DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: E5TN

 ${\bf MEDICARE/MEDICAID\ CERTIFICATION\ AND\ TRANSMITTAL}$

	PART I -	TO BE COMPI	LETED BY T	THE STAT	TE SURVEY AG	ENCY		Fac	eility ID: 00811
1. MEDICARE/MEDICAID PROVID (L1) 245514 2.STATE VENDOR OR MEDICAID (L2) 227432200		3. NAME AND AI (L3) MALA STR. (L4) 1001 COLU. (L5) NEW PRAG	ANA CARE & MBUS AVENU	REHABII	LITATION CENTER H (L6) 56071		4. TYPE C 1. Initial 3. Termin 5. Validat 7. On-Sit	tion	2 (L8) 2. Recertification 4. CHOW 6. Complaint 9. Other
5. EFFECTIVE DATE CHANGE OF (L9) 07/01/2015	OWNERSHIP	7. PROVIDER/SU 01 Hospital	JPPLIER CATEO	GORY 09 ESRD	02 (L7) 13 PTIP 2:	2 CLIA	8. Full Survey After Complaint		
6. DATE OF SURVEY 12/2 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	29/2021 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE		FISCAL YEA	AR ENDING	DATE: (L35)
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds	84 (L18) 84 (L17)	Compliance1. A X B. Not in Con	equirements e Based On:	gram	And/Or Approved 2. Technica 3. 24 Hour 4. 7-Day R 5. Life Safe * Code: B*	al Personnel RN N (Rural SN	6. So 7. M F) 8. Pa	Requirements cope of Servi dedical Direct titent Room S cds/Room	ces Limit tor
14. LTC CERTIFIED BED BREAKDO 18 SNF 18/19 SNF		ICF	IID		15. FACILITY MEE		(I	.15)	
(L37) (L38)	(L39)	(L42)	(L43)						
16. STATE SURVEY AGENCY REM	MARKS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION	DATE):					
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVE	Y AGENCY	APPROVAL		Date:
Kari Cistera, H	E NE II	0	01/20/2022	(L19)	Kamala Fiske-Downing, Enforcement Specialist 01/31/2022 (L20				
PA	RT II - TO BE	COMPLETED I	BY HCFA RI	EGIONAL	OFFICE OR SI	INGLE ST	TATE AGE	NCY	
DETERMINATION OF ELIGIBI 1. Facility is Eligible to 2. Facility is not Eligible	Participate		IPLIANCE WITI HTS ACT:	H CIVIL	2. Owne		cial Solvency (I l Interest Disclo :		CFA-1513)
22. ORIGINAL DATE OF PARTICIPATION 02/01/1988 (L24)	23. LTC AGREEN BEGINNING (L41)		4. LTC AGREEM ENDING DA (L25)		26. TERMINATION VOLUNTARY 01-Merger, Closure 02-Dissatisfaction W	00	(
25. LTC EXTENSION DATE: (L27)	27. ALTERNATI A. Suspension	VE SANCTIONS n of Admissions:	(L44) (L45)		03-Risk of Involuntar 04-Other Reason for	-	n <u>(</u>	<u>OTHER</u>	Status Change
28. TERMINATION DATE:	29). INTERMEDIARY/	/CARRIER NO.		30. REMARKS				
		06201							
	(L28)			(L31)					
31. RO RECEIPT OF CMS-1539		. DETERMINATION	N OF APPROVAL						
	(L32)			(L33)	DETERMINATI	ON APPR	ROVAL		



Protecting, Maintaining and Improving the Health of All Minnesotans

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

Minnesota Department of Health Licensing and Certification Program

Kamala Fiske Downing

Program Assurance Unit Health Regulation Division

Telephone: (651) 201-4112 Fax: (651) 215-9697

Email: Kamala.Fiske-Downing@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

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 <u>only a suggestion</u> 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

Minnesota Department of Health Licensing and Certification Program

Kamala Fiske Downing

Program Assurance Unit Health Regulation Division

Telephone: (651) 201-4112 Fax: (651) 215-9697

Email: <u>Kamala.Fiske-Downing@state.mn.us</u>

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:						SURVEY PLETED	
		00811		B. WING			C 29/2021
NAME OF	PROVIDER OR SUPPLIER		STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	·	
MALA S	TRANA CARE & REH	ABILITATION CEN		UMBUS AVE GUE, MN 5	ENUE NORTH 6071		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 000	Initial Comments			2 000			
	****ATTE	NTION*****					
	NH LICENSING CORRECTION ORDER						
	144A.10, this corre- pursuant to a surve found that the defic herein are not corre- not corrected shall with a schedule of f the Minnesota Depi Determination of wh corrected requires or requirements of the number and MN Ru When a rule contain comply with any of lack of compliance, re-inspection with a result in the assess that was violated du corrected. You may request a	hether a violation has compliance with all rule provided at the alle number indicated ns several items, failuthe items will be cons Lack of compliance my item of multi-part ment of a fine even it uring the initial inspec	issued ion, it is cited violation rdance rule of seen tag below. Ure to sidered e upon rule will f the item ction was seen seen seen tag seen tag below.				
	orders provided that the Department with	n non-compliance wit at a written request is hin 15 days of receip ent for non-complianc	made to t of a				
	licensing survey wayour facility by surv Department of Hea	rS: gh 12/29/21, a standa is conducted comple eyors from the Minne lth (MDH). Your facili bliance with the MN S	ted at esota ty was				

