefits of non-compliance with fluid restrictions, and make choices after being provided the education. The dialysis nurse stated R5 could be non-compliant with the fluid restriction, however, in the last month R5 had been really trying to decrease fluid intake amounts. The dialysis registered nurse manager stated R5 had been hospitalized at least twice in the previous 6 months for fluid volume overload on 6/24/17, and 9/6/17.	F 309		

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Review of R5's hospitalization records revealed R5 had been hospitalized with fluid overload twice in the last six months on 6/24/17, and 9/6/17. The Altru hospital dismissal summary dated 9/8/17, indicated R5 was admitted to the hospital on 9/6/17, with a diagnoses that included: fluid overload, chronic hypoxemic respiratory failure, and end stage renal failure. The dismissal summary indicated R5 had not been compliant with fluid intake restrictions, and required hospitalization where daily hemodialysis runs were implemented to remove the excess fluid. The dismissal summary indicated R5 had also been hospitalized on R5 discharged from Altru hospital on 9/8/17.
The hospitalization records for R5's hospitalization 6/24/17- 6/28/17, were requested from the facility but not provided.

Review of R5's dialysis run sheets from 10/1/17 - 10/16/17, revealed R5 was routinely 5-10 kg (11-22 pounds) over her target weight (dry weight), and had not reached her dry weight goal during any dialysis treatments in October 2017.

The director of nursing (DON) was interviewed on 10/20/17, at 10:32 a.m. regarding R5's fluid restrictions during which she confirmed the facility was still not monitoring her fluid intake despite the fact R5 had been hospitalized for fluid overload on 4/4/14, and 9/6/17, and on 8/23/17, the dialysis unit asked the facility to monitor fluid intake. The DON stated R5 was non-compliant with fluid restrictions, however, she wanted to monitor her own fluid restrictions and intake. The

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F 309	Continued From page 47 DON confirmed a judge appointed R5 a guardian because 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. In addition, The DON did not respond when asked if R5 had the mental capacity to make responsible and reasonable decisions concerning medical care. R37 was at risk for impaired skin integrity complication and the facility failed to identify, report, and treat a current wound. R37's Diagnosis Report dated 10/20/17, included diagnoses of diabetes type II, complete traumatic right below the knee amputation, peripheral vascular disease, chronic multifocal osteomyelitis (infections of the bone), edema, hypertension, muscle weakness, and chronic kidney disease (CKD) stage 3. R37's quarterly MDS dated 8/25/17, indicated R37 had no cognitive impairment and was independent with activities of daily living except he required supervision with eating. R37's cognition care plan last revised on 8/15/16, indicated R37 had cognitive loss/dementia or alteration in thought process evidenced by deficits in memory, judgement, and decision making. The CKD care plan revised on 8/17/16, directed staff to check body for breaks in skin and treat promptly as ordered by medical practitioner. The	F 309		

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F 309	Continued From page 48	F 309		

anticoagulant therapy care plan dated 11/1/16, directed daily skin inspections and to report abnormalities to the nurse/medical practitioner. The skin care plan dated 11/1/16, directed staff to use caution during bed mobility and transfers to prevent striking arms, legs, and hands against surfaces that may cause injury. R37's undated Nursing Assistant Care Plan indicated R37's bath day was on Mondays.

R37's Comprehensive Skin Assessment dated 9/13/17, indicated R37's ability to walk was severely limited or non-existent or could not bear own weight and/or must be assisted in/out of chair or wheelchair. R37 had a potential problem with friction and shear injuries, his lower extremities showed signs and symptoms of peripheral vascular disease, and had loss of sensation to lower extremities. The assessment indicated staff would inspect skin daily.

R37's medical record did not reflect any current skin impairment or evidence of daily skin monitoring as directed by the care plan.

On 10/18/17, at 7:54 a.m. R37 was observed seated in wheelchair, and the lower extremities were not covered. The right leg was amputated just below the knee and the left leg had a dime sized light yellow/reddish thin scab on the outside of the upper calf just below the knee. The skin around the wound was not red. Nursing assistant (NA)-D entered the room first and NA-E shortly after. The surveyor reported to both NAs and to R37 the wound on the outside of the leg. NAs were not previously aware of the wound. R37

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F 309	Continued From page 49 stated he got the injury a week ago when he transferred into the wheelchair. The NAs failed to report the wound to the nurse, as directed. -at 12:58 p.m. NA-B stated the resident's skin was looked at during daily cares or with each resident contact and areas of concern were reported to the nurse as soon as possible. On 10/19/17, at 3:45 p.m. the assistant director of nursing (ADON) stated she was not informed of R37's left leg wound. The ADON assisted R37 in his wheelchair back to his room to assess the wound. The wound periphery was now red and the scab had changed to a darker red and appeared to be thicker. The ADON cleansed, measured, and dressed the wound. R37 stated he had received the wound over a week ago when he bumped it on his wheelchair when transferring. R37 stated he had not told anybody about the wound because he figured it would just heal. The ADON stated the NAs should have reported the change in skin condition to the nurse. Following this assessment, a comprehensive skin assessment was completed for R37's wound. 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 dry with no drainage. Area measured 1.5 centimeters (cm) x 1.0 cm and surrounding skin 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.	F 309		

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F 309	Continued From page 50 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 provided education 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 provide effective and person-centered care of the resident that meet professional standards of quality of care and the care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable, mental and psychosocial well-being. A skin care policy was requested and not received.	F 309		
F 329 SS=D	DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS CFR(s): 483.45(d)(e)(1)-(2) 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from	F 329		11/29/17

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F 329	Continued From page 51 unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to obtain clear indication	F 329	The preparation of the following plan of correction for this deficiency does not	

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F 329	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 physical behaviors and received antipsychotic, antidepressant, antianxiety and antibiotic medications. R35's Medication Review Report (MRR) dated 10/6/17, indicated R35 received carbamazepine	F 329	constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because provisions of state and federal law require it. Without waiving the foregoing statement, the facility states with respect to: 1. R35 had a care plan review with changes made for the medication Carbamazepine for resident behaviors along with interventions for behaviors. R35 has not had a history of seizures. Pharmacy consultants state that when Carbamazepine is being utilized for behaviors, checking routine levels isn't clinically indicated. R6 and R30 have had care plan reviews with updates to include target behavior/mood symptoms for psychotropic medications. R6 has been reviewed by consulting pharmacist for gradual dose reduction (GDR) of an antipsychotic on 11/13/17. 2. All residents will be reviewed through chart review for clear indication for medication use, to ensure that they are care planned appropriately along w/ being identified on the MDS, and that monitoring needs have been identified and implemented for effectiveness. All residents have been reviewed for target behaviors/mood symptoms with psychotropic medication use and GDR's. 3. Staff education will be completed by 11/29/17 regarding: the need to address the use of medications and if side effects	

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F 329	Continued From page 53 300 milligrams (mg) in the evening for seizures, start date 12/14/16. R35's Medication Administration Record (MAR) dated 10/17, indicated R35 received carbamazepine 300 milligrams in the evening for seizures. R35's October 2015, MAR from a previous facility where R35 had resided included carbamazepine 200 mg twice daily for behaviors. R35's care plan, print date 10/20/17, identified psychoactive medication use of Zyprexa, Risperdal, Celexa, Klonopin, and Buspar. The care plan failed to identify the use of seizure medication and had not identified interventions for either seizures or behaviors. On 10/2/17, at 9:05 a.m. the assistant director of nursing (ADON) stated staff should have identified the need for monitoring R35's use of carbamazepine. The ADON verified she was not aware of R35 exhibiting any seizure activity and stated R35's last carbamazepine laboratory test was conducted on 12/8/16, with results of 4.3 mg (therapeutic reference range is 4-12 mg.). The ADON stated she would expect the use of an anti-seizure medication be monitored and the care plan should have also reflected the use of the medication, the potential for seizures, monitoring needs, and identified interventions. The ADON stated the facilty had a change in their MDS staff and discovered there had been resident health care areas that had slipped through the cracks and not identified on the care plan. On 10/20/17, at 1:16 p.m. the director of nursing	F 329	or behaviors warrant monitoring, regarding target behavior/ mood monitoring with psychotropic medication use and; the process and need for GDR's. 4. Audits of care plans will be completed by DNS or designee with all new admissions and for any resident having medication order changes for the following 3 months to ensure that all medication would be identified properly on the MDS, care plan, and the monitoring needs identified and implemented. DNS or designee will complete audits on the completion of Monthly Behavior Reviews on all residents that have physician orders on 2 residents per week for 3 months, to ensure that proper care planning GDR's have been attempted, or that there is appropriate physician documentation to not attempt a GDR. The data collected will be reviewed at the Monthly QAPI and Quarterly QA meeting. At that time the committee will make the decision/recommendation regarding any follow-up studies. Completion Date 11/29/17	

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F 329	Continued From page 54 (DON) confirmed R35's use of anti-seizure medications should have been identified accurately on the MDS, care plan, and the monitoring needs identified and implemented. The DON stated they had identified resident care plans were seriously lacking identified residents' needs, which was going to be addressed. R6's medication regimen had not identified or analyzed target mood symptoms for antidepressant use and had not attempted tapering or had physician justification for ongoing use. In addition, had not attempted a dose reduction or had a physician justification for on going antipsychotic medication. R6's Diagnosis Report dated 10/20/17, included diagnoses of major depressive disorder, anxiety disorder, and schizoaffective disorder. R6's annual MDS dated 8/1/17, indicated R6 had moderate cognitive impairment, no signs and symptoms of delirium, delusions, hallucinations, no depressive symptoms. The MDS also indicated R6 had problems with sleep, had verbal behaviors 1-3 days during the assessment period and received antipsychotic and antidepressant medications. R6's physician orders printed and provided by the facility on 10/20/17 included the following orders: -Latuda (atypical anti-antipsychotic medication used to treat bipolar depression) 80 mg in the evening for schizoaffective disorder. Start date of 7/26/16. -Lexapro (antidepressant medication) 15 mg in	F 329		

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F 329	Continued From page 55 the morning for depression. Start date of 7/26/16. -Trazodone (antidepressant medication) 50 mg at bedtime for major depressive disorder. Start date 4/21/17. However, the medical record lacked any clear indication for adding an addition antidepressant medication and did not reflect a comprehensive assessment of depressive symptoms, efficacy of current medications at the time and any other episodes of anxiety/depression between 3/22/17, and 4/22/17. R6's care plan provided by the facility on 10/20/17, and last revised 11/14/16, indicated R6 received psychotropic medication related to schizoaffective disorder-bipolar type. Interventions directed staff to consult with pharmacy, medical practitioner to consider dose reduction when clinically appropriate, follow gradual dose reduction protocols, and develop a behavior management program with alternative to medication use. The plan also indicated R6 received antianxiety/antidepressant medications related to anxiety and depression. Interventions directed to administer antianxiety medication as ordered, to attempt non-pharmacological interventions of redirection, diversion, have her go to her room away from other residents, and to observe the effectiveness of the interventions. However, the care plan failed to identify R6's individualized target mood symptoms of depression and or anxiety. R6's Mood and Behavior Evaluations dated 7/12/17, and 8/1/17, also lacked identified mood symptoms for antidepressant/antianxiety medications. Additionally, the behavior evaluation had not analyzed the target behaviors for	F 329		

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F 329	Continued From page 56 antipsychotic use. Furthermore, the evaluation lacked an indication or rationale to continue the use of both antipsychotic and antidepressant medications. R6's Treatment Administration Records (TARS) were reviewed from January-March and June through October 2017 (April and May requested but not received). The TARs identified the target behavior of sexual/negative comments for the antipsychotic use. The only incident of sexual/negative comments identified in R6's record was documented on 9/24/17, when R6 made a sexually based comment while watching TV with a male resident. The TARs had not identified symptoms for antidepressant use. R6's mental health provider consult referral note dated 6/19/17, indicated R6 was excessively somnolent during the appointment and reported complaints of mild depression and occasional anxiety and really wanted help with sleep more than anything. The physician identified the history of mental illness and R6 was unable to describe the history, and the history was more consistent with recurrent depression. The physician also indicated there was not enough history or quantifiable documentation of behaviors or mood symptoms to determine definitive diagnoses or recommend changes to medication dosages. The physician did not recommend any psychiatric medication changes and recommended no daytime napping. R6's physician visit notes dated, 6/20/17, 7/12/17, and 9/12/17, indicated R6's depression, anxiety,	F 329		

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and schizoaffective disorder were stable with no psychiatric medication changes. The physician notes lacked a reason or justification to continue the psychotropic medications at the same doses.

On 10/16/17, at 5:44 p.m. R6 was observed seated in her recliner in her room watching TV. R6 fell asleep multiple times during the resident interview and was difficult to keep awake. Her overall facial expressions were flat with little emotion in responses to questions.

On 10/18/17, at 7:12 a.m. R6 was observed awake sitting up in the recliner. R6 explained she occasionally felt down or depressed and she didn't feel like doing anything. She stated she sometimes felt anxious and overwhelmed and would report tightness in her chest, short of breath, and felt restless. R6 stated she didn't know what the staff did for her when she felt down, depressed, or anxious. However, R6 stated she went to a psych doctor and thought that helped with her mood symptoms. R6 explained she often felt tired.

On 10/20/17, at 9:04 a.m. R6 was observed sleeping in a chair in the main lobby area. At 12:58 p.m. NA-B stated R6's mood was down only every once in a while and seemed to act down when she didn't have anything to do.

On 10/20/17, at 9:37 a.m. licensed practical nurse (LPN)-A stated R6 sometimes felt anxious and it varied, sometimes she was quiet and sometimes refused cares and when she got in those moods,

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F 329	Continued From page 58 she would holler at staff and use profanities directed at staff. LPN-A indicated staff provided one to one visits, and called her friend for her to talk to which perks her up. LPN-A thought the Trazodone was for sleep because R6 was up most of the night. On 10/18/17, at 1:57 p.m. licensed social worker (LSW) verified there were no target/mood symptoms identified for the use of the antidepressant/antianxiety medication however, a target behavior of sexual/negative comments had been identified for the antipsychotic medication. On 10/19/17, at 9:45 a.m. the assistant director of nursing (ADON) confirmed the facility did not have a process in place to ensure ongoing analysis and/or evaluation of psychotropic mediations. ADON also indicated target mood symptoms should be identified on the care plan, monitored, and evaluated for efficacy. On 10/20/17, at 1:45 p.m. attempted to contact the consulting pharmacist (CP) for interview. On 10/23/17, at 1:35 p.m. CP returned the phone call and confirmed he had not recommended a dose reduction, had not looked for target behaviors, and expected the facility staff to identify target behaviors/mood symptoms, to monitor for effectiveness, and would also expect the target behaviors/mood symptoms to be identified on the care plan with corresponding interventions. R30's medication regimen had not identified or analyzed target mood symptoms for	F 329		

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F 329	Continued From page 59 antidepressant use. R30's facility Face Sheet dated 10/20/17, included diagnoses of dementia without behavioral disturbance, anxiety disorder, and major depressive disorder. R30's annual MDS dated 8/4/17, indicated R30 had severe cognitive impairment and had verbal behaviors directed towards others one to three days during the assessment period and there had not been a change in behaviors since the previous assessment. The MDS identified depressive symptoms of difficulty with sleep and feeling tired or having little energy and trouble concentrating. R30's physician orders included Celexa 20 milligrams every morning for major depressive disorder with a start date of 5/22/17, and mirtazapine 15 mg every bedtime for major depressive disorder (last dose change 4/11/17). R30's care plan printed and provided by the facility on 10/20/17, indicated antidepressant and antianxiety medication use related to depression, anxiety, and appetite stimulation. R30 had feelings of sadness, anxiety, and depression characterized by ineffective coping and fearfulness last revised on 12/21/16. The care plan directed staff to attempt non-pharmacological interventions and observe for effectiveness, provide nourishment, essential oil message, diversion, word finds, liked to look at newspapers, and to bring to a quiet area at night	F 329		

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

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F 329	Continued From page 60 if anxious in room. The plan also directed staff to consult with pharmacy/medical practitioner to consider dosage reductions when clinically appropriate, observe/document side effects and effectiveness, and do not just take to room and get ready for bed as this would cause anxiety. R30's physician orders dated 12/29/16, and TAR indicated target behaviors for anxiety were restless, crawling out of bed and directed staff to bring R30 to a quiet area and offer nourishment. The physician orders also directed staff to document the effectiveness of the medication used. The physician's orders did not identify target mood symptoms for depression. The TARs were reviewed for the last three months and revealed one documented episode on 9/1/17, when R30 was restless and crawling out of bed on 9/1/17. R30's progress nursing progress notes were reviewed from 7/17/17, through 10/16/17, and identified behavior and mood symptoms which included refusals of medication, cares and meals, agitation, resistive to cares, and hitting out at staff. However, these symptoms were not identified on the care plan. R30's Mood and Behavior Evaluation dated 8/4/17, lacked identified mood symptoms for antidepressant/antianxiety medication. Review of R30's physician visit notes from 6/20/17, through 7/11/17, indicated depression and anxiety were stable.	F 329		

