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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: E5TN

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: **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 **12/29/2021** (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 **84** (L18)
13.Total Certified Beds **84** (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
	84			
(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 :
Kari Cistera, HFE NE II 01/20/2022 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 01/31/2022 (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
January 9, 2022

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

RE: CCN: 245514
Cycle Start Date: December 29, 2021

Dear Administrator:

On December 29, 2021, a 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 constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Jamie Perell, Unit Supervisor
Metro B District Office
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: jamie.perell@state.mn.us
Office: (651) 245-8094

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. 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, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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.

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 March 29, 2022 (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).

In addition, if substantial compliance with the regulations is not verified by June 29, 2022 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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: https://mdhprovidercontent.web.health.state.mn.us/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: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

Electronically delivered
January 9, 2022

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

Re: State Nursing Home Licensing Orders
Event ID: E5TN11

Dear Administrator:

The above facility was surveyed on December 26, 2021 through December 29, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the

"Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

Jamie Perell, Unit Supervisor
Metro B District Office
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: jamie.perell@state.mn.us
Office: (651) 245-8094

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

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program

Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00811	A. BUILDING: _____ B. WING _____	C 12/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MALA STRANA CARE & REHABILITATION CEN	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) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 12/26/21, through 12/29/21, a standard licensing survey was conducted completed at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure.	2 000		

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2 000	Continued From page 1 The following complaints were found to be SUBSTANTIATED; however, no licensing orders were issued: H5514041C (MN77950) H5514043C (MN55009) H5514045C (MN59006) H5514046C (MN54710) The following complaints were found to be UNSUBSTANTIATED: H5514042C (MN73454) H5514047C (MN66093) H5514044C (MN68249) Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please	2 000		

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2 000	Continued From page 2 enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 550	MN Rule 4658.0400 Subp. 4 Comprehensive Resident Assessment; Review Subp. 4. Review of assessments. A nursing home must examine each resident at least quarterly and must revise the resident's comprehensive assessment to ensure the continued accuracy of the assessment. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to ensure the accuracy of the "Minimum Data Set (MDS)" assessment for one resident (Resident (R) 32) of 20 residents whose assessments were reviewed out of a total sample of 27 residents. The facility failed to accurately assess the use of an anticoagulant (blood-thinning) medication which placed R32 at risk for unmet care needs. Findings include:	2 550		

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2 550	Continued From page 3 Review of R32's quarterly "MDS" assessment with an Assessment Reference Date (ARD) of 11/30/21, revealed that R32's anticoagulant medication was not coded. Review of the "Physician Orders," located in the "Orders" tab of the electronic medical record (EMR), revealed R32 had an order for Apixaban (Eliquis-a blood-thinning medication) 2.5 milligrams (mgs) twice daily for treatment of Atrial Fibrillation (irregular heart rate) with a start date of 07/16/19. In an interview on 12/28/21 at 12:43 PM, the Director of Nursing (DON) was asked if R32 was administered Apixaban during the seven-day assessment period and was this coded on the assessment correctly. The DON stated that R32 was administered the medication, as ordered, and the assessment should have reflected the use of the anticoagulant medication therefore, it was an error in coding. SUGGESTED METHOD OF CORRECTION: The director of nursing, or designee, could review and/or revise policies and procedures, educate staff, and develop a monitoring system to assure accuracy of assessments TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 550		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident.	2 565		

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2 565	Continued From page 4	2 565		

This MN Requirement is not met as evidenced by:
Based on observation, record review, and staff and resident interviews, the facility failed to develop a comprehensive plan of care directing measurable goals and interventions for indwelling urinary catheters (a tube inserted into the bladder to drain urine) for one resident (R8) of six residents having indwelling urinary catheters out of a total sample of 27 residents. This failure placed the residents at risk for unmet care needs.

Findings include:

Review of the "Face Sheet" located in the "Profile" tab of the electronic medical record (EMR), revealed R8 was admitted to the facility on 06/17/19 with diagnoses that included heart disease and diabetes.

Review of the quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 10/01/21 revealed a "Brief Interview for Mental Status (BIMS)" score of 15 out of 15 which indicated R8 was cognitively intact for decision-making. This "MDS" assessment further indicated R8 had an indwelling urinary catheter.