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			D WING		C	
		00811	B. WING		12/2	9/2021
	PROVIDER OR SUPPLIER	1001 COI		STATE, ZIP CODE ENUE NORTH		
MALA S	TRANA CARE & REHA	ABILITATION CEN NEW PRA	AGUE, MN 50	6071		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 000	Continued From pa	ge 1	2 000			
	The following comp SUBSTANTIATED; were issued: H5514041C (MN77 H5514043C (MN55 H5514045C (MN59 H5514046C (MN54	laints were found to be however, no licensing orders 950) 009) 006) 710) laints were found to be ED: 454) 093)				
	the State Licensing Federal software. T assigned to Minnes Nursing Homes. Th appears in the far le Tag." The state stalisted in the "Summ column and replace the correction order the findings which a statute after the stales as evidence by." For	ent of Health is documenting Correction Orders using ag numbers have been ota state statutes/rules for e assigned tag number eft column entitled "ID Prefix tute/rule out of compliance is ary Statement of Deficiencies" es the "To Comply" portion of This column also includes are in violation of the state tement, "This Rule is not met of the state of the st				
	receipt of State lice the Minnesota Depa Informational Bullet http://www.health.st obul.htm. The State delineated on the a Department of Heal you electronically.	in 14-01, available at atte.mn.us/divs/fpc/profinfo/infelicensing orders are				

Minnesota Department of Health

STATE FORM 6899 E5TN11 If continuation sheet 2 of 8

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE : COMPL	
		00811	B. WING		12/2	; 9/2021
NAME OF I	PROVIDER OR SUPPLIER		DDESS CITY S	STATE, ZIP CODE	1 12/2	0/2021
		1001 COL		ENUE NORTH		
MALA S	TRANA CARE & REHA	ABILITATION CEN NEW PRA	GUE, MN 5	6071		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 000	Continued From pa	ge 2	2 000			
	available for text. You electronic State lice heading completion be corrected prior to the Minnesota Depais enrolled in ePOC not required at the listate form. PLEASE DISREGA FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE	RRECTED" in the box ou must then indicate in the ensure process, under the date, the date your orders will be electronically submitting to artment of Health. The facility and therefore a signature is pottom of the first page of IRD THE HEADING OF THE WHICH STATES, N OF CORRECTION." THIS ERAL DEFICIENCIES ONLY. R ON EACH PAGE.				
2 550	MN Rule 4658.0400 Resident Assessme	Subp. 4 Comprehensive ent; Review	2 550			
	home must examin quarterly and must comprehensive ass	assessments. A nursing e each resident at least revise the resident's essment to ensure the y of the assessment.				
	by: Based on interview failed to ensure the Data Set (MDS)" as (Resident (R) 32) or assessments were of 27 residents. The assess the use of a	dication which placed R32 at				

6899

Minnesota Department of Health STATE FORM

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00811	B. WING		12/2) 9/2021
NAME OF F	PROVIDER OR SUPPLIER		INRESS CITY S	STATE, ZIP CODE	12/2	3/2021
		1001 COI		ENUE NORTH		
WALA 5	TRANA CARE & REHA	NEW PRA	AGUE, MN 5	6071		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 550	Continued From pa	ge 3	2 550			
	with an Assessmen	arterly "MDS" assessment t Reference Date (ARD) of that R32's anticoagulant coded.				
	"Orders" tab of the (EMR), revealed R3 (Eliquis-a blood-thir milligrams (mgs) tw	sician Orders," located in the electronic medical record 32 had an order for Apixaban nning medication) 2.5 vice daily for treatment of Atrial r heart rate) with a start date				
	Director of Nursing administered Apixal assessment period assessment correct was administered the	2/28/21 at 12:43 PM, the (DON) was asked if R32 was ban during the seven-day and was this coded on the tly. The DON stated that R32 ne medication, as ordered, at should have reflected the ulant medication therefore, it ing.				
	The director of nurs	THOD OF CORRECTION: sing, or designee, could review es and procedures, educate a monitoring system to assure ments				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
2 565	MN Rule 4658.0405 Plan of Care; Use	5 Subp. 3 Comprehensive	2 565			
		omprehensive plan of care personnel involved in the				

