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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 7F5N

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00811

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245514**
2.STATE VENDOR OR MEDICAID NO.
(L2) **773542100**

3. NAME AND ADDRESS OF FACILITY
(L3) **MALA STRANA HEALTH CARE CENTER**
(L4) **1001 COLUMBUS AVENUE NORTH**
(L5) **NEW PRAGUE, MN** (L6) **56071**

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 **10/22/2013** (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 **90** (L18)

13.Total Certified Beds **90** (L17)

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

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

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	90			
(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 :
George Shellum, SFMO 06/16/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 06/16/2014 (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
02/01/1988
(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
11/25/2013
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN# 245514

On 10/22/13, a Post Certification Revisit (PCR) was completed by the Minnesota Department of Public Safety. Based on the PCR, it has been determined that the facility had achieved substantial compliance pursuant to the 08/28/13 survey, effective 09/17/13. Refer to the CMS 2567B for both health and life safety code.

Effective 09/17/13, the facility is certified for 90 skilled nursing facility beds.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5514

June 16, 2014

Mr. Mikenzi Hebel, Administrator
Mala Strana Health Care Center
1001 Columbus Avenue North
New Prague, Minnesota 56071

Dear Mr. Hebel:

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 September 19, 2013, the above facility is certified for:

90 - Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 90 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. Please note, it is your responsibility to share the information contained in this letter and the results of this PCR with the President of your facility's Governing Body.

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,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4124 Fax: (651) 215-9697

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

June 16, 2014

Mr. Mikenzi Hebel, Administrator
Mala Strana Health Care Center
1001 Columbus Avenue North
New Prague, Minnesota 56071

RE: Project Number S5514022 and F5514022

Dear Mr. Hebel:

On September 9, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 28, 2013. 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 October 22, 2013, 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 August 28, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 17, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 28, 2013, effective September 17, 2013 and therefore remedies outlined in our letter to you dated September 9, 2013, 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. Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit. Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124
Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245514	A. Building 01 - MAIN BUILDING 01 B. Wing	10/22/2013

Name of Facility	Street Address, City, State, Zip Code
MALA STRANA HEALTH CARE CENTER	1001 COLUMBUS AVENUE NORTH NEW PRAGUE, MN 56071

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).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0038	09/17/2013	ID Prefix Reg. # NFPA 101 LSC K0144	09/17/2013	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/AK	06/16/2014	22373	10/22/2013
CMS RO				

Followup to Survey Completed on: 8/28/2013

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: 7F5N

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00811

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(L1) **245514**
2.STATE VENDOR OR MEDICAID NO.
(L2) **773542100**

3. NAME AND ADDRESS OF FACILITY
(L3) **MALA STRANA HEALTH CARE CENTER**
(L4) **1001 COLUMBUS AVENUE NORTH**
(L5) **NEW PRAGUE, MN** (L6) **56071**

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 **08/28/2013** (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 **90** (L18)

13.Total Certified Beds **90** (L17)

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

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	90			
(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
Tammy Alberts, HFE NE II
Date : 09/09/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL
Enforcement Specialist
Date: 11/25/2013 (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
02/01/1988
(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
Posted 11/25/2013 CO. 7F5N

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
11/25/2013
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM	STATE AGENCY REMARKS

CCN# 245514

At the time of the standard survey completed July 25, 2013, the facility was not in substantial compliance and the most serious deficiencies were found 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. The facility has been given an opportunity to correct before remedies are imposed. See attached CMS-2567 for survey results. Post Certification Revisit to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 6947

September 9, 2013

Mr. Mikenzi Hebel, Administrator
Mala Strana Health Care Center
1001 Columbus Avenue North
New Prague, MN 56071

RE: Project Number S5514022

Dear Mr. Hebel:

On August 28, 2013, 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:

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

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

<u>Remedies</u> - 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:

Gayle Lantto, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55108-2970
Telephone: (651) 201-3794 Fax: (651) 201-3790

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 October 7, 2013, 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 October 7, 2013 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC 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,

- Include signature of provider and date.