Review of R8's comprehensive care plan did not show a focus, measurable goals, or interventions for the use of an indwelling urinary catheter.

In an interview on 12/29/21 at 8:10 AM, the Director of Nursing (DON) was asked if R8 had a care plan developed for the use of an indwelling urinary catheter. She stated, "I will get back to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 565	Continued From page 5 you on that." On 12/29/21 at 10:58 AM, the DON was again asked if a care plan had been developed for the indwelling urinary catheter. The DON stated, "I think he does have a care plan for the catheter, but I am not sure, but was told that he had a care plan." SUGGESTED METHOD OF CORRECTION: The director of nursing, or designee, could develop, review, and/or revise policies and procedures to ensure care a comprehensive care plan is developed which included resident centered goals and interventions. The director of nursing, or designee, could then educate all appropriate staff and develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
21610	MN Rule 4658.1340 Subp. 1 Medicine Cabinet and Preparation Area;Storage Subpart 1. Storage of drugs. A nursing home must store all drugs in locked compartments under proper temperature controls, and permit only authorized nursing personnel to have access to the keys. This MN Requirement is not met as evidenced by: Based on observations, interviews, and policy review, the facility failed to ensure that two of four medication carts were kept locked and under direct observation of authorized staff in areas where residents and visitors could access the medications. This deficient practice had the	21610		

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21610	Continued From page 6 potential to affect all residents who resided at the facility. Findings include: Review of the facility policy "Medication Storage in the Facility," revised January 2018 and initialed as revised 12/27/21 by the DON, revealed that the policy did not specifically state that the medication carts should be locked; however, under the controlled substance section the policy stated that "medications ... are subject to special handling, storage, disposal, and recordkeeping ... in accordance with federal, state, and other applicable laws and regulations." Review of the facility map revealed that the facility had two nurses' stations, the north/west wing and the east wing, with four medication carts serving the residents of the facility. Observation on 12/26/21 at 4:52 PM at the north/west nurses' station revealed that one of two medication carts was unlocked and no staff in the area. Ambulatory residents, visitors, and dietary staff delivering trays were observed in the hallways. The surveyor waited with the cart and Registered Nurse (RN) B came out of a resident room at 4:54 P.M. with a glucometer in her hand. When asked if the medication cart should be unlocked RN B said that she had gone to re-check a blood sugar, and when asked again if the medication cart should be unlocked RN B verified the cart should have been locked. When asked about the facility policy for locking medication carts RN B did not respond. Observation on 12/27/21 at 9:20 AM at the east wing nurses' station revealed one of the two medication carts was unlocked. There were no	21610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00811	A. BUILDING: _____ B. WING _____	C 12/29/2021

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21610	Continued From page 7 staff observed in the area. The surveyor stayed with the cart and Certified Nurse Assistant (CNA) A came out of a room behind the nurses' station. CNA A stated that she was a trained medication assistant. When asked if the medication cart should be unlocked, CNA A verified that the cart should not be unlocked and locked the cart before leaving the area. During an interview on 12/27/21 at 4:20 PM, the Director of Nursing (DON) stated that it was her expectation that the medication carts be locked per policy. SUGGESTED METHOD OF CORRECTION: The director of nursing, or designee, could development and implement policies and procedures to ensure that medications are secured appropriately. The director of nursing, or designee, could then educate staff and develop monitoring systems for adherence to the policies and procedures. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21610		

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 12/26/21, through 12/29/21, a standard licensing survey was conducted completed at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure.	2 000		

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2 000	Continued From page 1 The following complaints were found to be SUBSTANTIATED; however, no licensing orders were issued: H5514041C (MN77950) H5514043C (MN55009) H5514045C (MN59006) H5514046C (MN54710) The following complaints were found to be UNSUBSTANTIATED: H5514042C (MN73454) H5514047C (MN66093) H5514044C (MN68249) Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please	2 000		

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2 000	Continued From page 2 enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 550	MN Rule 4658.0400 Subp. 4 Comprehensive Resident Assessment; Review Subp. 4. Review of assessments. A nursing home must examine each resident at least quarterly and must revise the resident's comprehensive assessment to ensure the continued accuracy of the assessment. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to ensure the accuracy of the "Minimum Data Set (MDS)" assessment for one resident (Resident (R) 32) of 20 residents whose assessments were reviewed out of a total sample of 27 residents. The facility failed to accurately assess the use of an anticoagulant (blood-thinning) medication which placed R32 at risk for unmet care needs. Findings include:	2 550	Corrected.	1/31/22

