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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: AK8H

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) **227432200**

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: **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) **07/01/2015**

6. DATE OF SURVEY **09/27/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
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

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	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):

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

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Certification Specialist 10/04/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
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.
06201
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
10/03/2017
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245514

October 4, 2017

Ms. Lydia Rasmussen, Administrator
Mala Strana Care & Rehabilitation Center
1001 Columbus Avenue North
New Prague, MN 56071

Dear Ms. Rasmussen:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective September 25, 2017 the above facility is recommended for:

90 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

Please contact me if you have any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 4, 2017

Ms. Lydia Rasmussen, Administrator
Mala Strana Care & Rehabilitation Center
1001 Columbus Avenue North
New Prague, MN 56071

RE: Project Number S5514026

Dear Ms. Rasmussen:

On September 6, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 18, 2017. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On September 27, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on October 2, 2017 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on August 18, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 25, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 18, 2017, effective September 25, 2017 and therefore remedies outlined in our letter to you dated September 6, 2017, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: AK8H

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(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) **07/01/2015**

6. DATE OF SURVEY **08/18/2017** (L34)

8. ACCREDITATION STATUS: ___ (L10)
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2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
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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:
A. In Compliance With
Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	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):

17. SURVEYOR SIGNATURE Date :
Deanna Novak, HFE-NE II 09/19/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Certification Specialist 10/02/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
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.
06201
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
September 6, 2017

Ms. Lydia Rasmussen, Administrator
Mala Strana Care & Rehabilitation Center
1001 Columbus Avenue North
New Prague, MN 56071

RE: Project Number S5514026

Dear Ms. Rasmussen:

On August 18, 2017, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Susie Haben, Unit Supervisor
Metro D Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: susie.haben@state.mn.us
Phone: (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 27, 2017, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by September 27, 2017 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within ten calendar days of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have

been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

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

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

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by November 18, 2017 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the

identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 18, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

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

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

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 _____	08/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MALA STRANA CARE & REHABILITATION 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 On 8/14, 8/15, 8/16, 8/17, and 8/18/17, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. 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		
F 157 SS=D	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is,	F 157		9/25/17

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

Electronically Signed | 09/12/2017

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 _____	08/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MALA STRANA CARE & REHABILITATION 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 157	Continued From page 1 a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure the responsible party was notified of a significant change in condition post fall for 2 of 4 residents (R63 and R105) reviewed for falls with injury. Findings include: R105's minimum data set (MDS) assessment	F 157	Family of R 105 notified of incident on 7/7/17 at 2:30pm. All falls for the last month have been reviewed and all families have been notified. Mandatory Nurses meeting 9/19/17 to review proper notification of change to families, provider, and facility management.	

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 _____	08/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MALA STRANA CARE & REHABILITATION 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 157	Continued From page 2 dated 7/27/17, identified R105 with severe cognitive impairment. R105's Admission Record dated 11/27/16, identified family member (FM)-A to be R105's, "Emergency contact # 1," and, "Responsible Party." A progress note for R105 dated 6/7/17, at 2:35 a.m. indicated a late entry and identified R105 had a fall. On 8/18/17 at 1:15 p.m., licensed practical nurse (LPN)-B verified during interview that R105 experienced a fall on 6/7/17 at 2:35 a.m., but the family had not been notified until the following afternoon. LPN-B stated the family should have been notified right away. On 8/18/17 at 1:17 p.m., the registered nurse/clinical manager (RN/CM)-B confirmed FM-A had not been notified of R105's fall on 6/7/17, at 2:35 a.m. RN/CM-B stated the fall should have been reported right away. On 8/18/17 at 1:19 p.m., RN/CM-A also confirmed FM-A had not been immediately notified of R105's fall on 6/7/17, at 2:35 a.m. RN/CM-A confirmed there was no documentation of a report to R105's family, but stated the family should have been notified right away. On 8/18/17 at 1:30 p.m., the director of nursing (DON) also verified R105's family had not been notified timely regarding the resident's 6/7/17 fall. The DON further stated there was no documentation of family notification and stated his expectation would have been for the staff to have notified the family right away per the	F 157	Re-education was completed with RN/CM-A on 6/7/17 at 10pm after the incident occurred for failure to notify family. Policy for notification of change will be reviewed with all nurses at mandatory nurses meeting on 9/19/17. Random audits of documentation will be reviewed to ensure families are notified of incidents. Audit will be conducted weekly for one month, then bi weekly for 2 months. Audit results will be reported to QA&A committee for review and further recommendations.	