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F 329	Continued From page 61 On 10/16/17, at 5:13 a.m. R30 was observed calmly lying in bed awake. R30's mood was pleasant, she smiled and was unable to articulate words including her name. At 6:20 p.m. the DON stated R30 had refused dinner and explained once R30 refused, staff did not persist because R30 would become very easily agitated if asked too many questions. On 10/17/17, at 9:18 a.m. R30 was observed seated in the lobby area in her pajamas. R30 was calm and looking around. When questioned, R30 only smiled without verbally responding. On 10/18/17, at 7:10 a.m. R30 was observed resting in bed with her eyes closed. -At 7:53 a.m. R30's remained in bed, calmly awake. -At 8:24 a.m. NA-A entered the room and assisted R30 with morning cares. NA-A gave verbal cues during the cares, which R30 was calm, cooperative, and followed cues without evidence of any behavioral or mood symptoms. NA-A explained R30 did better with older NA's and if she did not like someone she would wave them away. NA-A stated R30's behaviors included pushing staff away, refusing care and her behaviors were sporadic and usually did not have a problem with redirection. NA-A stated staff would use interventions such as toileting, offer something to eat, and/or re-approaching at a later time. On 10/20/17, at 9:31 a.m. NA-C reported R30 liked to hit, pinch, scratch, and refuse meals.	F 329	REVISED	

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F 329	Continued From page 62 NA-C stated interventions included getting a different staff member, getting more help, re-approaching at a later time, and nails were kept short. -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. -At 12:58 a.m. NA-B explained R30 had behaviors once in a while when she was mad, angry, or tired which was was displayed by her facial expressions. NA-B stated R30 would tap on the NA's or shake her fist when she did not like something and staff were to stop what they were doing and help her calm down by sitting with her and telling her what you are doing step by step or attempt to try again later. 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	F 329		

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F 329	Continued From page 63 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 policy Mood and Behavior Documentation Guidelines last revised 11/16, 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 completed for all residents on admission, quarterly, annually, with significant change in status and prior to the use of, and/or dose change of psychoactive medication to evaluate the need for the medication and determine target behavior related to the use of the medication. The policy indicated the evaluation included assessment, appropriate use of medications, and documentation of dose reductions or provides rationale for continued use of medication regimen -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 329		
F 428 SS=D	DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON CFR(s): 483.45(c)(1)(3)-(5)	F 428		11/29/17

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F 428	Continued From page 64 c) Drug Regimen Review (1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. (3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. (4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending	F 428		

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F 428	Continued From page 65 physician should document his or her rationale in the resident's medical record. (5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the consultant pharmacist identified the lack of target behaviors/mood symptoms for the use of psychotropic medications for 2 of 5 residents (R6, R30) and failed to identify the lack of a required gradual dose reduction/dose taper and/or lack of a physician justification for not attempting a dose reduction for 1 of 5 residents (R6) reviewed for unnecessary medications. Findings include; R6's medication regimen had not identified or analyzed target mood symptoms for antidepressant use and had not attempted tapering or had physician justification for ongoing use. In addition, had not attempted a dose reduction or had a physician justification for on going antipsychotic medication. R6's Diagnosis Report dated 10/20/17, included diagnoses of major depressive disorder, anxiety disorder, and schizoaffective disorder.	F 428	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because provisions of state and federal law require it. Without waiving the foregoing statement, the facility states with respect to: 1. R6 and R30 have had consulting pharmacist reviews regarding psychotropic medications. R6's care plan has been reviewed with individualized target mood symptoms of depression /anxiety have been added. 2. All residents have been reviewed for GDR's w/ regards to psychotropic medication and care plans have been audited for appropriate target mood symptoms/behaviors. 3. Staff education will be completed by 11/29/17 regarding the Monthly Mood and Behavior Program. 4. DNS or designee will complete audits	

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F 428	Continued From page 66 R6's annual MDS dated 8/1/17, indicated R6 had moderate cognitive impairment, no signs and symptoms of delirium, delusions, hallucinations, no depressive symptoms. The MDS also indicated R6 had problems with sleep, had verbal behaviors 1-3 days during the assessment period and received antipsychotic and antidepressant medications. R6's physician orders printed and provided by the facility on 10/20/17 included the following orders: -Latuda (atypical anti-antipsychotic medication used to treat bipolar depression) 80 mg in the evening for schizoaffective disorder. Start date of 7/26/16. -Lexapro (antidepressant medication) 15 mg in the morning for depression. Start date of 7/26/16. -Trazodone (antidepressant medication) 50 mg at bedtime for major depressive disorder. Start date 4/21/17. However, the medical record lacked any clear indication for adding an addition antidepressant medication and did not reflect a comprehensive assessment of depressive symptoms, efficacy of current medications at the time and any other episodes of anxiety/depression between 3/22/17, and 4/22/17. R6's care plan provided by the facility on 10/20/17, and last revised 11/14/16, indicated R6 received psychotropic medication related to schizoaffective disorder-bipolar type. Interventions directed staff to consult with pharmacy, medical practitioner to consider dose reduction when clinically appropriate, follow	F 428	on the completion of Monthly Behavior Reviews on all residents that have physician orders on 2 residents per week for 3 months, to ensure that proper care planning GDR's have been attempted, or that there is appropriate physician documentation to not attempt a GDR. The data collected will be reviewed at the Monthly QAPI and Quarterly QA meeting. At that time the committee will make the decision/recommendation regarding any follow-up studies. Completion date 11/29/17 REVISED	

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F 428	Continued From page 67 gradual dose reduction protocols, and develop a behavior management program with alternative to medication use. The plan also indicated R6 received antianxiety/antidepressant medications related to anxiety and depression. Interventions directed to administer antianxiety medication as ordered, to attempt non-pharmacological interventions of redirection, diversion, have her go to her room away from other residents, and to observe the effectiveness of the interventions. However, the care plan failed to identify R6's individualized target mood symptoms of depression and or anxiety. R6's Mood and Behavior Evaluations dated 7/12/17, and 8/1/17, also lacked identified mood symptoms for antidepressant/antianxiety medications. Additionally, the behavior evaluation had not analyzed the target behaviors for antipsychotic use. Furthermore, the evaluation lacked an indication or rationale to continue the use of both antipsychotic and antidepressant medications. R6's Treatment Administration Records (TARS) were reviewed from January-March and June through October 2017 (April and May requested but not received). The TARs identified the target behavior of sexual/negative comments for the antipsychotic use. The only incident of sexual/negative comments identified in R6's record was documented on 9/24/17, when R6 made a sexually based comment while watching TV with a male resident. The TARs had not identified symptoms for antidepressant use.	F 428		

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F 428	Continued From page 68	F 428		

R6's mental health provider consult referral note dated 6/19/17, indicated R6 was excessively somnolent during the appointment and reported complaints of mild depression and occasional anxiety and really wanted help with sleep more than anything. The physician identified the history of mental illness and R6 was unable to describe the history, and the history was more consistent with recurrent depression. The physician also indicated there was not enough history or quantifiable documentation of behaviors or mood symptoms to determine definitive diagnoses or recommend changes to medication dosages. The physician did not recommend any psychiatric medication changes and recommended no daytime napping.

R6's physician visit notes dated, 6/20/17, 7/12/17, and 9/12/17, indicated R6's depression, anxiety, and schizoaffective disorder were stable with no psychiatric medication changes. The physician notes lacked a reason or justification to continue the psychotropic medications at the same doses.

R6's Pharmacist Medication Reviews from February through October 2017, were reviewed and revealed the consulting pharmacist had not identified the lack of target behaviors/mood symptoms or recommended a gradual dose reduction for the antipsychotic medication or a dose taper for the antidepressant medications.

On 10/16/17, at 5:44 p.m. R6 was observed seated in her recliner in her room watching TV. R6 fell asleep multiple times during the resident interview and was difficult to keep awake. Her

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F 428	Continued From page 69 overall facial expressions were flat with little emotion in responses to questions. On 10/18/17, at 7:12 a.m. R6 was observed awake sitting up in the recliner. R6 explained she occasionally felt down or depressed and she didn't feel like doing anything. She stated she sometimes felt anxious and overwhelmed and would report tightness in her chest, short of breath, and felt restless. R6 stated she didn't know what the staff did for her when she felt down, depressed, or anxious. However, R6 stated she went to a psych doctor and thought that helped with her mood symptoms. R6 explained she often felt tired. On 10/20/17, at 9:04 a.m. R6 was observed sleeping in a chair in the main lobby area. At 12:58 p.m. NA-B stated R6's mood was down only every once in a while and seemed to act down when she didn't have anything to do. On 10/20/17, at 9:37 a.m. licensed practical nurse (LPN)-A stated R6 sometimes felt anxious and it varied, sometimes she was quiet and sometimes refused cares and when she got in those moods, she would holler at staff and use profanities directed at staff. LPN-A indicated staff provided one to one visits, and called her friend for her to talk to which perks her up. LPN-A thought the Trazodone was for sleep because R6 was up most of the night. On 10/18/17, at 1:57 p.m. licensed social worker (LSW) verified there were no target/mood	F 428		

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F 428	Continued From page 70 symptoms identified for the use of the antidepressant/antianxiety medication however, a target behavior of sexual/negative comments had been identified for the antipsychotic medication. On 10/19/17, at 9:45 a.m. the assistant director of nursing (ADON) confirmed the facility did not have a process in place to ensure ongoing analysis and/or evaluation of psychotropic mediations. ADON also indicated target mood symptoms should be identified on the care plan, monitored, and evaluated for efficacy. On 10/20/17, at 1:45 p.m. attempted to contact the consulting pharmacist (CP) for interview. On 10/23/17, at 1:35 p.m. CP returned the phone call and confirmed he had not recommended a dose reduction, had not looked for target behaviors, and expected the facility staff to identify target behaviors/mood symptoms, to monitor for effectiveness, and would also expect the target behaviors/mood symptoms to be identified on the care plan with corresponding interventions. R30's medication regimen had not identified or analyzed target mood symptoms for antidepressant use. R30's facility Face Sheet dated 10/20/17, included diagnoses of dementia without behavioral disturbance, anxiety disorder, and major depressive disorder. R30's annual MDS dated 8/4/17, indicated R30	F 428		

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F 428	Continued From page 71 had severe cognitive impairment and had verbal behaviors directed towards others one to three days during the assessment period and there had not been a change in behaviors since the previous assessment. The MDS identified depressive symptoms of difficulty with sleep and feeling tired or having little energy and trouble concentrating. R30's physician orders included Celexa 20 milligrams every morning for major depressive disorder with a start date of 5/22/17, and mirtazapine 15 mg every bedtime for major depressive disorder (last dose change 4/11/17). R30's care plan printed and provided by the facility on 10/20/17, indicated antidepressant and antianxiety medication use related to depression, anxiety, and appetite stimulation. R30 had feelings of sadness, anxiety, and depression characterized by ineffective coping and fearfulness last revised on 12/21/16. The care plan directed staff to attempt non-pharmacological interventions and observe for effectiveness, provide nourishment, essential oil message, diversion, word finds, liked to look at newspapers, and to bring to a quiet area at night if anxious in room. The plan also directed staff to consult with pharmacy/medical practitioner to consider dosage reductions when clinically appropriate, observe/document side effects and effectiveness, and do not just take to room and get ready for bed as this would cause anxiety. R30's physician orders dated 12/29/16, and TAR indicated target behaviors for anxiety were	F 428		

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F 428	Continued From page 72	F 428		

restless, crawling out of bed and directed staff to bring R30 to a quiet area and offer nourishment. The physician orders also directed staff to document the effectiveness of the medication used. The physician's orders did not identify target mood symptoms for depression. The TARs were reviewed for the last three months and revealed one documented episode on 9/1/17, when R30 was restless and crawling out of bed on 9/1/17.

R30's progress nursing progress notes were reviewed from 7/17/17, through 10/16/17, and identified behavior and mood symptoms which included refusals of medication, cares and meals, agitation, resistive to cares, and hitting out at staff. However, these symptoms were not identified on the care plan.

R30's Mood and Behavior Evaluation dated 8/4/17, lacked identified mood symptoms for antidepressant/antianxiety medication.

Review of R30's physician visit notes from 6/20/17, through 7/11/17, indicated depression and anxiety were stable.

R30's Pharmacist Medication Reviews from February through October 2017, were reviewed; the consulting pharmacist had not identified the lack of target behaviors/mood symptoms.

On 10/16/17, at 5:13 a.m. R30 was observed calmly lying in bed awake. R30's mood was

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F 428	Continued From page 73 pleasant, she smiled and was unable to articulate words including her name. At 6:20 p.m. the DON stated R30 had refused dinner and explained once R30 refused, staff did not persist because R30 would become very easily agitated if asked too many questions. On 10/17/17, at 9:18 a.m. R30 was observed seated in the lobby area in her pajamas. R30 was calm and looking around. When questioned, R30 only smiled without verbally responding. On 10/18/17, at 7:10 a.m. R30 was observed resting in bed with her eyes closed. -At 7:53 a.m. R30's remained in bed, calmly awake. -At 8:24 a.m. NA-A entered the room and assisted R30 with morning cares. NA-A gave verbal cues during the cares, which R30 was calm, cooperative, and followed cues without evidence of any behavioral or mood symptoms. NA-A explained R30 did better with older NA's and if she did not like someone she would wave them away. NA-A stated R30's behaviors included pushing staff away, refusing care and her behaviors were sporadic and usually did not have a problem with redirection. NA-A stated staff would use interventions such as toileting, offer something to eat, and/or re-approaching at a later time. On 10/20/17, at 9:31 a.m. NA-C reported R30 liked to hit, pinch, scratch, and refuse meals. NA-C stated interventions included getting a different staff member, getting more help, re-approaching at a later time, and nails were	F 428		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245468	A. BUILDING _____ B. WING _____	C 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 74 kept short. -At 9:37 a.m. 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. -At 12:58 a.m. NA-B explained R30 had behaviors once in a while when she was mad, angry, or tired which was was displayed by her facial expressions. NA-B stated R30 would tap on the NA's or shake her fist when she did not like something and staff were to stop what they were doing and help her calm down by sitting with her and telling her what you are doing step by step or attempt to try again later. 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. On 10/20/17, at 1:45 p.m. attempted to contact the consulting pharmacist (CP) for interview. On 10/23/17, at 1:35 p.m. CP returned the phone call and confirmed he had not looked for target behaviors, and expected the facility staff to	F 428		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245468	A. BUILDING _____ B. WING _____	C 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 75 identify target behaviors/mood symptoms, to monitor for effectiveness, and would also expect the target behaviors/mood symptoms to be identified on the care plan with corresponding interventions. 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 policy Mood and Behavior Documentation Guidelines last revised 11/16 included: - 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 will be ongoing for the clinical situation. -A mood and behavior evaluation will be completed for all residents on admission, quarterly, annually, with significant change in status and prior to the use of, and/or dose change of psychoactive medication to evaluate the need for the medication and determine target behavior related tot he use of the medication. The policy indicated the evaluation includes, assessment, appropriate use of medications, and documentation of dose reductions or provides rationale for continued use of medication regimen	F 428	REVISED	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245468	A. BUILDING _____ B. WING _____	C 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 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 SS=F	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; (iii) Standard and transmission-based precautions	F 441	REVISED	11/29/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245468	A. BUILDING _____ B. WING _____	C 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 77 to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to develop an ongoing surveillance program to analyze patterns and trends of resident infections not treated with an antibiotic. This had the potential to affect all 36	F 441	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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245468	A. BUILDING _____ B. WING _____	C 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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 78 residents residing in the facility. Findings include: On 10/19/17, at 1:10 p.m. the facility infection control logs were reviewed with the director of nursing (DON). The logs were a tracking form which identified the date symptoms were identified, name of the resident, room number in which the resident resided, if the identified symptoms were new or ongoing, type of infection, if a culture was completed, the name of the organisms, and the type of antibiotic or treatment prescribed by the physician. However, the logs did not contain the tracking or trending of any illnesses which were not being treated with an antibiotic. On 10/19/17, at 1:30 p.m. the DON, also the infection control preventionist, confirmed only infections with prescribed antibiotics were tracked. She stated the facilty had not established a system to track infections which were not treated with antibiotics and verified the facility failed to follow their surveillance policy. The facility's Surveillance policy, revised 11/16, indicated surveillance was implemented to identify and report evidence of infection. Collecting, documenting, and analyzing data would be done by the infection preventionist or designated staff member.	F 441	conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because provisions of state and federal law require it. Without waiving the foregoing statement, the facility states with respect to: 1. All illnesses which are/are not being treated by antibiotics are being tracked and reviewed for any trending. 2. DNS or designee will daily review all physician orders and the 24 hour report sheet for residents exhibiting signs or symptoms of illness. Any illness will be logged onto a spread sheet to analyze for trending. 3. Staff education has been completed prior to 11/29/17 with regards to the need for accurate and concise documentation of resident symptoms and disease prevention. 4. DNS or designee will complete audits of the 24 hour report for accuracy of resident symptoms of illness 4x per week x1 month, then weekly x2 months. The data collected will be reviewed at the Monthly QAPI and Quarterly QA meeting. At that time the committee will make the decision/recommendation regarding any follow-up studies. Completion Date: 11/29/17	

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: RQUD

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00830

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245468**
2.STATE VENDOR OR MEDICAID NO.
(L2) **012028600**

3. NAME AND ADDRESS OF FACILITY
(L3) **KARLSTAD HEALTHCARE CENTER INC**
(L4) **304 WASHINGTON AVENUE WEST**
(L5) **KARLSTAD, MN** (L6) **56732**

4. TYPE OF ACTION: **7** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **12/07/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **46** (L18)
13.Total Certified Beds **46** (L17)

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

B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Theresa Gullingsrud, HFE-NE II 12/26/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 12/29/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
12/27/2017
(L33)

DETERMINATION APPROVAL

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.