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2 550	Continued From page 3 Review of R32's quarterly "MDS" assessment with an Assessment Reference Date (ARD) of 11/30/21, revealed that R32's anticoagulant medication was not coded. Review of the "Physician Orders," located in the "Orders" tab of the electronic medical record (EMR), revealed R32 had an order for Apixaban (Eliquis-a blood-thinning medication) 2.5 milligrams (mgs) twice daily for treatment of Atrial Fibrillation (irregular heart rate) with a start date of 07/16/19. In an interview on 12/28/21 at 12:43 PM, the Director of Nursing (DON) was asked if R32 was administered Apixaban during the seven-day assessment period and was this coded on the assessment correctly. The DON stated that R32 was administered the medication, as ordered, and the assessment should have reflected the use of the anticoagulant medication therefore, it was an error in coding. SUGGESTED METHOD OF CORRECTION: The director of nursing, or designee, could review and/or revise policies and procedures, educate staff, and develop a monitoring system to assure accuracy of assessments TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 550		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident.	2 565		1/31/22

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2 565	Continued From page 4 This MN Requirement is not met as evidenced by: Based on observation, record review, and staff and resident interviews, the facility failed to develop a comprehensive plan of care directing measurable goals and interventions for indwelling urinary catheters (a tube inserted into the bladder to drain urine) for one resident (R8) of six residents having indwelling urinary catheters out of a total sample of 27 residents. This failure placed the residents at risk for unmet care needs. Findings include: Review of the "Face Sheet" located in the "Profile" tab of the electronic medical record (EMR), revealed R8 was admitted to the facility on 06/17/19 with diagnoses that included heart disease and diabetes. Review of the quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 10/01/21 revealed a "Brief Interview for Mental Status (BIMS)" score of 15 out of 15 which indicated R8 was cognitively intact for decision-making. This "MDS" assessment further indicated R8 had an indwelling urinary catheter. Review of R8's comprehensive care plan did not show a focus, measurable goals, or interventions for the use of an indwelling urinary catheter. In an interview on 12/29/21 at 8:10 AM, the Director of Nursing (DON) was asked if R8 had a care plan developed for the use of an indwelling urinary catheter. She stated, "I will get back to	2 565	Corrected.	

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2 565	Continued From page 5 you on that." On 12/29/21 at 10:58 AM, the DON was again asked if a care plan had been developed for the indwelling urinary catheter. The DON stated, "I think he does have a care plan for the catheter, but I am not sure, but was told that he had a care plan." SUGGESTED METHOD OF CORRECTION: The director of nursing, or designee, could develop, review, and/or revise policies and procedures to ensure care a comprehensive care plan is developed which included resident centered goals and interventions. The director of nursing, or designee, could then educate all appropriate staff and develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
21610	MN Rule 4658.1340 Subp. 1 Medicine Cabinet and Preparation Area;Storage Subpart 1. Storage of drugs. A nursing home must store all drugs in locked compartments under proper temperature controls, and permit only authorized nursing personnel to have access to the keys. This MN Requirement is not met as evidenced by: Based on observations, interviews, and policy review, the facility failed to ensure that two of four medication carts were kept locked and under direct observation of authorized staff in areas where residents and visitors could access the medications. This deficient practice had the	21610	Corrected.	1/31/22

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21610	Continued From page 6 potential to affect all residents who resided at the facility. Findings include: Review of the facility policy "Medication Storage in the Facility," revised January 2018 and initialed as revised 12/27/21 by the DON, revealed that the policy did not specifically state that the medication carts should be locked; however, under the controlled substance section the policy stated that "medications ... are subject to special handling, storage, disposal, and recordkeeping ... in accordance with federal, state, and other applicable laws and regulations." Review of the facility map revealed that the facility had two nurses' stations, the north/west wing and the east wing, with four medication carts serving the residents of the facility. Observation on 12/26/21 at 4:52 PM at the north/west nurses' station revealed that one of two medication carts was unlocked and no staff in the area. Ambulatory residents, visitors, and dietary staff delivering trays were observed in the hallways. The surveyor waited with the cart and Registered Nurse (RN) B came out of a resident room at 4:54 P.M. with a glucometer in her hand. When asked if the medication cart should be unlocked RN B said that she had gone to re-check a blood sugar, and when asked again if the medication cart should be unlocked RN B verified the cart should have been locked. When asked about the facility policy for locking medication carts RN B did not respond. Observation on 12/27/21 at 9:20 AM at the east wing nurses' station revealed one of the two medication carts was unlocked. There were no	21610		