Minnesota Department of Health

STATE FORM 6899 E5TN11 If continuation sheet 4 of 8

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		00811	B. WING			C 2 9/2021
	PROVIDER OR SUPPLIER	ABILITATION CEN 1001 COL		STATE, ZIP CODE SNUE NORTH 6071		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
2 565	Continued From pa	ge 4	2 565			
	by: Based on observati and resident intervi- develop a compreh measurable goals a urinary catheters (a to drain urine) for o residents having inc of a total sample of placed the residents Findings include:	ent is not met as evidenced fon, record review, and staff ews, the facility failed to ensive plan of care directing and interventions for indwelling tube inserted into the bladder ne resident (R8) of six dwelling urinary catheters out 27 residents. This failure s at risk for unmet care needs.				
	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.					
	(MDS)" with an Ass (ARD) of 10/01/21 r Mental Status (BIM indicated R8 was co decision-making. T	terly "Minimum Data Set sessment Reference Date revealed a "Brief Interview for S)" score of 15 out of 15 which ognitively intact for his "MDS" assessment further n indwelling urinary catheter.				
	show a focus, meas	nprehensive care plan did not surable goals, or interventions dwelling urinary catheter.				
	Director of Nursing care plan develope	2/29/21 at 8:10 AM, the (DON) was asked if R8 had a d for the use of an indwelling he stated. "I will get back to				

Minnesota Department of Health

STATE FORM 6899 E5TN11 If continuation sheet 5 of 8

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00811	B. WING		12/2	; 9/2021
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE	1212	9/2021
	RANA CARE & REH	1001 COI		ENUE NORTH		
		NEW PRA	GUE, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROINT DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 565	Continued From pa	ige 5	2 565			
	you on that."					
	asked if a care plar indwelling urinary of think he does have	58 AM, the DON was again had been developed for the atheter. The DON stated, "I a care plan for the catheter, but was told that he had a care				
	director of nursing, review, and/or revise ensure care a complete developed which in and interventions. The designee, could the	THOD OF CORRECTION: The or designee, could develop, se policies and procedures to prehensive care plan is cluded resident centered goals. The director of nursing, or en educate all appropriate staff pring systems to ensure e.				
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one				
21610	MN Rule 4658.134 and Preparation Ar	0 Subp. 1 Medicine Cabinet ea;Storage	21610			
	must store all drugs under proper tempe	e of drugs. A nursing home is in locked compartments erature controls, and permit sing personnel to have				
	by: Based on observative review, the facility for medication carts we direct observation of where residents an	ent is not met as evidenced ions, interviews, and policy ailed to ensure that two of four ere kept locked and under of authorized staff in areas d visitors could access the deficient practice had the				

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING:			,
		00811	B. WING		12/2	9/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MALA S	TRANA CARE & REH	ABILITATION CEN	UMBUS AVE	ENUE NORTH 6071		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21610	Continued From pa	nge 6	21610			
	potential to affect all residents who resided at the facility.					
	Findings include:					
	in the Facility," revisas revised 12/27/27 the policy did not symedication carts shunder the controller stated that "medical handling, storage, or as revised to the state of	ty policy "Medication Storage sed January 2018 and initialed 1 by the DON, revealed that pecifically state that the nould be locked; however, d substance section the policy tions are subject to special disposal, and recordkeeping ith federal, state, and other d regulations."				
	had two nurses' sta	ty map revealed that the facility ations, the north/west wing and four medication carts serving facility.				
	north/west nurses' two medication car the area. Ambulato dietary staff deliver hallways. The surve Registered Nurse (room at 4:54 P.M. v When asked if the unlocked RN B said re-check a blood so the medication cart verified the cart sho asked about the fac medication carts R	26/21 at 4:52 PM at the station revealed that one of ts was unlocked and no staff in ry residents, visitors, and ing trays were observed in the eyor waited with the cart and RN) B came out of a resident with a glucometer in her hand. medication cart should be d that she had gone to ugar, and when asked again if a should be unlocked RN B bould have been locked. When cility policy for locking N B did not respond.				
	wing nurses' station	27/21 at 9:20 AM at the east n revealed one of the two as unlocked. There were no				

Minnesota Department of Health

STATE FORM 6899 E5TN11 If continuation sheet 7 of 8

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	
		00811			12/2	; 9/2021
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE	1212	3/2021
MALA S	TRANA CARE & REH	ABILITATION CEN 1001 COL		NUE NORTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE	(X5) COMPLETE DATE
21610	staff observed in the with the cart and Cook A came out of a rook CNA A stated that is assistant. When as should be unlocked should not be unlocked should not be unlocked before leaving the and During an interview Director of Nursing expectation that the per policy. SUGGESTED MET The director of nurs development and in procedures to ensure secured appropriate designee, could the monitoring systems and procedures.	e area. The surveyor stayed ertified Nurse Assistant (CNA) om behind the nurses' station. The was a trained medication ked if the medication cart I, CNA A verified that the cart exed and locked the cart	21610			