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the 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

DEPARTMENT OF HEALTH

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**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: RQUD

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00830

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245468**
2.STATE VENDOR OR MEDICAID NO.
(L2) **012028600**

3. NAME AND ADDRESS OF FACILITY
(L3) **KARLSTAD HEALTHCARE CENTER INC**
(L4) **304 WASHINGTON AVENUE WEST**
(L5) **KARLSTAD, MN** (L6) **56732**

4. TYPE OF ACTION: **2** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **10/20/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **46** (L18)
13.Total Certified Beds **46** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Debra Vincent, HFE- NE II 11/21/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 12/27/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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.

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

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:

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

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

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

Potential Consequences - the consequences of not attaining substantial compliance 6 months after the survey date; and

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

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

DEPARTMENT CONTACT

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

Lyla Burkman, Unit Supervisor
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: lyla.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; OR
- 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) AND 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: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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

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,

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

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

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F 000	INITIAL COMMENTS On 10/16/17, through 10/20/17, a recertification survey was completed by surveyors from the Minnesota Department of Health (MDH) to determine compliance with requirements at 42 CFR Part 483, subpart B, requirements for Long Term Care Facilities. The facility's electronic Plan of Correction (ePOC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. An investigation of complaint H5468004 was conducted and was found to be substantiated at F225, F226, and F250.	F 000		
F 201 SS=D	REASONS FOR TRANSFER/DISCHARGE OF RESIDENT CFR(s): 483.15(c)(1)(i)(ii) (c) Transfer and discharge (1) Facility requirements (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate	F 201		11/29/17

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

Electronically 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.

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F 201	Continued From page 1 because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the	F 201	The preparation of the following plan of	

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F 201	Continued From page 2 facility failed to complete an assessment to determine if a new plan of care would meet the needs of the resident and failed to obtain physician documentation supporting the facility's discharge related to the inability to meet the needs of 1 of 1 resident (R5) who was sent to the emergency room for evaluation and the facility refused to allow R5 to return to the facilty or inform R5 of the refusal for return resulting in two emergency room visits and an unnecessary hospital stay. Findings include: R5's cumulative diagnoses list dated 10/19/17, indicated R5 was admitted to the facility with diagnoses that included, but were not limited to: bipolar disorder, adjustment disorder with mixed anxiety & depressed mood, major depressive disorder, narcotic dependence, disruptive behavior disorder, post-traumatic stress disorder, end stage renal disease, chronic radicular low back pain, right hand and right below the knee amputation, and sociopathic borderline personality disorder. R5's quarterly Minimum Data Set (MDS) dated 7/6/17, indicated R5 had no cognitive or memory deficits, R5 had inappropriate behavior symptoms identified as inattention (trouble focusing attention, being easily distractible, or had difficulty keeping track of what was being said). The MDS also indicated R5 had the following mood symptoms present 2-6 days a week: Feeling down, depressed, or hopeless, feeling tired or having to little energy, and feeling bad about	F 201	correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because provisions of state and federal law require it. Without waiving the foregoing statement, the facility states with respect to: 1. R5 was readmitted to the facility on 10/12/17. A new assessment had been completed 10/6/17. Care Conferences were held 9/21/17, 10/13/17, and 10/26/17 to discuss plan of care with R5 and guardian(s). 2. The facility will permit each resident to remain in the facility, and not transfer or discharge the resident from the facility in accordance with state guidance. All residents going to ER/ physician appt will 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 which has the purpose to begin planning and provide for a safe transition plan for residents upon admission to facility. Discharge plan may include remaining in the senior living community, returning to the community or other facility including but not limited to another nursing home or ALF. 4. Executive Director (ED) or Designee will audit all resident discharges and/or transfers for discharge reason, physician	

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F 201	Continued From page 3 self-or that you are a failure or have let yourself or a family member down. The MDS indicated R5 did not have any symptoms of psychosis (hallucinations or delusions) however, R5 did have verbal behavior symptoms directed at others (threatening others, screaming or cursing at others) 1-3 days a week. The MDS indicated R5 required extensive assistance of two persons for bed mobility and toilet use, and required extensive assistance of one person for dressing, personal hygiene and locomotion on and off the unit using a wheelchair. R5 was unable to ambulate, and was totally dependent on two staff during transfers. 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. R5 was interviewed on 10/17/17, at 2:00 p.m. and stated she was extremely upset. R5 began to cry and stated the facility had tried sending her to a "nut house" last week and would not allow her to come back to the facility. R5 stated she had been sent to a local emergency room from dialysis, and because the nursing home refused to allow R5 to 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	F 201	documentation supporting the discharge, and resident and/or family involvement with discharge process. The data collected will be reviewed at the Monthly QAPI and Quarterly QA meeting. At that time the committee will make the decision/recommendation regarding any follow-up studies. Completion Date 11/29/17	

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F 201	Continued From page 4 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. Review of the Sanford Medical Center emergency room dismissal summary dated 10/8/17, indicated R5 arrived in the emergency room on 10/6/17, and stayed in the emergency room two days until 10/8/17. The dismissal summary indicated R5 was brought to the emergency room for psychiatric evaluation because of increasingly disruptive behavior in the care center where R5 resided. The crisis team completed an evaluation and determined R5 while being loud, disruptive, and verbally abusive towards staff, R5 was not aggressive towards others, was non-threatening, was not suicidal, and did not pose a threat to herself or others, and R5 did not meet criteria for hospital admission. The dismissal summary indicated the Karlstad Healthcare Center refused to take R5 back when the physician discharged R5 from the Sanford emergency room. The dismissal summary indicated R5 was then transferred to the emergency room at Mayo Medical Center in Rochester, MN for psychiatric evaluation. Review of the Mayo Clinic Medicine 9 Hospital	F 201		

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F 201	Continued From page 5 dismissal summary dated 10/12/17, indicated R5 was assessed in the emergency department and was found not in need of hospital admission for psychiatric care because R5's outbursts were more behaviorally based. The dismissal summary indicated the Karlstad Healthcare Center would not agree to accept R5 back into the facility, therefore, R5 had to be admitted to their hospital just to continue dialysis treatments. The dismissal summary indicated that while in the hospital, psychiatry was consulted and a behavior plan was employed to outline expected respectful behaviors and R5 did very well with this. R5's medical record lacked any evidence of a discharge notice being provided to the resident when the decision was made not readmit to the facility. The DON was interviewed on 10/19/2017, at 10:14 a.m. and confirmed she had not allowed R5 to return to the nursing home after being evaluated in the emergency room at Sanford Medical Center Fargo, ND on 10/6/17, and again from Mayo Medical Center on 10/8/17. The DON stated she was unsure if R5 would have transportation to dialysis while at the facility. When the DON was asked to provide evidence that the transportation service had refused ongoing transportation services to R5, the DON stated the transport company had not provided any documentation which identified R5 was denied transportation services. The DON confirmed there was an ambulance service for the community of Karlstad that could have provided transportation on an emergency basis, if needed.	F 201		

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F 201	Continued From page 6 Review of the Karlstad Healthcare Center Resident Admission Policy dated 6/9/11, revealed the following: "The facility reserved the right to discharge or transfer residents for the following reason, but not limited to these only: A: Persons who become mentally disturbed to the extent that they are dangerous to other residents, themselves, or staff members. B: Persons whose accounts are not paid in 60 days. C: Persons whom the facility is unable to care for adequately in conformance with the medical plan of care due to changes in their condition or due to family interference. The policy had not included directives for residents return to the facility following an emergency room visit or hospital stay.	F 201		
F 225 SS=D	INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS CFR(s): 483.12(a)(3)(4)(c)(1)-(4) 483.12(a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or	F 225		11/29/17

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F 225	Continued From page 7 (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.	F 225		

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F 225	Continued From page 8 (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to conduct a thorough investigation and ensure allegations of abuse were reported to the State agency prior to investigation for 1 of 3 resident (R5) vulnerable adult (VA) reports reviewed and failed to ensure allegations of financial exploitation had been thoroughly investigated for 1 of 3 residents (R41) VA reports reviewed. Lastly, the facility failed to include all information learned by the internal investigation which substantiated abuse had been reported to the State agency within 5 business days for 1 of 3 resident (R5) VA reports reviewed. Findings include: 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 director of nursing (DON) had completed a	F 225	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because provisions of state and federal law require it. Without waiving the foregoing statement, the facility states with respect to: 1. R5 has been reported to MDH and thoroughly investigated for potential abuse/mistreatment on 7/25/17 (and with re-submission on 11/10/17) and 10/23/17 (which had included statements from the aides that provided cares on the day in question). R41 had been reported to MDH and to local law enforcement on 8/9/17 for allegations of financial exploitation. Law enforcement closed this case on 8/11/17. This facility received email confirmation on 9/15/17, that the information had been reviewed and it has been determined that no further action was necessary. 2. Executive Director, DNS or assigned designee is immediately notified per	

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	245468	A. BUILDING _____ B. WING _____	10/20/2017

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F 225	Continued From page 9 cursory investigation and interviewed the alleged perpetrator who denied providing or assisting R5 with cares or transfers on 10/16/17. The progress note indicated the executive director was notified of the allegation, however, there was no indication the State agency (SA) had been notified of the allegation of abuse by R5. The DON was interviewed on 10/19/17, at 9:49 a.m. during which she was asked why the allegation R5 made about staff being rough with her on 10/16/17, wasn't reported to the SA prior to investigating the allegation. The DON stated in the past R5 had made false accusations of staff abuse and after talking to the alleged perpetrator, the DON stated it took only 10 minutes to complete the investigation enough to ascertain R5 had not been treated roughly. However, the investigation did not include interviewing the aides that did provide care to R5 the morning of 10/16/17, interviewing R5 for pertinent details, and interviewing other residents regarding the care received by the alleged perpetrator. The DON confirmed she had investigated the incident before reporting to the SA because she felt we needed to use common sense, and since R5 had a history of confabulating stories, the DON stated she didn't know whether to believe R5's report or not. The Karlstad Senior Living VA policy dated as revised November 2016, indicated "All incidents deemed reportable under MN statute are submitted to MDH via the on-line Reporting System immediately (as soon as possible)."	F 225	facility policy and procedure of incidents to determine if additional reporting to MDH, law enforcement or other agencies are required. All incidents are reviewed at daily IDT meetings to assure staff followed proper reporting and monitoring procedures. 3. VA Policy will be updated to include that results of the investigation will be submitted within 5 business days. Staff 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, initiation of the investigation, immediate notification of Administrator and DNS and the notification of the Common Entry Point and/or MDH. 4. Executive Director and DNS review all incident reports daily to assure proper reporting and monitoring procedures are followed. The incident reports will be reviewed/discussed at the Monthly QAPI and Quarterly QA meeting. At this time the QA committee will make the decision/recommendation regarding any follow-up studies. Completion Date: 11/29/17	

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F 225	Continued From page 10 During interview with the DON on 10/19/2017, at 9:49 a.m. she confirmed she investigated R5's allegation of abuse prior to reporting the incident to the SA. The DON confirmed R5's allegation of abuse had not been reported to the SA at point following R5's report of rough treatment. The VA report dated 8/9/17, alleged R42 was the victim of financial exploitation. The VA report identified R42 was admitted to the facility on 7/6/17, and had diagnoses that included, but were not limited to malignant neoplasm of prostate with mets to the bone, pain, weakness, anxiety disorder, hypertension, constipation, and palliative care. The alleged perpetrator was R42's son who received funds from R42's bank account in the amount of 3,000.00 dollars on 7/5/17, and another check was drafted on R42's account on 7/7/17, for 5,000.00 dollars which was returned for non-sufficient funds. The VA report indicated the SA was notified of the alleged financial exploitation on 8/9/17, and the Kittson County Sheriff's Office received the report on 8/11/17, from the Minnesota Adult Abuse Reporting Center. The investigation for this alleged financial exploitation had not included any interviews with the alleged perpetrator (R41's son) and had not included any interviews with R41, and it was never determined if the 3,000.00 dollars R41's son received was used for the benefit of R41 or who drafted the check that was returned for non-sufficient funds in the amount of 5,000.00 dollars. On 10/20/2017, at 12:30 p.m. the Administrator was interviewed and confirmed the investigation was not complete as R41, and the son of R41	F 225		

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F 225	Continued From page 11	F 225		

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

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F 225	Continued From page 12	F 225		

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 "kinda short tempered".

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F 225	Continued From page 13 -NA-C stated " [AP] can be harsh with staff and sometimes not really nice with [R5]. "Kinda mean, like [AP] wants to show [R5] who is boss, but with R5, you have to be kinda firm, or she will run you over, it's a fine line. I told her one day a resident was soaked, and she walked right by me and didn't respond at all. She doesn't like anyone telling her anything." -LPN-A and LPN-B stated that [AP] can be snappy, kinda short with residents. She will say "not right now" when a resident asks for something. -NA-H stated she had never heard the AP swear in front of any resident and she has never heard the AP tell R5 she was acting like a bitch or tell her to shut up. NA-H stated the AP presented herself in a harsh way to residents sometimes. The AP does tell R5 "no" sometimes and I have counseled AP that she shouldn't say that, but rather say "we will have to see if I have the time". NA-H had also heard the AP tell R5 to "knock it off" when R5 was asking for one thing after another. NA-H stated that another resident described the AP as "kinda pushy". On 10/19/17 at 2:34 p.m. the DON was interviewed and was asked why all of the aforementioned staff interviews had not been included in the follow-up investigation submitted to the SA and the DON stated she didn't think the statements were pertinent to R5 reporting she was told to shut up and your acting like a bitch. The DON was asked if the above statements constituted verbally abusive behavior, and the DON stated "Yes", I wouldn't want her taking care	F 225		

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F 225	Continued From page 14 of my grandmother. The DON confirmed she had not included all of the employee interviews in the follow up investigation report to the SA and with all of the NA/LPN interviews together, the AP's resident interactions suggested a pattern of verbal abuse. The DON stated she wanted to terminate this employee but corporate would not allow her to. The DON stated the AP was able to return to work after the investigation was completed and the suspension was lifted, but chose not too. The Karlstad Senior Living VA policy dated as revised November 2016, indicated the DON or Administrator would immediately institute an internal investigation of the reported allegation or incident. The investigation may include interviews with staff, residents, and witnesses, environmental review, resident health status review, and behavior and medication review. The VA policy failed to indicate the results of the investigation needed to be submitted to the SA within 5 business days.	F 225		
F 226 SS=D	DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES CFR(s): 483.12(b)(1)-(3), 483.95(c)(1)-(3) 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and	F 226		11/29/17

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F 226	Continued From page 15 (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the Vulnerable Adult (VA) policy had been implemented as written for reporting allegations of abuse to the State agency prior to investigation for 1 of 3 residents (R5) vulnerable adult (VA) reports reviewed; failed to ensure the facilities VA policy was implemented as written to ensure allegations of financial exploitation had been thoroughly investigated for 1 of 3 residents (R42) VA reports reviewed; and failed to ensure the facility VA policy was implemented as written to include all information learned by the internal investigation was reported to the State agency within 5 business days for 1 of 3 residents (R5) VA reports reviewed.	F 226	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because provisions of state and federal law require it. Without waiving the foregoing statement, the facility states with respect to: 1. R5 has been reported to MDH and thoroughly investigated for potential abuse/mistreatment on 7/25/17 (and with re-submission on 11/10/17) and 10/23/17.	

