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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 92AO

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 CARE & REHABILITATION 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 **12/15/2015** (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)
09/30

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:
X 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 :
Gary Schroeder, DSFM 01/11/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 01/12/2016 (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
10/13/2015
(L33)

DETERMINATION APPROVAL

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

CCN: 24-5514

A follow up of the Life Safety Code deficiency K11 from the August 20, 2015 standard survey, which had been recommended for a temporary waiver with a date of completion of December 14, 2015, was completed on December 15, 2015 and found corrected, effective December 14, 2015. Refer to the CMS 2567b for results of this revisit.

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

January 11, 2016

Ms. Dawn Chiabotti, Administrator
Mala Strana Health Care Center
1001 Columbus Avenue North
New Prague, Minnesota 56071

RE: Project Number F5514024

Dear Ms. Chiabotti:

On September 8, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 20, 2015. 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 27, 2015, we notified you that, based on our follow-up visit completed on October 12, 2015, we determined that your facility had corrected the deficiencies issued pursuant to our August 20, 2015 standard survey, effective October 16, 2015. On October 27, 2015, we also informed you that your request for a temporary waiver involving the Life Safety Code deficiency cited at K11, including the date of completion of December 14, 2015, had been approved.

A follow-up of the Life Safety Code deficiency cited at K11 was completed on December 15, 2015 and the deficiency was found to be corrected as of December 14, 2015. Enclosed is a copy of the Post Certification Revisit Form (CMS-2567B) from this visit.

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 letter.

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245514	A. Building B. Wing **01 - MAIN BUILDING 01**	12/15/2015

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	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # **NFPA 101** LSC K0011	Correction Completed **12/14/2015**	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	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	**Reviewed By** TL/mm	**Date:** 01/11/2016	**Signature of Surveyor:** 25822	**Date:** 12/15/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Followup to Survey Completed on: 8/20/2015		**Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?**	**YES**	**NO**

Minnesota Department of Health

Certified Mail # 7015 0640 0003 5695 5392

December 30, 2015

Ms. Dawn Chiabotti, Administrator
Mala Strana Health Care Center
1001 Columbus Avenue North
New Prague, Minnesota 56071

Subject: Mala Strana Health Care Center - IDR
CMS Certification Number (CCN): 24 5514
Project Number: S5514024

Dear Ms. Chiabotti:

This is in response to your letter of September 21, 2015, in regard to your request for an informal dispute resolution (IDR) for federal deficiencies issued at tags F257, F353 & F520 issued pursuant to the survey event 92AO11, completed on August 20, 2015.

The information presented with your letter, the CMS 2567 dated August 20, 2015 and corresponding Plan of Correction, as well as survey documents and discussion with representatives of L&C staff have been carefully considered and the following determination has been made:

F257 S/S – (D) 42 CFR §483.15(h) (6) §483.15(h) (6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 - 81° F (Fahrenheit).

Summary of the facility's reason for IDR of this tag: The facility alleges during the month of August 2015 the outside temperature changed daily, from a high of 92 degrees F to a low of 66 degrees F in the same week. During this time of temperature highs and lows both R51 and R6 who had complained of cool temperatures, were offered and used extra blankets for bed and sweaters to stay warm.

Summary of facts: At the time of the survey the lowest room air temperature taken was 70 degrees F in R6's room. R51's room and the activity room were identified by R51 to be cold however, there was no air temperature taken in these two rooms to determine whether they were in the 71-81 degree F range. R51 was observed during the survey to have two blankets on the bed and was wearing a sweater for warmth. R6 was observed to be in bed with a fuzzy blanket but was not interviewed to determine if warm enough at the time.

Summary of findings: During the month of August 2015, the outside temperature varied from the usual warmer temperatures to mild temperatures which caused the internal building temperature to require adjustment with the addition of air conditioning or heat. It would take time for the building air temperature to adjust in order to maintain temperatures between 71 and 81 degrees F. When the temperatures were cool, according to the residents, they were provided with extra blankets, warmer clothing was offered and the air conditioner was turned off. Although R6 had a room air temperature measured once during survey to be 70 degrees F, neither R51's room or the activity room had air temperatures measured during the survey to determine if they were within the 71-81 degree F range.

F257 is not a valid example of a deficient practice under this regulation and will be removed from the Statement of Deficiencies (CMS-2567 form) and Post Certification Revisit Report (CMS-2567b).

F353 S/S (F) 42 CFR §483.30 Nursing Services
The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.

Summary of the facility's reason for IDR of this tag: The facility asserts staffing in the memory care unit (Little Village) was sufficient to meet the needs of the 20 residents living in the memory care unit. Staffing on the day shift and evening shift was 1 nurse, 2 nursing assistants.

Summary of facts: The memory care unit (Little Village) had 20 residents at the time of the survey and the staffing level was 1 nurse with 2 nursing assistants plus an activity staff. The family complaint stated it took up to 10 minutes to have the call light answered. Review of the facility's call light log showed the longest wait was up to 20 minutes, but the average wait was five minutes. During interviews with nursing assistants, licensed staff and the family member, all made statements that the unit is "short staffed" however, there were no resident cares service issues cited due to lack of staffing on the memory care unit. R12 & R38 both lived on the memory care unit and were identified as having multiple falls however, a lack of sufficient staffing could not clearly be identified as the cause of the falls.

Summary of findings: There was a lack of clear evidence that the memory care unit had insufficient staff to meet the care and services of each resident living on the unit.

F353 is not a valid example of a deficient practice under this regulation and will be removed from the Statement of Deficiencies (CMS-2567 form) and Post Certification Revisit Report (CMS-2567b).

F520 S/S – (F) CFR 483.75(o) Quality Assessment and Assurance
(2) The quality assessment and assurance committee –
(i) Meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and
(ii) Develops and implements appropriate plans of action to correct identified quality deficiencies.

Summary of the facility's reason for IDR of this tag: The facility asserts they have demonstrated to have a functional quality assessment and assurance (QAA) process that identifies areas for improvement that action plans are developed, and data results reported. The facility asserts good faith attempts by the committee do identify and correct areas that may result in deficiencies or sanctions.

Summary of facts: The facility did not have an action plan to address short staffing on the memory care unit (Little Village) to meet the needs of each resident. However, the facility provided QAA meeting minutes dated July 29, 2015, which clearly included discussion in regards to staff recruitment and retention. The meeting minutes also indicated 8 nursing assistants and 1 registered nurse had resigned and there were 10 students starting class October 3, 2015.

Summary of findings: The facility has identified the ongoing needs of the residents they care for and have determined they have sufficient staff with the current census and care level needed for residents living on the memory care unit. The facility had discussed the concerns with staffing as part of their quarterly QAA meeting.

F520 is not a valid example of a deficient practice under this regulation and will be removed from the Statement of Deficiencies (CMS-2567 form) and Post Certification Revisit Report (CMS-2567b).

The revised Statement of Deficiencies and Post Certification Revisit Report are attached.

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

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

Sincerely,

Gary Nederhoff, Unit Supervisor
Licensing and Certification Program
Health Regulation Division
Wood Lake Drive SE
Rochester, MN 55904
Telephone: 507-206-2731 Fax: 507-206-2711
Gary.nederhoff@state.mn.us

cc: Office of Ombudsman for Long-Term Care
Maria King, Assistant Program Manager
Licensing and Certification File
Gayle Lantto, Metro Team D Unit Supervisor

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 _____	08/20/2015

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 The facility's plan of correction (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 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. This 2567 has been revised as a result of an Informal Dispute Resolution.	F 000		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain a safe environment for 1 of 3 residents (R88) reviewed for accidents by ensuring freedom from risk of head entrapment between the mattress and headboard. Findings include:	F 323		9/15/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 09/21/2015

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 _____	08/20/2015

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 323	Continued From page 1	F 323		

R88's room was observed on 8/18/15. A large gap was observed between the top of the mattress and the headboard of the bed. A metal mattress retaining bar was across the top of the mattress to prevent the mattress shifting toward the headboard. No such retaining bar was seen at the foot end of the mattress, and the mattress was up against the footboard of the bed frame.

On 8/19/15, at 7:49 a.m. the surveyor measured the gap, finding the distance was greater than 4 3/4 inches.

Review of the FDA [Food and Drug Administration] guidance, revealed Zone 7 as the area "Between the Head or Foot Board and the Mattress End." The guidance identified Zone 7 as an area for potential entrapment.

A nursing assistant (NA)-C familiar with R88 was interviewed on 8/20/15, at 8:08 a.m. NA-C reported, "She needs assist to move in bed mostly, but has fallen. That's why the bed is low to the floor with a floor mat."

R88's diagnoses included dementia. A review of R88's documentation revealed Care Area Assessments dated 1/16/15, that included dementia, urinary incontinence/catheter, falls, and psychotropic drug use. R88's assessments included a Brief Interview for Mental Status dated 7/3/15, with a score of 04/15, indicating severe cognitive impairment (altered mental status).

A maintenance worker-A (MW-A) viewed and measured the mattress gap on 8/19/15, at 8:49 a.m. MW-A reported, "That's about 5 inches. It's because there's no retainer at the foot end of the

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 _____	08/20/2015

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 323	Continued From page 2	F 323		

bed...I don't have a reason why it's not there. It should be, so the mattress doesn't slide back and forth. " MW-A said he was unaware of whether the facility had a policy that specified any acceptable distance between the footboard or headboard and the mattress. MW-A immediately requested his assistant find a retainer for the bed, and also stated they could adjust the headboard in or out to shorten or lengthen the frame to properly fit shorter and longer mattresses. MW-A stated, "We don't make rounds to look for that. That would be something I'd see in a room on a job, and think was not normal. I would think the aides would notice." MW-A notified the director of nursing (DON) of the issue on 8/19/15, at 9:01 a.m., and asked her whether there was a facility policy available related to minimizing the risk for entrapment.

On 8/19/15, at 11:35 a.m. MW-A was observed while re-measuring the gap. MW-A stated, "The retainer is there now" at the foot of the bed. After centering the mattress MW-A stated, "There, now it's 3 1/2 inches at this end, and 2 inches at that end...We check beds during monthly rounds but we haven't looked at that [gaps at the foot or head of bed]."

The facility's 12/07, Bed Safety policy was provided and included: "Our facility shall strive to provide a safe sleeping environment for the resident." The policy also indicated the facility would promote safety, to try to prevent deaths/injuries from the beds and related equipment, including the mattress, footboard, and headboard, with a number of approaches noted such as: "Inspection by maintenance staff of all beds and related equipment...to identify risks and problems including potential entrapment

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 _____	08/20/2015

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 323	Continued From page 3 risks...Identify additional safety measures for residents who have been identified as having a higher than usual risk for injury including entrapment (e.g., altered mental status...)."	F 323		

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 B. Wing	10/12/2015

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
ID Prefix **F0323** Reg. # **483.25(h)** LSC	**09/15/2015**
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 State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	MK/mm	12/31/2015	08769	10/12/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 8/20/2015

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: 92AO

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 **10/12/2015** (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:
X 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 :
Gayle Lantto, Unit Supervisor 10/27/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 10/27/2015 (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
10/13/2015
(L33)

DETERMINATION APPROVAL

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

CCN: 24 5514

Mala Strana Health Care Center was not in substantial compliance with Federal participation requirements at the time of the August 20, 2015 standard survey. On October 12, 2015, the Department of Health completed a Post Certification Revisit (PCR) by review of the plan of correction and on October 19, 2015, The Department of Public Safety completed a PCR. Based on the PCR, it has been determined that the facility achieved substantial compliance pursuant to the standard survey completed on August 20, 2015, effective October 16, 2015. Refer to the CMS-2567b for both health and life safety code.