If an acceptable PoC 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 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 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. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL 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 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 PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

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 November 28, 2013 (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 February 28, 2014 (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
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting a PoC 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 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. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145
Telephone: (651) 201-7205 Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Kate Johnston

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure
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
	245514	A. BUILDING _____ B. WING _____	08/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MALA STRANA HEALTH CARE CENTER	**1001 COLUMBUS AVENUE NORTH NEW PRAGUE, MN 56071**

(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 Mala Strana Health Care Center has been found to be in compliance with the requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities.	F 000		

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

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
	245514	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/28/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MALA STRANA HEALTH CARE CENTER	**1001 COLUMBUS AVENUE NORTH** **NEW PRAGUE, MN 56071**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 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 FORM-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE 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. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on August 28, 2013. At the time of this survey, Mala Strana Health Care Center was found not to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 444 Cedar St., Suite 145 St Paul, MN 55101-5145, or	K 000	RECEIVED SEP 23 2013 MN DEPT OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION Pack FR 9-24-13	

DC: 10.07.2013

EXIT: 08.28.2013

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

Administrator 9/17/13

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.

Mala Strana Health Care Center

Minnesota Department of Health Annual Survey and Life Safety Code Annual Survey

Exit Date of Survey: August 28, 2013

Project Number: S5514022

Citations:

- **Life Safety Code Survey- K038, K144**
- **MN Department of Health Survey- None**

Plan of Correction for Above Facility Deficiencies:

K038: Facility failed to provide reliable means of egress from at least one exit discharge location. The exits need to be readily accessible at all times in accordance with section 7.1. 19.2.1. A functional test was done on 8/28/13 at 10:45am, and revealed exit discharge door from the Northeast Sun Room corridor was equipped with an electronic magnetic door lock, interconnected with delayed egress panic hardware. During the test it revealed that the door did not unlatch within 15 seconds, and required a key override. Facility staff were in possession of the key and the door opened freely at that time. 9-17-13

Facility plan of Correction for Citation K038: Environmental Services Director investigated the issue and found that the weather stripping was the cause of the delay. The stripping was fixed on the Northeast Sun Room corridor and to prevent further similar issues in the future, all doors with mag locks will be inspected and monitored on a monthly basis. The documentation to ensure and track that this is happening has been enclosed for your review. EVS Director is responsible for monitoring this plan of correction.

K144: Generators are to be inspected weekly and exercised under load of 30 minutes per month as required in NFPA 110 (99) Sections 6-4.2 and 6-4.2.2. Based on staff interview and review of available records at the time, the facility was unable to come up with document proving minimal loading of 30% of the EPS nameplate rating during monthly load testing of the emergency generator. 9-17-13

Facility Plan of Correction for Citation K144: Environmental Services Director at the time of the Life Safety Code survey was unable to find the documents showing the load test checks. Enclosed you will find the weekly check list for the generator for 2012 that was found after survey as well as the new form that was recommended for the monthly test log. We have transferred the 2013 information that was found onto the new recommended form as we will now use this form on a monthly basis. We have also enclosed the original form that we were unable to locate at the time of survey due to employee turnover. We will now keep this form in a binder for easy access. New EVS staff have been educated on this process and the EVS Director is responsible for monitoring this plan of correction. **All above forms have been updated with the most current info, facility name, etc to be easier to read, as well as more facility specific and are enclosed; also enclosed is the staff education documentation.*

