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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: TBD1

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 **03/07/2017** (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:

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):

17. SURVEYOR SIGNATURE Date :
Lyla Burkman, Unit Supervisor 04/10/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Shellae Dietrich, Certification Specialist 07/24/2017 (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
03/10/2017
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245468

May 1, 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 February 23, 2017 the above facility is certified for:

46 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 46 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
April 10, 2017

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

RE: Project Number S5468027

Dear Mr. Ahlf:

On January 31, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on January 20, 2017. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On March 7, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on February 24, 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 January 20, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of February 23, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on January 20, 2017, effective February 23, 2017 and therefore remedies outlined in our letter to you dated January 31, 2017, will not be imposed.

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

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

cc: Licensing and Certification File

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
245468		3/7/2017

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
KARLSTAD HEALTHCARE CENTER INC	304 WASHINGTON AVENUE WEST KARLSTAD, MN 56732

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0315 Reg. # 483.25(e)(1)-(3) LSC	Correction Completed 02/23/2017	ID Prefix F0465 Reg. # 483.90(i)(5) LSC	Correction Completed 02/23/2017	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
1/20/2017	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245468 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	2/24/2017 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
KARLSTAD HEALTHCARE CENTER INC	304 WASHINGTON AVENUE WEST KARLSTAD, MN 56732

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0321	02/23/2017	LSC K0347	02/23/2017	LSC K0351	02/23/2017
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0353	02/23/2017	LSC K0363	02/23/2017	LSC K0372	02/23/2017
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. #	Completed
LSC K0712	02/23/2017	LSC K0918	02/23/2017	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☒	LB/mm	04/10/2017	28035	02/24/2017
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
1/19/2017

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: TBD1

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 **01/20/2017** (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

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):

17. SURVEYOR SIGNATURE — Date :
Theresa Gullingsrud HFE NEII — 02/09/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath Program Representative — 03/09/2017 (L20)

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

19. DETERMINATION OF ELIGIBILITY
_____ 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

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
January 31, 2017

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

RE: Project Number S5468027

Dear Mr. Ahlf:

On January 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.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

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

Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

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

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 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

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by March 1, 2017, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by March 1, 2017 the following remedy will be imposed:

- Per instance civil money penalty. (42 CFR 488.430 through 488.444)

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 remedies be imposed:

• Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

• Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC 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. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved 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.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by April 20, 2017 (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 July 20, 2017 (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.

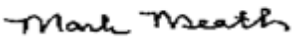
Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions related to this eNotice.

Sincerely,



Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

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 _____	01/20/2017

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 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 315 SS=D	483.25(e)(1)-(3) NO CATHETER, PREVENT UTI, RESTORE BLADDER (e) Incontinence. (1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. (2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition	F 315		2/23/17

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

Electronically Signed | 02/09/2017

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.

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 _____	01/20/2017

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F 315	Continued From page 1 demonstrates that catheterization is necessary and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. (3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure medical justification for the ongoing use of an indwelling Foley catheter was identified for 1 of 2 residents (R16) observed for urinary catheter use. Findings include: R16's quarterly Minimum Data Set (MDS) dated 10/13/16, indicated R16 had severe cognitive impairment and diagnoses which included retention of urine, chronic kidney disease, and benign prostatic hyperplasia with lower urinary tract symptoms. The MDS also indicated R16 had an indwelling catheter, required extensive assist of 1 for toilet use and personal hygiene and required supervision for bed mobility, transfer and ambulation. The Urinary Incontinence/Indwelling Catheter Care Area Assessment (CAA) dated 4/12/16, indicated R16 required assist of one staff for catheter cares and emptying his leg bag. Staff	F 315	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. DNS has reviewed resident #16□s chart to assure they are medically necessary and will work with the primary physician to ensure documentation of rationale for catheter use. 2. All residents in house with indwelling catheters will be reviewed for proper documentation of rationale for catheter use. 3. Staff education will be completed no	