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21610	Continued From page 7 staff observed in the area. The surveyor stayed with the cart and Certified Nurse Assistant (CNA) A came out of a room behind the nurses' station. CNA A stated that she was a trained medication assistant. When asked if the medication cart should be unlocked, CNA A verified that the cart should not be unlocked and locked the cart before leaving the area. During an interview on 12/27/21 at 4:20 PM, the Director of Nursing (DON) stated that it was her expectation that the medication carts be locked per policy. SUGGESTED METHOD OF CORRECTION: The director of nursing, or designee, could development and implement policies and procedures to ensure that medications are secured appropriately. The director of nursing, or designee, could then educate staff and develop monitoring systems for adherence to the policies and procedures. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21610		

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	245514	A. BUILDING _____ B. WING _____	C 12/29/2021

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E 000	Initial Comments On 12/26/21, through 12/29/21, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 12/26/21, through 12/29/21, a standard recertification survey was completed by surveyors from the Minnesota Department of Health (MDH). In addition, multiple complaint investigations were completed. Mala Strana Care and Rehabilitation Center was found not in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED; however, no deficiencies were issued due to corrective actions taken by the facility: H5514041C (MN77950) H5514043C (MN55009) H5514045C (MN59006) H5514046C (MN54710) The following complaints were found to be UNSUBSTANTIATED: H5514042C (MN73454) H5514047C (MN66093) H5514044C (MN68249)	F 000		

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

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F 000	Continued From page 1 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR	F 656		

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F 656	Continued From page 2	F 656		

recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
This REQUIREMENT is not met as evidenced by:
Based on observation, record review, and staff and resident interviews, the facility failed to develop a comprehensive plan of care directing measurable goals and interventions for indwelling urinary catheters (a tube inserted into the bladder to drain urine) for one resident (R8) of six residents having indwelling urinary catheters out of a total sample of 27 residents. This failure placed the residents at risk for unmet care needs.

Findings include:

Review of the "Face Sheet" located in the "Profile" tab of the electronic medical record (EMR), revealed R8 was admitted to the facility on 06/17/19 with diagnoses that included heart disease and diabetes.

Review of the quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date

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F 656	Continued From page 3 (ARD) of 10/01/21 revealed a "Brief Interview for Mental Status (BIMS)" score of 15 out of 15 which indicated R8 was cognitively intact for decision-making. This "MDS" assessment further indicated R8 had an indwelling urinary catheter. Review of R8's comprehensive care plan did not show a focus, measurable goals, or interventions for the use of an indwelling urinary catheter. In an interview on 12/29/21 at 8:10 AM, the Director of Nursing (DON) was asked if R8 had a care plan developed for the use of an indwelling urinary catheter. She stated, "I will get back to you on that." On 12/29/21 at 10:58 AM, the DON was again asked if a care plan had been developed for the indwelling urinary catheter. The DON stated, "I think he does have a care plan for the catheter, but I am not sure, but was told that he had a care plan."	F 656		
F 694 SS=D	Parenteral/IV Fluids CFR(s): 483.25(h) § 483.25(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to ensure a peripherally inserted central catheter (PICC) was appropriately managed for 1 of 1 resident (R29) who received intravenous (IV) medications.	F 694		