The facility has requested a temporary waiver for the life safety code deficiency cited at K11 with a completion date of December 14, 2015. The waiver requested has been approved.

Effective October 16, 2015, 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): 245514

October 27, 2015

Ms. Dawn Chiabotti, Administrator
Mala Strana Health Care Center
1001 Columbus Avenue North
New Prague, Minnesota 56071

Dear Ms. Chiabotti:

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 October 16, 2015 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.

Your request for waiver of K11 has been approved based on the submitted documentation.

If you are not in compliance with the above requirements at the time of your next survey, you will be required to submit a Plan of Correction for this deficiency or renew your request for waiver in order to continue your participation in the Medicare Medicaid Program.

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 letter.

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

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

October 27, 2015

Ms. Dawn Chiabotti, Administrator
Mala Strana Health Care Center
1001 Columbus Avenue North
New Prague, Minnesota 56071

RE: Project Number S5514024

Dear Ms. Chiabotti:

On September 8, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 20, 2015. 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 12, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on October 19, 2015 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 20, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of November 16, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 20, 2015, effective October 16, 2015 and therefore remedies outlined in our letter to you dated September 8, 2015, will not be imposed.

Correction of the Life Safety Code deficiency cited under K11 at the time of the August 20, 2015 standard survey, has not yet been verified. Your plan of correction for this deficiency, including your request for a temporary waiver with a date of completion of December 14, 2015, has been approved.

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 related to this letter.

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

Enclosure(s)

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 B. Wing	10/12/2015

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
ID Prefix **F0257** Reg. # **483.15(h)(6)** LSC	**09/15/2015**
ID Prefix **F0323** Reg. # **483.25(h)** LSC	**09/15/2015**
ID Prefix **F0353** Reg. # **483.30(a)** LSC	**09/21/2015**
ID Prefix **F0520** Reg. # **483.75(o)(1)** LSC	**09/21/2015**
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 State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	GL/mm	10/27/2015	15507	10/12/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 8/20/2015

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

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 B. Wing **01 - MAIN BUILDING 01**	10/19/2015

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	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix	Correction Completed **09/15/2015**	ID Prefix	Correction Completed **09/15/2015**	ID Prefix	Correction Completed **08/29/2015**
Reg. # **NFPA 101**		Reg. # **NFPA 101**		Reg. # **NFPA 101**	
LSC K0029		LSC K0033		LSC K0046	
ID Prefix	Correction Completed **10/06/2015**	ID Prefix	Correction Completed **10/07/2015**	ID Prefix	Correction Completed **09/08/2015**
Reg. # **NFPA 101**		Reg. # **NFPA 101**		Reg. # **NFPA 101**	
LSC K0054		LSC K0062		LSC K0076	
ID Prefix	Correction Completed **09/10/2015**	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # **NFPA 101**		Reg. #		Reg. #	
LSC K0144		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	GS/mm	10/27/2015	25822	10/19/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
8/20/2015			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 92AO

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: **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 **08/20/2015** (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 Date :
Douglas Stevens, HFE NEII 10/02/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 10/12/2015 (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
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
(L33)

DETERMINATION APPROVAL

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

CCN: 24 5514

At the time of the August 20, 2015 standard survey the facility was not in substantial compliance with Federal participation requirements. The facility has been given an opportunity to correct before remedies would be imposed. The most serious deficiency is a widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) Please refer to the CMS-2567 for both health and life safety code along with the facility's plan of correction. Post Certification Revisit to follow.

The facility has requested a temporary waiver for the life safety code deficiency cited at K11 with a completion date of December 14, 2015. The waiver requested has been approved.

Refer to the CMS 2567 for both health and life safety code along with the facilitys plan of correction.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7008 0150 0001 1713 0121

September 8, 2015

Ms. Dawn Chiabotti, Administrator
Mala Strana Health Care Center
1001 Columbus Avenue North
New Prague, Minnesota 56071

RE: Project Number S5514024

Dear Ms. Chiabotti:

On August 20, 2015, 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;

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

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

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

DEPARTMENT CONTACT

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

Gayle Lantto, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Gayle.Lantto@state.mn.us
Telephone: (651) 201-3794
Fax: (651) 215-9697

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 September 26, 2015, 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 September 26, 2015 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 20, 2015 (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 20, 2016 (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 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. Gary Schroeder, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
gary.schroeder@state.mn.us
Telephone: (507) 361-6204

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112
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 _____	08/20/2015

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 The facility's plan of correction (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 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	TAG #:F 257 D: Comfortable rooms Mala Strana takes pride in providing a comfortable and safe environment for all the residents. The facility respectfully disagrees with this deficiency, but understands the importance of maintaining a comfortable environment.	
F 257 SS=D	483.15(h)(6) COMFORTABLE & SAFE TEMPERATURE LEVELS The facility must provide comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 - 81° F This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to maintain comfortable room temperatures for 2 of 4 residents (R6, R51) reviewed for environmental concerns. Findings include: R6 reported on 8/17/15, at 5:09 p.m. that it was too cold in her room, and she always needed an extra blanket. She said that although staff tried to increase the temperature in her room, the temperature never went up. A non-pharmacological intervention on R6's physician orders included "offer blanket."	F 257	Resident R6 and R51 have been assessed for temperatures in the rooms. Thermostats have been evaluated for functioning and temps in all areas of the building have been taken. Audits have been completed daily for 10 working days than 3 times per week for one month, than weekly for 3 months and random rooms monthly thereafter during preventative maintenance.	

Accepted Plan to 10/2/15

Scanned FT POC 9/23/15

RECEIVED
SEP 23 2015
COMPLIANCE MONITORING DIVISION
LICENSE AND CERTIFICATION

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Dawn Chiabotti — TITLE: Administrator — (X6) DATE: 9/21/15

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 _____ B. WING _____	08/20/2015

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 257	Continued From page 1 R51 reported on 8/17/15, at 7:18 p.m. "It's always cool in my room." R51 stated she had complained to maintenance staff about the cool temperatures. In a follow-up interview in R51's room on 8/19/15, at 10:02 a.m. she stated, "Some days it is cooler in here. The air blows in here so I tell maintenance." At the time R51 was seated in a wheelchair with a wool shawl over her shoulders. Two blankets were on the resident's bed and the resident stated she needed the extra blankets to stay warm at night, as "they always keep it cool in here." R51 also stated that it was cool in the great room where activities and church were held when there were few people in the room. R51's current care plan indicated the resident had anemia (iron deficiency). Staff was directed to monitor for symptoms of anemia such as "feeling of cold" and report symptoms to the resident's physician. During interview with the director of maintenance (DM) on 8/19/15, at 9:50 a.m. he explained that Mondays through Fridays he looked at thermostats throughout the building to note temperature readings. When asked if he knew if the thermostats read accurately he answered, "I do not know if the thermostats read accurate. I trust the people who made them." He stated he had just turned the heat back on and set the temperature to 72 degrees Fahrenheit (F), as the administrator informed him the building felt a little cool. The DM further stated he had left the temperature set at 72 degrees and had just turned the air off. He said he did not perform testing of temperatures. He was unsure of temperature requirements, but said he kept the building at 72 degrees, as that where the temperatures had been set when he started in	F 257	Thermostats have been evaluated for functioning and temps in all areas of the building have been taken. Audits have been completed as noted above. An audit of the facility has been completed on 8/21/2015 to evaluate temperature and thermostat variations. A memo was put out to staff to not adjust thermostats or to open windows. The vent in the Little Village has been evaluated to turn it off or to reduce the amount of air blowing out 9/2/15. Thermostats have been evaluated for functioning and temps in all areas of the building have been taken. Audits have been completed as noted above. Maintenance Director is responsible for this to be completed and monitored. Education has been provided to the staff on September 14 and 15, 2015. All results will be reported at the Quarterly QA meetings.	9/15/15

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	245514	A. BUILDING _____ B. WING _____	08/20/2015

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F 257	Continued From page 2 January. An environmental tour was then conducted with the DM. R51 said it was always cold and asked, "Do you have to keep it so cold in here?" R51's roommate then stated, "Don't make it too warm in here." The DM explained that the only way to warm up resident rooms was to warm up the hallways so the rooms would get residual heat. The DM stated regarding the thermostat in R51's room, "With no numbers on this thermostat I don't have a clue what the temperature is in this room." He explained that the temperature was at the bottom of the comfort zone, and was blocked at the mid comfort zone. Regarding R51's concerns the DM stated, "She tells everyone she is cold." R6's temperature in the room was set at 68 degrees and registered 68 degrees. The DM was unsure whether the measurement was accurate, but set a Taylor hand-held thermometer by R6's bed and it registered 70 degrees. The DM did not know if the thermostat was accurate. R6 was lying in her bed covered up with a fuzzy blanket, and was heard coughing. R6 when asked stated it was better in the room today than on the previous day. The window was open in the room adjacent to R51's room, and the thermostat read 65 degrees. The thermostat at the nursing station read 72 degrees. After the tour the administrator was asked about room temperature checks. The administrator stated, "They should be checking resident room temperatures." The administrator also reported the staff in the secure unit were opening resident room windows. The following day at 9:20 a.m. the director of	F 257	Maintenance Director is responsible for this to be completed and monitored. Education has been provided to the staff on September 14 and 15, 2015. All results will be reported at the Quarterly QA meetings.	

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F 257	Continued From page 3 nursing stated residents needed to be comfortable, and their needs "should be first and foremost." At approximately 9:30 a.m. the DM informed the surveyor a laser gun thermometer had been purchased. Later that morning the administrator informed the surveyor she had requested an audit of air temperatures, and had informed the maintenance staff of temperature guidelines. A 3/09 Environmental Services (draft revision) read, "This Center provides sufficient housekeeping and maintenance personnel to maintain the interior and exterior of the Center in an attractive, safe, clean and orderly manner, in accordance with Federal and State rules and regulations."	F 257		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed maintain a safe environment for 1 of 3 residents (R88) reviewed for accidents by ensuring freedom from risk of head entrapment between the mattress and headboard.	F 323		

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F 323	Continued From page 4	F 323	TAG #:F 323D: Freedom from risk of head entrapment between the mattress and headboard Mala Strana takes pride in providing a safe, warm and comfortable environment for all the residents. R88 bed was immediately assessed and issue was resolved on 8/19/15. Mattress bar was applied. An audit of the entire facility was completed by 8/21/15 and any issues were resolved. An audit will be completed weekly until the end of September 2015, than will be done monthly times 3 and changed to quarterly Jan 1, 2016. All results will be reported at the Quarterly QA meetings.	

Findings include:

R88's room was observed on 8/18/15. A large gap was observed between the top of the mattress and the headboard of the bed. A metal mattress retaining bar was across the top of the mattress to prevent the mattress shifting toward the headboard. No such retaining bar was seen at the foot end of the mattress, and the mattress was up against the footboard of the bed frame. The gap was an approximate large fist-width and larger than guidelines governing safety to prevent entrapment.