6899

Minnesota Department of Health STATE FORM

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3) DAT COM			JRVEY ETED	
		00811	B. WING		C 12/29 /	/2021
	PROVIDER OR SUPPLIER	ARII ITATION CEN 1001 COL		STATE, ZIP CODE ENUE NORTH 6071	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTEI	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the deficiency herein are not corrected shall with a schedule of the Minnesota Department of the Minnesota Department of the Minnesota MN Rumber and MN Rumber and MN Rumber and MN Rumber and many of lack of compliance. re-inspection with a result in the assess	nether a violation has been				
	that may result from orders provided tha the Department with	hearing on any assessments non-compliance with these at a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	licensing survey wayour facility by survey Department of Hea	rs: gh 12/29/21, a standard us conducted completed at eyors from the Minnesota lth (MDH). Your facility was oliance with the MN State				

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed 01/17/22

TITLE

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

-	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
			A. BUILDING:			
		00811	B. WING		12/2	; 29/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	STATE, ZIP CODE		
MALA S	TRANA CARE & REH	ARII ITATION CEN	LUMBUS AVE AGUE, MN 50	ENUE NORTH 6071		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
2 000	SUBSTANTIATED; were issued: H5514041C (MN75H5514043C (MN55H5514045C (MN55H5514046C (MN55H5514046C (MN55H5514042C (MN66H5514044C (MN66H551404AC (MN66H54AC (MN66H551404AC (MN66H54AC (MN66H54AC (MN66H54AC (MN66H54AC (MN66H54AC (MN66H5	plaints were found to be however, no licensing orders (7950) (5009) (5009) (5006) (5710) (5009) (5006) (5710) (5009) (5006) (5710) (5009) (5006) (5009) (500				

Minnesota Department of Health

STATE FORM 6899 E5TN11 If continuation sheet 2 of 8

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
			A. BUILDING	·		,
		00811	B. WING			9/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
MALA ST	TRANA CARE & REHA	ARII ITATION CEN	.UMBUS AVI .GUE, MN 5	ENUE NORTH 6071		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000 2 550	available for text. Yelectronic State lice heading completion be corrected prior to the Minnesota Depis enrolled in ePOC not required at the state form. PLEASE DISREGATOURTH COLUMN "PROVIDER'S PLATOURTH COLUMN" PROVIDER'S PLATOURTH SWILL APPEARMENT OF FEDERMENT OF	PRRECTED" in the box ou must then indicate in the ensure process, under the date, the date your orders will o electronically submitting to artment of Health. The facility and therefore a signature is bottom of the first page of	2 000			1/31/22
2 330	Resident Assessment Subp. 4. Review of home must examin quarterly and must comprehensive assecontinued accurace. This MN Requirement by: Based on interview failed to ensure the Data Set (MDS)" as (Resident (R) 32) of assessments were of 27 residents. The assess the use of assessment in the second seco	ent; Review f assessments. A nursing he each resident at least revise the resident's resident to ensure the hy of the assessment. ent is not met as evidenced and record review, the facility haccuracy of the "Minimum resessment for one resident hf 20 residents whose reviewed out of a total sample he facility failed to accurately han anticoagulant hedication which placed R32 at	2 330	Corrected.		1/31/22

6899

Minnesota Department of Health STATE FORM

STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00044			10/0	
		00811	b. WING		12/2	9/2021
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
MALA ST	RANA CARE & REHA	ARII ITATION CEN	GUE, MN 5	ENUE NORTH 6071		
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (E			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 550	Continued From pa	ge 3	2 550			
	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.					
	"Orders" tab of the (EMR), revealed R3 (Eliquis-a blood-thir milligrams (mgs) tw	sician Orders," located in the electronic medical record 32 had an order for Apixaban nning medication) 2.5 vice daily for treatment of Atrial r heart rate) with a start date				
	Director of Nursing administered Apixa assessment period assessment correc was administered the and the assessment	2/28/21 at 12:43 PM, the (DON) was asked if R32 was ban during the seven-day and was this coded on the tly. The DON stated that R32 he medication, as ordered, at should have reflected the ulant medication therefore, it ing.				
	The director of nurs and/or revise policies	THOD OF CORRECTION: sing, or designee, could review es and procedures, educate a monitoring system to assure ments				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
2 565	MN Rule 4658.0409 Plan of Care; Use	5 Subp. 3 Comprehensive	2 565			1/31/22
		omprehensive plan of care personnel involved in the 				