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F 315	Continued From page 2 were to assist with peri cares at least twice daily and after any bowel movements. Staff were to monitor urinary output every shift and notify the physician if any concerns with output or with the catheter. R16's current physician orders signed 12/20/16, indicated an order for the indwelling catheter, however, lacked indication for the use of the catheter. On 1/18/16 at 4:50 p.m. R16 was observed resting on his bed on his left side. A urinary leg bag was observed attached just above R16's left ankle. R16's physician notes from 4/27/16 to 12/1/16 were reviewed and lacked documentation of rationale for the ongoing use of the indwelling catheter. A Fax dated 9/7/16, indicated the following concern was sent to the physician: R16 has a diagnosis of urinary retention. We are wondering if a diagnosis of neurogenic bladder with urinary retention would be appropriate. The physician response dated 9/7/16, indicated: I checked his hospital records and just see BPH [benign prostatic hypertrophy]/urinary retention so from what I see, can't diagnose neurogenic bladder. On 1/20/17, at 8:31 a.m. registered nurse (RN)-A stated R16 was admitted to the facility with the indwelling catheter. RN-A stated she didn't think they had ever tried to discontinue the catheter and didn't believe R16 had ever been seen by a urologist. RN-A also stated she was under the impression the diagnosis of urinary retention with BPH was an adequate indication for ongoing use	F 315	later than 2/10/17 with regards to medically necessary diagnosis and documentation needed for indwelling catheter appropriateness. 4. The DNS and/or her designee will audit any new resident/ admission w/ orders for an indwelling catheter through 3/31/17 and will report findings monthly to the monthly QAPI/ Quality Assurance Committee. At that point, the committee will make the decision/recommendation regarding any necessary follow-up studies.	

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F 315	Continued From page 3 of the catheter. As a result, nothing else had been pursued. On 1/20/17, at 9:06 a.m. the assistant director of nursing (ADON) confirmed the facility had not attempted a trial discontinuation of the catheter nor had R16 seen a urologist. The ADON stated she was under the impression that urinary retention with BPH was an adequate indication for ongoing usage of the catheter. The ADON confirmed the record lacked further documentation of an indication for its use. A policy regarding indwelling catheter usage was requested but none was provided.	F 315		
F 465 SS=E	483.90(h)(5) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON (h) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. (h)(5) Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also take into account non-smoking residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain floors in a clean and sanitary condition in the kitchen and for 8 of 8 resident rooms (103, 104, 111, 116, 117, 118, 121, 139) and failed to maintain bathroom	F 465	1. Floors in the kitchen, resident rooms (103,104,111,116, 117, 118, 121, 139), bathroom vents in rooms (119, 125) have been cleaned. Walls/Floors in laundry room and walls, floors, and window	2/23/17

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F 465	Continued From page 4 vents in a clean and sanitary condition for 2 of 2 rooms (119, 125). In addition, the facility failed to maintain walls, floors and windows in good repair in the laundry room and Heritage dining room. This had the potential to affect all 40 residents, staff and visitors of the facility. Findings include: The facility environment was observed on 1/19/17, at 8:25 a.m. during an initial tour and on 1/20/17, at 8:23 a.m. on tour with the administrator. The following environmental issues were noted and verified by the facility administrator: -Floors in resident rooms were not clean, black ground in dirt, around the outer perimeter of the floor, by the closet doors and dust/debris was observed on the floor in rooms- 103, 104, 111, 116, 117, 118, 121, 139. - On 1/18/17, at 5:50 p.m. family member (FM)-A stated the housekeeping was "not the best", my mother's room did not look clean, the floors were not clean. - On 1/19/17, at 3:26 p.m. FM-B stated the floor in my mom's room did not get cleaned very well. FM-B stated tissues were observed under her bed, "we watched and the tissues remained there for three weeks." The facility "could do a better job" cleaning the rooms. - Bathroom vents were observed to be covered with thick gray dust in rooms 119 and 125. -Kitchen floors were observed to have black/grimy ground in dirt at the base of storage	F 465	Heritage Dining room have been repaired or have had parts ordered for repair. 2. Floors and bathroom vents have been cleaned in all resident rooms. The facility housekeeping and maintenance responsibility policy and procedure have been reviewed and necessary staff educated. 3. Staff education will be done by 2/17/17 for proper notification of items that need repair/replacement. 4. Maintenance Director or Designee will audit environmental cleanliness in the building weekly for 1 month then biweekly for 2 months then monthly for one year. All results will be reported to the QA Committee for review and or recommendation.	