Mia [illegible], LNHA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245514	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/28/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MALA STRANA HEALTH CARE CENTER	**1001 COLUMBUS AVENUE NORTH NEW PRAGUE, MN 56071**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 By email to: Barbara.Lundberg@state.mn.us and, Marian.Whitney@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. Mala Strana Health Care Center was constructed as follows: The original building was constructed in 1972, is one-story, has a partial basement, is fully fire sprinkler protected and is of Type II(111) construction; The 2002 Addition is one-story, has no basement, is fully fire sprinkler protected and is of Type II(111) construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. The facility has a capacity of 90 beds and had a census of 82 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD	K 038		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245514	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/28/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MALA STRANA HEALTH CARE CENTER	**1001 COLUMBUS AVENUE NORTH NEW PRAGUE, MN 56071**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 038	Continued From page 2 Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide a reliable means of egress from at least one exit discharge location, in accordance with NFPA 101 (00) Chapter 19, Section 19.2.1, Chapter 7, Sections 7.1.10 and 7.2.1.5.4. In an emergency evacuation situation, this deficient practice could adversely affect 20 of 90 residents, staff and visitors. FINDINGS INCLUDE: On 08/28/2013 at 10:45 AM, observation revealed the exit discharge door from the Northeast Sun Room corridor was equipped with an electric magnetic door lock, interconnected with delayed egress panic hardware. A functional test of the delayed egress revealed the door did not unlatch within 15 seconds, requiring a hard key override. Facility staff were in possession of the key, and the door opened freely. This finding was verified with the chief building engineer at the time of discovery.	K 038		
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.	K 144		

Mala Strana Health Care Center

Monthly Door Mag Locks Check

Location	Jan	Feb	Mar	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec
Receiving Door												
ALF- Dining Room and West Hall Door												
Dementia Kitchen Hall going into Little Village												
Dementia Dining Room Door												
South Dementia Door (Living Room)												
East Dementia Door												
New Service Hallway												
Door next to new post office boxes												
New Front Door (no locking device, alarm only)												
Great Room												
Nursing Home SW Door												
Nursing Home NW Door												
Nursing Home Employee Entrance												
Nursing Home NE Door												
East Wing Entrance to Little Village (only door going into LV)												

Green Light- Door is not monitored

Red Steady Light- Door is locked and monitored

Red Flashing Light- Door is locked, but someone exited

(This monthly check is to ensure mag locks are working properly and unlatching timely- within the 15 second timeframe)

(This is the 2012 check list we couldn't originally find)

WEEKLY CHECK LIST

Date:	Ambient Temp:	Oil Level:	Water Level:	Heaters:	Belts:	Battery Charger:	Battery Levels & Cables:	Leaks – Oil, water or fuel	Amp:	Volts:	Freq:	Oil Pressure:	Water Temp:	BC Amp:	RTM:	ATS:	Mechanic:	Comments:
5/27	55	O/K	O/K	OK	O/K	✓	✓	✓	12	208	60	59	144			O/K	MM	5 min
6/3/11	70	O/K	OK	OK	OK	✓	✓	✓	12	207	60	59	143			OK	AA	5 min
6/13/11	70	O/K	O/K	O/K	O/K	✓	✓	✓	12	208	60.1	60	146			OK	MK	30 min
6/28/11	85	O/K	O/K	O/K	O/K	✓	✓	✓	12	207	60	59	145			O/K	NN	5 min
7/7/11	87	OK	O/K	OK	OK	✓	✓	✓	12	207	60	60	146			O/K	NK	30 min
7/19/11	89	O/K	O/K	O/K	O/K	✓	✓	✓	12	206	60	59	145			OK	MM	5 min
7/26/11	91	OK	OK	O/K	OK	✓	✓	✓	12	206	60	59	145			OK	NN	5 min
8/1/11	88	O/K	O/K	O/K	OK	✓	✓	✓	12	207	60.1	60	146			O/K	NN	30 min
8/16/11	82	O/K	O/K	OK	O/K	✓	✓	✓	12	201	60	59	148			O/K	NN	5 min
8-24	81	O/K	OK	OK	O/K	✓	✓	✓	12	206	60.1	59	147			O/K	NN	5 min
9-1-11	92	O/K	OK	OK	OK	✓	✓	✓	12	207	60.1	59	147			OK	NN	5 min
9-13-11	58	O/K	O/K	OK	OK	✓	✓	✓	12	206	60	59	147			O/K	NN	30 min
9-24-11	64	O/K	O/K	OK	OK	✓	✓	✓	12	207	60.1	59	148			O/K	NN	5 min
10-5	80	O/K	O/K	O/K	O/K	✓	✓	✓	12	207	60.1	59	147			O/K	NN	30 min
10-13	62	O/K	O/K	OK	OK	✓	✓	✓	12	207	60.	59	147			O/K	NN	5 min
10-24	58	O/K	OK	O/K	O/K	✓	✓	✓	12	207	60.1	60	148			O/K	NN	5 min
11-3-11	54	O/K	O/K	O/K	OK	✓	✓	✓	12	208	60	59	147			O/K	NN	30 min
11-10-11	50	O/K	O/K	O/K	O/K	✓	✓	✓	12	207	60.1	59	147			O/K	NN	5 min
11-30-11	32	O/K	O/K	O/K	O/K	✓	✓	✓	12	209	60.1	61	148			O/K	NN	30 min
12-9-11	7	O/K	O/K	O/K	O/K	✓	✓	✓	12	208	60.1	61	150			O/K	NN	5 min
12-18-11	36	O/K	O/K	O/K	O/K	✓	✓	✓	12	209	60.1	60	145			O/K	NN	5 min
12-28-11	30	O/K	O/K	O/K	O/K	✓	✓	✓	12	208	60.1	60	143			O/K	NN	5 min
1-2-12	20	O/K	O/K	O/K	O/K	✓	✓	✓	12	208	60.1	60	144			O/K	NN	30 min
1/10/12	25	O/K	O/K	O/K	O/K	✓	✓	✓	12	209	60.1	59	143			O/K	NN	5 min
1-16-12	27	O/K	O/K	O/K	O/K	✓	✓	✓	12	208	60.1	61	148			O/K	NN	5 min
1-23-12	12	O/K	O/K	O/K	O/K	✓	✓	✓	12	209	60.1	60	144			O/K	NN	5 min