Minnesota Department of Health

STATE FORM 6899 E5TN11 If continuation sheet 4 of 8

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING:			
		00811	B. WING		12/2	, 9/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
MALA S	TRANA CARE & REH	ARII ITATION CEN	.UMBUS AVE AGUE, MN 5	ENUE NORTH 6071		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 565	Continued From pa	age 4	2 565			
	by: Based on observati and resident intervi develop a compreh measurable goals a urinary catheters (a to drain urine) for o residents having inc of a total sample of	ent is not met as evidenced ion, record review, and staff lews, the facility failed to be nensive plan of care directing and interventions for indwelling a tube inserted into the bladder one resident (R8) of six dwelling urinary catheters out for 27 residents. This failure is at risk for unmet care needs.		Corrected.		
	"Profile" tab of the (EMR), revealed R	e Sheet" located in the electronic medical record 8 was admitted to the facility agnoses that included heart es.				
	(MDS)" with an Ass (ARD) of 10/01/21 Mental Status (BIM indicated R8 was c decision-making. T	terly "Minimum Data Set sessment Reference Date revealed a "Brief Interview for IS)" score of 15 out of 15 which ognitively intact for his "MDS" assessment further n indwelling urinary catheter.				
	show a focus, mea	nprehensive care plan did not surable goals, or interventions dwelling urinary catheter.				
	Director of Nursing care plan develope	12/29/21 at 8:10 AM, the (DON) was asked if R8 had a od for the use of an indwelling the stated, "I will get back to				

Minnesota Department of Health

STATE FORM 6899 E5TN11 If continuation sheet 5 of 8

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
						;	
		00811	B. WING		12/2	12/29/2021	
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
MALA ST	RANA CARE & REHA	ABILITATION CEN	GUE, MN 5	ENUE NORTH 6071			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 565	Continued From pa	ge 5	2 565				
	you on that."						
	asked if a care plar indwelling urinary c think he does have	58 AM, the DON was again had been developed for the atheter. The DON stated, "I a care plan for the catheter, but was told that he had a care					
	director of nursing, review, and/or revise ensure care a complete developed which in and interventions. It designee, could the	THOD OF CORRECTION: The or designee, could develop, se policies and procedures to prehensive care plan is cluded resident centered goals. The director of nursing, or en educate all appropriate staff pring systems to ensure e.					
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one					
21610	MN Rule 4658.1344 and Preparation Are	0 Subp. 1 Medicine Cabinet ea;Storage	21610			1/31/22	
	must store all drugs under proper tempe	e of drugs. A nursing home in locked compartments erature controls, and permit sing personnel to have					
	by: Based on observation review, the facility for medication carts we direct observation of where residents an	ent is not met as evidenced fons, interviews, and policy ailed to ensure that two of four ere kept locked and under of authorized staff in areas d visitors could access the deficient practice had the		Corrected.			

Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING:			`
		00811	B. WING		12/2	, 9/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MALA S	TRANA CARE & REHA	ARII ITATION CEN	.UMBUS AVE AGUE, MN 5	ENUE NORTH 6071		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21610	Continued From pa	age 6	21610			
	potential to affect a facility.	Il residents who resided at the				
	Findings include:					
	in the Facility," revis as revised 12/27/21 the policy did not sp medication carts sh under the controlled stated that "medical handling, storage, of	ty policy "Medication Storage sed January 2018 and initialed 1 by the DON, revealed that pecifically state that the nould be locked; however, d substance section the policy tions are subject to special disposal, and recordkeeping ith federal, state, and other d regulations."				
	had two nurses' sta	ty map revealed that the facility ations, the north/west wing and four medication carts serving a facility.				
	north/west nurses's two medication card the area. Ambulato dietary staff deliver hallways. The surve Registered Nurse (room at 4:54 P.M. when asked if the unlocked RN B said re-check a blood suthe medication card verified the card she asked about the face	r26/21 at 4:52 PM at the station revealed that one of ts was unlocked and no staff in rry residents, visitors, and ing trays were observed in the eyor waited with the cart and RN) B came out of a resident with a glucometer in her hand. medication cart should be d that she had gone to ugar, and when asked again if a should be unlocked RN B ould have been locked. When cility policy for locking N B did not respond.				
	wing nurses' station	27/21 at 9:20 AM at the east nevealed one of the two as unlocked. There were no				

Minnesota Department of Health

STATE FORM 6899 E5TN11 If continuation sheet 7 of 8

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION :	(X3) DATE COMP	PLETED
		00811	B. WING		12/2	C 29/2021
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE	•	
MALA S	TRANA CARE & REH	ARII ITATION CEN	LUMBUS AVE AGUE, MN 5	ENUE NORTH 6071		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
21610	staff observed in the with the cart and Co A came out of a roo CNA A stated that is assistant. When as should be unlocked should not be unlocked before leaving the a During an interview Director of Nursing expectation that the per policy. SUGGESTED MET The director of nurs development and in procedures to ensure secured appropriate designee, could the monitoring systems and procedures.	e area. The surveyor stayed ertified Nurse Assistant (CNA) om behind the nurses' station. The was a trained medication ked if the medication cart I, CNA A verified that the cart exed and locked the cart				