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F 226	Continued From page 16 Findings include: The Karlstad Senior Living VA policy dated as revised November 2016, indicated the director of nursing (DON) or Administrator would immediately institute an internal investigation of the reported allegation or incident. The investigation may include interviews with staff, residents, and witnesses, environmental review, resident health status review, and behavior and medication review. The VA policy failed to indicate the results of the investigation needed to be submitted to the SA within 5 business days. The Karlstad Senior Living VA policy dated as revised November 2016, indicated "All incidents deemed reportable under MN statute are submitted to MDH via the on-line Reporting System immediately (as soon as possible)." 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	F 226	R41 had been reported to MDH and to local law enforcement on 8/9/17 for allegations of financial exploitation. Law enforcement closed this case on 8/11/17. This facility received email confirmation on 9/15/17, that the information had been reviewed and it has been determined that no further action was necessary. 2. Executive Director, DNS or assigned designee are notified per facility policy and procedure of incidents to determine if additional reporting to MDH, law enforcement or other agencies are required. All incidents are reviewed at IDT to assure staff followed proper reporting and monitoring procedures. 3. VA Policy will be updated/changed to include that results of the investigation will be submitted within 5 business days. Staff 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, initiation of the investigation, notification of Administrator and DNS and the notification of the Common Entry Point and/or MDH. . 4. Executive Director and DNS review all incident reports to assure proper reporting and monitoring procedures are followed. The incident reports will be reviewed/discussed at the Monthly QAPI and Quarterly QA meeting. At this time the QA committee will make the decision/recommendation regarding any follow-up studies. Completion Date: 11/29/17	

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indicated the executive director was notified of the allegation, however, there was no indication the State agency (SA) had been notified of the allegation of abuse by R5.

The DON was interviewed on 10/19/17, at 9:49 a.m. during which she was asked why the allegation R5 made about staff being rough with her on 10/16/17, wasn't reported to the SA prior to investigating the allegation. The DON stated in the past, R5 had made false accusations of staff abuse and after talking to the alleged perpetrator, the DON stated it took only 10 minutes to complete the investigation enough to ascertain R5 had not been treated roughly. However, the investigation did not include interviewing the aides that did provide care to R5 the morning of 10/16/17, interviewing R5 for pertinent details, and interviewing other residents regarding the care received by the alleged perpetrator. The DON confirmed she had investigated R5's allegation of abuse before reporting to the SA because she felt we needed to use common sense, and since R5 had a history of confabulating stories, the DON stated she didn't know whether to believe R5's report or not.

The VA report dated 8/9/17, alleged R42 was the victim of financial exploitation. The VA report identified R42 was admitted to the facility on 7/6/17, and had diagnoses that included, but were not limited to malignant neoplasm of prostate with mets to the bone, pain, weakness, anxiety disorder, hypertension, constipation, and palliative care. The alleged perpetrator was R42's son who received funds from R42's bank account in the amount of 3,000.00 dollars on 7/5/17, and

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another check was drafted on R42's account on 7/7/17, for 5,000.00 dollars which was returned for non-sufficient funds. The VA report indicated the SA was notified of the alleged financial exploitation on 8/9/17, and the Kittson County Sherriff's Office received the report on 8/11/17, from the Minnesota Adult Abuse Reporting Center. The investigation for this alleged financial exploitation had not included any interviews with the alleged perpetrator (R41's son) and had not included any interviews with R41, and it was never determined if the 3,000.00 dollars R41's son received was used for the benefit of R41 or who drafted the check that was returned for non-sufficient funds in the amount of 5,000.00 dollars.

On 10/20/2017, at 12:30 p.m. the Administrator was interviewed and confirmed the investigation 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.

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

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F 226	Continued From page 19 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. 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 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	F 226		

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F 226	Continued From page 20	F 226		

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 "kinda short tempered".

-NA-C stated " [AP] can be harsh with staff and sometimes not really nice with [R5]. "Kinda mean, like [AP] wants to show [R5] who is boss, but with R5, you have to be kinda firm, or she will run you over, it's a fine line. I told her one day a resident was soaked, and she walked right by me and didn't respond at all. She doesn't like anyone telling her anything."

-LPN-A and LPN-B stated that [AP] can be snappy, kinda short with residents. She will say "not right now" when a resident asks for something.

-NA-H stated she had never heard the AP swear in front of any resident and she has never heard the AP tell R5 she was acting like a bitch or tell

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F 226	Continued From page 21 her to shut up. NA-H stated the AP presented herself in a harsh way to residents sometimes. The AP does tell R5 "no" sometimes and I have counseled AP that she shouldn't say that, but rather say "we will have to see if I have the time". NA-H had heard the AP tell R5 to "knock it off" when R5 was asking for one thing after another. NA-H stated that another resident described the AP as "kinda pushy". On 10/19/17 at 2:34 p.m. the DON was interviewed and asked why all of the aforementioned staff interviews had not been included in the follow-up investigation submitted to the SA and the DON stated she didn't think the statements were pertinent to R5 reporting she was told to shut up and your acting like a bitch. The DON was asked if the above statements constituted verbally abusive behavior, and the DON stated "Yes", I wouldn't want her taking care of my grandmother. The DON confirmed she had not included all of the employee interviews in the follow up investigation report to the SA and with all of the NA/LPN interviews together, the AP's resident interactions suggested a pattern of verbal abuse. The DON stated she wanted to terminate this employee but corporate would not allow her to. The DON stated the AP was able to return to work after the investigation was completed and the suspension was lifted, but chose not too.	F 226		
F 250 SS=G	PROVISION OF MEDICALLY RELATED SOCIAL SERVICE CFR(s): 483.40(d) (d) The facility must provide medically-related social services to attain or maintain the highest	F 250		11/29/17

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F 250	Continued From page 22 practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 1 resident (R5) was provided the necessary social services to ensure individualized needs were met for identified mental health needs, issues with non-compliance with necessary care and services, and increased inappropriate behavior symptoms. R5 experienced actual psychosocial harm related to the ongoing worry of being displaced from her home, a decline in physical functioning, and the onset of increased mood and behavioral problems that had not been systematically addressed by the facility. Findings include: R5's cumulative diagnoses list dated 10/19/17, indicated R5 was admitted to the facility with diagnoses that included, but were not limited to: bipolar disorder, adjustment disorder with mixed anxiety and depressed mood, major depressive disorder, narcotic dependence, disruptive behavior disorder, post-traumatic stress disorder, end stage renal disease, chronic radicular low back pain, right hand and right below the knee amputation, and sociopathic borderline personality disorder. R5's quarterly Minimum Data Set (MDS) dated 7/6/17, indicated R5 had no cognitive or memory deficits, R5 had inappropriate behavior symptoms identified as inattention (trouble focusing attention, being easily distractible, or had difficulty	F 250	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because provisions of state and federal law require it. Without waiving the foregoing statement, the facility states with respect to: 1. R5 had a Care Plan review completed 10/16/17 w/ changes made on 10/18/17. Social Service (SS) has met with R5 on: 10/24/17 and 10/26/17. R5 had Psychotherapist appointment on 10/26/17, with pending weekly appointments thereafter. R5 had Psychiatrist appointments scheduled for 10/12/17, 10/31/17 and 11/14/17. Behavioral care plan received from Mayo on 10/19/17. SS started constructing personalized facility behavioral care plan 10/19/17. R5 hospitalized 10/6-12/17 and 10/30-11/2/17. R5 expired 11/3/17. 2. All residents will be reviewed quarterly or with any significant change, through chart and medication review for mental health needs, issues w/ non-compliance with necessary care and services, and increased inappropriate behavior symptoms. 3. Care plans and assignment sheets for those residents initially found with mental	

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F 250	Continued From page 23 keeping track of what was being said). The MDS also indicated R5 had the following mood symptoms present 2-6 days a week: feeling down, depressed, or hopeless, feeling tired or having to little energy, and feeling bad about self-or that you are a failure or have let yourself or a family member down. The MDS indicated R5 did not have any symptoms of psychosis (hallucinations or delusions), however, R5 did have verbal behavior symptoms directed at others (threatening others, screaming or cursing at others) 1-3 days a week. The MDS indicated R5 required extensive assistance of two persons for bed mobility and toilet use, and required extensive assistance of one person for dressing, personal hygiene and locomotion on and off the unit using a wheelchair. R5 was unable to ambulate, and was totally dependent on two staff during transfers. R5 was interviewed on 10/17/17, at 2:00 p.m. and stated she was extremely upset because the director of nursing (DON) had told her the previous week that she had one month to drastically improve her behavior or else she would be discharged to a facility over 300 miles south from where she was currently living in the nursing home. R5 began to cry and stated the facility had tried sending her to a "nut house" last week and would not allow her to come back to the facility. R5 stated she had been sent to the emergency room at Sanford Medical Center in Fargo, ND from dialysis, and because the nursing home refused to allow R5 to come back to the nursing home, she 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 DON at Karlstad	F 250	health needs/ non-compliance issues/ increased behavior symptoms will be reviewed and updated as needed by 11/29/17. SS and nursing staff will be re-educated to care plan changes and the need for providing individualized care by 11/29/17. An individual's Care Plan will be developed in cooperation with resident/ responsible party and the facility care team that includes the optimal frequency of SS and other supportive visits. 4. Audits will be completed by DNS or designee with all new admissions for the following 3 months to ensure that mental health and individualized needs will be met. The data collected will be reviewed at the Monthly QAPI and Quarterly QA meeting. At that time the committee will make the decision/recommendation regarding any follow-up studies. Completion Date: 11/29/17	

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Healthcare Center and made the nursing home allow R5 to come back to the facility. R5 stated she was frustrated, anxious, and felt panicked that she may be discharged from the facility if her behavior did not improve in the next 30 days. R5 continued crying throughout the interview and stated, "I make a big goof of myself like a retard so people laugh at me, instead being mad at me." R5 explained she had increased anxiety throughout every day and cried daily with worry that she would become homeless or have to leave to another facility since being told by the DON she had to "drastically improve" her behavior in order to stay in the facility. R5 stated that since returning to the facility she had felt isolated because facility staff no longer seemed to want to talk with her or visit. When R5 was asked what type of behavior needed to improve over the next 30 days, R5 stated she had been screaming loudly when she needed something or needed assistance. When R5 was asked why she screamed loudly, she stated she screamed because she was anxious and frustrated and could get assistance in a timelier manner.

Registered nurse (RN)-A was interviewed on 10/18/17, at 8:35 a.m. and stated R5 screamed many times a day, if it was a bad day. RN-A stated she could not quantify how many times R5 screamed every day because the facility had not tracked how often the behavior occurred or the antecedent to the behavior. RN-A stated R5 screamed loudly when she wanted something immediately, and had anxiety about not getting care and assistance timely.

The DON was interviewed on 10/19/17, at 10:14

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F 250	Continued From page 25 a.m. during which she stated the reason R5 was told she had 30 days to change her behavior in order to keep living at Karlstad Healthcare Center was because the transport company which transported R5 to dialysis three times a week had verbally notified the facility that they would no longer transport R5 due to behavior of yelling, screaming, and making false allegations of the driver's driving ability, behavior, and conduct. The DON stated because there was only one transport company available in the Karlstad area the facility had no choice but to attempt to find R5 a different nursing home to live at where R5 had transportation to dialysis. When the DON was asked to provide evidence the transportation service had refused ongoing transportation services to R5, the DON stated the transport company had not provided any documentation which identified R5 was denied transportation services. 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. The progress notes for R5 were reviewed from 10/1/17 - 10/18/17, during which the following was learned regarding R5's transportation issues, emergency room visits, and hospitalizations:	F 250		

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F 250	Continued From page 26 -On 10/4/17, R5 returned to the facility via R&L transport service and stated the transport driver tried to kill her. The progress note indicated R5 was too upset to eat supper, and wanted to report the van driver to the owner of the transport service because R5 indicated the van driver had driven onto the shoulder of the road for many feet. -On 10/5/17, R&L transport reported to the nursing home staff that R5's behavior was escalating and R&L doesn't know how long they could continue to transport R5 to dialysis. -On 10/6/17, R5 was sent to the emergency room at Sanford Fargo, ND after having dialysis at Sanford Thief River Falls, MN. R5 was evaluated in the emergency room and was not admitted for inpatient stay. The emergency room at Sanford Fargo, ND attempted to discharge R5 back to Karlstad Healthcare Center, however, they refused to allow R5 back into the facility. -On 10/8/17, R5 was sent to the emergency room at Mayo Medical Center for psychiatric evaluation. -On 10/9/17, R&L transport refused to provide any further transportation services. -On 10/9/17, indicated the DON refused to allow R5 to return to the facility because R&L transportation refused to provide further transport to dialysis. -On 10/11/17, indicated the licensed social worker (LSW) at the Mayo Medical Center contacted R5's insurance provider to assist with dialysis transportation needs for R5. R5's insurance provider got R&L to agree to provide transport services for the month of October. -On 10/12/17, indicated R5 finally returned back to Karlstad Healthcare Center on 10/12/17, at 5:30 p.m. (six days after R5 had initially went to the Sanford Fargo, ND ER for evaluation).	F 250		

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F 250	Continued From page 27 Review of R5's behavior progress notes from 4/1/17, through 8/24/17, revealed three behavior progress notes had been documented on dated 4/1/17, and 5/9/17, and 8/24/17 which indicated R5 had inappropriate screaming behavior. A General progress note dated 8/7/17, indicated, "Behaviors are not a problem right now". However, the behavior progress note dated 8/24/17, indicated R5 had had an "increase" in behaviors over the past month which included hollering, screaming, and demanding staff to clean her glasses 15-20 times per shift, requesting oxygen tubing re-arranged 10-15 times per shift, and wanting wheelchair adjusted 1-2 millimeters (mm) to the right or left 10-20 times per shift. The behavior progress note identified possible causal factors included declining physical health. Interventions identified included staff attempt to meet needs as quickly as possible. From 8/24/17 - 10/16/17, there were seven behavior progress notes which identified R5 had increased inappropriate behaviors which included screaming, yelling, and demanding repetitive assistance with cares. Despite the aforementioned increase in behavioral progress notes that identified R5 had increased inappropriate behaviors, there was no evidence R5 had been comprehensively assessed to determine causal factors for the increased behaviors, and interventions to minimize ongoing inappropriate behaviors had not been developed or implemented. R5 was observed on 10/17/17, from 1:15 p.m. to 4:00 p.m., 10/18/17, from 7:00 a.m. to 9:30 p.m.,	F 250		

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F 250	Continued From page 28 10/19/17, from 8:30 a.m. to 3:30 p.m. and again on 10/20/17, from 8:30 a.m.-9:30 a.m. during which R5 was not heard yelling, screaming, or cursing. It was noted when R5 was observed being dropped off by R&L transportation on 10/17/17, at 1:15 p.m. R5 gave the van driver a hug and expressed words of thanks for the transportation provided. The van driver returned the hug to R5 and told R5 he would be at the facility the following day for transport to dialysis. Review of the Mayo Clinic Medicine 9 Hospital dismissal summary dated 10/12/17, indicated R5 was assessed in the emergency department and was found not in need of hospital admission for psychiatric services because R5's outbursts were more behaviorally based. The dismissal summary indicated the Karlstad Healthcare Center would not agree to accept R5 back into the facility, therefore R5 had to be admitted to the hospital so that she could receive dialysis treatments. The dismissal summary indicated while in the hospital, psychiatry was consulted and a behavior plan was employed to outline expected respectful behaviors and R5 did very well with this. R5's care plan dated 10/13/17, indicated the following: R5's diagnoses with many other health issues contribute to R5's verbally abusive behavior, striking out at staff and refusal of cares and crying. R5 has no cognitive impairment. Care planned interventions included the following: -Administer medications as ordered. Observe/document for side effects and	F 250		

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F 250	Continued From page 29 effectiveness. Alert medical practitioner to side effects or ineffectiveness of medication. Pharmacy review monthly or as needed. No medications are to be sent with R5 when out of building for appointments. -Allow opportunity for R5 to express her feelings/concerns. -Remove from common areas and leave in safe manner and explain you will return when unable to redirect. -R5 needs as much encouragement, assistance, and support to maintain as much independence and control over her environment as possible. -Crying: interventions included diversion with talking about church/hymns, country music and 1:1 visits. -Verbal Aggression: interventions included remove from common areas, leave in a safe manner and explain you will return when unable to redirect. Invite to activities of choice. Offer to escort her to activities, if desired. Non-pharmacological interventions included to leave alone in safe environment and reapproach, remove from common areas, discuss hymn or country music, offer coloring books, take outside weather permitting, spiritual support. -Observe/document/report to Nurse/MD signs and symptoms of depression, including hopelessness, anxiety, sadness, insomnia, anorexia, verbalizing, negative statements, repetitive anxious or health-related complaints, tearfulness. -Observe/record target behaviors/symptoms and document per facility protocol. Two staff at all times when doing any personal cares with R5. Staff may go in alone to answer call light but if personal cares are needed wait till another staff is there to assist.	F 250		

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F 250	Continued From page 30 The care plan dated 10/13/17, failed to identify R5's screaming/yelling behavior or behavior of repeatedly asking for assistance with tasks that had already been recently completed (i.e. washing glasses, adjusting fan, putting on the call light repeatedly and when answered denying that she had put it on). The care plan had not included any therapeutic conversation interventions with the licensed social worker (LSW) to work through inappropriate behavior symptoms and the frequency of those LSW services would be offered in an attempt to calm R5's anxiety and frustration before behavior escalated to repeatedly yelling and screaming. R5's care plan had not identified the issues with R&L transportation providing transport for R5 only on a trial basis for the month of October due to R5's inappropriate behavior during transport. The care plan did not identify behavioral interventions developed to assist R5 with being successful with maintaining appropriate behavior during transportation to and from dialysis. Additionally, the behavioral plan used while at Mayo Medical Center and found to be successful while R5 was hospitalized there, was not added to R5's nursing home care plan, nor were the behavioral interventions implemented. On 10/18/17 at 8:43 a.m. the facility LSW was interviewed and asked if she had any residents in the facility that had high psychosocial needs, and also had a care plan developed with appropriate interventions and goals which addressed mood and behavior symptoms. The LSW stated she did not have any residents with high psychosocial needs with mood and inappropriate behavior symptom's. The LSW confirmed R5's mood and behavior symptom's had not been	F 250		

