

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245468	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/24/2024
NAME OF PROVIDER OR SUPPLIER Karlstad Healthcare Center Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 304 Washington Avenue West Karlstad, MN 56732	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40943</p> <p>Based on observation, interview and document review, the facility failed to ensure pillows were not used in a manner to restrain residents while in bed for 1 of 1 residents (R17) reviewed for restraints.</p> <p>Findings include:</p> <p>R17's quarterly Minimum Data Set (MDS) dated [DATE], identified R17 had severe cognitive impairment and diagnoses of dementia and legal blindness. R17 used no restraints.</p> <p>R17's care plan reviewed 5/31/24, identified R17 had limited physical mobility and was a fall risk related to poor vision and weakness. R17 used a grab bar on the exiting side of R17's bed to enable R17 to go from lying to sitting, to aid in turning/repositioning and to get in and out of bed. Staff were directed to assess R17's grab bars routinely and with changes in condition to assure appropriateness of use, safety/security of the bar to the bed frame and potential for entrapment. R17 used a landing pad next to his bed as R17 liked to purposefully crawl out of bed onto the floor. R17's care plan did not identify the use of pillows under his fitted sheet to prevent R17 from crawling out of bed.</p> <p>R17's Physical Device Evaluation dated 5/16/24, identified R17 used a right and left grab bar, hi-low bed, and floor mats by his bed. However, the assessment did not identify the use of pillows to prevent R17 from rolling out of bed.</p> <p>R17's Morse Fall Scale 6-16 V3 dated 5/16/24, identified R17 was at high risk for falls.</p> <p>During an observation on 7/23/24 at 8:34 a.m., R17 was lying on his back in the middle of his bed with his blankets covering to his chest. On R17's right side two pillows were tucked under the fitted sheet and ran along R17's body from his shoulders to his knees. R17's bed was in low position with a fall mat next to his bed.</p> <p>- At 8:40 a.m., nursing assistant (NA)-A entered R17's room and greeted R17. R17 declined getting up for the day. NA-A exited R17's room and did not remove the pillows.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- At 8:56 a.m., the director of nursing (DON) entered R17's room and turned-on music for R17. The DON did offer to assist R17 with morning cares, but R17 declined. The DON then removed the pillows from underneath R17's fitted sheet and placed them on the unused bed in the room before exiting R17's room.</p> <p>During an interview on 7/23/24 at 8:57 a.m., the DON stated R17 could have significant behaviors. NA-A was a new nursing assistant who had been working day shift for approximately a month and was extremely nervous to be observed. DON stated she was guessing the pillows were put underneath the fitted sheet by night shift. R17 could wiggle and move around in the bed and the night shift staff were probably worried R17 was going to fall out of bed. R17 had a mat, and the bed was 6 inches off the floor. R17 was not going to get hurt if there was a fall. The DON stated the pillows should never be placed under the fitted sheet because that was a restraint. The DON removed the pillows and planned to speak to staff and explain why the staff could not do that. NA-A should have removed the pillows and immediately reported the pillows to nursing.</p> <p>During an interview on 7/23/24 at 9:08 a.m., NA-A stated R17's pillows were underneath the fitted sheet so R17 could not roll out of bed, we do it all the time. R17 can put his legs over the side of the bed and roll out onto the mat. NA-A stated she did not know if R17 could remove the pillows if R17 wanted to and would have to ask the nurse.</p> <p>During an interview on 7/23/24 at 9:20 a.m., NA-B stated Yea, we put pillows underneath the fitted sheet all the time because R17 rolled out of bed. R17 could remove the pillows if the pillows were not underneath the fitted sheet.</p> <p>A facility policy related to restraints was requested but not received.</p>		