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F 465	Continued From page 5 cabinets, convection oven, clean dish area, cook stove/range, clean food storage shelves, food prep counters, and around the outer perimeter of the kitchen floor. -On 1/20/17 at 8:16 a.m. the dietary manager (DM) verified the floors were very bad, they were not clean, they needed a deep cleaning. The DM stated maintenance was responsible for deep cleaning the floors. - The laundry room corner wall was missing a corner protector and sheet rock was exposed on both sides of the wall. Sheet rock chunks were missing. At the entrance to the laundry room near the wash sink area there were 4 floor tiles partially or fully broken and chipped out of the floor. - On 1/20/17, at 8:30 a.m. the laundry aide stated the tiles have been missing for about a year when they took out a hot water heater that was positioned there. The other tiles in the laundry room were stained with an orange/rusty color. - In the Heritage dining room, one of the upper windows on the main wall was cracked. On 1/20/17, at 8:23 a.m. during the environmental tour, the administrator confirmed the above findings and stated they required cleaning. In addition, he stated the window in the dining room required repair. The administrator stated he was unaware of the broken window. The administrator verified they have not had a maintenance person for about 6 weeks and were in the process of hiring one. The administrator verified the maintenance person would be responsible for maintaining the above mentioned areas. The	F 465		

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F 465	Continued From page 6 administrator stated we do have two individuals who were available to come to the facility to provide maintenance services. The undated facility policy and procedure Housekeeping and Maintenance Department Responsibility, indicated the facility would provide a clean, safe and sanitary environment for residents, and provide rigorous daily cleaning of all horizontal surfaces in the building and other areas that need to be cleaned.	F 465		

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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
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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 separated with at least a 2-hour fire barrier from the original building. Attached to the original building at the south west corner and separated with a 2-hour fire barrier is a connecting link to an 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 smoke barrier doors and in the corridor system

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K 000	Continued From page 2 with extended spacing, installed in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition. 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 40 at 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 b. Laundries (larger than 100 square feet)	K 321		2/23/17

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K 321	Continued From page 3 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 one hazardous storage room and one combustible 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 11 of the 46 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:00 am to 12:00 pm on 01/19/2017 observations and staff interview revealed the soiled utility room across from resident room 109 was deteriorated and no longer smoke resistant and the record room (combustible storage) across from the Admin office did not have a closer. 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. Door to soiled utility room across from room 101 has been repaired to meet standards and a closer on the record storage room has been installed. 2. Completion date: 2/23/17 3. Maintenance Director will perform regular checks in accordance with preventative maintenance program.	
K 347 SS=E	NFPA 101 Smoke Detection Smoke Detection 2012 EXISTING Smoke detection systems are provided in spaces open to corridors as required by 19.3.6.1.	K 347		2/23/17

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K 347	Continued From page 4 19.3.4.5.2 This STANDARD is not met as evidenced by: Based on observations and staff interview the facility failed to install the smoke detection in accordance with NFPA 101 Life Safety Code, (2012) section 19.3.6.1 & 9.6.2.10 and NFPA 72 National Fire Alarm Code (2010) section 17.6.3.1.1 This deficient practice could affect the ability of the alarm system to sound in a timely manner during a fire event which could affect 10 of the 46residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:00 am to 12:00 pm on 01/19/2017 observations, record review and staff interview revealed the smoke detectors in the Heritage corridor and in the Kitchen corridor exceeded 30 feet apart and there was no documentation to substantiate the distance. This deficient condition was confirmed by the Facility Administrator and the Environmental Services Supervisor.	K 347	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. Identified smoke detectors will be moved per licensed contractor according to NFPA regulations. 2. Completion date: 2/23/17 3. Maintenance Director. Contractor will annually audit system for compliance.	
K 351 SS=E	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING 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.	K 351		2/23/17

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K 351	Continued From page 5 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 10 of the 46 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:00 am to 12:00 pm on 01/19/2017 observations and staff interview revealed there are two different types of sprinkler heads, quick response and standard, in the resident corridor across from the kitchen near resident room 123. 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. Identified sprinkler heads will be replaced by licensed contractor according to manufacturer and NFPA regulations. 2. Completion date: 2/23/17 3. Maintenance Director. Contractor will annually audit system for compliance.	
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	K 353		2/23/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245468	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/19/2017**

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K 353	Continued From page 6 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 46 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:00 am to 12:00 pm on 01/19/2017 observations, record review and staff interview revealed there was no record of a flow test in the 4th quarter of 2016 and all the sprinkler heads in the kitchen were covered with a heavy layer of dust. This deficient condition was confirmed by the Facility Administrator and the Environmental	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. 4th quarter flow test of 2016 was completed and documentation placed in fire book. All sprinkler heads in kitchen cleaned from dust. 2. Completion date: 2/23/17 3. Maintenance Director will complete monthly inspections on all sprinkler heads in accordance with our preventative maintenance program.	