On 8/19/15, at 7:49 a.m. the surveyor measured the gap, finding the distance was greater than 4 3/4 inches, which was the maximum distance or dimensional limit recommendation cited in Guidance for Industry and FDA [Food and Drug Administration] Staff as the critical threshold for head entrapment. This guideline also specified Zone 7 was the area "Between the Head or Foot Board and the Mattress End" as an area where there is a potential for entrapment.

A nursing assistant (NA)-C familiar with R88 was interviewed on 8/20/15, at 8:08 a.m. NA-C reported, "She needs assist to move in bed mostly, but has fallen. That's why the bed is low to the floor with a floor mat."

R88's diagnoses included dementia. A review of R88's documentation revealed Care Area Assessments dated 1/16/15, that included dementia, urinary incontinence/catheter, falls, and psychotropic drug use. R88's assessments included a Brief Interview for Mental Status dated 7/3/15, with a score of 04/15, indicating severe

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F 323	Continued From page 5 cognitive impairment (altered mental status). A maintenance worker-A (MW-A) viewed and measured the mattress gap on 8/19/15, at 8:49 a.m. MW-A reported, "That's about 5 inches. It's because there's no retainer at the foot end of the bed...I don't have a reason why it's not there. It should be, so the mattress doesn't slide back and forth. " MW-A said he was unaware of the acceptable distance between mattresses/rails and bed frames or whether the facility had a policy that specified the acceptable distance. A retainer was immediately requested of his assistant. He indicated they could also adjust the headboard in or out to shorten or lengthen the frame to properly fit shorter and longer mattresses. MW-A stated, "We don't make rounds to look for that. That would be something I'd see in a room on a job, and think was not normal. I would think the aides would notice." The director of nursing (DON) was then notified by MW-A called the DON on 8/19/15, at 9:01 a.m. and was asked if a policy was available related to minimizing the risk for entrapment and the maximum allowable gap width between a mattress and a headboard. On 8/19/15, at 11:35 a.m. MW-A was observed while re-measuring the gap: "The retainer is there now" at the foot of the bed. After centering the mattress MW-A stated, "There, now it's 3 1/2 inches at this end, and 2 inches at that end...We check beds during monthly rounds but we haven't looked at that [gaps at the foot or head of bed]." The facility's 12/07, Bed Safety policy "Our facility shall strive to provide a safe sleeping environment for the resident." It further indicated the facility would promote, to try to prevent	F 323	This has been added to the monthly preventative maintenance form for ongoing monitoring and prevention. Maintenance Director is responsible for this to be completed and monitored. Education has been provided to the staff on September 14 and 15, 2015.	9/15/15

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F 323	Continued From page 6 deaths/injuries from the beds and related equipment, including the mattress, footboard, and headboard, with a number of approaches noted such as "Inspection by maintenance staff of all beds and related equipment...to identify risks and problems including potential entrapment risks...that gaps...are within the dimensions established by the FDA...Identify additional safety measures for residents who have been identified as having a higher than usual risk for injury including entrapment (e.g., altered mental status...)." The document included no guidelines as to maximum allowable gaps between mattresses and bed components to minimize the risk of entrapment.	F 323		
F 353 SS=F	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of	F 353		

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F 353	Continued From page 7 duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure sufficient nursing staffing was available to meet the needs of residents who voiced or whose representatives voiced concerns regarding lack of staff to assure resident needs could be met in a timely manner. This had the potential to affect all 86 resident residing in the facility. Findings include: R6's family member (FM)-A was interviewed on 8/17/15, at 5:02 p.m. R6 resided on the memory care unit (Little Village). FM-A reported concerns related to the care of his mother and other residents on the unit related to almost daily staffing shortages to meet the needs of the residents in a timely manner. FM-A stated that R6's call light had been activated, but sometimes it took over 10 minutes for a response for her call light as well as other call lights to be answered. R6's current nursing assistant (NA) assignment sheet indicated the resident required the assistance of two staff and a Hoyer (mechanical full body lift) for hourly repositioning. In addition, it was noted the resident received hospice care and had daily treatments for pressure ulcers. R6 was observed on 8/19/15, at 12:04 p.m. when a NA brought R6 to her room and stated, "I will be right back to help you to bed." Within five minutes two NAs entered R6's room. NA-A said to the surveyor, "I just want you to know we do not have	F 353	F 353 F Mala Strana strives to maintain adequate staffing levels in all sections of our facility. The facility respectfully disagrees with this deficiency, but understands the importance of maintaining adequate staffing and levels of care to meet the resident needs. Resident R6 family member is an active family member and attends council meetings and visits. The pressure area referred to by this family is an area that we are treating regularly has a diagnosis of non pressure chronic ulcer. A long standing pressure area to her bottom has been healed for several months. Will continue to monitor call lights and response times for this resident. Call light sheets will be monitored, continue to monitor falls daily and will begin weekly to monitor for trends and patterns.	

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F 353	Continued From page 8 enough staff on this floor." NA-A explained the residents on the unit needed high levels of assistance and were "always on the move." Because of this, the residents required greater supervision, "but we can't be in two places at one time." On 8/20/15, at 9:39 a.m. NA-B explained there had been three NAs on the memory care unit as well as a bath NA. Management staff, however, cut the staffing leaving only two NAs on the unit. The NAs were also responsible for giving two to three baths for residents per shift. When asked if the staff were able to complete all their assigned work NA-B paused and stated, "I can get my work done, but resident cares do not get done in a timely manner." For example, if toileting and repositioning was required every hour or two hours, with only two NAs, sometimes the residents would need to wait an extra half hour to an hour past their assessed need. July 2015 Call light audit sheets were reviewed for the memory care unit and revealed 90 times residents' call light were on greater than five minutes with the longest times being 20 minutes, 38 seconds for R6. In addition, call light audits for all rooms showed 1,198 times when call lights exceeded 10 minutes, with the longest time being one hour, 15 minutes. The audit revealed 197 times residents' call lights were on greater than 20 minutes or 16% of the time. During an interview on 8/20/15, at 11:27 a.m. a registered nurse (RN)-A explained that the memory care unit had the following staffing: a nurse manager, a housekeeper, two NAs, and an activity staff person. This was consistent with staffing observations during the four days of the	F 353	Will continue to discuss patterns of open areas for residents with the weekly skin meetings. Skin areas will continue to be monitored and treated as needed. Will monitor the staffing patterns in the facility and will add staff and adjust hours as identified. Included in this is the adjustment of the nurse manager in the Little Village to be more visible and providing more leadership to that area of the building. Evaluate and attempt to hire a short shift bath aide for the Little Village. We have run ads on both the radio and in the papers, we have finished a NAR training class and will begin a new one on 9/28/15 (planned), we have started four employees during the week of 9/14/15. It is noted that any discussion related to staffing and management was related to the new organization ownership and the need to understand our process and systems.	

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F 353	Continued From page 9 survey. RN-A stated that staff had reported feeling there were not enough staff on the unit to care for the residents, and she had informed the administrator of the concerns. RN-A confirmed she was aware there had been a decrease in staffing by management staff, however, she was unsure why the decision was made to cut the staffing on the unit. RN-A explained that one staff person came from the assisted living unit to help for cares for one hour in the morning. If help was still needed, the NAs were to call the east wing to summon assistance. Accident reports related to falls were reviewed. The reports revealed R12 and R38 who resided in the memory care unit had experienced multiple falls in the memory care unit. R12's fall record indicated from 5/12/15 to 8/7/15 he had experienced 15 falls without injury. R38's fall record indicated from 3/19/15 to 5/15/15 he had experienced 14 falls. During an interview on 8/20/15, at 11:32 a.m. NA-D stated that she had worked at the facility for about four months. She reported that she works both on the west and memory care units. She noted that on the dementia unit "things are not getting done on time." She stated that at bedtime hours call lights were not answered in a timely fashion because "You're in a room for a half an hour to an hour at a ." She also reported that toileting and repositioning is not completed in a timely manner in the "Village" as "We are short staffed in the evenings". NA-D clarified that there used to be a short 5-9 p.m. shift on the unit, however, that position was eliminated. She reported having the short shift staff person was very helpful during evening meals and bedtime cares, but management "thought it was not	F 353	There has been a job fair/hiring event on 9/3/15 and we obtained two employees from that. Walkie Talkies are monitored as needed for functioning and there have been more ordered to assure they are readily available. Call lights throughout the facility will be monitored weekly for trends and patterns. Will provide education to staff as needed. Education provided to the staff to not use the call lights to ask other staff for help, but to use the walkie talkies on 9/15/15. Continue to monitor the falls and pressure areas in the facility. Will monitor these daily at our stand up meeting, weekly at our skin and nutrition meeting and will develop action plans as needed, providing data to the QA committee. Will add falls to our weekly meeting discussions to identify patterns and trends. Staff review and education was provided on September 14 and 15, 2015. The DON or her designee is responsible to monitor this and maintain this.	9/21/15

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F 353	Continued From page 10 necessary." NA-D pointed out that most residents in the dementia unit sundown (common with dementia where persons experience increased confusion and anxiety) and it becomes "extremely difficult for only two aides to provide appropriate cares." NA-D stated that depending on the day, sometimes they were able to take their breaks, but sometimes in the evening they were unable to take their breaks. "It depends on the day and how things are going." NA-D further reported that management had been made aware of the insufficient staffing in the Village unit, but no changes had been made to correct the problem. She also noted that when a staff person called in sick, most of the time the staff was not replaced because, "There is not a lot of staff to replace people with." A review of the call light logs for the east and west wings indicated and increase in wait times for residents' call lights to be answered from May 2015 to August 2015. In May 412 call lights were unanswered within 10 minutes. Review of June records indicated 495 call lights unanswered within 10 minutes, in July 561 call lights unanswered within 10 minutes and as of August 20th, 637 call lights unanswered within 10 minutes from time call light activated. Fall logs for the facility indicated falls nearly doubled from May 2015 to July 2015. In May 12 residents experienced falls, and in June 16 resident falls, and in July, 21 residents experienced falls. The Daily Staffing postings for July 2015 indicated daily changes in census for residents' admissions and discharges. In an interview with the director of nursing (DON) on 8/20/15, at 9:20 a.m. she stated the	F 353	This action has gone into effect on September 21, 2015. This issue will be ongoing and will be reported at the QA meetings quarterly.	