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F 250	Continued From page 31 comprehensively assessed and care plan interventions and goals to address the mood symptom's and inappropriate behavior had not been developed or implemented. The LSW indicated she was not aware a successful behavioral plan had been developed for R5 while hospitalized at Mayo Medical Center. The LSW confirmed the behavioral plan developed by Mayo Medical Center had not been implemented after R5 returned to Karlstad Healthcare Center 10/12/17.	F 250		
F 279 SS=D	DEVELOP COMPREHENSIVE CARE PLANS CFR(s): 483.20(d);483.21(b)(1) 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable	F 279		11/29/17

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F 279	Continued From page 32 physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the 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	F 279	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	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 33 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 effects and monitoring needs. 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, identifies R35 as severely impaired, exhibits verbal and physical behaviors and received antipsychotic, antidepressant, antianxiety and antibiotic medications. 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. R35's Medication Administration Record, dated 10/2017, indicated R35 received Carbamazepine 300 milligrams in the evening for seizures.	F 279	facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because provisions of state and federal law require it. Without waiving the foregoing statement, the facility states with respect to: 1. R35 had a care plan review with changes made for the medication Carbamazepine for resident behaviors. R35 has not had a history of seizures. Pharmacy consultants state that when Carbamazepine is being utilized for behaviors, checking routine levels isn't clinically indicated. 2. All residents will be reviewed through chart review for seizure history, to ensure that they are care planned appropriately along w/ being identified on the MDS, and that monitoring needs have been identified and implemented. 3. Staff education will be completed by 11/29/17 regarding the need to address the use of medications and if side effects or behaviors warrant monitoring. 4. Audits of care plans will be completed by DNS or designee with all new admissions and for any resident having medication order changes for the following 3 months to ensure that all psychoactive or anti-seizure medication would be identified properly on the MDS, care plan, and the monitoring needs identified and implemented. The data collected will be reviewed at the Monthly QAPI and Quarterly QA meeting. At that time the committee will make the decision/recommendation regarding any	

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	245468	A. BUILDING _____ B. WING _____	10/20/2017

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F 279	Continued From page 34 R35's care plan, print date 10/20/17, identified psychoactive medication use for Zyprexa, Risperdal, Celexa, Klonopin, and Buspar. The care plan lacked identification of a focus identification of seizure medication use, monitoring, or interventions. On 10/2/17, at 9:05 a.m. the ADON stated, R35 recently returned from a short hospital stay, and her Carbamazepine was not a new medication and staff should have identified the need for monitoring R35's use of Carbamazepine. The ADON stated she was not aware of R35 exhibiting any seizure activity and verified R35's last Carbamazepine laboratory test on 12/8/16, indicated a result of 4.3 mg (therapeutic reference range is 4-12 mg.) The ADON stated she would expect the use of an anti-seizure medication to be monitored and the care plan should reflect identification of the anti-seizure medication use, potential for seizures, monitoring needs, and identified interventions. The ADON stated the facility had a change in their MDS staff and have had resident health care areas/resident needs which had had slipped through the cracks and recognized the care plans were not reflecting resident needs. On 10/20/17, at 1:16 p.m. the director or nursing (DON) confirmed the use of psychoactive and anti-seizure medications should be identified accurately on the MDS, care plans, and the monitoring needs identified and implemented. The DON further stated that on the second day of the survey they had identified the care plans were seriously lacking the identification of residents	F 279	follow-up studies. Completion Date: 11/29/17	

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F 279	Continued From page 35 needs, which needed to be addressed. Facility policy Person Centered Care Plan Guideline last revised 11/16, indicated the care plan must be reviewed and revised annually, quarterly, with a significant change in status and as needed. The policy also included, the overall person centered care plan should be orientated towards: preventing avoidable declines, and managing risk factors. The policy also directed staff to include target behaviors, non-pharmacological interventions, psychoactive medication class if applicable with appropriate diagnosis/indication for use, and gradual dose reductions/pharmacy reviews.	F 279		
F 280 SS=D	RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP CFR(s): 483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items	F 280		11/29/17

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F 280	Continued From page 36 included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident.	F 280		

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F 280	Continued From page 37 (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to ensure the written care plan was revised to include fluid restriction interventions and ongoing monitoring of fluid intake for 1 of 1 (R5) resident in the sample reviewed for dialysis, and failed to revise the care plan to include target behavior/mood symptoms for psychotropic medications for 2 of 5 residents (R6, R30) reviewed for unnecessary medications. Findings include: R5's cumulative diagnoses list dated 10/19/17, indicated R5 was admitted to the facility with diagnoses that included, but were not limited to: end stage renal disease requiring hemodialysis,	F 280	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because provisions of state and federal law require it. Without waiving the foregoing statement, the facility states with respect to: 1. R5 did not have a physician order for fluid restriction due to an extensive history of non-compliance. R5 has had a care plan review to include fluid restriction interventions and monitoring of fluid intake. R6 and R30 have had care plan	

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F 280	Continued From page 38 bipolar disorder, disruptive behavior disorder, post-traumatic stress disorder, and sociopathic borderline personality disorder. On 10/20/17, at 9:22 a.m. R5 was observed at the end of the breakfast meal and was noted to have four cups of fluid each which held at least 240 cubic centimeters (cc) per cup for a total of 960 cc of fluid on her breakfast tray. R5 drank all of the fluids provided. R5 stated the facility did not serve her the correct amount of fluids according to her dialysis diet. R5 stated she herself tracked how much fluid she consumed each day and showed the surveyor a notebook with numbers written down for each day. However, there were no totals which identified how much fluid was consumed in a day and many of the days didn't look complete. R5 also stated the fluid calculation was not correct and she did not know if her fluid restriction was 32 or 36 ounces. R5 stated the dialysis unit had not even looked at her personal fluid intake log because they did not believe her recordings. R5 stated she was trying to do better with fluid management because she didn't want to keep going into the hospital for fluid overload. Review of R5's undated physician orders revealed there was no fluid restriction ordered, however, when R5's medical record was reviewed, a progress note dated 8/23/17, indicated a dialysis nurse notified the facility that R5 should have no more than four 8 ounce servings (960 cc) of fluid daily. Review of R5's care plan for dialysis last revised on 10/13/17, revealed no fluid restriction was	F 280	reviews with updates to include target behavior/mood symptoms for psychotropic medications. 2. Residents receiving dialysis will have their care plans reviewed for fluid restrictions and ongoing monitoring of fluid intake. Residents that received psychotropic medication will have care plans reviewed for target behavior/mood symptoms. 3. Staff education will be completed 11/15/17 regarding target behavior/ mood monitoring care plan need, and the need for fluid intake monitoring with residents receiving dialysis. 4. DNS or designee will complete audits on any new residents/ new orders for current residents on dialysis or with psychotropic medication ordered for the following 3 months and, to ensure that proper care planning. The data collected will be reviewed at the Monthly QAPI and Quarterly QA meeting. At that time the committee will make the decision/recommendation regarding any follow-up studies. Completion Date: 11/29/17	

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F 280	Continued From page 39	F 280		

identified, and the care plan stated R5 "monitors her own fluid restrictions." The care plan directed total intake to be distributed between dietary and nursing and to document non-compliance. The care plan had not identified a plan for how many cc's of fluid was allotted for each meal and medication pass and had not identified R5 was non-compliant with fluid restrictions. The care plan also failed to identify interventions to minimize fluid consumption like offering ice chips instead of water, offering a popsicle rather than juice, or offering hard candy or lemon drops for symptoms of dry mouth.

Further review of R5's medical record revealed intake monitoring and R5's fluid balance had not been documented and monitored.

Licensed practical nurse (LPN)-A was interviewed on 10/20/17, 9:50 a.m. and stated R5's fluid intake was not monitored by the facility, and there was no way to tell where R5 was with fluid balance.

The director of nursing (DON) was interviewed on 10/20/17, at 10:32 a.m. regarding R5's fluid restrictions during which she confirmed R5's care plan had not identified R5's fluid restriction, had not delineated how many fluids R5 would receive during meals, and how much fluid R5 received during medication pass by nursing.

R6's care plan was not revised to include target/mood symptoms

R6's Diagnosis Report dated 10/20/17, included

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F 280	Continued From page 40 diagnoses of major depressive disorder, anxiety disorder, and schizoaffective disorder. R6's annual Minimum Data Set (MDS) dated 8/1/17, identified R6 had verbal behaviors 1-3 days during the assessment period and took antipsychotic and antidepressant medications. R6's Behavioral symptom Care Area Assessment dated 8/3/17, indicated R6's behaviors included calling out to staff when she needed assistance transferring rather than using her call light. The CAA indicated the behavioral symptoms would not be care planned, no further analysis was noted on the CAA. R6's physician orders provided by the facility on 10/20/17 included: -Benzotropine Mesylate (used to treat symptom of Parkinson's disease or involuntary movements due to side effects of certain psychiatric drugs) milligram (mg) at bedtime for behaviors. Start date of 7/26/16. -Lexapro (antidepressant medication) 15 mg in the morning for depression. Start date of 7/26/16. -Trazodone (antidepressant medication) 50 mg at bedtime for major depressive disorder. Start date 4/21/17. The physician orders did not include an anti-anxiety medication. R6's care plan printed and provided by the facility on 10/20/17, indicated R6 used antianxiety medications related to anxiety and antidepressant medications related to depression (last revised 11/14/16). The associated interventions included instruction to give anti-anxiety medication ordered by the physician. The care plan lacked target behaviors/ and mood symptoms including	F 280		

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F 280	Continued From page 41 symptoms identified on the CAA. On 10/16/17, at 5:44 p.m. R6 was observed seated in her recliner in her room, watching TV. R6 fell asleep multiple times during the resident interview and was difficult to keep awake. Her overall facial expressions were flat with little emotion in responses to questions. On 10/17/17, at 8:59 a.m. R6 was observed to ambulate down the hallway using her walker, her mood was light and appropriate, had slightly more emotion when conversing. On 10/18/17, at 1:57 p.m. licensed social worker (LSW) reviewed R6's care plan and verified the target/mood symptoms for depression were not identified. LSW explained R6 had depression and anxiety and had up and down days and R6 displayed depressive symptoms by not doing her hair or makeup and generally would not come out of her room on those days. LSW stated when R6 was anxious it seemed like she was more impulsive and perceived things more negatively than what they were. On 10/19/17, at 9:45 a.m. assistant director of nursing (ADON) verified the lack of target mood symptoms on the care plan and stated the target mood symptoms should have been identified on the care plan. R30's care plan was not revised to include target behaviors/mood symptoms. R30's facility Face Sheet dated 10/20/17, included diagnoses of dementia without	F 280		

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F 280	Continued From page 42 behavioral disturbance, anxiety disorder, and major depressive disorder. R30's annual Minimum Data Set (MDS) dated 8/4/17, indicated R30 had severe cognitive impairment and had verbal behaviors directed towards others one to three days during the assessment period and there had not been a change in behaviors since the previous assessment. R30's Behavioral CAA dated 8/7/17, indicated R30 had the potential for behavioral problems by being resistive to cares and indicated the behavioral symptoms would not be addressed on the care plan. The CAA lacked indication of the verbal behaviors identified on the MDS. R30's physician orders included Celexa (antidepressant) 20 milligrams every morning for major depressive disorder with a start date of 5/22/17, and mirtazapine 15 mg every bedtime for major depressive disorder. R30's target behaviors for anxiety to be monitored indicated on the physician orders, and were dated 12/29/16, included restlessness and crawling out of bed and directed staff to bring R30 to quiet area and offer nourishment. The physician's orders did not identify target mood symptoms for depression. R30's care plan printed and provided by the facility on 10/20/17, indicated R30 received antidepressant and antianxiety medication related to depression, anxiety, and appetite stimulation.	F 280		

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F 280	Continued From page 43 The care plan indicated R30 had feelings of sadness, anxiety, and depression characterized by ineffective coping and fearfulness last revised on 12/21/16. R30's Progress Notes reviewed from 7/17/17-10/16/17, reflected behaviors of refusals of care, medication and meals, agitation, hollering and hitting staff. The care plan was also not revised to include resistive to care that was identified on the CAA. On 10/16/17, at 5:13 p.m. R30 was observed calmly lying in bed awake. R30's mood was pleasant; she smiled and was unable to articulate words including her name. At 6:20 p.m. director of nursing (DON) reported she refused dinner and explained once she refused, staff did not persist because R30 would become very easily agitated if asked too many questions. On 10/17/17, at 9:18 a.m. R30 was observed seated in the lobby area in her pajamas. R30 was calm and looking around. When asked how she was doing, R30 smiled without verbally responding. On 10/18/17, at 7:10 a.m. R30 was observed resting in bed with her eyes closed. -At 7:53 a.m. R30 was resting calmly in bed with her eyes open. -At 8:24 a.m. nursing assistant (NA)-A entered the room and assisted R30 with morning cares. NA-A gave verbal cues during the cares, R30 was calm, cooperative, and followed cues without	F 280		

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evidence of any behavioral or mood symptoms. NA-A explained R30 did better with older NA's and if she didn't like someone she would wave them away. NA-A reported R30's behaviors included pushing staff away, refusing care, and her behaviors were sporadic and usually did not have a problem with redirection. NA-A stated staff would use interventions such as toileting, offer something to eat, and/or re-approaching at a later time.

On 10/19/17, at 9:45 a.m. the ADON confirmed the care plan did not identify all of R30's behaviors/moods and stated the facility did not have a process in place to ensure ongoing analysis and/or evaluation of psychotropic mediations.

On 10/20/17, at 9:31 a.m. NA-C stated R30 would hit, pinch, scratch, and refuse meals. NA-C stated interventions included getting a different staff member, getting more help, re-approaching at a later time, and nails were kept short.

-At 9:37 a.m. licensed practical nurse (LPN)-A stated R30 hit staff during cares, refused cares, refused medications, and had thrown her hearing aides across the room. LPN-A explained when R30 exhibited the behaviors they would re-approach and use different staff members.

-At 12:58 a.m. NA-B stated R30 had behaviors once in a while when she was mad, angry, or tired and this was displayed by her facial expressions. NA-B stated R30 would tap on the NA's or shake her fist when she didn't like something and staff were to stop what they are

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F 280	Continued From page 45 doing and help her calm down by sitting with her and telling her what you are doing step by step or attempt to try again later. Facility policy Person Centered Care Plan Guideline last revised 11/16, indicated the care plan must be reviewed and revised annually, quarterly, with a significant change in status and as needed. The policy also included, the overall person centered care plan should be orientated towards: preventing avoidable declines, and managing risk factors. The policy also directed staff to include target behaviors, non-pharmacological interventions, psychoactive medication class if applicable with appropriate diagnosis/indication for use, and gradual dose reductions/pharmacy reviews.	F 280		
F 282 SS=D	SERVICES BY QUALIFIED PERSONS/PER CARE PLAN CFR(s): 483.21(b)(3)(ii) (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to implement the care plan related to the reporting of newly identified skin impairment for 1 of 3 residents (R37) with a wound which was not reported, assessed or treated. In addition, the facilty failed to document	F 282	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	11/29/17

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 46 and monitor behaviors related to the use of psychotropic medication as directed by the care plan for 1 of 5 residents (R1) reviewed for unnecessary medications. Findings include: R37's care plan revised on 8/17/16, indicated R37 had chronic kidney disease and directed staff to check body for breaks in skin and treat promptly as ordered by medical practitioner. The anticoagulant therapy care plan dated 11/1/16, directed staff to perform daily skin inspections and to report abnormalities to the nurse/medical practitioner. The skin care plan dated 11/1/16, directed staff to use caution during bed mobility and transfers to prevent striking arms, legs, and hands against surfaces that may cause injury. R37's medical record did not reflect any areas of skin impairment or daily skin inspections as directed by the care plan. On 10/18/17, at 7:54 a.m. R37 was observed seated in wheelchair, lower extremities were not covered. The right leg was amputated just below the knee and the left leg had a dime sized light yellow/reddish thin scab on the outside of the upper calf just below the knee. The skin around the wound was not red. Nursing assistant (NA)-D entered the room first and NA-E shortly after. The surveyor reported to both NA's and to R37 the wound on the outside of the leg. NA's were not previously aware of the wound. R37 stated he got the injury a week ago when he transferred into	F 282	deficiencies. The plan of correction prepared for this deficiency was executed solely because provisions of state and federal law require it. Without waiving the foregoing statement, the facility states with respect to: 1. R37 has had his skin impairment assessed and treated. R1 has had behaviors monitored and documented. 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 use and proper documentation or behavior along with non-pharmacologic alternatives tried prior to prn medication use. 3. Staff education will be completed by 11/29/17 regarding the need to report, monitor and document any resident skin injury or behavior. 4. DNS or designee will audit 5 residents weekly x1 month, then 1 resident weekly for 2 months regarding the proper documentation of skin injury, resident target behavior monitoring and PRN medication administration. The data collected will be reviewed at the Monthly QAPI and Quarterly QA meeting. At that time the committee will make the decision/recommendation regarding any follow-up studies. Completion Date 11/29/17	

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	245468	A. BUILDING _____ B. WING _____	10/20/2017

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F 282	Continued From page 47 the wheelchair. The NAs failed to report the wound to the nurse, as directed. On 10/19/17, at 3:45 p.m. assistant director of nursing (ADON) stated she was not informed of R37's left leg wound. ADON assisted R37 in his wheelchair back to his room. The wound periphery was now red and the scab had changed to a darker red and appeared to be thicker. The ADON cleaned, measured, and dressed the wound. R37 stated he had received the wound over a week ago when he bumped it on his wheelchair when transferring. R37 stated he had not told anybody about the wound because he figured it would just heal. The ADON stated the NAs should report changes in skin condition to the nurse. Following this assessment, a comprehensive skin assessment was completed for R37's wound. R37's Incident progress noted dated 10/20/17, indicated maintenance would pad on wheelchair which caused wound, dietary informed and protein powder added to the diet plan, wound to be monitored and education provided to staff. R1's care plan was not followed for monitoring/documenting of target behaviors, interventions and outcomes. R1's care plan, print date 10/20/17, indicated R1 had feelings of uneasiness and sadness related to anxiety, depression and episodic mood disorder. Target behaviors identified for depression and anxiety was explosive behaviors	F 282		

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F 282	Continued From page 48	F 282		

and directed staff to redirect, provide one to one visits, ensure safety, divert attention, offer baby doll, and engage in conversations. Staff was also directed to record the number of occurrences, interventions used, and outcomes.