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	245514	A. BUILDING _____ B. WING _____	08/18/2017

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F 157	Continued From page 3 facility's policy. A policy regarding notification of responsible party regarding significant change was requested, but was not provided.	F 157		
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such	F 309		9/25/17

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F 309	Continued From page 4 services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide treatment and services to meet the highest practicable level for 2 of 4 (R105, R63) residents reviewed for falls with injuries. Findings include: R105's admission face sheet identified an admission date of 11/26/16, with diagnoses including: diabetes, hip fracture, Parkinson's disease, atrial fibrillation, and kidney calculus. R105's discharge Minimum Data Set (MDS) dated 6/8/17, identified R105 to be severe cognitively impaired. R105's care plan dated 6/16/17, identified R105 to have a history of and risk for falls. The care plan indicated R105 needed extensive assist with activities of daily living (ADLs). In addition, the care plan identified R105 had pain and a hip fracture as a result of a fall 6/7/17. The interventions directed staff to follow physical therapy (PT) and occupational therapy (OT) recommendations. A Nursing Progress Note dated 6/7/17, at 2:35 a.m. indicated R105 was sitting on the floor next to his wheel chair by the nurse's station. R105 did not have complaints of pain or discomfort. No red or bruised areas noted at this time. Vital signs were within normal limits. R105 was back in his wheel chair sitting next to staff behind nurse's station. The medical record lacked evidence of any post fall assessments being completed other	F 309	Residents that have fallen since survey have been audited and received proper post fall assessments. On 8/18/17 face sheets, with responsible party information for all residents, were printed and placed in paper charts on all the wings. Face sheets will be printed upon admission and when changes are made. Hard copy will be placed in the resident□s charts and updated as needed. Education and policy review on fall assessments and follow-up will be conducted at Nurses Meeting on 9/19/2017. Random audits of documentation will be reviewed to ensure proper fall follow-up and assessments were completed. Audits will be conducted weekly for one month, then bi weekly for 2 months. Audit results will be reported to QA&A committee for review and further recommendations.	

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than the vital signs and pain level.

R105's Medication Administration Record (MAR) indicated on 6/7/17, at 4:22 a.m. R105 required an as needed Tramadol 50 milligrams (mg) by mouth, due to documented pain level of 5. The MAR indicated R105 also received scheduled/routine Tramadol 50 mg by mouth 2 tablets every day, and Tylenol Arthritis Pain (a mild analgesic) tablet extended release 650 mg 1 tablet by mouth three times a day.

During interview on 8/17/17, at 1:38 p.m. family member (F)-A stated she had arrived at the facility on 6/7/17, at approximately 2:30 p.m. to visit R105 and take him to an appointment. F-A stated when she had arrived, R105 was in his wheel chair and she had requested staff to transfer him to a recliner. F-A stated a nursing assistant (NA- no name specified) and herself had attempted to transfer R105 to the recliner, however R105 would not stand up or bear any weight. F-A indicated that was unusual for R105. F-A said at that time, the NA had informed her R105 had fallen during the night. F-A said prior to that, she had been unaware of R105's fall because no one had notified her. F-A stated since she and the NA could not transfer R105, the NA transferred R105 with the E-Z lift (mechanical lift) to a recliner. F-A then stated she had then questioned licensed practical nurse (LPN)-B, who was the nurse on duty, and LPN-B was unaware of R105's changes and fall in the middle of the night. F-A stated she informed LPN-B that R105 was complaining of pain and unable to bare weight. F-A stated on the following day 6/8/17, there was a scheduled care conference that she requested the nurse practitioner (NP) to attend due to concerns regarding R105's condition. F-A

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stated she was informed by the care conference attendees there was no report regarding R105's fall on 6/7/17. F-A informed NP that R105 was not bearing weight and complaining of pain. F-A further stated she never directed staff not to call her in the middle of the night to notify of a change. F-A stated prior to the fall on 6/7/17, R105 was able to transfer and walk with his walker with one person assist, but now required an E-Z stand.

On 8/17/17, at 2:23 p.m. the director of nursing (DON) stated he was unaware of R105's fall until F-A came in on 6/8/17, and was upset. The DON stated he then saw a Progress Note which indicated R105 fell on 6/7/17, at 2:30 a.m. The DON stated registered nurse (RN)-C should have notified family, the provider, and completed an incident report. Further, the DON expected an assessment to be completed which would have included documenting R105's range of motion status and for the incident to be communicated with the following shift.

On 8/18/17, at 8:20 a.m. LPN-B stated she was the day nurse on 6/7/17. LPN-B stated she was unaware that R105 fell in the middle of the night. LPN-B recalled R105 had increased pain on the day shift, however, LPN-B could not recall if she assessed R105 on 6/7/17. LPN-B confirmed R105's medical record did not reflect that an assessment had been completed. LPN-B was unaware how staff were transferring and assisting R105.