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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 694	Continued From page 4 Findings include: R29's Admission Record dated 12/29/21, indicated R29 had diagnoses which included staphylococcal arthritis of the right knee (infection of the joint). R29's 5-Day Prospective Payment System Minimum Data Set (MDS) dated 5/24/21, indicated R29 had a moderate cognitive impairment and received IV medications at the facility. A Hospital Discharge Summary dated 12/14/21, indicated R29 had a PICC line. R29's Order Summary Report dated 12/21/21, directed staff to administer cefazolin sodium (antibiotic) two grams IV every 12 hours through 1/17/22. The order further directed staff to monitor R29's PICC line for patency and to notify the provider of resistance. R29's December 2021 Medication Administration Record indicated R29 was to be administer cefazolin twice daily at 7:00 a.m. and 7:00 p.m. R29's care plan dated 12/29/21, lacked indication R29 had a PICC line or related interventions. Review of R29's progress notes revealed: - On 12/24/21, at 12:24 p.m. R29 was found still connected to the antibiotic during the morning. Licensed practical nurse (LPN)-C attempted to flush R29's PICC line with normal saline, however, it was met with resistance. - On 12/24/21, at 2:51 p.m. the on-call provided was notified and recommenced to send R29 to	F 694		

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	245514	A. BUILDING _____ B. WING _____	C 12/29/2021

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the emergency room for evaluation related to an increased creatinine, CRP, and SED rate (labs).
- On 12/24/21, at 5:40 p.m. R29 was sent to the hospital around 4:00 p.m. and emergency medical technicians (EMTs) were notified R29's PICC line had resistance.
- On 12/28/21, at 1:28 p.m. LPN-A was requested to disconnect the IV medication from R29's PICC line at 6:00 a.m. The progress note further revealed the IV medication was from 12/27/21, at 7:00 p.m. LPN-A disconnected the IV medication and flushed the PICC line with 10 cubic centimeters (cc) of normal saline. The IV site was patent and flushed without resistance.

During an interview on 12/28/21, at 7:00 a.m. LPN-A stated she had just removed the IV medication from R29 (from 12/27/21). At 7:45 a.m. LPN-A stated the night nurse (from 12/27/2) left the IV antibiotic connected to R29 and did not remove it once completed. LPN-A stated she was informed by R29's nursing assistant (NA) the antibiotic was still connected to R29's PICC line. LPN-A stated if IV medication was left and not removed after administration it could cause the PICC line to clot off.

During an interview on 12/28/21, at 1:00 p.m. pharmacist (P)-A stated R29 had an order for cefazolin which was to be administered twice a day. Her recommendation for nursing staff would be to administer the medication per physician's orders and disconnect the antibiotic from the PICC line after the infusion was completed. The antibiotic should be removed immediately after infusion and infusions last for 30 to 45 minutes. The complication from not disconnecting the antibiotic and flushing the PICC line would be a line occlusion.

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F 761 SS=F	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)	F 761		

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F 761	Continued From page 7 §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and policy review, the facility failed to ensure that two of four medication carts were kept locked and under direct observation of authorized staff in areas where residents and visitors could access the medications. This deficient practice had the potential to affect all residents who resided at the facility. Findings include: Review of the facility policy "Medication Storage	F 761		

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F 761	Continued From page 8	F 761		

in the Facility," revised January 2018 and initialed as revised 12/27/21 by the DON, revealed that the policy did not specifically state that the medication carts should be locked; however, under the controlled substance section the policy stated that "medications ... are subject to special handling, storage, disposal, and recordkeeping ... in accordance with federal, state, and other applicable laws and regulations."

Review of the facility map revealed that the facility had two nurses' stations, the north/west wing and the east wing, with four medication carts serving the residents of the facility.

Observation on 12/26/21 at 4:52 PM at the north/west nurses' station revealed that one of two medication carts was unlocked and no staff in the area. Ambulatory residents, visitors, and dietary staff delivering trays were observed in the hallways. The surveyor waited with the cart and Registered Nurse (RN) B came out of a resident room at 4:54 P.M. with a glucometer in her hand. When asked if the medication cart should be unlocked RN B said that she had gone to re-check a blood sugar, and when asked again if the medication cart should be unlocked RN B verified the cart should have been locked. When asked about the facility policy for locking medication carts RN B did not respond.