R1's Medication Administration Record (MAR), dated 10/2017, indicated R1 received Remeron 7.5 mg at bedtime for depression and Ativan 1 mg orally as needed for anxiety/explosive disorder. The MAR indicated R1 received as needed Ativan 1 mg on:

-8/27/17 at 3:30 p.m.
-9/8/17 at 12:00 a.m.
-9/20/17 at 12:15 a.m.
-9/21/17 at 12:00 p.m.

The MAR identified the explosive behavior, Interventions, and outcomes for monitoring every shift, daily. The monitoring forms for 8/17, 9/17, 10/17, were all blank and did not identify behaviors, non-pharmacological interventions or outcomes for the days R1 utilized as needed Ativan.

On 10/18/2017, at 7:20 a.m. licensed practical nurse (LPN)-A stated staff were supposed to document on the MAR when R1 had any behaviors and not just when she received the Ativan. The LPN confirmed the aforementioned documentation forms were blank and should have been completed, as directed.

-At 7:29: a.m. the ADON stated the documentation forms were to be completed when

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F 282	Continued From page 49 behaviors occurred, not just when R1 received as needed Ativan. The ADON stated R1 would be awake for a couple of days looking for her baby followed by exhaustion and sleeping. R1 had days when she uncontrollably cried. The ADON stated R1 received as needed Ativan once this month, several times in September due to periods of looking for her baby. The ADON stated staff were supposed to be documenting the behaviors on the MAR along with interventions attempted and the outcomes. During review of the MAR's with the ADON for 10/17, 9/17, and 8/17, the ADON confirmed they were void of any 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. On 10/20/17, at 1:16 p.m. the DON confirmed resident MDS assessments, care plans and monitoring of psychoactive and other medications should have been completed in order to accurately reflect the residents medical and personal needs. The DON confirmed it was her expectation that monitoring of medications, the identification of target behaviors and documentation of the use of non-pharmacological interventions be documented which was not currently being done. In addition, the DON stated the facilty knew on the second day of the survey that the resident care plans and other areas of monitoring was seriously lacking identified resident needs and should not have been.	F 282		

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F 282	Continued From page 50 The facility policy, Mood and Behavior Documentation Guidelines, dated 11/16, indicated the facility would monitor behaviors to communicate concerns in resident mood and /or behaviors and provide documentation of evidence for practice decisions and modifications to the resident plan of care. 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 provide effective and person-centered care of the resident that meet professional standards of quality of care and the care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable, mental and psychosocial well-being.	F 282		
F 309 SS=G	PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING CFR(s): 483.24, 483.25(k)(l) 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure	F 309		11/29/17

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F 309	Continued From page 51 that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure dialysis fluid restriction was monitored to minimize hospitalizations for fluid overload for 1 of 1 resident (R5) reviewed for dialysis. Actual harm occurred as a result of the facility's lack of monitoring R5's fluid intake despite repeated hospitalizations for fluid overload. In addition, based on observation, interview, and document review the facility failed to identify and monitor impaired skin integrity for 1 of 1 resident (R37) observed who was at risk for developing serious complications from impaired skin integrity. Findings include:	F 309	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because provisions of state and federal law require it. Without waiving the foregoing statement, the facility states with respect to: 1. Fluid intake monitoring was implemented on R5. R37 impaired skin integrity was identified, monitored and received treatment. 2. All resident care plans will be reviewed to insure that each includes a	

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F 309	Continued From page 52 R5's cumulative diagnoses list dated 10/19/17, indicated R5 was admitted to the facility with diagnoses that included, but were not limited to: bipolar disorder, adjustment disorder with mixed anxiety and depressed mood, major depressive disorder, narcotic dependence, disruptive behavior disorder, post-traumatic stress disorder, end stage renal disease, chronic radicular low back pain, right hand and right below the knee amputation, and sociopathic borderline personality disorder. 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. R5's quarterly Minimum Data Set (MDS) dated 7/6/17, indicated R5 had no cognitive or memory deficits, R5 had inappropriate behavior symptoms identified as inattention (trouble focusing attention, being easily distractible, or had difficulty keeping track of what was being said). The MDS also indicated R5 had the following mood symptoms present 2-6 days a week: Feeling down, depressed, or hopeless, feeling tired or having to little energy, and feeling bad about self-or that you are a failure or have let yourself or a family member down. The MDS indicated R5 did not have any symptoms of psychosis (hallucinations or delusions), however, R5 did	F 309	baseline care plan that includes instructions needed to provide effective and person-centered care of the resident. It will also describe the services that are to be furnished to attain or maintain the resident's highest practicable, mental and psychosocial well-being. All dialysis residents will have fluid intake monitored and the dialysis center will be notified w/ results. All current residents will have a full body assessment completed to evaluate skin integrity 3. Staff education will be completed prior to 11/29/17 regarding the need for accurate care plans being effectively person-centered and must include services provided for their physical, mental and psychosocial needs. Protocols with regard to communication with dialysis have been revised. 4. DNS or designee will audit all new admission care plans for the following 2 months and 2 resident changes in needs with regard to care planning weekly x2 month. The data collected will be reviewed at the Monthly QAPI and Quarterly QA meeting. At that time the committee will make the decision/recommendation regarding any follow-up studies. Completion Date 11/29/17	

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F 309	Continued From page 53 have verbal behavior symptoms directed at others (threatening others, screaming or cursing at others) 1-3 days a week. The MDS indicated R5 required extensive assistance of two persons for bed mobility and toilet use, and required extensive assistance of one person for dressing, personal hygiene and locomotion on and off the unit using a wheelchair. R5 was unable to ambulate, and was totally dependent on two staff during transfers. On 10/20/17, at 9:22 a.m. R5 was observed at the end of the breakfast meal and was noted to have four cups of fluid each which held 240 cubic centimeters (cc) per cup for a total of 960 cc of fluid on her breakfast tray. R5 drank all of the fluids provided. R5 stated the facility did not serve her the correct amount of fluids according to her dialysis diet. R5 stated she herself tracked how much fluid she consumed each day and showed the surveyor a notebook with numbers written down for each day. However, there were no totals which identified how much fluid was consumed in a day and many of the days did not look complete. R5 also stated the fluid calculation was not correct and she did not know if her fluid restriction was 32 or 36 ounces per day. R5 stated the dialysis unit had not even looked at her personal fluid intake log because they did not believe her recordings. R5 stated she was trying to do better with fluid management because she did not want to keep going into the hospital for fluid overload. Review of R5's undated physician orders revealed there was no fluid restriction ordered, however, when R5's medical record was	F 309		

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F 309	Continued From page 54 reviewed a progress note dated 8/23/17, indicated a dialysis nurse notified the facility that R5 should have no more than four 8 ounce servings (960 cc) of fluid daily. Review of R5's care plan for dialysis last revised on 10/13/17, revealed no fluid restriction was identified, and the care plan stated R5 "monitors her own fluid restrictions." The care plan directed total intake to be distributed between dietary and nursing and to document non-compliance. The care plan had not identified a plan for how many cc's of fluid was to be allotted for each meal and medication pass and R5's noncompliance with fluid restrictions. The care plan had not included interventions to minimize fluid consumption like offering ice chips instead of water, offering a popsicle rather than juice, offering hard candy or lemon drops for symptoms of dry mouth. Further review of R5's medical record revealed intake monitoring and R5's fluid balance had not been documented and monitored. Licensed practical nurse (LPN)-A was interviewed on 10/20/17, 9:50 a.m. and stated R5's fluid intake was not monitored by the facility, and there was no way to tell where R5 was in regards to fluid balance. On 10/20/17, at 9:59 a.m. the dialysis registered nurse manager was interviewed regarding R5's fluid intake and monitoring. The dialysis nurse manager stated R5's fluid restriction was 1000 cc of fluid daily, and R5 was fluid overloaded. The	F 309		

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F 309	Continued From page 55 dialysis nurse stated R5 was 8-12 kilograms over her dry weight, and was gaining large amounts of fluids between dialysis treatments (3-5 kg). The dialysis nurse stated she expected the facility to record and monitor R5's fluid intake so when R5 got close to daily total of fluid intake, R5 could be educated regarding the risks and benefits of non-compliance with fluid restrictions, and make choices after being provided the education. The dialysis nurse stated R5 could be non-compliant with the fluid restriction, however, in the last month R5 had been really trying to decrease fluid intake amounts. The dialysis registered nurse manager stated R5 had been hospitalized at least twice in the previous 6 months for fluid volume overload on 6/24/17, and 9/6/17. Review of R5's hospitalization records revealed R5 had been hospitalized with fluid overload twice in the last six months on 6/24/17, and 9/6/17. The Altru hospital dismissal summary dated 9/8/17, indicated R5 was admitted to the hospital on 9/6/17, with a diagnoses that included: fluid overload, chronic hypoxemic respiratory failure, and end stage renal failure. The dismissal summary indicated R5 had not been compliant with fluid intake restrictions, and required hospitalization where daily hemodialysis runs were implemented to remove the excess fluid. The dismissal summary indicated R5 had also been hospitalized on R5 discharged from Altru hospital on 9/8/17. The hospitalization records for R5's hospitalization 6/24/17- 6/28/17, were requested from the facility but not provided. Review of R5's dialysis run sheets from 10/1/17 -	F 309		

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F 309	Continued From page 56 10/16/17, revealed R5 was routinely 5-10 kg (11-22 pounds) over her target weight (dry weight), and had not reached her dry weight goal during any dialysis treatments in October 2017. The director of nursing (DON) was interviewed on 10/20/17, at 10:32 a.m. regarding R5's fluid restrictions during which she confirmed the facility was still not monitoring her fluid intake despite the fact R5 had been hospitalized for fluid overload on 4/4/14, and 9/6/17, and on 8/23/17, the dialysis unit asked the facility to monitor fluid intake. The DON stated R5 was non-compliant with fluid restrictions, however, she wanted to monitor her own fluid restrictions and intake. The DON confirmed a judge appointed R5 a guardian because 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. In addition, The DON did not respond when asked if R5 had the mental capacity to make responsible and reasonable decisions concerning medical care. R37 was at risk for impaired skin integrity complication and the facility failed to identify, report, and treat a current wound. R37's Diagnosis Report dated 10/20/17, included diagnoses of diabetes type II, complete traumatic right below the knee amputation, peripheral vascular disease, chronic multifocal osteomyelitis (infections of the bone), edema, hypertension, muscle weakness, and chronic kidney disease	F 309		

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F 309	Continued From page 57 (CKD) stage 3. R37's quarterly MDS dated 8/25/17, indicated R37 had no cognitive impairment and was independent with activities of daily living except he required supervision with eating. R37's cognition care plan last revised on 8/15/16, indicated R37 had cognitive loss/dementia or alteration in thought process evidenced by deficits in memory, judgement, and decision making. The CKD care plan revised on 8/17/16, directed staff to check body for breaks in skin and treat promptly as ordered by medical practitioner. The anticoagulant therapy care plan dated 11/1/16, directed daily skin inspections and to report abnormalities to the nurse/medical practitioner. The skin care plan dated 11/1/16, directed staff to use caution during bed mobility and transfers to prevent striking arms, legs, and hands against surfaces that may cause injury. R37's undated Nursing Assistant Care Plan indicated R37's bath day was on Mondays. R37's Comprehensive Skin Assessment dated 9/13/17, indicated R37's ability to walk was severely limited or non-existent or could not bear own weight and/or must be assisted in/out of chair or wheelchair. R37 had a potential problem with friction and shear injuries, his lower extremities showed signs and symptoms of peripheral vascular disease, and had loss of sensation to lower extremities. The assessment indicated staff would inspect skin daily.	F 309		

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F 309	Continued From page 58 R37's medical record did not reflect any current skin impairment or evidence of daily skin monitoring as directed by the care plan. On 10/18/17, at 7:54 a.m. R37 was observed seated in wheelchair, and the lower extremities were not covered. The right leg was amputated just below the knee and the left leg had a dime sized light yellow/reddish thin scab on the outside of the upper calf just below the knee. The skin around the wound was not red. Nursing assistant (NA)-D entered the room first and NA-E shortly after. The surveyor reported to both NAs and to R37 the wound on the outside of the leg. NAs were not previously aware of the wound. R37 stated he got the injury a week ago when he transferred into the wheelchair. The NAs failed to report the wound to the nurse, as directed. -at 12:58 p.m. NA-B stated the resident's skin was looked at during daily cares or with each resident contact and areas of concern were reported to the nurse as soon as possible. On 10/19/17, at 3:45 p.m. the assistant director of nursing (ADON) stated she was not informed of R37's left leg wound. The ADON assisted R37 in his wheelchair back to his room to assess the wound. The wound periphery was now red and the scab had changed to a darker red and appeared to be thicker. The ADON cleansed, measured, and dressed the wound. R37 stated he had received the wound over a week ago when he bumped it on his wheelchair when transferring. R37 stated he had not told anybody about the wound because he figured it would just heal. The ADON stated the NAs should have	F 309		

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

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F 309	Continued From page 59 reported the change in skin condition to the nurse. Following this assessment, a comprehensive skin assessment was completed for R37's wound. 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 dry with no drainage. Area measured 1.5 centimeters (cm) x 1.0 cm and surrounding skin 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 provided education 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	F 309		

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F 309	Continued From page 60 provide effective and person-centered care of the resident that meet professional standards of quality of care and the care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable, mental and psychosocial well-being. A skin care policy was requested and not received.	F 309		
F 329 SS=D	DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS CFR(s): 483.45(d)(e)(1)-(2) 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that--	F 329		11/29/17

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F 329	Continued From page 61 (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to obtain clear indication 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	F 329	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because provisions of state and federal law require it. Without waiving the foregoing statement, the facility states with respect to: 1. R35 had a care plan review with changes made for the medication Carbamazepine for resident behaviors along with interventions for behaviors. R35 has not had a history of seizures. Pharmacy consultants state that when Carbamazepine is being utilized for behaviors, checking routine levels isn't clinically indicated. R6 and R30 have had care plan reviews with updates to include target behavior/mood symptoms for psychotropic medications. R6 has been	