WEEKLY CHECK LIST

Date:	Ambient Temp:	Oil Level:	Water Level:	Heaters:	Belts:	Battery Charger:	Battery Levels & Cables:	Leaks – Oil, water or fuel	Amp:	Volts:	Freq:	Oil Pressure:	Water Temp:	BC Amp:	RTM:	ATS:	Mechanic:	Comments:
2-6-12	25	OK	OK	OK	OK	✓	✓	✓	14.2	209	60.1	52	151	OK	OK	OK	RM	30 min
2-8-12	18	OK	OK	OK	OK	✓	✓	✓	14.3	208	60.1	53	149	OK	OK	OK	RM	5 min
2-17-12	30	OK	OK	OK	OK	✓	✓	✓	14.1	209	60.1	51	148	OK	OK	OK	RM	5 min
2-23-12	25	OK	OK	OK	OK	✓	✓	✓	14.2	207	60.1	51	148	OK	OK	OK	RM	5 min
3-1	35	OK	OK	OK	OK	✓	✓	✓	14.1	207	60.1	52	148	OK	OK	OK	RM	5 min
3-14	50	OK	OK	OK	OK	✓	✓	✓	14.1	208	60.1	52	149	OK	OK	OK	RM	30 min
3-22	56	OK	OK	OK	OK	✓	✓	✓	14.2	207	60.1	51	148	OK	OK	OK	RM	5 min
3-30	55	OK	OK	OK	OK	✓	✓	✓	14.2	208	60.1	53	147	OK	OK	OK	RM	5 min
4-2	50	OK	OK	OK	OK	✓	✓	✓	13.9	209	60.1	55	146	OK	OK	OK	RM	30 min
4-9-12	60	OK	OK	OK	OK	✓	✓	✓	14.2	207	60.1	54	147	OK	OK	OK	RM	5 min
4-20-12	55	OK	OK	OK	OK	✓	✓	✓	14.2	206	60.1	53	146	OK	OK	OK	RM	5 min
4-27-12	50	OK	OK	OK	OK	✓	✓	✓	13.9	207	60.1	54	145	OK	OK	OK	RM	5 min
5-8-12	55	OK	OK	OK	OK	✓	✓	✓	14.2	207	60.1	51	146	OK	OK	OK	RM	30 min
5-16-12	78	OK	OK	OK	OK	✓	✓	✓	14.2	206	60.1	54	145	OK	OK	OK	RM	5 min
5-22-12	78	OK	OK	OK	OK	✓	✓	✓	14.2	207	60.1	55	146	OK	OK	OK	RM	5 min
5-29-12	60	OK	OK	OK	OK	✓	✓	✓	14.1	206	60.1	54	145	OK	OK	OK	RM	5 min
6-4-12	80	OK	OK	OK	OK	✓	✓	✓	14.1	207	60.1	55	146	OK	OK	OK	RM	5 min
6-13-12	72	OK	OK	OK	OK	✓	✓	✓	14.1	208	60.1	57	148	OK	OK	OK	RM	30 min
6-21-12	84	OK	OK	OK	OK	✓	✓	✓	14.1	207	60.1	58	147	OK	OK	OK	RM	5 min
7-2-12	90	OK	OK	OK	OK	✓	✓	✓	14.1	207	60.1	57	148	OK	OK	OK	RM	30 min
7-11-12	92	OK	OK	OK	OK	✓	✓	✓	14.1	208	60.1	58	149	OK	OK	OK	RM	5 min
7-20-12	91	OK	OK	OK	OK	✓	✓	✓	14.1	206	60.1	58	148	OK	OK	OK	RM	5 min
8-3-12	85	OK	OK	OK	OK	✓	✓	✓	14.1	207	60.1	57	147	OK	OK	OK	RM	30 min
8-13-12	80	OK	OK	OK	OK	✓	✓	✓	14.1	206	60.1	58	149	OK	OK	OK	RM	5 min
8-27-12	75	OK	OK	OK	OK	✓	✓	✓	14.1	207	60.1	57	148	OK	OK	OK	RM	5 min
8-30-12	78	OK	OK	OK	OK	✓	✓	✓	14.1	208	60.1	58	147	OK	OK	OK	RM	5 min
9-11-12	84	OK	OK	OK	OK	✓	✓	✓	14.1	208	60.1	58	147	OK	OK	OK	RM	30 min