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F 353	Continued From page 11 administrator had decided how much nursing staff was required for each wing. The DON also stated the number of staff had been consistent during the past three months. As a group, the management staff reviewed the falls and incident reports daily. The admissions and discharges took place almost weekly, and the census had been around 86 residents during the past few months. The DON stated the memory unit had 20 residents with two NAs on day shift and two NAs on evening shift and that east and west wings each had three NAs on day and evening shifts. Two night nurses and four NAs worked during the night shift. Later that morning while interviewing the administrator with the DON the administrator reported the facility had not received any grievances related to staffing concerns. The administrator stated she knew the staff worked hard as mentioned in the review of the August Resident Council minutes where some of the residents expressed concern as to how hard the staff had to work. The administrator further stated a year ago a staffing change had been made where the number of NAs was reduced. In addition, staff worked longer hours, were busier, but voluntarily picked up overtime shifts. The Little Village NAs were expected to complete their own baths, and a float NA was supposed to go into the unit to assist the staff, but there was a lack of cooperation on the part of the float staff. In addition, some staff were taking unscheduled smoke breaks. The administrator reported the resident Case Mix acuity was .95 that day, but the administrator was unable to break this down by wing. She the health information manager could assist with determining the acuity per unit. The administrator explained that determining staffing	F 353		

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F 353	Continued From page 12 per unit was between the nursing staff and managers. Two NAs were scheduled for Little Village, and then three staff on both east and west. The administrator said that last week she was trying to justify more staffing in Little Village. In addition, she had scheduled a psychologist to come on the 28th to teach the staff how to work with residents with dementia who presented behavioral issues. The new management staff had asked her to write a proposal justifying the need for additional staff in the Little Village unit. When asked about the increase in resident falls, the administrator stated they had noted an increase in falls, as well as in admissions and discharges, however, no additional staff had been added during this time. Regarding call lights, it was all staffs' responsibility to answer call lights in three to five minutes. The administrator had reported increased call light times to the quality assurance committee, however, no action plan had been developed to address the issue at this time. The administrator and human relations director (HRD) were then interviewed together, as the HRD was the acting staffing person at the time. The HRD reported she just filled in the numbers of staff that had been set at two in the Little Village, and three on both the east and west wings. She was unable to add additional staff in the units without managements' approval. The facility's 4/07 Staffing policy indicated, "Our facility provides adequate staffing to meet needed care and services for our resident population. 1. Our facility maintains adequate staffing on each unity to ensure that our resident's needs and services are met. 2. Certified Nursing Assistants are available on	F 353		

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 _____	08/20/2015

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

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F 353	Continued From page 13 each shift to provide the needed care and services of each resident as outlined on the resident's comprehensive care plan."	F 353		
F 520 SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interview the facility's quality assessment and assurance (QAA) committee failed to identify and develop an action plan to address concerns related to insufficient staffing.	F 520		

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F 520	Continued From page 14 This potentially affected all residents in the facility. Findings include: In an interview at approximately 10:30 a.m. the administrator and director of nursing (DON) reported the facility had not received any grievances related to staffing concerns. The administrator stated she knew the staff worked hard as mentioned in the review of the August Resident Council minutes where some of the residents expressed concern as to how hard the staff had to work. The administrator further stated a year ago a staffing change had been made where the number of NAs was reduced. In addition, staff worked longer hours, were busier, but voluntarily picked up overtime shifts. The Little Village NAs were expected to complete their own baths, and a float NA was supposed to go into the unit to assist the staff, but there was a lack of cooperation on the part of the float staff. In addition, some staff were taking unscheduled smoke breaks. The administrator reported the resident Case Mix acuity was .95 that day, but the administrator was unable to break this down by wing. She the health information manager could assist with determining the acuity per unit. The administrator explained that determining staffing per unit was between the nursing staff and managers. Two NAs were scheduled for Little Village, and then three staff on both east and west. The administrator said that last week she was trying to justify more staffing in Little Village. In addition, she had scheduled a psychologist to come on the 28th to teach the staff how to work with residents with dementia who presented behavioral issues. The new management staff had asked her to write a proposal justifying the	F 520		

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F 520	Continued From page 15 need for additional staff in the Little Village unit. When asked about the increase in resident falls, the administrator stated they had noted an increase in falls, as well as in admissions and discharges, however, no additional staff had been added during this time. Regarding call lights, it was all staffs' responsibility to answer call lights in three to five minutes. The administrator had reported increased call light times to the quality assurance committee, however, no action plan had been developed to address the issue at this time. A registered nurse (RN)-D, who was also the QAA Committee contact, was interviewed on 8/20/15 at 12:48 p.m. When asked for examples of QAA Committee projects, RN-D stated, "I'm not thinking of anything off the top of my head. Let me pull an agenda." The director of nursing (DON) was also present for part of the interview, and when asked about staffing concerns that had been reported to surveyors, she stated, "We go over recruitment and retention at every meeting, and talk about hiring and needs, who's terminated, who's hired, retention rates...." She further indicated they held (interdisciplinary) standup staff meetings every morning, followed by a meeting with just nurses. "We look at facility-wide and individual falls daily, how many, time of day, etc. I noticed and we started monitoring chair falls on one resident and made multiple changes [such as hourly checks]. We summarize all this and bring it to review at QAA meetings...." An interview was conducted on 8/20/15 at 1:48 p.m. with the facility medical director (MD). He indicated he regularly attended the quarterly QAA	F 520		

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F 520	Continued From page 16 meetings. He was asked whether he was aware of any staffing issues in the facility and replied, "Yes, but I was not aware that that was a major problem at Mala Strana," and said it had not been frequently brought up at QAA meetings. When asked if he was aware of staffing patterns on the various units and whether the acuity of residents was considered, he stated, "I was not aware that was an issue. It's not a recurring issue at QAA meetings. The admit acuities have been rising and staffing should reflect that." The medical director further indicated he was aware of a staffing cut in Little Village, a memory care unit at the facility, adding, "I would presume staffing changes are based on the acuity needs of the residents, to provide service to meet the residents needs...I think the nursing personnel, administrative folks determine the residents' needs." He was unaware of proposals to increase staffing at the facility. A 1/08 Continuous Quality Improvement Process policy, "The Thro Company Health Care Centers are committed to providing quality care and services which enable each resident to attain the highest practicable, physical, mental and psychosocial well being. The continuous quality improvement improvement process shall include a comprehensive, ongoing evaluation of services provided to assure quality outcomes for each resident. The Administrator, Education Director and Interdisciplinary team shall be ultimately responsible for the proper outcome of this ongoing process.' The policy also indicated 'The Thro Company Health Care Centers will assure quality of service and care to all residents, using CQI methods/audit tools to evaluate measurable outcomes. Based upon outcome of the findings, interventions will be completed by the	F 520	F 520 F Mala Strana is proud to maintain a quality assessment and assurance committee that meets at least quarterly. The facility respectfully disagrees with this deficiency, but understands the importance of maintaining a QAA committee that effectively identifies and develops an action plan to address concerns. The facility will continue to meet quarterly and will continue to develop action plans as needed and deemed appropriate by the committee. Items such as falls, pressure ulcers and call lights will continue to be monitored. The call light report will be monitored weekly and identify trends and patterns. It is also noted that the discussion regarding staffing will continue to be addressed in the Quality Assurance meetings. A formal action plan for staffing will be developed. The Medical Director will continue to be informed as needed. The Quality Assurance/ OHL Director is responsible for this action and it is in effect September 21, 2015	9/21/15

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F 520	Continued From page 17 Interdisciplinary team appropriate to the issue/trends.'"	F 520		

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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 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. 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 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or	K 000	APPROVED By Gary Schroeder at 10:46 pm, Oct 03, 2015	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Dawn Cheabotti	Administrator	9/21/15

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 000	Continued From page 1 By email 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. Mala Strana Health Care Center was constructed at 2 different times. The original building was built in 1972, it is one-story in height, with a partial basement and was determined to be of Type II(111) construction. In 2002, a one-story in height addition with no basement was constructed and was determined to be of Type II(111) construction. Because the original building and the 1 addition are of the same type of construction and meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is fully sprinklered. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 92 beds and had a census of 87 at the time of the survey.	K 000		

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K 000	Continued From page 2 The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 011 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 19.1.1.4.1, 19.1.1.4.2 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide 2-hour fire rated construction at building separation wall in accordance with 2000 - NFPA 101, sections 19.1.1.4.1. The deficient practice could affect all 87 residents. Findings include: On facility tour between 8:45 AM and 1:00 PM 08/20/2015, observation revealed, that the 2 hour fire rated building separation wall between the nursing home and assisted living has two storage rooms entrance doors from the assisted living side that only have 60 minute fire rate doors instead of 90 minute fire rated doors. Make sure walls are constructed to 2 hours fire rated construction.	K 011	TAG #:K 11 F Two hour fire separation wall. 90 minute wooden doors are on order and will be completed by Bid by Kendell, 9/9/15 Estimated Date 11/16/15. Contractor blue print verifies it is a 2 hour separation wall. A waiver for date due has been requested. Is corrected and Environmental Services is responsible to complete this project and to monitor. Education to the staff was presented September 14 and 15. Will be reported at next QA meeting. T.W. REQUESTED	12/14/15

KENDELL

Doors & Hardware, Inc.

Quotation

To: Mala Strana Health Care Center *Date:* September 2, 2015

Attention: Mary O'Brien *Quote #:* SL090215

Following is our quote to furnish the following material for: **Mala Strana Health Care Center**
No labor for installation or erection is included unless otherwise noted.

VEND	QTY	DESCRIPTION - HOLLOW METAL/HARDWARE/WD DRS
		* 90 MINUTE RATED PAINT GRADE DOORS - PAINTING BY OTHERS.
MDS	1	3668 PC5 LHR 90M FLUSH GA MDO WD DOOR (453,G2A)@
MDS	1	3668 PC5 RHR 90M FLUSH GA MDO WD DOOR (453,G2A)@
REE	2	F-797B21 GASKET

* REUSE ALL EXISTING HARDWARE AND FRAMES. DOORS ARE PREPPED FOR CYLINDRICAL LOCKSETS.

* TO HAVE KENDELL DOORS INSTALL DOORS AND HARDWARE ADD: $600.00 TO THE QUOTE.

* 90 MINUTE RATED PAINT GRADE DOORS. PAINTING BY OTHERS.

Mary See Notes
MALA Strana
WILL install

Total: $1,284.00

1) 6.875% sales tax is included. Other taxes now or hereafter levied on sale of this material is not included.
2) Prices are net. Payment in full is due within 30 days of delivery.
3) Proposal is void 30 days after above date unless extended by Kendell in writing.
4) No back charge claims will be allowed unless approved by Kendell in writing.
5) No glass or glazing is included unless otherwise noted above.
6) Price is based on standard factory delivery schedules, please allow 8 weeks minimum for delivery.
7) Price does not include delivery to job site.