Observation on 12/27/21 at 9:20 AM at the east wing nurses' station revealed one of the two medication carts was unlocked. There were no staff observed in the area. The surveyor stayed with the cart and Certified Nurse Assistant (CNA) A came out of a room behind the nurses' station. CNA A stated that she was a trained medication assistant. When asked if the medication cart

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F 761	Continued From page 9 should be unlocked, CNA A verified that the cart should not be unlocked and locked the cart before leaving the area. During an interview on 12/27/21 at 4:20 PM, the Director of Nursing (DON) stated that it was her expectation that the medication carts be locked per policy.	F 761		

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E 000	Initial Comments On 12/26/21, through 12/29/21, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 12/26/21, through 12/29/21, a standard recertification survey was completed by surveyors from the Minnesota Department of Health (MDH). In addition, multiple complaint investigations were completed. Mala Strana Care and Rehabilitation Center was found not in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED; however, no deficiencies were issued due to corrective actions taken by the facility: H5514041C (MN77950) H5514043C (MN55009) H5514045C (MN59006) H5514046C (MN54710) The following complaints were found to be UNSUBSTANTIATED: H5514042C (MN73454) H5514047C (MN66093) H5514044C (MN68249)	F 000		

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

Electronically Signed | 01/17/2022

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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F 000	Continued From page 1 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR	F 656		1/31/22

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F 656	Continued From page 2 recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff and resident interviews, the facility failed to develop a comprehensive plan of care directing measurable goals and interventions for indwelling urinary catheters (a tube inserted into the bladder to drain urine) for one resident (R8) of six residents having indwelling urinary catheters out of a total sample of 27 residents. This failure placed the residents at risk for unmet care needs. Findings include: Review of the "Face Sheet" located in the "Profile" tab of the electronic medical record (EMR), revealed R8 was admitted to the facility on 06/17/19 with diagnoses that included heart disease and diabetes. Review of the quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date	F 656	• R8's comprehensive plan of care and interventions for indwelling urinary catheter has been reviewed and updated to include risk vs. benefits of catheter use. • Like residents have been identified for the use of indwelling urinary catheters and their comprehensive plan of care and interventions have been reviewed and updated to include risk vs. benefit of catheter use. • Facility will initiate education to appropriate staff on development of comprehensive plan of care and interventions for indwelling urinary catheter including risks vs. benefits • DON or designee will complete audits weekly x 4, then monthly x 2 • Audit results will be reviewed by QAPI committee for possible further recommendations	

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F 656	Continued From page 3 (ARD) of 10/01/21 revealed a "Brief Interview for Mental Status (BIMS)" score of 15 out of 15 which indicated R8 was cognitively intact for decision-making. This "MDS" assessment further indicated R8 had an indwelling urinary catheter. Review of R8's comprehensive care plan did not show a focus, measurable goals, or interventions for the use of an indwelling urinary catheter. In an interview on 12/29/21 at 8:10 AM, the Director of Nursing (DON) was asked if R8 had a care plan developed for the use of an indwelling urinary catheter. She stated, "I will get back to you on that." On 12/29/21 at 10:58 AM, the DON was again asked if a care plan had been developed for the indwelling urinary catheter. The DON stated, "I think he does have a care plan for the catheter, but I am not sure, but was told that he had a care plan."	F 656		
F 694 SS=D	Parenteral/IV Fluids CFR(s): 483.25(h) § 483.25(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to ensure a peripherally inserted central catheter (PICC) was appropriately managed for 1 of 1 resident (R29) who received intravenous (IV) medications.	F 694	• R29's PICC line has been discontinued. • Like residents have been identified for the use of a PICC line and their comprehensive care plan has been	1/31/22

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F 694	Continued From page 4 Findings include: R29's Admission Record dated 12/29/21, indicated R29 had diagnoses which included staphylococcal arthritis of the right knee (infection of the joint). R29's 5-Day Prospective Payment System Minimum Data Set (MDS) dated 5/24/21, indicated R29 had a moderate cognitive impairment and received IV medications at the facility. A Hospital Discharge Summary dated 12/14/21, indicated R29 had a PICC line. R29's Order Summary Report dated 12/21/21, directed staff to administer cefazolin sodium (antibiotic) two grams IV every 12 hours through 1/17/22. The order further directed staff to monitor R29's PICC line for patency and to notify the provider of resistance. R29's December 2021 Medication Administration Record indicated R29 was to be administer cefazolin twice daily at 7:00 a.m. and 7:00 p.m. R29's care plan dated 12/29/21, lacked indication R29 had a PICC line or related interventions. Review of R29's progress notes revealed: - On 12/24/21, at 12:24 p.m. R29 was found still connected to the antibiotic during the morning. Licensed practical nurse (LPN)-C attempted to flush R29's PICC line with normal saline, however, it was met with resistance. - On 12/24/21, at 2:51 p.m. the on-call provided was notified and recommenced to send R29 to	F 694	reviewed and updated to include PICC line use. • Facility will initiate education to appropriate staff on medication administration through PICC line and documentation of removal of medication. • DON or designee will complete audits weekly x 4 and monthly x 2. • Audit results will be reviewed by QAPI committee for possible further recommendations.	