On 8/18/17 at 8:58 a.m., R105 told the surveyor he had fallen and broken his hip which still hurt once in awhile. R105 could not recall how he fell. R105 stated he would rather use his walker, but

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now used an E-Z stand since his fall with hip fracture.

On 8/18/17, at 9:10 a.m. RN-C stated R105 fell when she was on duty at approximately 3:00 a.m. RN-C stated R105 was in the hallway and attempted to get out of his wheel chair. RN-C stated she questioned R105 of what happened and if he was in any pain. RN-C stated R105 denied pain and/or any injuries. RN-C stated she assessed R105's skin and manually assisted him off of the floor. RN-C confirmed she did not fill out an incident report or notify family. RN-C stated she gave R105 an as needed (PRN) Tramadol (narcotic) due to complaints of pain.

On 8/18/17, 9:28 a.m. NA-E stated R105 was in his wheel chair in the hallway when she came on the night shift on 6/7/17, due to attempting to self-transfer in his room. NA-E stated she observed R105 after he fell in the hallway and was laying on his back with one leg bent back and the other leg was straight out. NA-E stated R105 looked uncomfortable and then three nursing staff manually assisted him up.

On 8/18/17, at 10:12 a.m. NP-A stated there are four NPs that take call and all denied getting a call the night that R105 fell. NP-A stated F-A requested her to be at R105's care conference on 6/8/17, and reported R105 was unable to bear weight and was complaining of pain which NP-A was unaware of. NP-A stated when she questioned staff they reported R105 complained of knee pain. R105 reported pain during assessment and she ordered x-rays which revealed a left hip fracture. NP-A stated she would have expected a call for this situation. NP-A stated she would not expect staff to use an

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E-Z stand (mechanical lift) post fall. NP-A expected a thorough assessment to be completed post fall which would include heart, lungs, musculoskeletal, skin, neuro, range of motion, and pain to be assessed.

On 8/17/17, at 2:09 p.m. physical therapist stated R105 was assist x 1 with walker prior to the fall and was to walk to and from all meals. Physical therapist stated after R105's fall and left hemi arthroplasty, R105 was discharged from therapy. Physical therapist stated nursing staff should not have changed R105's transfer device after the fall without informing therapy and seeking approval. Physical therapist would not expect the E-Z stand to be used with a possible hip fracture.

R63 was admitted 3/1/17, per the Admission Record. R63's care plan dated 5/9/17, identified R63 to be a fall risk. R63's quarterly MDS assessment dated 6/7/17, identified R63 to be cognitively intact. Further R63's diagnoses included: subdural hemorrhage, anemia, heart failure, and hypertension. R63 needed limited assistance of one person with: bed mobility, transfers, walking, and locomotion on and off the unit. R63 needed extensive assistance with toileting, dressing, and personal hygiene.

R63's MAR identified R63 received an additional/as needed (PRN) Tylenol Tablet 650 mg by mouth on 7/12/17, at 10:02 p.m. with a documented pain level of a 2 out of 10 and that the medication was ineffective.

A Nursing Progress Note dated 7/12/17, at 11:05 p.m. indicated the nurse was called to R63's room and observed him on the floor between his recliner and bed. R63 was believed to be

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attempting to transfer into bed. R63 stated he hit his head. R63 denied pain but was bleeding from a skin tear on his left forearm. The RN on call was notified. R63 was ready to get into bed 45 minutes' post fall and complained of left hip and groin pain with transfer and was given as needed Tylenol which "somewhat relieved the pain." The Progress Note continued to depict the fall information would be passed on to day shift and NP the following day due to not being an emergency. The incident report for the fall of 7/12/17, and medical record lacked any evidence of a post fall assessment other than the pain level and specific vital signs being completed.

R63's MAR identified R63 received another dose of as needed Tylenol tablet 650 mg by mouth on 7/13/17, at 2:10 a.m. with a documented pain level of a 1 out of 10, however the MAR documentation indicated the medication was ineffective.

The medical record lacked evidence of any alternative interventions for pain management and/or documentation of any other measures the facility may have attempted to relieve R63's pain when the Tylenol was ineffective.

A Nursing Progress Note dated 7/13/17, at 3:43 a.m. indicated R63 had increased pain in his left leg and groin area throughout the night. R63 requested to sit in his recliner at 1:30 a.m., however, when the nurse was assisting R63 he "shouted out in pain and could not stand up on his L [left] leg." The documentation revealed R63 could not tolerate any passive range of motion or any movement in his left leg. NP was notified who gave orders to send to the emergency room (ER) for x-rays. Although the resident was cognitively

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intact, the facility waited to transfer him to the ER until family notification at 3:30 a.m. due to computer systems being down and R63 was finally transferred to the ER at 3:45 a.m. and R63 "was very relieved."