*** THIS PROPOSAL IS A QUOTATION ONLY: NO MATERIALS WILL BE ORDERED, MANUFACTURED, OR FURNISHED UNTIL A SIGNED COPY OF THIS PROPOSAL IS RETURNED TO KENDELL DOORS.**

Respectfully submitted,

Scott Lundgren

Dawn Chastoth
Accepted

9/9/15
Date

*Kendell Doors & Hardware, Inc. * 1703 N. Riverfront Drive * Mankato, MN 56001 * (507) 388-8629 * Fax:(507) 388-8084*

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K 011	Continued From page 3 This deficient practice was confirmed by the Director of Maintenance (RH) at the time of discovery.	K 011	TAG #:K 011 F Two hour fire separation wall. 90 minute wooden doors are on order and will be completed by Bid by Kendell, 9/9/15 Estimated Date 11/16/15. Contractor blue print verifies it is a 2 hour separation wall. A waiver for date due has been requested. Is corrected and Environmental Services is responsible to complete this project and to monitor. Education to the staff was presented September 14 and 15. Will be reported at next QA meeting.	
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke-resisting partitions and doors in accordance with the following requirements of 2000 NFPA 101, Section 19.3.2.1. The deficient practice could affect 15 out 87 residents. Findings include: On facility tour between 8:45 AM and 1:00 PM 08/20/2015, observation revealed, that the following was found: 1. Boiler room - north wall open penetration around conduit lines 2. Storage room # 118 - no automatic door closer	K 029		

MACH LUMBER INC.
201 2ND AVE SW
NEW PRAGUE, MN 56071

PHONE: (952) 758-3235

CUST NO:	JOB NO:	PURCHASE ORDER:	REFERENCE:	TERMS:	CLERK:	DATE / TIME:
23023	000		90 MIN DOORS	DUE BY THE 15TH	PAUL	9/3/15 10:14

TERMINAL: 552

SOLD TO:
MALA STRANA
1001 COLUMBUS AVE N.
NEW PRAGUE MN 56071

SHIP TO:

EXP. DATE: 9/18/15

SALESPERSON: 01 HOUSE ACCOUNT
TAX: 001 MN 6.875% SALES TAX

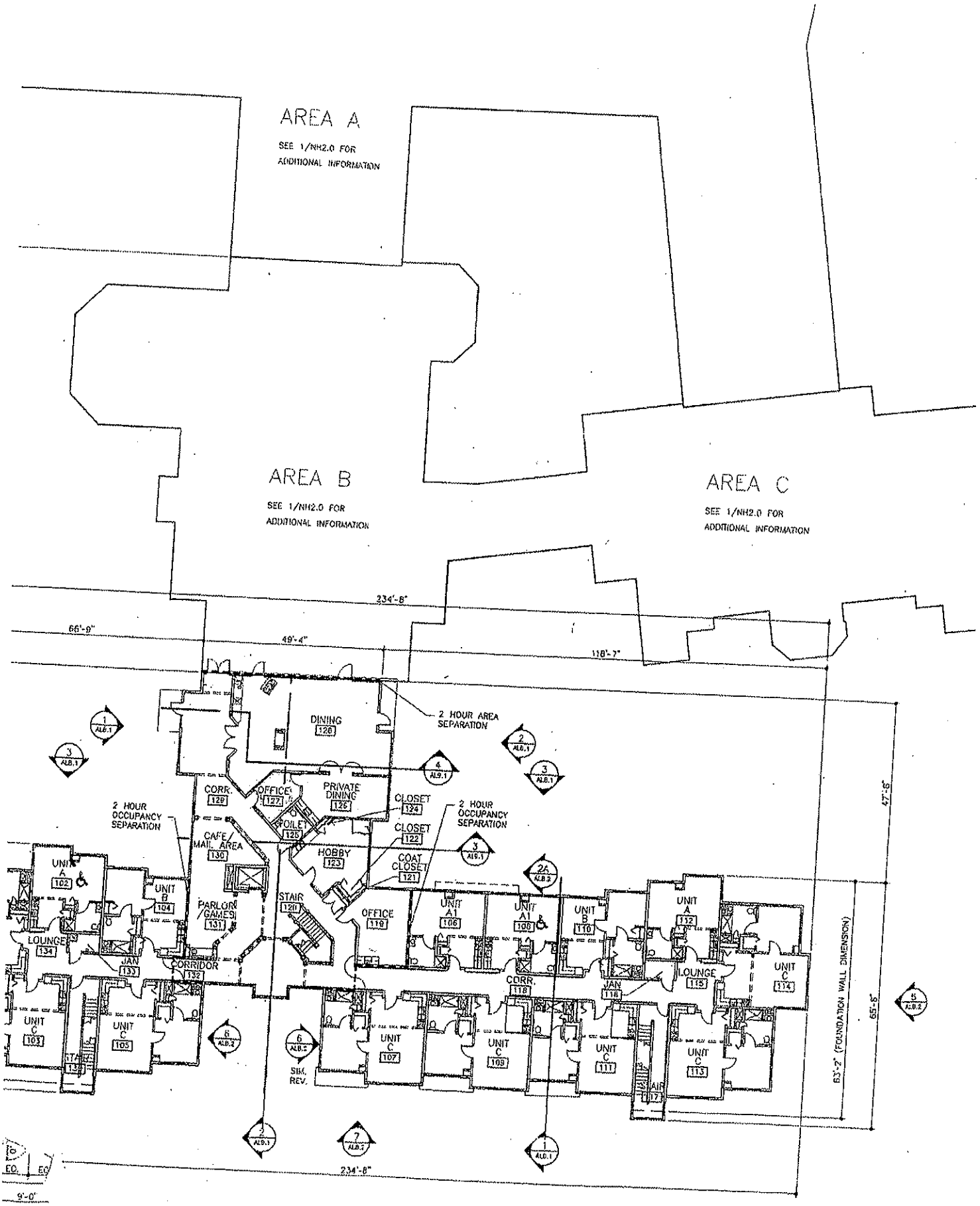
ESTIMATE: 563396

LINE	SHIPPED	ORDERED	UM	SKU	DESCRIPTION	SUGG	UNITS	PRICE/ PER	EXTENSION
1		2	EA	18	90 MIN HOLLOW METAL DOOR SLAB		2	665.85 /EA	1,331.70
2					MADE TO THE EXACT				
3					SPECS OF THE EXISTING				
4					DOORS				
5		1	EA	97	FREIGHT / DELIVERY		1	125.00 /EA	125.00 N

TAXABLE	1331.70
NON-TAXABLE	125.00
SUBTOTAL	1456.70
TAX AMOUNT	91.55
TOTAL	**1548.25**

TOT WT: 0.00

X _____
Received By


AREA A
SEE 1/NH2.0 FOR ADDITIONAL INFORMATION
AREA B
SEE 1/NH2.0 FOR ADDITIONAL INFORMATION
AREA C
SEE 1/NH2.0 FOR ADDITIONAL INFORMATION
234'-8"
66'-9"
49'-4"
118'-7"
47'-8"
65'-8"
63'-2" (FOUNDATION WALL DIMENSION)
DINING 128
2 HOUR AREA SEPARATION
CORR. 129
OFFICE 127
PRIVATE DINING 126
TOILET 125
CLOSET 124
CLOSET 122
COAT CLOSET 121
2 HOUR OCCUPANCY SEPARATION
CAFE/ MAIL AREA 130
HOBBY 123
STAIR 120
OFFICE 119
PARLOR GAMES 131
UNIT A 102
UNIT B 104
LOUNGE 134
JAN 133
CORRIDOR 132
UNIT C 103
UNIT C 105
STA 135
UNIT A1 106
UNIT A1 108
UNIT B 110
UNIT A 112
LOUNGE 115
UNIT C 114
CORR. 118
JAN 116
UNIT C 107
UNIT C 109
UNIT C 111
UNIT C 113
STAIR 117
SIM. REV.
EQ.
EQ.
9'-0"
234'-8"

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K 029	Continued From page 4 This deficient practice was confirmed by the Director of Maintenance (RH) at the time of discovery.	K 029	TAG #:K 33 D Basement stairwell open penetration around sprinkler has been sealed 8/8/15. Is corrected and Environmental Services is responsible to monitor this. Education to the staff was presented September 14 and 15, 2015.	
K 033 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit components (such as stairways) are enclosed with construction having a fire resistance rating of at least one hour, are arranged to provide a continuous path of escape, and provide protection against fire or smoke from other parts of the building. 8.2.5.2, 19.3.1.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain a fire resistance rating of at least one hour in the exit component accordance with the following requirements of 2000 NFPA 101, Section 19.3.1.1, 8.2.5.2. This could effect 15 out of 87 residents. Findings include: On facility tour between 8:45 AM and 1:00 PM 08/20/2015, observation revealed that the basement stairwell, has an open penetration around the sprinkler line. This deficient practice was confirmed by the Director of Maintenance (RH) at the time of discovery.	K 033		
K 046	NFPA 101 LIFE SAFETY CODE STANDARD	K 046		

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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 046 SS=D	Continued From page 5 Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide reliable battery operated emergency lighting as required by 2000 NFPA 101, Section 19..2.9.1, and 7.9.2. The deficient practice could affect 35 out of 87 residents. Findings include: On facility tour between 8:45 AM and 1:00 PM 08/20/2015, observation revealed that the following battery operated emergency lighting / exit signs did not work when tested. 1. In hallway by room # 110 2. Entrance to memory care unit 3. In hallway by room # 310 These deficient practices were confirmed by the Director of Maintenance (RH) at the time of discovery.	K 046	TAG #:K 46 D Emergency Battery operated signs were tested and are operational. Lighting was fixed on 8/29/15 and checked the rest of the building. Bimonthly checks to be completed for 3 months and then will re-evaluate. Room #110 hallway, entrance to memory care unit, and hall by #310 have been corrected on 8/29/15 Is corrected and Environmental Services is responsible to monitor this. Education to the staff was presented September 14 and 15, 2015.	
K 054 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by:	K 054		

K46 tag

Maint. Ryan Hauser went through all the emergency lights on 8-29-15 and fixed the ones listed and also checked rest of the emergency lights that were all working properly.

Will be put on bi-monthly check for 6 months then re evaluated.

EMERGENCY LIGHTS
Nursing Home

LOCATION	CHECKED											
1. Public Restroom Hallways												
a. Combo sign by Social Services												
b. Exit sign by Social Services												
c. Exit sign by Public Restrooms												
2. Tolie Dining Room Doors												
3. Between Dining Rooms												
4. Main Doors in Carpet Dining Room												
5. Great Room Entrance												
6. Great Room – Exit Door to Outside												
7. Hallway before Assisted Living												
8. Service Hallway by Serving Kitchen												
a. Exit sign by doorway												
b. Exit sign by boiler room												
c. Exit sign by boiler room												
9. Kitchen going into Dining Room												
a. Emergency Light going into service hallway												
10. Kitchen dishroom entrance from service hallway												
a. Exit sign by dishroom												
b. Exit sign by garage door												
c. Exit sign by garage door												
11. Electrical room												
12. Entrance to Little Village from service hallway												
13. Entrance from Little Village to service hallway												
14. Hallway by Little Village Activities Porch												
15. Little Village Living Room Exit												
16. Quiet Room												
17. Exit Door by Room 310												
18. Outside Door in Little Village (North)												
19. Outside Door in Little village (North)												
20. Little Village by Room 308-309												
a. Exit sign by Room 306-307												

EMERGENCY LIGHTS (Continued)

LOCATION	CHECKED												
Nursing Home													
42. Main Front Entrance													
a. Exit sign by Front Office													
b. Exit sign by Mailboxes													
43. Hallway by Beauty Shop													
44. Hallway by Room 140-141													
45. Hallway by Room 148-149													
46. By West Wing Nursing Station													
47. South West Sunporch Exit Door													
~~a. Remote pack for S/W Outside Light~~													
48. North West Sunporch Exit Door													
~~a. Remote pack for N/W Outside Light~~													
49. Hallway Outside D.O.N. Office													
50. Exit Sign in hallway going outside the back entrance.													
51. By the Back Entrance													
a. ~~Remote pack for Outside Light by Back Entrance~~													
52. Hallway by the Conference Room													
53. Hallway by room 110-111													
54. Hallway by Room 118-119													
55. By East Wing Nursing Station													
56. Hallway by Room 124-125													
57. North East Sunporch Exit													
~~a. Remote pack for N/E Outside Light~~													
58. Hallway by Room 306-307 (138-139)													
59. Exit Sign in hallway by room 300-301 (132-133)													
Basement													
60. Exit Sign by the door going upstairs by Janitor Room													
61. Exit Sign in Hallway by Boiler Room													
62. Outside Door by Boiler Room													
63. By Exit in Education Room													
64. In Boiler Room													
65. Hallway by the Elevator													
66. Bottom of staircase steps going into basement.													