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- On 12/28/21, at 1:28 p.m. LPN-A was requested to disconnect the IV medication from R29's PICC line at 6:00 a.m. The progress note further revealed the IV medication was from 12/27/21, at 7:00 p.m. LPN-A disconnected the IV medication and flushed the PICC line with 10 cubic centimeters (cc) of normal saline. The IV site was patent and flushed without resistance.

During an interview on 12/28/21, at 7:00 a.m. LPN-A stated she had just removed the IV medication from R29 (from 12/27/21). At 7:45 a.m. LPN-A stated the night nurse (from 12/27/2) left the IV antibiotic connected to R29 and did not remove it once completed. LPN-A stated she was informed by R29's nursing assistant (NA) the antibiotic was still connected to R29's PICC line. LPN-A stated if IV medication was left and not removed after administration it could cause the PICC line to clot off.

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F 761 SS=F	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)	F 761		1/31/22

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	245514	A. BUILDING _____ B. WING _____	C 12/29/2021

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 761	Continued From page 7 §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and policy review, the facility failed to ensure that two of four medication carts were kept locked and under direct observation of authorized staff in areas where residents and visitors could access the medications. This deficient practice had the potential to affect all residents who resided at the facility. Findings include: Review of the facility policy "Medication Storage	F 761	• All medication carts were immediately audited to ensure that they were properly locked under direct and indirect observation of authorized staff in resident care areas. • Each medication cart has the potential to be unlocked and unattended. • Facility will initiate education to appropriate staff on labeling and storage of drugs and biologicals • DON or designee will continue to audit medication carts weekly x 4, then	

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	245514	A. BUILDING _____ B. WING _____	C 12/29/2021

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MALA STRANA CARE & REHABILITATION CENTER	**1001 COLUMBUS AVENUE NORTH NEW PRAGUE, MN 56071**

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F 761	Continued From page 8 in the Facility," revised January 2018 and initialed as revised 12/27/21 by the DON, revealed that the policy did not specifically state that the medication carts should be locked; however, under the controlled substance section the policy stated that "medications ... are subject to special handling, storage, disposal, and recordkeeping ... in accordance with federal, state, and other applicable laws and regulations." Review of the facility map revealed that the facility had two nurses' stations, the north/west wing and the east wing, with four medication carts serving the residents of the facility. Observation on 12/26/21 at 4:52 PM at the north/west nurses' station revealed that one of two medication carts was unlocked and no staff in the area. Ambulatory residents, visitors, and dietary staff delivering trays were observed in the hallways. The surveyor waited with the cart and Registered Nurse (RN) B came out of a resident room at 4:54 P.M. with a glucometer in her hand. When asked if the medication cart should be unlocked RN B said that she had gone to re-check a blood sugar, and when asked again if the medication cart should be unlocked RN B verified the cart should have been locked. When asked about the facility policy for locking medication carts RN B did not respond. Observation on 12/27/21 at 9:20 AM at the east wing nurses' station revealed one of the two medication carts was unlocked. There were no staff observed in the area. The surveyor stayed with the cart and Certified Nurse Assistant (CNA) A came out of a room behind the nurses' station. CNA A stated that she was a trained medication assistant. When asked if the medication cart	F 761	monthly x 2. • Audit results will be reviewed by QAPI committee for possible further recommendations.	