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K 353	Continued From page 7 Services Supervisor.	K 353		
K 363 SS=E	NFPA 101 Corridor - Doors Corridor - Doors 2012 EXISTING Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 1-3/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Doors shall be provided with a means suitable for keeping the door closed. There is no impediment to the closing of the doors. Clearance between bottom of door and floor covering is not exceeding 1 inch. Roller latches are prohibited by CMS regulations on corridor doors and rooms containing flammable or combustible materials. Powered doors complying with 7.2.1.9 are permissible. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This STANDARD is not met as evidenced by:	K 363		2/23/17

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K 363	Continued From page 8 Based on observation and staff interview the facility failed to provide two corridor doors with a means suitable to resist the passage of smoke in accordance with the 2012 Life Safety Code (NFPA 101) section 19.3.6.3.1 & 19.3.6.3.5. This deficient practice could allow for smoke to enter the corridor making it difficult to exit in the case of fire, affecting 11 of the 46 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:00 am to 12:00 pm on 01/19/2017 observations and staff interview revealed resident room door 102 and 111 did not fit tight in the frame. This deficient condition was confirmed by the Facility Administrator and the Environmental Services Supervisor	K 363	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. Doors to resident rooms 102 and 111 have been adjusted to fit tightly and prevent the passage of smoke 2. Completion date: 2/23/17 3. Maintenance Director will complete monthly inspections on all doors 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.	K 372		2/23/17

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K 372	Continued From page 9 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 15 of the 46 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:00 am to 12:00 pm on 01/19/2017 observations, and staff interview revealed a duct penetration was not fire caulked in the smoke barrier across from the business office near resident room 101 and a penetration in the smoke barrier above the ceiling line in resident room 116. This deficient condition was confirmed by the Facility Administrator and the Environmental Services Supervisor.	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: 1. Identified penetrations have been sealed per NFPA guidelines. 2. Completion date: 2/23/17 3. Maintenance Director	
K 712 SS=F	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used	K 712		2/23/17

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K 712	Continued From page 10 instead of audible alarms. 18.7.1.4 through 18.7.1.7, 19.7.1.4 through 19.7.1.7 This STANDARD is not met as evidenced by: Based on record review and staff interview the facility failed to provide documentation of fire drills at least quarterly on each shift as required by the Life Safety Code (NFPA 101) 2012 edition, section 19.7.1.4 to 19.7.1.7. This deficient practice could reduce the ability of staff to conduct a safe and timely response to a fire emergency, which would affect all 46 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:00 am to 12:00 pm on 01/19/2017 record review and staff interview revealed there was no record of 2 fire drills in the 1st quarter of 2016 and 1 drill in the 3rd quarter of 2016. This deficient condition was confirmed by the Facility Administrator and the Environmental Services Supervisor.	K 712	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. Fire Drills will be conducted timely per NFPA guidelines. 2. Completion date: 2/23/17 3. Maintenance Director and Administrator will meet monthly to ensure all Life Safety Code Regulations are being met.	
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	K 918		2/23/17

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K 918	Continued From page 11 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 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: On the facility tour between 8:00 am to 12:00 pm on 01/19/2017 record review and staff interview revealed there was no record of 9 of the 12	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 timely per NFPA guidelines.	

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K 918	Continued From page 12 monthly generator tests. This deficient condition was confirmed by the Facility Administrator and the Environmental Services Supervisor	K 918	2. Completion date: 2/23/17 3. Maintenance Director and Administrator will meet monthly to ensure all Life Safety Code Regulations are being met.	

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
January 31, 2017

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5468027

Dear Mr. Ahlf:

The above facility was surveyed on January 18, 2017 through January 20, 2017 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction

order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, **you should immediately contact Lyla Burkman at: (218) 308-2104 or email: lyla.burkman@state.mn.us**.