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 _____	08/20/2015

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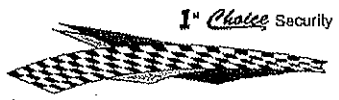
MALA STRANA HEALTH CARE CENTER	1001 COLUMBUS AVENUE NORTH NEW PRAGUE, MN 56071

(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 054	Continued From page 6 Based on documentation review and staff interview, the facility failed maintain the fire alarm system in accordance with the requirement 1999 NFPA 72, Section 7-3.2. The deficient practice could affect all 87 residents. Findings include: On facility tour between 8:45 AM and 1:00 PM 08/20/2015, the review of the annual fire alarm system report from 1st Choice Security revealed that the fire alarm system was not inspected/tested in a 12 month period (09/12/13 & 10/06/14). This deficient practice was confirmed by the Director of Maintenance (RH) at the time of discovery.	K 054	TAG #:K 54 D Yearly inspection of the fire system and smoke detectors was completed, First Choice Security was working on the system at that time and did a full security check on 10/6/15. The entire system has been tested and is functional on 9/4/15 by First Choice.	
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the fire sprinkler system in accordance with the requirements of 2000 NFPA 101, Sections 19.3.4.1 and 9.6, as well as 1998 NFPA 25, sections 2-2.1.1 and 2-4.1.4. This deficient practice could affect all 87 residents	K 062		



1st Choice Security
19224 517 Lane
Lake Crystal, MN. 56055
Phone: 507-380-1864
Fax: 507-726-2515

Dear Mr. Schrader,

Mary Obrien has brought it to our attention that you were concerned as to our yearly test being about a month late from when it was conducted last year. We were aware of the date the test was due, but at that time, we were in the process of changing out much of the fire alarm system, and since we were on site working on it, it was getting tested daily. We just didn't log it down because we would be doing a final inspection of the entire system once the job was complete.

I hope this helps out, as the system was tested, just not logged due to circumstance.

Thanks
Layne Johnson
1st Choice Security
19224 517 Lane
Lake Crystal, MN. 56055
507-380-1864

Inspection and Testing NFPA Report

Customer Name : malastrana

Panel Type : 636 Pt. Addr. **Uploaded Date and Time :** ~~10/6/2014 12:31:04 PM~~

General Information

Date : 9-4-2015 ~~10/6/2014~~ Time : 1100 ~~12:28~~

Service Organization

Name : 1st Choice Security

Address :

Representative : Matt Hennek

License No. : Telephone : 507-380-1864

Monitoring Entity

Contact : MAS

Telephone : 507-345-4185

Monitoring Account 4445

Ref. No. :

Approving Agency

Contact : Ann Reeves

Telephone : 507-345-4185

Service

☐ Weekly ☐ Monthly ☐ Quarterly ☐ Semiannually ☒ Annually

Other (specify) :

Property Name (User)

Name : Mala Strana

Address : 1001 Columbus Ave North

Owner Contact :

Telephone : 952-758-2511

Type Transmission

☐ McCulloh ☐ Multiplex ☒ Digital ☐ Reverse Priority ☐ RF

☐ Other (specify) :

Control Unit Manufacturer : Firelite

Model No. : MS9600UDLS

Circuit Styles : Addressable

Number of Circuits :

Software Rev. :

Last Date System Had Any Service Performed : 10/6/2014

Last Date That Any Software or Configuration Was Revised : 10/6/2014

Signaling Line Circuit

Loop 1 : Quantity : 116 Style(s) : SLC

Loop 2 : Quantity : 99 Style(s) : SLC

Alarm - Initiating Devices and Circuit Information

	Quantity of Devices Installed	Circuit Style	Quantity of Devices Tested
Manual Fire Alarm Boxes	11		11
Ion Detectors	0		
Photo Detectors	143		143
Duct Detectors	5		5
Heat Detectors	8		8
Water flow Switches	0		
Supervisory Switches	0		
Other (Specify):			

See report

Alarm verification feature is ○ Enabled ◉ Disabled

Alarm Notification Devices and Circuit Information

	Quantity of Appliances Installed		Circuit Style	Quantity of Appliances Tested
	SLC	NAC		
Bells	0	4		
Horns	0			
Chimes				
Strobes	0			
Speakers				
Other (Specify):				

Are circuits monitored for Integrity? ○ Yes ◉ No

Supervisory Signal - Initiating Devices and Circuit Information

	Quantity of Devices Installed	Circuit Style	Quantity of Devices Tested
Building Temp.			
Site Water Temp.			
Site Water Level	N/A		
Fire Pump Power			
Fire Pump Running			
Fire Pump Auto Position			
Fire Pump or Pump Controller Trouble			
Fire Pump Running			
Generator in Auto Position			
Generator or Controller Trouble			
Switch Transfer			
Generator Engine Running			
Other (Specify):			

System Power Supplies - (a) Primary (Main) :

Nominal voltage : 120

Amps :

Overcurrent protection Type : Breaker

Amps :

Location (of primary supply panelboard) :

Disconnecting means location : 1119 B Breaker 10

System Power Supplies - (b) Secondary (Standby) :

Description : Battery

Storage battery : Amp-Hr Rating 36

Calculated capacity in Amp-Hrs to operate system for .30 idle Amps Hours

Engine-driven generator dedicated to fire alarm system :

Location of fuel storage :

System Power Supplies - (c) Emergency or standby system used as a backup to primary power supply, instead of using a secondary power supply :

Legally required standby described in NFPA 70®, Article 701

Optional standby system described in NFPA 70®, Article 702, which also meets the performance

Emergency system described in NFPA 70®, Article 700

Type Battery

☐ Dry Cell ☐ Lead-Acid ☐ Nickel-Cadmium ☒ Sealed Lead Acid

☐ Other (specify) :

Notification Prior To Any Testing

Notifications are Made	Yes	No	Who	Time
Monitoring Entity	☒	○	Matt	~~12:28~~ 8:00am
Building Occupants	☒	○	Mary	~~12:28~~ 8:00 am
Building Management	☒	○	Mary	~~12:28~~ 8:00 am
Other (Specify)	○	○		~~12:28~~
AHJ Notified of Any Impairments	○	○		~~12:28~~

System Tests and Inspections

Type	Visual	Functional	Comments
Control Unit	☒	☒	
Interface Equipment	☒	☒	
Lamps/LEDs	☒	☐	
Fuses	☐	☐	
Primary Power Supply	☒	☒	
Trouble Signals	☒	☒	
Disconnect Switches	☐	☐	
Ground - Fault Monitoring	☐	☐	

Secondary Power

Type	Visual	Functional	Comments
Battery Condition	☒		
Load Voltage		☒	
Discharge Test		☒	
Charger Test		☒	
Specific Gravity		☐	
TRANSIENT SUPPRESSORS	☐		
REMOTE ANNUNCIATORS	☒	☐	
NOTIFICATION APPLIANCES			
Audible	☒	☒	
Visible	☒	☒	
Speakers	☐	☐	
Voice Clarity		☐	

Combination Systems

	Visual	Device Operation	Simulated Operation
Fire Extinguisher Monitoring Device/System N/A	☐	☐	☐
Carbon Monoxide Detector/System N/A	☐	☐	☐
(Specify)	☐	☐	☐
Interface Equipment			
(Specify)	☐	☐	☐
(Specify)	☐	☐	☐
(Specify)	☐	☐	☐
Special Hazard Systems			
(Specify)	☐	☐	☐
(Specify)	☐	☐	☐
(Specify)	☐	☐	☐

Special Procedure :

Emergency Communications Equipment

	Visual	Functional	Comments
Phone Set	☐	☐	
Phone Jacks	☐	☐	N/A
Off-Hook Indicator	☐	☐	
Amplifier(s)	☐	☐	
Tone Generator(s)	☐	☐	
Call-In Signal	☐	☐	
System Performance	☐	☐	

Supervisory Station Monitoring

	Yes	No	Time	Comments
Alarm Signal	X	○	~~12:26~~ 845	
Alarm Restoration	X	○	~~12:28~~ 1030	
Trouble Signal	X	○	~~12:28~~ 830	
Trouble Signal Restoration	X	○	~~12:28~~ 1030	
Supervisory Signal	X	○	~~12:28~~ 900	
Supervisory Signal Restoration	X	○	~~12:28~~ 1030	

Notifications that Testing is Complete

	Yes	No	Who	Time
Building Management	X	○	Mary	~~12:28~~ 1030
Monitoring Agency	X	○	Matt	~~12:28~~ 1100
Building Occupants	X	○	Mary	~~12:28~~ 1030
Other (Specify)	○	○		~~12:28~~

The following are not functioning correctly

System restored to normal operation :

Date : ~~10/6/2014~~ 9-4-2015 Time : ~~12:28~~ 1100

The testing was performed in accordance with applicable NFPA Standards

Name of Inspector : Matt Hennek

Signature : M Hennek

Date : ~~10/6/2014~~ 9-4-2015 Time : ~~12:28~~ 1130

Name of Owner or Representative:

Signature :

Date : ~~10/6/2014~~ Time : ~~12:28~~

I, Matt Hennek changed all time and date on the inspection form to the correct time and date the Annual inspection took place.

M Hennek
Matt Hennek

1	34	SMOKE(PHOTO)	HALL BY ROOM 110	4069	0.25	1346	-0.004301075
1	35	USER-DEF-6	SMOKE IN ROOM 110	4081	0.25	1349	
1	41	USER-DEF-6	SMOKE IN ROOM 130	4081	0.25	1349	
1	42	USER-DEF-6	SMOKE IN ROOM 131	4081	0.25	1349	
1	43	SMOKE(PHOTO)	HALL BY ROOM 131	4077	0.25	1348	-0.002150538
1	50	USER-DEF-6	SMOKE IN ROOM 300	4081	0.25	1349	
1	51	SMOKE(PHOTO)	HALL BY ROOM 300	4081	0.25	1349	-0.001075269
1	52	USER-DEF-6	SMOKE IN ROOM 301	4081	0.25	1349	
1	53	USER-DEF-6	SMOKE IN ROOM 302	4081	0.25	1349	
1	54	USER-DEF-6	SMOKE IN ROOM 303	4051	0.24	1304	
1	55	USER-DEF-6	SMOKE IN ROOM 304	4081	0.25	1349	
1	56	SMOKE(PHOTO)	HALL BY ROOM 304	4069	0.25	1346	-0.004301075
1	57	USER-DEF-6	SMOKE IN ROOM 305	4069	0.25	1346	
1	58	USER-DEF-6	SMOKE IN ROOM 306	4081	0.25	1349	
1	59	SMOKE(PHOTO)	HALL BY ROOM 306	4081	0.25	1349	-0.001075269
1	60	USER-DEF-6	SMOKE IN ROOM 307	4081	0.25	1349	
1	61	USER-DEF-6	SMOKE IN ROOM 308	4081	0.25	1349	
1	62	SMOKE(PHOTO)	HALL BY ROOM 308	4073	0.25	1347	-0.003225806
1	63	USER-DEF-6	SMOKE IN ROOM 309	4081	0.25	1349	
1	64	DUCT SUPERV	LITTLE VILLAGE	4081	0.25	1349	
1	69	SMOKE(PHOTO)	LIL VIL NURS STATION	4081	0.25	1349	-0.001075269
1	70	SMOKE(PHOTO)	LIL VIL NURS STATION	4073	0.25	1347	-0.003225806
1	71	SMOKE(PHOTO)	LIL VIL NURS STATION	4073	0.25	1347	-0.003225806
1	72	SMOKE(PHOTO)	HALL BY 310 CLOSET	4081	0.25	1349	-0.001075269
1	73	USER-DEF-6	SMOKE IN ROOM 310	4081	0.25	1349	
1	74	USER-DEF-6	SMOKE IN ROOM 311	4081	0.25	1349	
1	75	USER-DEF-6	SMOKE IN ROOM 312	4065	0.25	1345	
1	76	SMOKE(PHOTO)	HALL BY ROOM 312	4081	0.25	1349	-0.001075269
1	77	USER-DEF-6	SMOKE IN ROOM 313	4073	0.25	1347	
1	78	USER-DEF-6	SMOKE IN ROOM 314-1	4081	0.25	1349	
1	79	USER-DEF-6	SMOKE IN ROOM 314-2	4069	0.25	1346	
1	80	USER-DEF-6	SMOKE IN ROOM 316	4081	0.25	1349	
1	86	SMOKE(PHOTO)	LIL VIL LIVING ROOM	4081	0.25	1349	-0.001075269