Minnesota Department of Health STATE FORM

PRINTED: 01/09/2022 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		E CONSTRUCTION		E SURVEY PLETED
		245514	B. WING				C 29/2021
NAME OF F	PROVIDER OR SUPPLIER	1		S	TREET ADDRESS, CITY, STATE, ZIP CODE		10/2021
MALA ST	RANA CARE & REH	ABILITATION CENTER			001 COLUMBUS AVENUE NORTH IEW PRAGUE, MN 56071		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
E 000	Initial Comments		EC	000			
F 000	compliance with Appreparedness Requented during a survey. The facility The facility is enrol signature is not recognized from the CMS-2 correction is required acknowledge receins in addition, multiple completed. Mala Signature was found in addition, multiple completed. Mala Signature was found in Part 483, Requirem Facilities. The following compounds SUBSTANTIATED; were issued due to the facility: H5514041C (MN77H5514043C (MN58H5514046C (MN58H56T) (MN58H56T) (MN58H56T) (MN58H56T) (MN58H56T) (MN	ugh 12/29/21, a standard ey was completed by surveyors a Department of Health (MDH). e complaint investigations were trana Care and Rehabilitation not in compliance with 42 CFR ments for Long Term Care plaints were found to be to however, no deficiencies to corrective actions taken by (7950) (5009) (9006) (1710) plaints were found to be ED: (3454) (5093)	FC	000			
I ABORATORY	/ DIRECTOR'S OR PROVI	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE		(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

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

AND DUAN OF CORRECTION IDENTIFICATION NUMBER.			TIPLE CONSTRUCTION	CON	(X3) DATE SURVEY COMPLETED	
		245514	B. WING			C / 29/2021
	PROVIDER OR SUPPLIER	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 1001 COLUMBUS AVENUE NORTH NEW PRAGUE, MN 56071		29/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 656 SS=D	as your allegation of Departments accepted in ePOC, yat the bottom of the form. Your electronic be used as verificated. Upon receipt of an account on site revisit of you validate substantial regulations has been Develop/Implement CFR(s): 483.21(b)(1) The fill implement a comprise plan for each resident rights set for §483.21(b)(1) The fill implement a comprise plan for each resident rights set for §483.10(c)(3), that objectives and time medical, nursing, and needs that are ident assessment. The condescribe the following (i) The services that or maintain the resident physical, mental, arrequired under §483.24, §484 provided due to the	f correction (POC) will serve f compliance upon the stance. Because you are our signature is not required first page of the CMS-2567 ic submission of the POC will ion of compliance. acceptable electronic POC, an r facility may be conducted to compliance with the en attained. Comprehensive Care Plans facility must develop and ehensive person-centered resident, consistent with the orth at §483.10(c)(2) and includes measurable frames to meet a resident's and mental and psychosocial tified in the comprehensive comprehensive care plan must ing - t are to be furnished to attain dent's highest practicable and psychosocial well-being as 3.24, §483.25 or §483.40; and it would otherwise be required 3.25 or §483.40 but are not resident's exercise of rights uding the right to refuse	F 0	00		
		services or specialized es the nursing facility will of PASARR				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245514	B. WING				C 29/2021
	PROVIDER OR SUPPLIER	ABILITATION CENTER	,	100	EET ADDRESS, CITY, STATE, ZIP CODE 1 COLUMBUS AVENUE NORTH W PRAGUE, MN 56071	<u>,</u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 656	recommendations. findings of the PAS rationale in the resi (iv)In consultation versident's represent (A) The resident's represent (A) The resident's redesired outcomes. (B) The resident's purchastic future discharge. For the resident community was as local contact agency entities, for this purchastic for this purchastic formulation. This REQUIREMED by: Based on observation and resident intervidevelop a comprehesist measurable goals a urinary catheters (at to drain urine) for oresidents having into fatotal sample of placed the resident. Findings include: Review of the "Face" "Profile" tab of the resident of the resident disease and diabet. Review of the quarter of the q	If a facility disagrees with the ARR, it must indicate its dent's medical record. with the resident and the tative(s)-goals for admission and preference and potential for acilities must document in t's desire to return to the sessed and any referrals to sies and/or other appropriate pose. In the comprehensive care et, in accordance with the orth in paragraph (c) of this in paragraph (c) of this in not met as evidenced ation, record review, and staff ews, the facility failed to be ensive plan of care directing and interventions for indwelling and interventions for indwelling and interventions for indwelling and interventions. This failure is at risk for unmet care needs. The Sheet' located in the electronic medical record in the facility agnoses that included heart	F 6	56			