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

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

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00830	A. BUILDING: _____ B. WING _____	01/20/2017

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm> The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 1/18-20/17, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure medical justification for the ongoing use of an indwelling Foley catheter was identified for 1 of 2 residents (R16) observed for urinary catheter use. Findings include: R16's quarterly Minimum Data Set (MDS) dated 10/13/16, indicated R16 had severe cognitive impairment and diagnoses which included	2 910	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	2/23/17

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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) COMPLETE DATE
2 910	Continued From page 3 retention of urine, chronic kidney disease, and benign prostatic hyperplasia with lower urinary tract symptoms. The MDS also indicated R16 had an indwelling catheter, required extensive assist of 1 for toilet use and personal hygiene and required supervision for bed mobility, transfer and ambulation. The Urinary Incontinence/Indwelling Catheter Care Area Assessment (CAA) dated 4/12/16, indicated R16 required assist of one staff for catheter cares and emptying his leg bag. Staff were to assist with peri cares at least twice daily and after any bowel movements. Staff were to monitor urinary output every shift and notify the physician if any concerns with output or with the catheter. R16's current physician orders signed 12/20/16, indicated an order for the indwelling catheter, however, lacked indication for the use of the catheter. On 1/18/16 at 4:50 p.m. R16 was observed resting on his bed on his left side. A urinary leg bag was observed attached just above R16's left ankle. R16's physician notes from 4/27/16 to 12/1/16 were reviewed and lacked documentation of rationale for the ongoing use of the indwelling catheter. A Fax dated 9/7/16, indicated the following concern was sent to the physician: R16 has a diagnosis of urinary retention. We are wondering if a diagnosis of neurogenic bladder with urinary retention would be appropriate. The physician response dated 9/7/16, indicated: I checked his hospital records and just see BPH [benign	2 910	respect to: 1. DNS has reviewed resident #16□s chart to assure they are medically necessary and will work with the primary physician to ensure documentation of rationale for catheter use. 2. All residents in house with indwelling catheters will be reviewed for proper documentation of rationale for catheter use. 3. Staff education will be completed no later than 2/10/17 with regards to medically necessary diagnosis and documentation needed for indwelling catheter appropriateness. 4. The DNS and/or her designee will audit any new resident/ admission w/ orders for an indwelling catheter through 3/31/17 and will report findings monthly to the monthly QAPI/ Quality Assurance Committee. At that point, the committee will make the decision/recommendation regarding any necessary follow-up studies.	

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	00830	A. BUILDING: _____ B. WING _____	01/20/2017

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2 910	Continued From page 4 prostatic hypertrophy]/urinary retention so from what I see, can't diagnose neurogenic bladder. On 1/20/17, at 8:31 a.m. registered nurse (RN)-A stated R16 was admitted to the facility with the indwelling catheter. RN-A stated she didn't think they had ever tried to discontinue the catheter and didn't believe R16 had ever been seen by a urologist. RN-A also stated she was under the impression the diagnosis of urinary retention with BPH was an adequate indication for ongoing use of the catheter. As a result, nothing else had been pursued. On 1/20/17, at 9:06 a.m. the assistant director of nursing (ADON) confirmed the facility had not attempted a trial discontinuation of the catheter nor had R16 seen a urologist. The ADON stated she was under the impression that urinary retention with BPH was an adequate indication for ongoing usage of the catheter. The ADON confirmed the record lacked further documentation of an indication for its use. A policy regarding indwelling catheter usage was requested but none was provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could review all residents with indwelling catheters to assure they are medically necessary and work with the primary physician to ensure documentation of rationale for use. The director of nursing or designee, could review and/or revise facility policies and procedures related to residents with indwelling catheters to ensure all residents have appropriate rationale for us and appropriate systems for discontinuation as assessed to be appropriate. The DON could	2 910		