1	87	SMOKE(PHOTO)	LIL VIL DAY ROOM	4081	0.25	1349	-0.001075269
1	88	USER-DEF-6	SMOKE IN ROOM 317	4081	0.25	1349	
1	89	SMOKE(PHOTO)	HALL BY ROOM 317	4077	0.25	1348	-0.002150538
1	90	USER-DEF-6	SMOKE IN ROOM 318-1	4081	0.25	1349	
1	91	USER-DEF-6	SMOKE IN ROOM 318-2	4081	0.25	1349	
1	92	SMOKE(PHOTO)	LIL VIL DINING ROOM	4077	0.25	1348	-0.002150538
1	93	SMOKE(PHOTO)	HALL BY ROOM 318	4059	0.24	1306	-0.04731183
1	97	DUCT SUPERV	KITCHEN AIR UNIT	4081	0.25	1349	
1	99	SMOKE(PHOTO)	HALL BY ROOM 229	4081	0.25	1349	-0.001075269
1	100	SMOKE(PHOTO)	HALL BY ROOM 229	4073	0.25	1347	-0.003225806
1	102	SMOKE(PHOTO)	HALL BY ROOM 228	4069	0.25	1346	-0.004301075
1	105	SMOKE(PHOTO)	HALL BY KITCHEN	4081	0.25	1349	-0.001075269
1	106	SMOKE(PHOTO)	HALL BY KITCHEN	4081	0.25	1349	-0.001075269
1	107	SMOKE(PHOTO)	SMOKE IN ROOM 225	4081	0.25	1349	-0.001075269
1	108	USER-DEF-6	SMOKE IN ROOM 224	4077	0.25	1348	
1	109	SMOKE(PHOTO)	HALL BY KITCHEN	4077	0.25	1348	-0.002150538
1	110	SMOKE(PHOTO)	HALL BY KITCHEN	4077	0.25	1348	-0.002150538
2	1	SMOKE(PHOTO)	SOUTH WEST SUN PORCH	4081	0.25	1349	-0.001075269
2	2	SMOKE(PHOTO)	SOUTH WEST SUN PORCH	4081	0.25	1349	-0.001075269
2	3	USER-DEF-6	SMOKE IN ROOM 168	4073	0.25	1347	
2	4	SMOKE(PHOTO)	HALL BY ROOM 168	4081	0.25	1349	-0.001075269
2	5	USER-DEF-6	SMOKE IN ROOM 169	4069	0.25	1346	
2	6	USER-DEF-6	SMOKE IN ROOM 166	4081	0.25	1349	
2	7	USER-DEF-6	SMOKE IN ROOM 167	4081	0.25	1349	
2	8	USER-DEF-6	SMOKE IN ROOM 164	4081	0.25	1349	
2	9	SMOKE(PHOTO)	HALL BY ROOM 164	4073	0.25	1347	-0.003225806
2	10	USER-DEF-6	SMOKE IN ROOM 165	4061	0.25	1344	
2	11	USER-DEF-6	SMOKE IN ROOM 162	4081	0.25	1349	
2	12	USER-DEF-6	SMOKE IN ROOM 163	4081	0.25	1349	
2	13	USER-DEF-6	SMOKE IN ROOM 161	4081	0.25	1349	
2	14	SMOKE(PHOTO)	HALL BY ROOM 161	4081	0.25	1349	-0.001075269
2	15	USER-DEF-6	SMOKE IN ROOM 160	4081	0.25	1349	

2	16	DUCT SUPERV	WEST CARE AREA	4081	0.25	1349	
2	21	USER-DEF-6	SMOKE IN ROOM 150	4065	0.25	1345	
2	22	USER-DEF-6	SMOKE IN ROOM 151	4081	0.25	1349	
2	23	SMOKE(PHOTO)	HALL BY ROOM 151	4065	0.25	1345	-0.005376344
2	24	USER-DEF-6	SMOKE IN ROOM 152	4081	0.25	1349	
2	25	SMOKE(PHOTO)	HALL BY ROOM 152	4061	0.25	1344	-0.006451613
2	26	USER-DEF-6	SMOKE IN ROOM 153	4081	0.25	1349	
2	27	USER-DEF-6	SMOKE IN ROOM 154	4073	0.25	1347	
2	28	USER-DEF-6	SMOKE IN ROOM 155	4085	0.25	1350	
2	29	USER-DEF-6	SMOKE IN ROOM 156	4085	0.25	1350	
2	30	SMOKE(PHOTO)	HALL BY ROOM 156	4081	0.25	1349	-0.001075269
2	31	USER-DEF-6	SMOKE IN ROOM 157	4085	0.25	1350	
2	32	USER-DEF-6	SMOKE IN ROOM 158	4081	0.25	1349	
2	33	USER-DEF-6	SMOKE IN ROOM 159	4065	0.25	1345	
2	34	SMOKE(PHOTO)	NORTH WEST SUN PORCH	4077	0.25	1348	-0.002150538
2	35	SMOKE(PHOTO)	NORTH WEST SUN PORCH	4081	0.25	1349	-0.001075269
2	41	SMOKE(PHOTO)	WEST NURSE STATION	4081	0.25	1349	-0.001075269
2	42	SMOKE(PHOTO)	WEST NURSE STATION	4081	0.25	1349	-0.001075269
2	43	USER-DEF-6	SMOKE IN ROOM 148	4081	0.25	1349	
2	44	SMOKE(PHOTO)	HALL BY ROOM 148	4073	0.25	1347	-0.003225806
2	45	USER-DEF-6	SMOKE IN ROOM 149	4053	0.25	1342	
2	46	USER-DEF-6	SMOKE IN ROOM 146	4069	0.25	1346	
2	47	USER-DEF-6	SMOKE IN ROOM 147	4081	0.25	1349	
2	48	USER-DEF-6	SMOKE IN ROOM 144	4085	0.25	1350	
2	49	SMOKE(PHOTO)	HALL BY ROOM 144	4081	0.25	1349	-0.001075269
2	50	USER-DEF-6	SMOKE IN ROOM 145	4051	0.24	1304	
2	51	USER-DEF-6	SMOKE IN ROOM 142	4061	0.25	1344	
2	52	USER-DEF-6	SMOKE IN ROOM 143	4081	0.25	1349	
2	53	USER-DEF-6	SMOKE IN ROOM 140	4069	0.25	1346	
2	54	SMOKE(PHOTO)	HALL BY ROOM 140	4081	0.25	1349	-0.001075269
2	55	USER-DEF-6	SMOKE IN ROOM 141	4081	0.25	1349	
2	56	SMOKE(PHOTO)	HALL BY ROOM 207	4081	0.25	1349	-0.001075269

2	62	SMOKE(PHOTO)	MAIN ENTRY HALL	4081	0.25	1349	-0.001075269
2	63	SMOKE(PHOTO)	MAIN ENTRY HALL	4081	0.25	1349	-0.001075269
2	64	SMOKE(PHOTO)	RESIDENT MAIL ROOM	4085	0.25	1350	0
2	65	SMOKE(PHOTO)	MAIN ENTRY	4061	0.25	1344	-0.006451613
2	66	SMOKE(PHOTO)	MAIN ENTRY	4081	0.25	1349	-0.001075269
2	67	SMOKE(PHOTO)	SMOKE IN ROOM 220	4081	0.25	1349	-0.001075269
2	68	SMOKE(PHOTO)	MAIN ENTRY HALL	4081	0.25	1349	-0.001075269
2	69	SMOKE(PHOTO)	HALL BY GREAT ROOM	4073	0.25	1347	-0.003225806
2	70	SMOKE(PHOTO)	GREAT ROOM	4081	0.25	1349	-0.001075269
2	71	SMOKE(PHOTO)	GREAT ROOM	4081	0.25	1349	-0.001075269
2	72	SMOKE(PHOTO)	GREAT ROOM	4065	0.25	1345	-0.005376344
2	73	SMOKE(PHOTO)	GREAT ROOM	4077	0.25	1348	-0.002150538
2	74	SMOKE(PHOTO)	GREATROOM	4081	0.25	1349	-0.001075269
2	75	SMOKE(PHOTO)	GREAT ROOM	4081	0.25	1349	-0.001075269
2	80	DUCT SUPERV	DINING AIR HANDLER	4065	0.25	1345	
2	81	SMOKE(PHOTO)	HALL BY GREAT ROOM	4077	0.25	1348	-0.002150538
2	82	SMOKE(PHOTO)	MAIN DINING ROOM	4081	0.25	1349	-0.001075269
2	85	SMOKE(PHOTO)	MAIN DINING ROOM	4081	0.25	1349	-0.001075269
2	86	SMOKE(PHOTO)	MAIN DINING ROOM	4065	0.25	1345	-0.005376344
2	87	SMOKE(PHOTO)	MAIN DINING ROOM	4073	0.25	1347	-0.003225806
2	88	SMOKE(PHOTO)	MAIN DINING ROOM	4081	0.25	1349	-0.001075269
2	89	SMOKE(PHOTO)	HALL BY ROOM 217	4077	0.25	1348	-0.002150538
2	90	SMOKE(PHOTO)	HALL BY ROOM 216	4059	0.24	1306	-0.04731183
2	91	SMOKE(PHOTO)	HALL BY ROOM 215	4077	0.25	1348	-0.002150538
2	92	SMOKE(PHOTO)	HALL BY ROOM 211	4065	0.25	1345	-0.005376344
2	93	SMOKE(PHOTO)	HALL BY ROOM 208	4081	0.25	1349	-0.001075269
2	94	SMOKE(PHOTO)	ACTIVITY PORCH PHONE	4081	0.25	1349	-0.001075269
2	95	SMOKE(PHOTO)	ACTIVITY PORCH	4069	0.25	1346	-0.004301075
2	96	SMOKE(PHOTO)	HALL BY ROOM 205	4081	0.25	1349	-0.001075269
2	97	SMOKE(PHOTO)	MAIN ELEVATOR LOBBY	4069	0.25	1346	-0.004301075
2	98	SMOKE(PHOTO)	EMPLOYEE LOUNGE	4081	0.25	1349	-0.001075269
2	103	SMOKE(PHOTO)	ELEVATOR EQUIPMNT RM	4081	0.25	1349	-0.001075269

2	104	SMOKE(PHOTO)	LL BY ELEVATR	4073	0.25	1347	-0.003225806

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 _____	08/20/2015

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 062	Continued From page 7 Findings include: On facility tour between 8:45 AM and 1:00 PM 08/20/2015, observation revealed the following: 1. Observation revealed that the spare sprinkler head box does not contain 2 of each type of fire sprinkler heads in the facility. 2. Kitchen walk in cooler/freezers the dry sprinkler heads are over 10 years old 3. Kitchen area - sprinkler heads have lint and or corroded These deficient practices were confirmed by the Director of Maintenance (RH) at the time of discovery.	K 062	TAG #:K 62 D Sprinklers in kitchen, cooler and freezer Extra heads for the box have been obtained and placed in storage. Olympic Fire Protection was contacted on 9/15/15 and it will take 10 business days for parts. Work will be completed by 10/7/15. Replacement of the heads with porcelain so they will not rust or corrode. Environmental Services is responsible for this.	
K 076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by:	K 076		

1355 State Ave NW
Owatonna, MN 55060
Phone: (507) 455-1150
Fax: (507) 455-1651
Email: gevans@olyfire.com

Olympic Fire Protection Corp.