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F 329	Continued From page 62 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 physical behaviors and received antipsychotic, antidepressant, antianxiety and antibiotic medications. R35's Medication Review Report (MRR) dated 10/6/17, indicated R35 received carbamazepine 300 milligrams (mg) in the evening for seizures, start date 12/14/16. R35's Medication Administration Record (MAR) dated 10/17, indicated R35 received carbamazepine 300 milligrams in the evening for seizures. R35's October 2015, MAR from a previous facility where R35 had resided included carbamazepine 200 mg twice daily for behaviors. R35's care plan, print date 10/20/17, identified psychoactive medication use of Zyprexa, Risperdal, Celexa, Klonopin, and Buspar. The care plan failed to identify the use of seizure medication and had not identified interventions for either seizures or behaviors. On 10/2/17, at 9:05 a.m. the assistant director of nursing (ADON) stated staff should have identified the need for monitoring R35's use of carbamazepine. The ADON verified she was not aware of R35 exhibiting any seizure activity and	F 329	reviewed by consulting pharmacist for gradual dose reduction (GDR) of an antipsychotic on 11/13/17. 2. All residents will be reviewed through chart review for clear indication for medication use, to ensure that they are care planned appropriately along w/ being identified on the MDS, and that monitoring needs have been identified and implemented for effectiveness. All residents have been reviewed for target behaviors/mood symptoms with psychotropic medication use and GDR's. 3. Staff education will be completed by 11/29/17 regarding: the need to address the use of medications and if side effects or behaviors warrant monitoring, regarding target behavior/ mood monitoring with psychotropic medication use and; the process and need for GDR's. 4. Audits of care plans will be completed by DNS or designee with all new admissions and for any resident having medication order changes for the following 3 months to ensure that all medication would be identified properly on the MDS, care plan, and the monitoring needs identified and implemented. DNS or designee will complete audits on the completion of Monthly Behavior Reviews on all residents that have physician orders on 2 residents per week for 3 months, to ensure that proper care planning GDR's have been attempted, or that there is appropriate physician documentation to not attempt a GDR. The data collected will be reviewed at the Monthly QAPI and Quarterly QA meeting. At that time the committee will make the	

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F 329	Continued From page 63 stated R35's last carbamazepine laboratory test was conducted on 12/8/16, with results of 4.3 mg (therapeutic reference range is 4-12 mg.). The ADON stated she would expect the use of an anti-seizure medication be monitored and the care plan should have also reflected the use of the medication, the potential for seizures, monitoring needs, and identified interventions. The ADON stated the facilty had a change in their MDS staff and discovered there had been resident health care areas that had slipped through the cracks and not identified on the care plan. On 10/20/17, at 1:16 p.m. the director of nursing (DON) confirmed R35's use of anti-seizure medications should have been identified accurately on the MDS, care plan, and the monitoring needs identified and implemented. The DON stated they had identified resident care plans were seriously lacking identified residents' needs, which was going to be addressed. R6's medication regimen had not identified or analyzed target mood symptoms for antidepressant use and had not attempted tapering or had physician justification for ongoing use. In addition, had not attempted a dose reduction or had a physician justification for on going antipsychotic medication. R6's Diagnosis Report dated 10/20/17, included diagnoses of major depressive disorder, anxiety disorder, and schizoaffective disorder. R6's annual MDS dated 8/1/17, indicated R6 had moderate cognitive impairment, no signs and	F 329	decision/recommendation regarding any follow-up studies. Completion Date 11/29/17	

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F 329	Continued From page 64 symptoms of delirium, delusions, hallucinations, no depressive symptoms. The MDS also indicated R6 had problems with sleep, had verbal behaviors 1-3 days during the assessment period and received antipsychotic and antidepressant medications. R6's physician orders printed and provided by the facility on 10/20/17 included the following orders: -Latuda (atypical anti-antipsychotic medication used to treat bipolar depression) 80 mg in the evening for schizoaffective disorder. Start date of 7/26/16. -Lexapro (antidepressant medication) 15 mg in the morning for depression. Start date of 7/26/16. -Trazodone (antidepressant medication) 50 mg at bedtime for major depressive disorder. Start date 4/21/17. However, the medical record lacked any clear indication for adding an addition antidepressant medication and did not reflect a comprehensive assessment of depressive symptoms, efficacy of current medications at the time and any other episodes of anxiety/depression between 3/22/17, and 4/22/17. R6's care plan provided by the facility on 10/20/17, and last revised 11/14/16, indicated R6 received psychotropic medication related to schizoaffective disorder-bipolar type. Interventions directed staff to consult with pharmacy, medical practitioner to consider dose reduction when clinically appropriate, follow gradual dose reduction protocols, and develop a behavior management program with alternative to medication use. The plan also indicated R6 received antianxiety/antidepressant medications	F 329		

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F 329	Continued From page 65 related to anxiety and depression. Interventions directed to administer antianxiety medication as ordered, to attempt non-pharmacological interventions of redirection, diversion, have her go to her room away from other residents, and to observe the effectiveness of the interventions. However, the care plan failed to identify R6's individualized target mood symptoms of depression and or anxiety. R6's Mood and Behavior Evaluations dated 7/12/17, and 8/1/17, also lacked identified mood symptoms for antidepressant/antianxiety medications. Additionally, the behavior evaluation had not analyzed the target behaviors for antipsychotic use. Furthermore, the evaluation lacked an indication or rationale to continue the use of both antipsychotic and antidepressant medications. R6's Treatment Administration Records (TARS) were reviewed from January-March and June through October 2017 (April and May requested but not received). The TARs identified the target behavior of sexual/negative comments for the antipsychotic use. The only incident of sexual/negative comments identified in R6's record was documented on 9/24/17, when R6 made a sexually based comment while watching TV with a male resident. The TARs had not identified symptoms for antidepressant use. R6's mental health provider consult referral note dated 6/19/17, indicated R6 was excessively somnolent during the appointment and reported complaints of mild depression and occasional	F 329		

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anxiety and really wanted help with sleep more than anything. The physician identified the history of mental illness and R6 was unable to describe the history, and the history was more consistent with recurrent depression. The physician also indicated there was not enough history or quantifiable documentation of behaviors or mood symptoms to determine definitive diagnoses or recommend changes to medication dosages. The physician did not recommend any psychiatric medication changes and recommended no daytime napping.

R6's physician visit notes dated, 6/20/17, 7/12/17, and 9/12/17, indicated R6's depression, anxiety, and schizoaffective disorder were stable with no psychiatric medication changes. The physician notes lacked a reason or justification to continue the psychotropic medications at the same doses.

On 10/16/17, at 5:44 p.m. R6 was observed seated in her recliner in her room watching TV. R6 fell asleep multiple times during the resident interview and was difficult to keep awake. Her overall facial expressions were flat with little emotion in responses to questions.

On 10/18/17, at 7:12 a.m. R6 was observed awake sitting up in the recliner. R6 explained she occasionally felt down or depressed and she didn't feel like doing anything. She stated she sometimes felt anxious and overwhelmed and would report tightness in her chest, short of breath, and felt restless. R6 stated she didn't know what the staff did for her when she felt down, depressed, or anxious. However, R6

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F 329	Continued From page 67 stated she went to a psych doctor and thought that helped with her mood symptoms. R6 explained she often felt tired. On 10/20/17, at 9:04 a.m. R6 was observed sleeping in a chair in the main lobby area. At 12:58 p.m. NA-B stated R6's mood was down only every once in a while and seemed to act down when she didn't have anything to do. On 10/20/17, at 9:37 a.m. licensed practical nurse (LPN)-A stated R6 sometimes felt anxious and it varied, sometimes she was quiet and sometimes refused cares and when she got in those moods, she would holler at staff and use profanities directed at staff. LPN-A indicated staff provided one to one visits, and called her friend for her to talk to which perks her up. LPN-A thought the Trazodone was for sleep because R6 was up most of the night. On 10/18/17, at 1:57 p.m. licensed social worker (LSW) verified there were no target/mood symptoms identified for the use of the antidepressant/antianxiety medication however, a target behavior of sexual/negative comments had been identified for the antipsychotic medication. On 10/19/17, at 9:45 a.m. the assistant director of nursing (ADON) confirmed the facility did not have a process in place to ensure ongoing analysis and/or evaluation of psychotropic mediations. ADON also indicated target mood symptoms should be identified on the care plan, monitored, and evaluated for efficacy.	F 329		

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F 329	Continued From page 68 On 10/20/17, at 1:45 p.m. attempted to contact the consulting pharmacist (CP) for interview. On 10/23/17, at 1:35 p.m. CP returned the phone call and confirmed he had not recommended a dose reduction, had not looked for target behaviors, and expected the facility staff to identify target behaviors/mood symptoms, to monitor for effectiveness, and would also expect the target behaviors/mood symptoms to be identified on the care plan with corresponding interventions. R30's medication regimen had not identified or analyzed target mood symptoms for antidepressant use. R30's facility Face Sheet dated 10/20/17, included diagnoses of dementia without behavioral disturbance, anxiety disorder, and major depressive disorder. R30's annual MDS dated 8/4/17, indicated R30 had severe cognitive impairment and had verbal behaviors directed towards others one to three days during the assessment period and there had not been a change in behaviors since the previous assessment. The MDS identified depressive symptoms of difficulty with sleep and feeling tired or having little energy and trouble concentrating. R30's physician orders included Celexa 20 milligrams every morning for major depressive disorder with a start date of 5/22/17, and	F 329		

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F 329	Continued From page 69 mirtazapine 15 mg every bedtime for major depressive disorder (last dose change 4/11/17). R30's care plan printed and provided by the facility on 10/20/17, indicated antidepressant and antianxiety medication use related to depression, anxiety, and appetite stimulation. R30 had feelings of sadness, anxiety, and depression characterized by ineffective coping and fearfulness last revised on 12/21/16. The care plan directed staff to attempt non-pharmacological interventions and observe for effectiveness, provide nourishment, essential oil message, diversion, word finds, liked to look at newspapers, and to bring to a quiet area at night if anxious in room. The plan also directed staff to consult with pharmacy/medical practitioner to consider dosage reductions when clinically appropriate, observe/document side effects and effectiveness, and do not just take to room and get ready for bed as this would cause anxiety. R30's physician orders dated 12/29/16, and TAR indicated target behaviors for anxiety were restless, crawling out of bed and directed staff to bring R30 to a quiet area and offer nourishment. The physician orders also directed staff to document the effectiveness of the medication used. The physician's orders did not identify target mood symptoms for depression. The TARs were reviewed for the last three months and revealed one documented episode on 9/1/17, when R30 was restless and crawling out of bed on 9/1/17. R30's progress nursing progress notes were	F 329		

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F 329	Continued From page 70 reviewed from 7/17/17, through 10/16/17, and identified behavior and mood symptoms which included refusals of medication, cares and meals, agitation, resistive to cares, and hitting out at staff. However, these symptoms were not identified on the care plan. R30's Mood and Behavior Evaluation dated 8/4/17, lacked identified mood symptoms for antidepressant/antianxiety medication. Review of R30's physician visit notes from 6/20/17, through 7/11/17, indicated depression and anxiety were stable. On 10/16/17, at 5:13 a.m. R30 was observed calmly lying in bed awake. R30's mood was pleasant, she smiled and was unable to articulate words including her name. At 6:20 p.m. the DON stated R30 had refused dinner and explained once R30 refused, staff did not persist because R30 would become very easily agitated if asked too many questions. On 10/17/17, at 9:18 a.m. R30 was observed seated in the lobby area in her pajamas. R30 was calm and looking around. When questioned, R30 only smiled without verbally responding. On 10/18/17, at 7:10 a.m. R30 was observed resting in bed with her eyes closed. -At 7:53 a.m. R30's remained in bed, calmly awake. -At 8:24 a.m. NA-A entered the room and assisted R30 with morning cares. NA-A gave	F 329		

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F 329	Continued From page 71 verbal cues during the cares, which R30 was calm, cooperative, and followed cues without evidence of any behavioral or mood symptoms. NA-A explained R30 did better with older NA's and if she did not like someone she would wave them away. NA-A stated R30's behaviors included pushing staff away, refusing care and her behaviors were sporadic and usually did not have a problem with redirection. NA-A stated staff would use interventions such as toileting, offer something to eat, and/or re-approaching at a later time. On 10/20/17, at 9:31 a.m. NA-C reported R30 liked to hit, pinch, scratch, and refuse meals. NA-C stated interventions included getting a different staff member, getting more help, re-approaching at a later time, and nails were kept short. -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. -At 12:58 a.m. NA-B explained R30 had behaviors once in a while when she was mad, angry, or tired which was was displayed by her facial expressions. NA-B stated R30 would tap on the NA's or shake her fist when she did not like something and staff were to stop what they were doing and help her calm down by sitting with her and telling her what you are doing step by step or attempt to try again later.	F 329		

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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 policy Mood and Behavior Documentation Guidelines last revised 11/16, 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 completed for all residents on admission, quarterly, annually, with significant change in status and prior to the use of, and/or dose change

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F 329	Continued From page 73 of psychoactive medication to evaluate the need for the medication and determine target behavior related to the use of the medication. The policy indicated the evaluation included assessment, appropriate use of medications, and documentation of dose reductions or provides rationale for continued use of medication regimen -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 329		
F 428 SS=D	DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON CFR(s): 483.45(c)(1)(3)-(5) c) Drug Regimen Review (1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. (3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. (4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph	F 428		11/29/17

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F 428	Continued From page 74 (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. (5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the consultant pharmacist identified the lack of target behaviors/mood symptoms for the use of psychotropic medications for 2 of 5 residents (R6, R30) and failed to identify the lack of a required gradual dose reduction/dose taper and/or lack of a physician justification for not attempting a dose reduction for 1 of 5 residents (R6) reviewed for unnecessary medications.	F 428	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because provisions of state and federal law require it. Without waiving the foregoing statement, the facility states with respect to:	

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F 428	Continued From page 75 Findings include; R6's medication regimen had not identified or analyzed target mood symptoms for antidepressant use and had not attempted tapering or had physician justification for ongoing use. In addition, had not attempted a dose reduction or had a physician justification for on going antipsychotic medication. R6's Diagnosis Report dated 10/20/17, included diagnoses of major depressive disorder, anxiety disorder, and schizoaffective disorder. R6's annual MDS dated 8/1/17, indicated R6 had moderate cognitive impairment, no signs and symptoms of delirium, delusions, hallucinations, no depressive symptoms. The MDS also indicated R6 had problems with sleep, had verbal behaviors 1-3 days during the assessment period and received antipsychotic and antidepressant medications. R6's physician orders printed and provided by the facility on 10/20/17 included the following orders: -Latuda (atypical anti-antipsychotic medication used to treat bipolar depression) 80 mg in the evening for schizoaffective disorder. Start date of 7/26/16. -Lexapro (antidepressant medication) 15 mg in the morning for depression. Start date of 7/26/16. -Trazodone (antidepressant medication) 50 mg at bedtime for major depressive disorder. Start date 4/21/17. However, the medical record lacked any	F 428	1. R6 and R30 have had consulting pharmacist reviews regarding psychotropic medications. R6's care plan has been reviewed with individualized target mood symptoms of depression /anxiety have been added. 2. All residents have been reviewed for GDR's w/ regards to psychotropic medication and care plans have been audited for appropriate target mood symptoms/behaviors. 3. Staff education will be completed by 11/29/17 regarding the Monthly Mood and Behavior Program. 4. DNS or designee will complete audits on the completion of Monthly Behavior Reviews on all residents that have physician orders on 2 residents per week for 3 months, to ensure that proper care planning GDR's have been attempted, or that there is appropriate physician documentation to not attempt a GDR. The data collected will be reviewed at the Monthly QAPI and Quarterly QA meeting. At that time the committee will make the decision/recommendation regarding any follow-up studies. Completion date 11/29/17	

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F 428	Continued From page 76 clear indication for adding an addition antidepressant medication and did not reflect a comprehensive assessment of depressive symptoms, efficacy of current medications at the time and any other episodes of anxiety/depression between 3/22/17, and 4/22/17. R6's care plan provided by the facility on 10/20/17, and last revised 11/14/16, indicated R6 received psychotropic medication related to schizoaffective disorder-bipolar type. Interventions directed staff to consult with pharmacy, medical practitioner to consider dose reduction when clinically appropriate, follow gradual dose reduction protocols, and develop a behavior management program with alternative to medication use. The plan also indicated R6 received antianxiety/antidepressant medications related to anxiety and depression. Interventions directed to administer antianxiety medication as ordered, to attempt non-pharmacological interventions of redirection, diversion, have her go to her room away from other residents, and to observe the effectiveness of the interventions. However, the care plan failed to identify R6's individualized target mood symptoms of depression and or anxiety. R6's Mood and Behavior Evaluations dated 7/12/17, and 8/1/17, also lacked identified mood symptoms for antidepressant/antianxiety medications. Additionally, the behavior evaluation had not analyzed the target behaviors for antipsychotic use. Furthermore, the evaluation lacked an indication or rationale to continue the use of both antipsychotic and antidepressant medications.	F 428		

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R6's Treatment Administration Records (TARS) were reviewed from January-March and June through October 2017 (April and May requested but not received). The TARs identified the target behavior of sexual/negative comments for the antipsychotic use. The only incident of sexual/negative comments identified in R6's record was documented on 9/24/17, when R6 made a sexually based comment while watching TV with a male resident. The TARs had not identified symptoms for antidepressant use.

R6's mental health provider consult referral note dated 6/19/17, indicated R6 was excessively somnolent during the appointment and reported complaints of mild depression and occasional anxiety and really wanted help with sleep more than anything. The physician identified the history of mental illness and R6 was unable to describe the history, and the history was more consistent with recurrent depression. The physician also indicated there was not enough history or quantifiable documentation of behaviors or mood symptoms to determine definitive diagnoses or recommend changes to medication dosages. The physician did not recommend any psychiatric medication changes and recommended no daytime napping.