WEEKLY CHECK LIST

12 Am #2

Date:	Ambient Temp:	Oil Level:	Water Level:	Heaters:	Belts:	Battery Charger:	Battery Levels & Cables:	Leaks – Oil, water or fuel	Amp:	Volts:	Freq:	Oil Pressure:	Water Temp:	BC Amp:	RTM:	ATS:	Mechanic:	Comments:
9-17-12	62	OK	OK	OK	OK	OK	✓	✓	14.2	208	60.1	53	146	OK	OK	OK	NR	5 min
9-24-12	70	OK	OK	OK	OK	✓	✓	✓	14.1	207	60.1	52	145	OK	OK	OK	NR	5 min
10-3-12	55	OK	OK	OK	OK	✓	12 Amp	✓	14.2	208	60.1	58	145	OK	OK	OK	NR	30 min
10-11-12	60	OK	OK	OK	OK	✓	✓	✓	14.1	207	60.1	57	144	OK	OK	OK	NR	5 min
10-19-12	50	OK	OK	OK	OK	✓	✓	✓	14.2	208	60.1	58	145	OK	OK	OK	NR	5 min
11-8-12	40	OK	OK	OK	OK	✓	14	✓	14.2	209	60.1	60	144	OK	OK	OK	NR	30 min
11-15-12	38	OK	OK	OK	OK	✓	14	✓	14.2	208	60.1	58	144	OK	OK	OK	NR	5 min
11-21-12	38	OK	OK	OK	OK	✓	14	✓	14.2	209	60.1	59	145	OK	OK	OK	NR	5 min
11-28-12	30	OK	OK	OK	OK	✓	14	✓	14.2	208	60.1	58	144	OK	OK	OK	NR	5 min
12-3	15	OK	OK	OK	OK	✓	14	✓	14.2	209	60.1	58	145	OK	OK	OK	NR	5 min
12-11-12	25	OK	OK	OK	OK	✓	14	✓	14.2	208	60.1	59	144	OK	OK	OK	NR	30 min
12-19-12	23	OK	OK	OK	OK	✓	14	✓	14.2	209	60.1	58	144	OK	OK	OK	E.P	2 HRS – Transfer Power