` /		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245514	B. WING			12/2	29/2021
	PROVIDER OR SUPPLIER	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1001 COLUMBUS AVENUE NORTH NEW PRAGUE, MN 56071			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHORES CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD E	3E	(X5) COMPLETION DATE
F 656	Mental Status (BIM indicated R8 was codecision-making. Trindicated R8 had an Review of R8's comshow a focus, measfor the use of an incomplete of Nursing care plan developed urinary catheter. So you on that." On 12/29/21 at 10:50 asked if a care plan indwelling urinary catheter. So you on that." On 12/29/21 at 10:50 asked if a care plan indwelling urinary catheter. So you on that." Parenteral/IV Fluids CFR(s): 483.25(h) § 483.25(h) Parente Parenteral fluids movith professional staccordance with phase comprehensive per the resident's goals This REQUIREMENT by: Based on interview facility failed to ensicentral catheter (Pl	revealed a "Brief Interview for S)" score of 15 out of 15 which ognitively intact for his "MDS" assessment further in indwelling urinary catheter. Inprehensive care plan did not surable goals, or interventions dwelling urinary catheter. 2/29/21 at 8:10 AM, the (DON) was asked if R8 had a d for the use of an indwelling he stated, "I will get back to 68 AM, the DON was again had been developed for the atheter. The DON stated, "I a care plan for the catheter, but was told that he had a care of a care plan for the catheter, and and preferences. Seral Fluids. Let be administered consistent andards of practice and in ysician orders, the son-centered care plan, and and preferences. No is not met as evidenced of the care a peripherally inserted consistent and document review, the care a peripherally inserted consistent (R29) who received	F 6				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245514	B. WING				C 29/2021
	PROVIDER OR SUPPLIER	ABILITATION CENTER		1	STREET ADDRESS, CITY, STATE, ZIP CODE 1001 COLUMBUS AVENUE NORTH NEW PRAGUE, MN 56071	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	X	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 694	Continued From pa	ge 4	F 6	94			
	Findings include:						
	indicated R29 had	ecord dated 12/29/21, diagnoses which included ritis of the right knee (infection					
	Minimum Data Set indicated R29 had a	ective Payment System (MDS) dated 5/24/21, a moderate cognitive eived IV medications at the					
	A Hospital Dischargindicated R29 had a	ge Summary dated 12/14/21, a PICC line.					
	directed staff to adr (antibiotic) two gran 1/17/22. The order	ary Report dated 12/21/21, minister cefazolin sodium ns IV every 12 hours through further directed staff to C line for patency and to notify stance.					
	Record indicated R	021 Medication Administration 29 was to be administer y at 7:00 a.m. and 7:00 p.m.					
		ed 12/29/21, lacked indication e or related interventions.					
	- On 12/24/21, at 12 connected to the ar Licensed practical r flush R29's PICC lir however, it was me - On 12/24/21, at 2:	ogress notes revealed: 2:24 p.m. R29 was found still attibiotic during the morning. The nurse (LPN)-C attempted to the with normal saline, to with resistance. 51 p.m. the on-call provided commenced to send R29 to					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		245514	B. WING		12	C 2/ 29/2021
	PROVIDER OR SUPPLIER	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIF 1001 COLUMBUS AVENUE NORT NEW PRAGUE, MN 56071	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 694	increased creatinir - On 12/24/21, at 5 hospital around 4:0 medical technician PICC line had resis - On 12/28/21, at 1 to disconnect the l' line at 6:00 a.m. TI revealed the IV medical technician from patent and flushed the Plucentimeters (cc) of patent and flushed buring an interview LPN-A stated left the IV antibiotic remove it once cor informed by R29's antibiotic was still of LPN-A stated if IV removed after administer and plushed be to administer the orders and discont PICC line after the antibiotic should be infusion and infusion from the complication of the state of the antibiotic should be infusion and infusion from the complication of the state of the state of the antibiotic should be infusion and infusion from the complication of the state	im for evaluation related to an ite, CRP, and SED rate (labs). 1:40 p.m. R29 was sent to the 100 p.m. and emergency its (EMTs) were notified R29's estance. 1:28 p.m. LPN-A was requested if wedication from R29's PICC interpretation in the progress note further edication was from 12/27/21, at its its connected the IV medication in its connected the IV is its was without resistance. If you is a removed the IV its its its in the removed the IV its its in the removed the IV its its in the removed the IV its in the removed the R29 and did not in its in the removed to R29 and did not in its in the removed to R29's PICC line. Its interest in the removed the removed the removed to R29's PICC line. Its interest in the removed the removed the removed the removed to R29's PICC line. Its interest in the removed th	F 6	94		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245514	B. WING _			C / 29/2021
	PROVIDER OR SUPPLIER	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 1001 COLUMBUS AVENUE NORTH NEW PRAGUE, MN 56071		23/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE ((EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 694	director of nursing (would be to administ and flush the PICC made aware R28's attached from the particle (RN)-B left an antib R29's PICC line on 12/27/21, at 6:09 p. RN-B was provided included the proper medication. A Teachable Mome indicated on 12/27/2 hooked up an antib lacked documentat removed. A Teachable Mome indicated on 12/27/2 hooked up an antib lacked documentat removed. Facility policy titled indicated staff would the use of elastome policy directed staff sphere when infusiod directed to docume resident's medical resident's m	on 12/28/21, at 2:06 p.m. the (DON) stated her expectation aster medications as ordered line. The DON stated she was IV medication was still previous evenings dosing. dicated registered nurse iotic medication connected to 12/24/21, at 3:30 a.m. and m. The letter further indicated competency training which administration of IV Int Form dated 12/28/21, 21, LPN-D documented she iotic to R29's PICC line, but ion the antibiotic was Int Form dated 12/28/21, 21, RN-B documented she iotic to R29's PICC line, but ion the antibiotic was Infusion Therapy dated 4/17, d be knowledgeable regarding eric infusion devices. The to disconnect and dispose of on is finished. Staff are further int the following in the record.	F 69			
	Label/Store Drugs a CFR(s): 483.45(g)(F 70	61		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION ING		TE SURVEY MPLETED
	245514	B. WING		12	C / 29/2021
NAME OF PROVIDER OR SUPPLIER MALA STRANA CARE & REHAE	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP C 1001 COLUMBUS AVENUE NORTH NEW PRAGUE, MN 56071		20,2021
PREFIX (EACH DEFICIENCY N	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
Drugs and biologicals labeled in accordance professional principle appropriate accessor instructions, and the applicable. §483.45(h) Storage of \$483.45(h)(1) In according to the personnel to have accessor instructions, and the applicable. §483.45(h)(1) In according to the personnel to have accessor in locked temperature controls personnel to have accessor in l	of Drugs and Biologicals is used in the facility must be evith currently accepted es, and include the ry and cautionary expiration date when of Drugs and Biologicals ordance with State and compartments under proper, and permit only authorized		61		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	CON	(X3) DATE SURVEY COMPLETED C		
		245514	B. WING _			/29/2021		
	PROVIDER OR SUPPLIEI	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP C 1001 COLUMBUS AVENUE NORTH NEW PRAGUE, MN 56071	•	20,2021		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 761	as revised 12/27/2 the policy did not a medication carts of under the controlled stated that "medic handling, storage, in accordance of applicable laws and Review of the facility had two nurses's the east wing, with the residents of the Observation on 12 north/west nurses two medication cathe area. Ambulated dietary staff delives hallways. The sur Registered Nurse room at 4:54 P.M. When asked if the unlocked RN B sare-check a blood of the medication carts of the medication cart	vised January 2018 and initialed 21 by the DON, revealed that specifically state that the should be locked; however, ed substance section the policy rations are subject to special disposal, and recordkeeping with federal, state, and other and regulations." lity map revealed that the facility rations, the north/west wing and a four medication carts serving	F 76	1				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED		
		245514	B. WING				C 29/2021
	PROVIDER OR SUPPLIER	IABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COI 1001 COLUMBUS AVENUE NORTH NEW PRAGUE, MN 56071	DE		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		BE	(X5) COMPLETION DATE
F 761	should not be unlo before leaving the During an interview Director of Nursing	d, CNA A verified that the cart cked and locked the cart	F7	61			