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2 910	Continued From page 5 ensure training for all appropriate staff Random audits could be conducted and reviewed with the quality assurance group to ensure on-going compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 910		
21695	MN Rule 4658.1415 Subp. 4 Plant Housekeeping, Operation, & Maintenance Subp. 4. Housekeeping. A nursing home must provide housekeeping and maintenance services necessary to maintain a clean, orderly, and comfortable interior, including walls, floors, ceilings, registers, fixtures, equipment, lighting, and furnishings. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain floors in a clean and sanitary condition in the kitchen and for 8 of 8 resident rooms (103, 104, 111, 116, 117, 118, 121, 139) and failed to maintain bathroom vents in a clean and sanitary condition for 2 of 2 rooms (119, 125). In addition, the facility failed to maintain walls, floors and windows in good repair in the laundry room and Heritage dining room. This had the potential to affect all 40 residents, staff and visitors of the facility. Findings include: The facility environment was observed on 1/19/17, at 8:25 a.m. during an initial tour and on 1/20/17, at 8:23 a.m. on tour with the administrator. The following environmental issues	21695	1. Floors in the kitchen, resident rooms (103,104,111,116, 117, 118, 121, 139), bathroom vents in rooms (119, 125) have been cleaned. Walls/Floors in laundry room and walls, floors, and window Heritage Dining room have been repaired or have had parts ordered for repair. 2. Floors and bathroom vents have been cleaned in all resident rooms. The facility housekeeping and maintenance responsibility policy and procedure have been reviewed and necessary staff educated. 3. Staff education will be done by 2/17/17 for proper notification of items that need repair/replacement. 4. Maintenance Director or Designee will audit environmental cleanliness in the	2/23/17

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21695	Continued From page 6 were noted and verified by the facility administrator: -Floors in resident rooms were not clean, black ground in dirt, around the outer perimeter of the floor, by the closet doors and dust/debris was observed on the floor in rooms- 103, 104, 111, 116, 117, 118, 121, 139. - On 1/18/17, at 5:50 p.m. family member (FM)-A stated the housekeeping was "not the best", my mother's room did not look clean, the floors were not clean. - On 1/19/17, at 3:26 p.m. FM-B stated the floor in my mom's room did not get cleaned very well. FM-B stated tissues were observed under her bed, "we watched and the tissues remained there for three weeks." The facility "could do a better job" cleaning the rooms. - Bathroom vents were observed to be covered with thick gray dust in rooms 119 and 125. -Kitchen floors were observed to have black/grimy ground in dirt at the base of storage cabinets, convection oven, clean dish area, cook stove/range, clean food storage shelves, food prep counters, and around the outer perimeter of the kitchen floor. -On 1/20/17 at 8:16 a.m. the dietary manager (DM) verified the floors were very bad, they were not clean, they needed a deep cleaning. The DM stated maintenance was responsible for deep cleaning the floors. - The laundry room corner wall was missing a corner protector and sheet rock was exposed on both sides of the wall. Sheet rock chunks were	21695	building weekly for 1 month then biweekly for 2 months then monthly for one year. All results will be reported to the QA Committee for review and or recommendation.	

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21695	Continued From page 7 missing. At the entrance to the laundry room near the wash sink area there were 4 floor tiles partially or fully broken and chipped out of the floor. - On 1/20/17, at 8:30 a.m. the laundry aide stated the tiles have been missing for about a year when they took out a hot water heater that was positioned there. The other tiles in the laundry room were stained with an orange/rusty color. - In the Heritage dining room, one of the upper windows on the main wall was cracked. On 1/20/17, at 8:23 a.m. during the environmental tour, the administrator confirmed the above findings and stated they required cleaning. In addition, he stated the window in the dining room required repair. The administrator stated he was unaware of the broken window. The administrator verified they have not had a maintenance person for about 6 weeks and were in the process of hiring one. The administrator verified the maintenance person would be responsible for maintaining the above mentioned areas. The administrator stated we do have two individuals who were available to come to the facility to provide maintenance services. The undated facility policy and procedure Housekeeping and Maintenance Department Responsibility, indicated the facility would provide a clean, safe and sanitary environment for residents, and provide rigorous daily cleaning of all horizontal surfaces in the building and other areas that need to be cleaned. SUGGESTED METHOD OF CORRECTION: The administrator, or designee could develop a system for staff to report identified concerns with	21695		

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21695	Continued From page 8 the physical plant. All facility staff could be educated on these systems. The administrator, or designee could develop an appropriate preventative maintenance program and ensure the implementation of that plan. The administrator or designee could develop a monitoring system to ensure ongoing compliance and report those results to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21695		