MALA STRANA

2013

#201

WEEKLY CHECK LIST

Date:	Ambient Temp:	Oil Level:	Water Level:	Heaters:	Belts:	Battery Charger:	Battery Levels & Cables:	Leaks – Oil, water or fuel	Amp:	Volts:	Freq:	Oil Pressure:	Water Temp:	BC Amp:	RTM:	ATS:	Mechanic:	Comments:
2-5-13	20	✓	✓	✓	✓	✓	14.2	✓	14	208	60.1	61	150	✓	✓	✓	RR	30 min
2-18-13	24	✓	✓	✓	✓	✓	14.2	✓	14	209	60.1	60	149	✓	✓	✓	RR	5 min
2-27-13	28	✓	✓	✓	✓	✓	14.2	✓	15	209	60.1	61	149	✓	✓	✓	RR	5 min
3-7-13	25	✓	✓	✓	✓	✓	14.2	✓	14.5	208	60	60	148	✓	✓	✓	RR	5 min
3-13-13	15	✓	✓	✓	✓	✓	14.2	✓	15	209	60.1	62	148	✓	✓	✓	RR	30 min
3-21	20	✓	✓	✓	✓	✓	14.2	✓	14	208	60.1	61	145	✓	✓	✓	RR	5 min
3-29	37	✓	✓	✓	✓	✓	14.2	✓	15	209	60.1	62	147	✓	✓	✓	RR	5 min
4-3-13	30	✓	✓	✓	✓	✓	14.2	✓	14	208	60.1	61	141	✓	✓	✓	RR	5 min
4-12-13	87	✓	✓	✓	✓	✓	14.2	✓	14	208	60.1	62	146	✓	✓	✓	RR	30 min
4-19	22	✓	✓	✓	✓	✓	14.2	✓	14	206	60.1	61	147	✓	✓	✓	RR	5 min
4-24	42	✓	✓	✓	✓	✓	14.2	✓	15	209	60.1	61	147	✓	✓	✓	RR	30 min
5-3	55	✓	✓	✓	✓	✓	14.2	✓	14	206	60.1	62	147	✓	✓	✓	RR	5 min
5-12	62	✓	✓	✓	✓	✓	14.2	✓	14	208	60.1	61	146	✓	✓	✓	RR	5 min
5-21	64	✓	✓	✓	✓	✓	14.2	✓	15	208	60.1	62	147	✓	✓	✓	RR	30 min
5-31	72	✓	✓	✓	✓	✓	14.2	✓	15	208	60.1	61	145	✓	✓	✓	RR	5 min
6-6-13	55	✓	✓	✓	✓	✓	14.2	✓	14	208	60.1	59	145	✓	✓	✓	RR	30 min
6-14-13	80	✓	✓	✓	✓	✓	14.2	✓	15	207	60.1	62	147	✓	✓	✓	RR	5 min
6-25-13	85	✓	✓	✓	✓	✓	14.2	✓	14	208	60.1	61	147	✓	✓	✓	RR	5 min
7-1-13	80	—	—	—	—	—	14.2	—	14	208	60.1	62	147	—	—	—	RR	5 min
7-10-13	85	—	—	—	—	—	14.2	—	14	207	60.1	62	147	—	—	—	RR	5 min
7-18-13	Interstate did semi-annual inspection																	30 min
8-6-13	85	✓	✓	✓	✓	✓	14.1	NO	14	209	60.1	61	141	✓	✓	✓	S+M+M	5 min
8-13-13	75	✓	✓	✓	✓	✓	14.1	NO	14	209	60.1	61	144	✓	✓	✓	M+S	30 min
8-19-13	80	✓	✓	✓	✓	✓	14.1	✓	14	209	60.1	61	144	✓	✓	✓	M+S	5 min
8-26-13	90	✓	✓	✓	✓	✓	14.1	✓	14	209	60.1	61	144	✓	✓	✓	M+S	5 min
9-6-13	83	✓	✓	✓	✓	✓	14.1	✓	14	209	60.1	61	143	✓	✓	✓	M+S	5 min
9-16-13	70	✓	✓	✓	✓	✓	14.2	✓	15	208	60.1	60	143	✓	✓	✓	M+S	

*updated form we will now use.