R6's physician visit notes dated, 6/20/17, 7/12/17, and 9/12/17, indicated R6's depression, anxiety, and schizoaffective disorder were stable with no psychiatric medication changes. The physician notes lacked a reason or justification to continue the psychotropic medications at the same doses.

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F 428	Continued From page 78	F 428		

R6's Pharmacist Medication Reviews from February through October 2017, were reviewed and revealed the consulting pharmacist had not identified the lack of target behaviors/mood symptoms or recommended a gradual dose reduction for the antipsychotic medication or a dose taper for the antidepressant medications.

On 10/16/17, at 5:44 p.m. R6 was observed seated in her recliner in her room watching TV. R6 fell asleep multiple times during the resident interview and was difficult to keep awake. Her overall facial expressions were flat with little emotion in responses to questions.

On 10/18/17, at 7:12 a.m. R6 was observed awake sitting up in the recliner. R6 explained she occasionally felt down or depressed and she didn't feel like doing anything. She stated she sometimes felt anxious and overwhelmed and would report tightness in her chest, short of breath, and felt restless. R6 stated she didn't know what the staff did for her when she felt down, depressed, or anxious. However, R6 stated she went to a psych doctor and thought that helped with her mood symptoms. R6 explained she often felt tired.

On 10/20/17, at 9:04 a.m. R6 was observed sleeping in a chair in the main lobby area. At 12:58 p.m. NA-B stated R6's mood was down only every once in a while and seemed to act down when she didn't have anything to do.

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F 428	Continued From page 79 On 10/20/17, at 9:37 a.m. licensed practical nurse (LPN)-A stated R6 sometimes felt anxious and it varied, sometimes she was quiet and sometimes refused cares and when she got in those moods, she would holler at staff and use profanities directed at staff. LPN-A indicated staff provided one to one visits, and called her friend for her to talk to which perks her up. LPN-A thought the Trazodone was for sleep because R6 was up most of the night. On 10/18/17, at 1:57 p.m. licensed social worker (LSW) verified there were no target/mood symptoms identified for the use of the antidepressant/antianxiety medication however, a target behavior of sexual/negative comments had been identified for the antipsychotic medication. On 10/19/17, at 9:45 a.m. the assistant director of nursing (ADON) confirmed the facility did not have a process in place to ensure ongoing analysis and/or evaluation of psychotropic mediations. ADON also indicated target mood symptoms should be identified on the care plan, monitored, and evaluated for efficacy. On 10/20/17, at 1:45 p.m. attempted to contact the consulting pharmacist (CP) for interview. On 10/23/17, at 1:35 p.m. CP returned the phone call and confirmed he had not recommended a dose reduction, had not looked for target behaviors, and expected the facility staff to identify target behaviors/mood symptoms, to monitor for effectiveness, and would also expect the target behaviors/mood symptoms to be identified on the	F 428		

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F 428	Continued From page 80 care plan with corresponding interventions. R30's medication regimen had not identified or analyzed target mood symptoms for antidepressant use. R30's facility Face Sheet dated 10/20/17, included diagnoses of dementia without behavioral disturbance, anxiety disorder, and major depressive disorder. R30's annual MDS dated 8/4/17, indicated R30 had severe cognitive impairment and had verbal behaviors directed towards others one to three days during the assessment period and there had not been a change in behaviors since the previous assessment. The MDS identified depressive symptoms of difficulty with sleep and feeling tired or having little energy and trouble concentrating. R30's physician orders included Celexa 20 milligrams every morning for major depressive disorder with a start date of 5/22/17, and mirtazapine 15 mg every bedtime for major depressive disorder (last dose change 4/11/17). R30's care plan printed and provided by the facility on 10/20/17, indicated antidepressant and antianxiety medication use related to depression, anxiety, and appetite stimulation. R30 had feelings of sadness, anxiety, and depression characterized by ineffective coping and fearfulness last revised on 12/21/16. The care	F 428		

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F 428	Continued From page 81 plan directed staff to attempt non-pharmacological interventions and observe for effectiveness, provide nourishment, essential oil message, diversion, word finds, liked to look at newspapers, and to bring to a quiet area at night if anxious in room. The plan also directed staff to consult with pharmacy/medical practitioner to consider dosage reductions when clinically appropriate, observe/document side effects and effectiveness, and do not just take to room and get ready for bed as this would cause anxiety. R30's physician orders dated 12/29/16, and TAR indicated target behaviors for anxiety were restless, crawling out of bed and directed staff to bring R30 to a quiet area and offer nourishment. The physician orders also directed staff to document the effectiveness of the medication used. The physician's orders did not identify target mood symptoms for depression. The TARs were reviewed for the last three months and revealed one documented episode on 9/1/17, when R30 was restless and crawling out of bed on 9/1/17. R30's progress nursing progress notes were reviewed from 7/17/17, through 10/16/17, and identified behavior and mood symptoms which included refusals of medication, cares and meals, agitation, resistive to cares, and hitting out at staff. However, these symptoms were not identified on the care plan. R30's Mood and Behavior Evaluation dated 8/4/17, lacked identified mood symptoms for antidepressant/antianxiety medication.	F 428		

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Review of R30's physician visit notes from 6/20/17, through 7/11/17, indicated depression and anxiety were stable.

R30's Pharmacist Medication Reviews from February through October 2017, were reviewed; the consulting pharmacist had not identified the lack of target behaviors/mood symptoms.

On 10/16/17, at 5:13 a.m. R30 was observed calmly lying in bed awake. R30's mood was pleasant, she smiled and was unable to articulate words including her name. At 6:20 p.m. the DON stated R30 had refused dinner and explained once R30 refused, staff did not persist because R30 would become very easily agitated if asked too many questions.

On 10/17/17, at 9:18 a.m. R30 was observed seated in the lobby area in her pajamas. R30 was calm and looking around. When questioned, R30 only smiled without verbally responding.

On 10/18/17, at 7:10 a.m. R30 was observed resting in bed with her eyes closed.
-At 7:53 a.m. R30's remained in bed, calmly awake.
-At 8:24 a.m. NA-A entered the room and assisted R30 with morning cares. NA-A gave verbal cues during the cares, which R30 was calm, cooperative, and followed cues without evidence of any behavioral or mood symptoms. NA-A explained R30 did better with older NA's

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F 428	Continued From page 83 and if she did not like someone she would wave them away. NA-A stated R30's behaviors included pushing staff away, refusing care and her behaviors were sporadic and usually did not have a problem with redirection. NA-A stated staff would use interventions such as toileting, offer something to eat, and/or re-approaching at a later time. On 10/20/17, at 9:31 a.m. NA-C reported R30 liked to hit, pinch, scratch, and refuse meals. NA-C stated interventions included getting a different staff member, getting more help, re-approaching at a later time, and nails were kept short. -At 9:37 a.m. 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. -At 12:58 a.m. NA-B explained R30 had behaviors once in a while when she was mad, angry, or tired which was was displayed by her facial expressions. NA-B stated R30 would tap on the NA's or shake her fist when she did not like something and staff were to stop what they were doing and help her calm down by sitting with her and telling her what you are doing step by step or attempt to try again later. On 10/19/17, at 9:45 a.m. the ADON verified there was no evaluation of R30's behaviors or	F 428		

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F 428	Continued From page 84 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. On 10/20/17, at 1:45 p.m. attempted to contact the consulting pharmacist (CP) for interview. On 10/23/17, at 1:35 p.m. CP returned the phone call and confirmed he had not looked for target behaviors, and expected the facility staff to identify target behaviors/mood symptoms, to monitor for effectiveness, and would also expect the target behaviors/mood symptoms to be identified on the care plan with corresponding interventions. 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 policy Mood and Behavior Documentation Guidelines last revised 11/16 included: - 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	F 428		

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F 428	Continued From page 85 utilized to meet the needs of the resident. -Efforts to reduce dosage or discontinue psychopharmacological medications will be ongoing for the clinical situation. -A mood and behavior evaluation will be completed for all residents on admission, quarterly, annually, with significant change in status and prior to the use of, and/or dose change of psychoactive medication to evaluate the need for the medication and determine target behavior related tot he use of the medication. The policy indicated the evaluation includes, assessment, appropriate use of medications, and documentation of dose reductions or provides rationale for continued use of medication regimen -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 SS=F	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);	F 441		11/29/17

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 86 (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245468	A. BUILDING _____ B. WING _____	10/20/2017

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F 441	Continued From page 87 actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to develop an ongoing surveillance program to analyze patterns and trends of resident infections not treated with an antibiotic. This had the potential to affect all 36 residents residing in the facility. Findings include: On 10/19/17, at 1:10 p.m. the facility infection control logs were reviewed with the director of nursing (DON). The logs were a tracking form which identified the date symptoms were identified, name of the resident, room number in which the resident resided, if the identified symptoms were new or ongoing, type of infection, if a culture was completed, the name of the organisms, and the type of antibiotic or treatment prescribed by the physician. However, the logs did not contain the tracking or trending of any illnesses which were not being treated with an antibiotic. On 10/19/17, at 1:30 p.m. the DON, also the infection control preventionist, confirmed only	F 441	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because provisions of state and federal law require it. Without waiving the foregoing statement, the facility states with respect to: 1. All illnesses which are/are not being treated by antibiotics are being tracked and reviewed for any trending. 2. DNS or designee will daily review all physician orders and the 24 hour report sheet for residents exhibiting signs or symptoms of illness. Any illness will be logged onto a spread sheet to analyze for trending. 3. Staff education has been completed prior to 11/29/17 with regards to the need for accurate and concise documentation of resident symptoms and disease prevention. 4. DNS or designee will complete audits of the 24 hour report for accuracy of	

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F 441	Continued From page 88 infections with prescribed antibiotics were tracked. She stated the facilty had not established a system to track infections which were not treated with antibiotics and verified the facility failed to follow their surveillance policy. The facility's Surveillance policy, revised 11/16, indicated surveillance was implemented to identify and report evidence of infection. Collecting, documenting, and analyzing data would be done by the infection preventionist or designated staff member.	F 441	resident symptoms of illness 4x per week x1 month, then weekly x2 months. The data collected will be reviewed at the Monthly QAPI and Quarterly QA meeting. At that time the committee will make the decision/recommendation regarding any follow-up studies. Completion Date: 11/29/17	

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	245468	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/17/2017**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey Karlstad Healthcare Center 01 Main Building was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of the Health Care Facilities Code (NFPA 99). PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or	K 000	EPOC	

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

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K 000	Continued From page 1	K 000		

By e-mail to:
Marian.Whitney@state.mn.us
and
Angela.kappenman@state.mn.us

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A description of what has been, or will be, done to correct the deficiency.

2. The actual, or proposed, completion date.

3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.

Karlstad Healthcare Center is a 1-story building without a basement and constructed at 2 different times. The original building was constructed in 1974, was determined to be of Type II(222) construction. In 1983 an addition was constructed south of the original building, which was determined to be of Type II (000) construction and is not separated from the original building with a 2-hour fire barrier so the construction type is Type II (000). Attached to the original building at the south west corner and separated with a 2-hour fire barrier is a connecting link to an assisted living building.

The entire building is protected with an automatic fire sprinkler system installed in accordance with NFPA 13 Standard for the Installation of Automatic Sprinkler Systems. The facility has a fire alarm system with smoke detection at the

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K 000	Continued From page 2 smoke barrier doors and in the corridor system with extended spacing, installed in accordance with NFPA 72 "The National Fire Alarm Code" . The fire alarm system is monitored for automatic fire department notification. Hazardous areas have either heat detection or smoke detection that are on the fire alarm system. The facility is divided into 4 smoke zones with at least 30 minute fire barriers. The facility has a capacity of 46 beds and had a census of 36at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 321 SS=E	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure 2012 EXISTING Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4-hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms	K 321		12/10/17

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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 (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to maintain a hazardous storage room in accordance with the 2012 Life Safety Code (NFPA 101) section 19.3.2.1.3. This deficient condition could allow smoke or fire to enter the corridor making it untenable and affect the quick and efficient exiting for 8 of the 36 residents and an undetermined amount of staff and visitors. Findings include: At 10:50 am on 10/17/2017 observations revealed the oxygen storage room inside the clean utility room of the Heritage wing did not have a self closing door and did not have the proper signage and the maintenance room across from the boiler room contained combustible storage and did not have a self closing door. This deficient condition was confirmed by the Facility Administrator and the Environmental Services Supervisor.	K 321	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because provisions of state and federal law require it. Without waiving the foregoing statement, the facility states with respect to: 1. A door closer has been installed to the maintenance room door across from the boiler room and to the door of the oxygen storage room inside of clean utility room on Heritage wing. Proper signage has also been added to the oxygen storage room inside of clean utility room on Heritage wing in accordance with NFPA 101. 2. Completion date: 12/10/2017 3. Maintenance Director	
K 351 SS=D	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING	K 351		10/27/17

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K 351	Continued From page 4 Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to install sprinkler heads in accordance with the 2012 edition of the Life Safety Code (NFPA 101) sections 19.3.5.1, 9.7.1.1 and the 2010 edition of NFPA 13, The Standard for the Installation of Sprinkler Systems. This deficient practice could cause a delay in extinguishing a fire affecting the safety of 8 of the 36 residents and an undetermined amount of staff and visitors. Findings include: At 10:30 am on 10/17/2017 observations revealed the electrical room in Heritage lane did not have complete sprinkler coverage. This deficient condition was confirmed by the Facility Administrator and the Environmental Services Supervisor.	K 351	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because provisions of state and federal law require it. Without waiving the foregoing statement, the facility states with respect to: 1. Electrical Room in Heritage Lane has been reviewed by a licensed contractor and a sprinkler head added according to manufacturer and NFPA regulations. 2. Completion date: 10/27/2017 3. Maintenance Director. Contractor will annually audit system for compliance.	

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K 353	Continued From page 5	K 353		
K 353 SS=F	**NFPA 101 Sprinkler System - Maintenance and Testing** 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 system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to test and maintain the sprinkler system in accordance with the 2012 Life Safety Code (NFPA 101) and NFPA 25 section 5.2.1.1.2. The standard for testing and maintenance of sprinkler systems. This deficient condition could cause the sprinkler system not to function properly and allow for the spread of fire. This could affect all of the 36 residents and an undetermined amount of staff and visitors. Findings include: At 10:32 am on 10/17/2017 observations revealed the sprinkler heads in the kitchen contained a heavy layer of dust and dirt.	K 353	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because provisions of state and federal law require it. Without waiving the foregoing statement, the facility states with respect to: 1. All sprinkler heads in kitchen cleaned from dust and dirt. 2. Completion date: 10/11/2017	10/17/17

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K 353	Continued From page 6 This deficient condition was confirmed by the Facility Administrator and the Environmental Services Supervisor.	K 353	3. Maintenance Director will complete monthly inspections on all sprinkler heads in accordance with our preventative maintenance program.	
K 372 SS=E	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to maintain two of four smoke barriers as required by the 2012 Life Safety Code (NFPA 101) section 19.3.7.3, 8.8.7.1 (1). This deficient practice could allow smoke to transfer from one smoke compartment to another affecting the exiting of 18 of the 36 residents and an undetermined amount of staff and visitors. Findings include: During the facility tour on 10/17/17 observations	K 372	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because provisions of state and federal law require it. Without waiving the foregoing statement, the facility states with respect to:	12/10/17

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K 372	Continued From page 7 revealed penetrations in 2 smoke barriers in the following locations. 1. At 10:00 am in the wilderness wing above the cross corridor doors an annular space around a cable. 2. At 10:10 am in the Heritage wing above the cross corridor doors the top of the 3" pipes. 3. At 10:15 am in the Heritage wing opposite side of the pipe penetrations is a hole about the size of a golf ball. This deficient condition was confirmed by the Facility Administrator and the Environmental Services Supervisor.	K 372	1. All penetrations in smoke barriers have been filled with fire barrier sealant per NFPA guidelines. 2. Completion date: 12/10/2017 3. Maintenance Director	
K 918 SS=F	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder	K 918		12/10/17

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K 918	Continued From page 8 circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked and readily identifiable. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This STANDARD is not met as evidenced by: Based on record review and staff interview the facility failed to provide test documentation in accordance with the 2012 edition of the Life Safety Code (NFPA 101) section 9.1.3.1 and the 2010 edition of NFPA 110 the Standard for Emergency and Standby Power Systems. This deficient practice could affect the safety of all of the 46 residents if the generator failed to operate during a power outage. Findings include: At 9:15 am on 10/17/2017 record review revealed the generator reports did not show the tests were being conducted weekly and monthly as required. This deficient condition was confirmed by the Facility Administrator and the Environmental Services Supervisor	K 918	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because provisions of state and federal law require it. Without waiving the foregoing statement, the facility states with respect to: 1. Generator tests will be conducted and documented timely per NFPA guidelines. 2. Completion date: 12/10/2017 3. Maintenance Director and Administrator will meet monthly to ensure all Life Safety Code Regulations are being met.	