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 _____	C 12/29/2021

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

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F 761	Continued From page 9 should be unlocked, CNA A verified that the cart should not be unlocked and locked the cart before leaving the area. During an interview on 12/27/21 at 4:20 PM, the Director of Nursing (DON) stated that it was her expectation that the medication carts be locked per policy.	F 761		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 245514	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 12/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MALA STRANA CARE & REHABILITATION CENTE	**1001 COLUMBUS AVENUE NORTH NEW PRAGUE, MN**

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 641	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure the accuracy of the "Minimum Data Set (MDS)" assessment for one resident (Resident (R) 32) of 20 residents whose assessments were reviewed out of a total sample of 27 residents. The facility failed to accurately assess the use of an anticoagulant (blood-thinning) medication which placed R32 at risk for unmet care needs. Findings include: Review of R32's quarterly "MDS" assessment with an Assessment Reference Date (ARD) of 11/30/21, revealed that R32's anticoagulant medication was not coded. Review of the "Physician Orders," located in the "Orders" tab of the electronic medical record (EMR), revealed R32 had an order for Apixaban (Eliquis-a blood-thinning medication) 2.5 milligrams (mgs) twice daily for treatment of Atrial Fibrillation (irregular heart rate) with a start date of 07/16/19. In an interview on 12/28/21 at 12:43 PM, the Director of Nursing (DON) was asked if R32 was administered Apixaban during the seven-day assessment period and was this coded on the assessment correctly. The DON stated that R32 was administered the medication, as ordered, and the assessment should have reflected the use of the anticoagulant medication therefore, it was an error in coding.

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

The above isolated deficiencies pose no actual harm to the residents

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245514	A. BUILDING **01** B. WING _____	**12/28/2021**

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
K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 12/28/2021. At the time of this survey, Mala Strana Care & Rehabilitation Center was found 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) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, the Health Care Facilities Code. The nursing home was built in 1972 and had an addition built in 2003, with both buildings being type II construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors, which is monitored for automatic fire department notification, and the building is fully sprinkered. The nursing home is separated from an assisted living facility by a complying two-hour firewall assembly. The facility has a capacity of 84 beds and had a census of 42 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a), is MET.	K 000		

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

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FIRE SAFETY SURVEY REPORT
CRUCIAL DATA EXTRACT
(TO BE USED WITH CMS-2786 FORMS)

PROVIDER NUMBER	FACILITY NAME	SURVEY DATE
K1 245514	**MALA STRANA CARE & REHABILITATION CENTER**	*K4 **12/28/2021**

K6 DATE OF PLAN APPROVAL

K3 : MULTIPLE CONSTRUCTION

TOTAL NUMBER OF BUILDINGS 1

NUMBER OF THIS BUILDING 01

[A]

A BUILDING
B WING
C FLOOR
D APARTMENT UNIT

LSC FORM INDICATOR

Health Care Form		
12	2786 R	2012 EXISTING
13	2786 R	2012 NEW

ASC Form		
14	2786 U	2012 EXISTING
15	2786 U	2012 NEW

ICF/MR Form		
16	2786 V, W, X	2012 EXISTING
17	2786 V, W, X	2012 NEW

*K7 [12] SELECT NUMBER OF FORM USED FROM ABOVE

(Check if K321 or K351 are marked as not applicable in the 2786 M, R, T, U, V, W, X, Y and Z.)

K321: [3] K351: [3]

COMPLETE IF ICF/MR IS SURVEYED UNDER CHAPTER 21

SMALL (16 BEDS OR LESS)

K8: [ ]

1 PROMPT
2 SLOW
3 IMPRACTICAL

LARGE

K8: [ ]

4 PROMPT
5 SLOW
6 IMPRACTICAL

APARTMENT HOUSE

K8: [ ]

7 PROMPT
8 SLOW
9 IMPRACTICAL

ENTER E-SCORE HERE

K5: [ ] e.g 2.5

*K9 : FACILITY MEETS LSC BASED ON: (*Check all that apply*)

A1 [X]	A2 [ ]	A3 [ ]	A4 [ ]	A5 [ ]
(COMP. WITH ALL PROVISIONS)	(ACCEPTABLE POC)	(WAIVERS)	(FSES)	(PERFORMANCE BASED DESIGN)

FACILITY DOES NOT MEET LSC:

B. [ ]

K180:

A. [X]	B. [ ]	C. [ ]
FULLY SPRINKLERED (All required areas are sprinklered)	PARTIALLY SPRINKLERED (Not all required areas are sprinklered)	NONE (No sprinkler system)

*MANDATORY