Mala Strana Health Care Center

Weekly Generator Checklist

Date	Ambient Temp	Oil Level	Water Level	Heat-ers	Belts	Battery Charger	Battery levels/ Cables	Leaks- Oil, water or fuel	Amp:	Volts:	Freq:	Oil Pressure	Water Temp	BC Amp:	RTM:	ATS:	Mech-anic:	Comments:

(The form we will now use for the monthly check as recommended.)

[2013 information has been transferred to this form + original form is enclosed also]

<<MALA STRANA HEALTH CARE

Emergency Generator – Monthly Test Log

Generator Model: _KATOLIGHT Engine Model: 120/208 VOLT 3 PHRASE Date installed: _____

Standby kW nameplate rating: 40 KW 30% of standby rating = 12 KW Fuel type: NATURAL GAS Normal operating temp: _____

Month	Test Date	Time Meter Reading		Transfer Switch		Battery Specific Gravity	Oil Pressure	Operating Temp.	Load kW	Tested By	Comments
		Start	End	Inspection	Test						
January				OK	OK	Sealed Battery				RR	
February	2/8/13			OK	OK		61	150	5	RR	
March	3/13/13			OK	OK		62	148	5.35	RR	
April	4/3/13			OK	OK		61	145	5	RR	
May	5/31/13			OK	OK		62	147	5.35	RR	
June	6/6/13			OK	OK		59	145	5	RR	
July	7/18/13					New battery put in Interstate Sealed					done by Interstate semi. annual inspection
August	8/13/13			OK	OK		61	141	5	MO	
September	9/16/13			OK	ok		61	143	5	MO	
October											
November											
December											

(Blank form)

<<MALA STRANA HEALTH CARE

Emergency Generator – Monthly Test Log

Generator Model: _KATOLIGHT Engine Model: 120/208 VOLT 3 PHRASE Date installed: _____

Standby kW nameplate rating: 40 KW 30% of standby rating = 12 KW Fuel type: NATURAL GAS Normal operating temp: _____

Month	Test Date	Time Meter Reading		Transfer Switch		Battery Specific Gravity	Oil Pressure	Operating Temp.	Load kW	Tested By	Comments
		Start	End	Inspection	Test						
January											
February											
March											
April											
May											
June											
July											
August											
September											
October											
November											
December											

Mala Strana Health Care Center

Monthly Preventative Maintenance Checklist

Monthly	Jan	Feb	Mar	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec
Fire Extinguishers												
Hand Rails in Hallway												
Century Tub and Lift												
BR Ventilation fans (oil, clean and lube)												
Water Heater (drain)												
Emergency Generator (30 min ok battery, oil, filter)												
Circulation Pumps (heating season)												
Vacuum Cleaner (clean)												
Door Alarms (mag locks)												
Emergency Lights (30 sec if on longer note day)												
Quarterly												
Water- Flow test												

MALA STRANA HEALTH CARE
1001 COLUMBUS AVE
NEW PRAGUE, MN.

ON SEPTEMBER 3, 2013 I WENT THROUGH THE NEW PAPER WORK THAT IS
NEEDED FOR THE EMERGENCY GENERATOR FOR OUR SURVEY BOOK WITH
SCOTT ANDRUS AND MIKE OGREN.
WE STARTED THE NEW FORMS FOR THE MONTH OF SEPTEBER 2013 AND
WILL FOLLOW THROUGH IT WITH THE MAINT. DEPT.

Mike Ogren
Scott Andrus
Mary O'Brien