Quote

To:	mobrien@monarchmn.com	**Re:**	
Att:	Mary	**From:**	Greg Evans
Fax:		**Date:**	
Phone:		**Pages:**	1

☐ **Urgent** ☑ **For Review** ☐ **Please Comment** ☐ **Please Reply** ☐ **Hard Copy to Follow**

QUOTE

Hi Mary,

This is a quote to replace 4 dry sprinkler heads in the coolers and 22 heads in the kitchen. The new heads in the kitchen will be white with white plates. This price will also include 2 new QR heads for the homes head box.
Total cost for labor and material is. $1560.00

Thank you,

Greg Evans
Field Superintendent

Approved by: Dawn Chiabotti Date: 9/9/15
This price is good for 30 days.

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 _____	08/20/2015

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

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K 076	Continued From page 8 Based on observations and staff interview, the facility has oxygen cylinders not properly stored in compliance with the requirements of 1999 NFPA 99, Sections 4-3.1.1.2. This deficient practice could affect 20 out of 87 residents. Findings include: On facility tour between 8:45 AM and 1:00 PM 08/20/2015, observation revealed that in the oxygen store room / transfill room over 3000 cubic feet, the following was found: 1. Light switches are less than 5 ft off of floor 2. Open penetration around water line for steam heater in ceiling 3. No proper signage on both doors going into room for transfilling These deficient practices were confirmed by the Director of Maintenance (RH) at the time of discovery.	K 076	TAG #:K 76 D Oxygen room switches are to be moved, signs are changed. Open penetration around water line has been sealed. Cedar Lake Electric did relocate light switches on 9/4/15. Penetration sealed on 9/8/15. Two signs on both doors were placed on 9/4/15 to indicate Transfer of Liquids and No Smoking within. The other is Oxygen Storage and No Smoking within. Is corrected and Environmental Services is responsible to monitor this. Education to the staff was presented September 14 and 15, 2015.	
K 144 SS=D	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. This STANDARD is not met as evidenced by:	K 144		

K76

Oxygen room

1. Light switches were replaced on 9-4-15 by Cedar lake Electrical from Faribault Mn.
2. Maint. Closed the penetration around water line on 9-8-15.
3. Signage was put on both doors on 9-4-15.

Mary O'Brien

From: Fritz Nerud <fritzn@cedarlakeelectric.com>
Sent: Friday, August 28, 2015 8:29 AM
To: Mary O'Brien
Subject: RE: Updated Draft Statement and State Orders

Mary
The cost to raise the 2 light switches in the oxygen storage room should cost you approx. $200.00
Please let me know when want done and I will schedule Marc to take care of it

Thank You

Fritz Nerud
Senior Estimator/ Project Manager
Cedar Lake Electric, Inc.
20700 Bagley Avenue
Faribault, MN 55021
Phone: 800-658-7002
Fax: 507-334-5402
Cell: 612-685-4911
E-mail: Fritzn@cedarlakeelectric.com

From: Mary O'Brien [mailto:MObrien@monarchmn.com]
Sent: Thursday, August 27, 2015 2:47 PM
To: Fritz Nerud
Subject: FW: Updated Draft Statement and State Orders
Importance: High

Fritz,
Just received this and is forwarding it on to you.
Mary O'Brien

From: Schroeder, Gary (DPS) [mailto:gary.schroeder@state.mn.us]
Sent: Wednesday, August 26, 2015 11:54 PM
To: Mary O'Brien
Subject: Updated Draft Statement and State Orders
Importance: High

Mary,

I have attached an updated draft statement and state order.

1. I removed K76 Item #4 – the power vent I have to stand corrected
2. The electrician wanted to know what code requires the electrical light switches and outlets to be off the floor by 5ft; When I call back I'll tell him to see you for a copy.

1999 NFPA 99 - **4-3.1.1.2 Storage Requirements**

Maint. Ryan Fire caulked these areas and checked all areas to make sure everything was caulked.

Storage Room #118 automatic hinges were put on door to automatic close door on 8/25/15

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 _____	08/20/2015

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 144	Continued From page 9 Based on documentation review and staff interview, the facility failed to document a reliable fuel source for the natural gas emergency generator in accordance with the requirements of 2000 NFPA 101 - 9.1.3. The deficient practice could affect all 87 residents. Findings include: On facility tour between 8:45 AM and 1:00 PM 08/20/2015, documentation review of the natural gas emergency generator revealed and the Facility Maintenance Director confirmed the fuel source is natural gas for the emergency generator. The Facility Maintenance Director confirmed the facility did have a letter. The letter did not contain all five points as required below: 1. A statement of reasonable reliability of the natural gas delivery 2. A brief description that supports the statement regarding the reliability 3. A statement that there is a low probability of interruption of the natural gas 4. A brief description that supports the statement regarding the low probability of interruption 5. The signature of technical personnel from the natural gas vendor. This deficient practice was confirmed by the Director of Maintenance (RH) at the time of discovery. *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 144	TAG #:K 144 D Documentation review of the natural gas for the emergency generator. This letter has been received September 10, 2015. Education to the staff was presented September 14 and 15. Environmental services are responsible to maintain this letter.	

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

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 _____	08/20/2015

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

CenterPoint Energy

September 10, 2015

Mary O'Brien
Mala Strana Rehab Center
1001 Columbus Avenue North
New Prague, MN 56071

Subject: Reliability of Natural Gas Supply
Firm Meter #M19991197819, Account #6400445332

The natural gas service CenterPoint Energy provides has been and continues to be reliable in our service area. This natural gas system is designed to deliver natural gas supplies to all firm customers, even during periods of severe cold temperatures when the demand for natural gas is at its peak. This natural gas system can accommodate Mala Strana Rehab Center firm natural gas needs including the natural gas emergency back-up generator under full fuel load. Network modeling software and actual system conditions are used to identify areas where system reliability could be a concern. Once areas of reliability concern are discovered, plans are developed and executed to address the issue.

There is a low probability of interruption of the natural gas. Occasionally there are situations that can cause an unplanned or planned natural gas outage. Both of these situations are rare. For an unplanned outage, CenterPoint Energy uses all available resources to restore natural gas service in a reasonable amount of time. For a planned outage such as required maintenance, CenterPoint Energy will notify you in advance and try to make arrangements to accommodate your specific needs.

CenterPoint Energy's natural gas system is designed, installed, operated and maintained in compliance with company policies and federal and state regulations. These safety and reliability measures provide protection to the natural gas system and helps to ensure a continuous supply of natural gas to all firm customers including Mala Strana Rehab Center in New Prague.

Please feel free to contact me with any questions or concerns.

Sincerely,

David Henningsgaard, P.E.
Engineer 5
CenterPoint Energy Minnesota Region
700 Linden Avenue West
Minneapolis, Minnesota 55403
612-321-5316

Whitney, Marian (DPS)

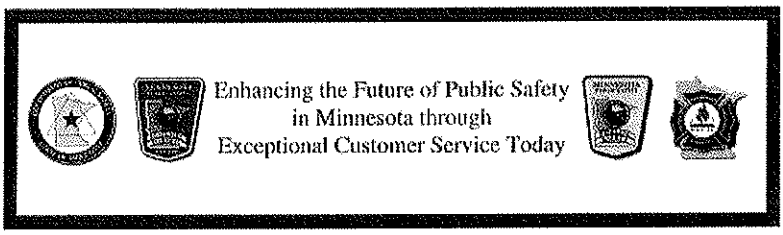
From: Schroeder, Gary (DPS)
Sent: Monday, October 05, 2015 9:20 AM
To: Suzuki, Jan M. (CMS/CQISCO)
Cc: Meath, Mark (MDH); Henderson, Mary (MDH); Whitney, Marian (DPS); Leach, Colleen (MDH); Dehler, Robert (MDH); Fiske-Downing, Kamala (MDH); Dietrich, Shellae (MDH); Kleppe, Anne (MDH); Johnston, Kate (MDH); mobrien@monarchmn.com
Subject: MALA STRANA REHABILITATION CENTER (245514) - K11 Temporary Waiver

Good Morning,

This is to notify you that I am accepting MALA STRANA REHABILITATION CENTER request for a temporary waiver until 12/14/2015 for K11, for the fire door replacement. The survey exit date was 08/20/2015.

Thank you,

Gary L. Schroeder – Interim Fire Safety Supervisor
Health Care / Adult Foster Care / Corrections
Minnesota State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Office/Cell: 507-361-6204
Fax: 507-282-7899
Web: https://dps.mn.gov/divisions/sfm/programs-services/inspections/Pages/health-care-inspection.aspx



Name of Facility **2000 CODE**

MALA STRANA REHABILATION CENTER - 245514

PART IV RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

For each item of the Life Safety code recommended for waiver, list the survey report form item number and state the reason for the conclusion that: (a) the specific provisions of the code, if rigidly applied, would result in unreasonable hardship on the facility, and (b) the waiver of such unmet provisions will not adversely affect the health and safety of the patients. If additional space is required, attach additional sheet(s).

PROVISION NUMBER(S)	JUSTIFICATION
K84 K11	A temporary waiver is being requested for K011 until 12/14/2015. MALA STRANA REHABILATION CENTER fully intends to comply with the survey finding K011. However, the resolution will be delayed due to lead time constraints of manufacture and distributor. The required 90 minute fire rated doors have been ordered and delivery is anticipated the week of 11/30/2015. Completion date will be by 12/14/2015. Safe guards are: 1. Full corridor, resident room and areas open to the corridor smoke detection, which is interconnect to the building fire alarm system for automatic fire department notification 2. Fire department is located half a mile away 3. Doors in area are closed when staff is not present 4. Area in question is not accessible by residents

Surveyor *(Signature)*	Title	Office	Date
Fire Authority Official *(Signature)*	Title Interim Fire Safety Supervisor	Office State Fire Marshal Division	Date 10/03/2015