An Abbott Northwestern Hospital Physician noted on 7/13/17, that R63 went to the emergency room due to hip pain post fall and had a superior pubic rami fracture. Physician noted R63 complained of 10/10 pain with movement.

PT worked with R63 post fall with fracture from 7/17/17 through 7/26/17, and discharged due to enrollment into hospice services with recommendations for staff to utilize the E-Z stand (mechanical stand) for transfers.

During interview on 8/18/17, at 10:39 a.m. the DON stated during staff interviews regarding the incident R63 was believed to be okay post fall, however, at approximately 1:00 a.m. R63 requested to go to the bathroom which was when R63 had a lot of pain and could not stand. The DON stated the computer systems were down so staff did not have accessibility to contact family. The DON stated R63 was in pain and could not bear weight from 1:00 a.m. and was sent to the hospital at approximately 3:30 a.m. due to not being able to contact family. The DON confirmed when the system was down staff did not have any other method of accessibility to family contacts.

On 8/18/17, at 12:44 p.m. R63 stated he was aware he fell and obtained a fracture. R63 could not recall pain level or time frames but remembered not being able to stand. R63 stated staff would not need family member approval for treatment as he was his own responsible party.

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On 8/18/17, at 2:13 p.m. NA-F stated R63 was in his recliner and attempted to self-transfer and was observed on the floor and was manually assisted off of the floor with approximately three to four staff members. R63 had a skin tear on his left arm and did not complain of pain initially but approximately one-hour post fall R63 began to complain of pain. NA-F was aware R63 was sent to the hospital but could not recall time frames.

On 8/18/17, at 2:23 p.m. RN-E stated she was informed a fall after she punched in for night shift (approximately 10:00 p.m.) and she went to assist. RN-E stated she went into R63's room and R63 was sitting in his wheelchair. RN-E stated she addressed R63's skin tear and had left the room as other nurses were tending to R63. RN-E stated later in the night (could not recall time) R63 complained of pain and RN-E informed the nurse to send him to the hospital but was aware the computer systems were down so "had to wait to print off papers to send to the hospital." R63 was sent to the hospital in the middle of the night. RN-E confirmed since the system was down staff did not have access to family contacts.

The facility's policy titled "Assessing Falls and Their Causes" dated 5/13, identified residents must be assessed in a timely manner for potential causes of falls and the medical chart should be accessible. The policy stated after a fall vital signs, any possible injuries to head, neck, spine, extremities, and neuros must be documented. Further, if there is significant injury such as bleeding or a fracture for appropriate first aid to be completed. The policy continued that nursing will notify the resident's physician and family in an appropriate time frame, however, when there is

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F 309	Continued From page 12 suspected significant injury or condition change they will be notified immediately by phone. The policy directed staff to have an incident report completed by the on-duty nurse and to observe for delayed complications of a fall for approximately 48 hours post fall, and to document those findings in the medical record.	F 309		
F 371 SS=E	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to appropraitely label	F 371	All supplements that are thawed and do not have a thaw date of expiration have	9/25/17

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F 371	Continued From page 13 thawed nutritional supplements which would have the potentail to affect any resident recieving MightyShake supplements. The findings include: During an inital kitchen tour with the culinary services director (CSD) at 1:32 p.m. on 8/14/17, the following observations were made: The East Wing nourishment refrigerator was observed to contain fourteen MightyShakes. The West Wing nourishment refrigerator was observed to contain eight MightyShakes. The CSD was interviewed at 2:10 p.m. on 8/14/17. The CSD stated the MightyShakes were sent to the nursing units frozen and the nursing staff were expected to rotate them in the fridge. During subsequent observation of unit refrigerators, on 8/16/17 at 10:28 a.m., the following observations were made and verified with the CSD: The Little Village unit refrigerator contained ten chocolate flavored MightyShakes with an expiration date of 7/12/18. The East Wing unit refrigerator contained twenty-one MightyShakes six chocolate flavor with expiration date of 7/12/18, and fifteen vanilla flavor with expiration date of 7/28/18. The West Wing refrigerator contained eight vanilla flavored MightyShakes with an expiration date of 6/28/18. During an interview with the CSD on 8/17/17, at 1:22 p.m., the CSD indicated they use the expiration date on the MightyShakes. She further	F 371	been disposed of. Dietary has created stickers to place on supplements that say use this product within two weeks of the following date. They will be marked on their thaw date. Culinary Services Director will complete weekly audits for one month, followed by bi weekly for 2 months. Will re-assess on going need for audits at the QA&A committee for review and further recommendations.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 14	F 371		

stated they counted on the nursing staff to monitor the expiration of the MightyShakes because dietary only filled the nursing stock slips as delivered to the units.

During an interview on 8/18/17, at 1:41 p.m., registered nurse-A stated the label on the MightyShakes identified an expiration date and indicated, "store frozen, thaw at or below 40 degrees fahrenheit, use thawed product within fourteen days." When asked when the thawed MightyShakes should be discarded, she verified that without a date as to when thawed, she wound not know when it was to be discarded.

During an interview on 8/18/17 at 1:47 p.m., licensed practical nurse-B indicated to use the expiration date on the thawed MightyShake carton on when the product was to be expired.

Further review of the supplement information indicated the MightyShake shelf life unopened and frozen was fifteen months, but was fourteen days when thawed and stored in the refrigerator.

The facility's policy Infection Control-Dietary Department dated 12/2016, indicated "Food and bevarges for nourishments are prepared by dietary personnel." There was no facility policy addressing dating and or labeling of thawed supplements.

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	245514	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/16/2017**

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K 000	INITIAL COMMENTS 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 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 Care Center) was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. 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 By email to: Marian.Whitney@state.mn.us and	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/12/2017

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

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K 000	Continued From page 1 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 protected by a full fire sprinkler system. 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 90 beds and had a census of 81 at the time of the survey.	K 000		
K 211 SS=F	NFPA 101 Means of Egress - General	K 211		9/25/17

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K 211	Continued From page 2 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This STANDARD is not met as evidenced by: Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Findings Include: On facility tour between 12:00 AM and 04:00 PM on 8/16/2017, based on observation and interview revealed that the following include: Carts and plastic containers are being stored in corridors in both the east and west wings. This deficient practice could affect the safety of all the (40) residents, staff and visitors within the smoke compartments. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 211	Carts and plastic containers were removed and purchased hanging containers for over the residents door for infection control items. All staff to monitor hallways for objects in hallways.	
K 221 SS=D	NFPA 101 Patient Sleeping Room Doors Patient Sleeping Room Doors Locks on patient sleeping room doors are not permitted unless the key-locking device that	K 221		9/25/17

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K 221	Continued From page 3 restricts access from the corridor does not restrict egress from the patient room, or the locking arrangement is permitted for patient clinical, security or safety needs in accordance with 18.2.2.2.5 or 19.2.2.2.5. 18.2.2.2, 19.2.2.2, TIA 12-4 This STANDARD is not met as evidenced by: Patient Sleeping Room Doors Locks on patient sleeping room doors are not permitted unless the key-locking device that restricts access from the corridor does not restrict egress from the patient room, or the locking arrangement is permitted for patient clinical, security or safety needs in accordance with 18.2.2.2.5 or 19.2.2.2.5. 18.2.2.2, 19.2.2.2, TIA 12-4 Findings Include: On facility tour between 12:00 AM and 04:00 PM on 8/16/17, based on observation and interview revealed that the following include: Resident room 121 door does not close tight when tested. This deficient practice could affect the safety of the resident within the smoke compartment. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 221	Door in room 121 was shaved down to latch properly by maintenance department.	
K 321 SS=D	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure 2012 EXISTING Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4-hour	K 321		9/25/17

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K 321	Continued From page 4 fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This STANDARD is not met as evidenced by: Hazardous Areas - Enclosure 2012 EXISTING Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4-hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates	K 321	1 hour fire rated door has been ordered and will be installed when arrives. Estimate date of completion is October 31st 2017	

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K 321	Continued From page 5 that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) Findings Include: On facility tour between 12:00 AM and 04:00 PM on 8/16/17, based on observation and interview revealed that the following include: The door assembly is not rated for storage room 118. This deficient practice could affect the safety of all (9) the residents, staff and visitors within the smoke compartment. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 321		
K 374 SS=E	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier	K 374		9/25/17

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K 374	Continued From page 6 Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This STANDARD is not met as evidenced by: Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 Findings Include: On facility tour between 12:00 AM and 04:00 PM on 8/16/17, based on observation and interview revealed that the following include: Smoke compartment doors by 125 and 224 rooms does not close tight when tested.	K 374	Smoke compartment doors were checked and maintenance readjusted doors. Maintenance will monitor monthly.	

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K 374	Continued From page 7 This deficient practice could affect the safety of all (12) the residents, staff and visitors within the smoke compartment. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 374		