PRINTED: 01/20/2022 FORM APPROVED OMB NO. 0938-0391

-	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245514	B. WING				C 29/2021
	PROVIDER OR SUPPLIER	ABILITATION CENTER		1001	COLUMBUS AVENUE NORTH V PRAGUE, MN 56071		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
E 000		igh 12/29/21, a survey for pendix Z, Emergency	E 0	000			
	Preparedness Required conducted during a survey. The facility	uirements, §483.73(b)(6) was standard recertification was IN compliance.					
F 000	signature is not req page of the CMS-29 correction is require	ed in ePOC and therefore a uired at the bottom of the first 567 form. Although no plan of ed, it is required that the facility of the electronic documents.	F 0	000			
1 000	On 12/26/21, throu recertification surve from the Minnesota In addition, multiple completed. Mala St Center was found n	igh 12/29/21, a standard by was completed by surveyors Department of Health (MDH). complaint investigations were trana Care and Rehabilitation not in compliance with 42 CFR ments for Long Term Care					
	SUBSTANTIATED;	5009) 9006)					
	The following comp UNSUBSTANTIATE H5514042C (MN73 H5514047C (MN66 H5514044C (MN68	3454) 3093)					
I ABORATORY	Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE		(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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.

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG		E SURVEY IPLETED
		245514	B. WING			C 29/2021
	PROVIDER OR SUPPLIER	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1001 COLUMBUS AVENUE NORTH NEW PRAGUE, MN 56071		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	D BE	(X5) COMPLETION DATE
F 656 SS=D	as your allegation of Departments accept enrolled in ePOC, yat the bottom of the form. Your electron be used as verificated. Upon receipt of an onsite revisit of you validate substantial regulations has been Develop/Implement CFR(s): 483.21(b)(1) The simplement a compression of the care plan for each resident rights set for \$483.21(b)(1) The simplement acompression of the care plan for each resident rights set for \$483.10(c)(3), that objectives and time medical, nursing, an eeds that are iden assessment. The condession of the care physical, mental, arrequired under \$48 (ii) Any services that under \$483.24, \$48 provided due to the	of correction (POC) will serve of compliance upon the otance. Because you are your signature is not required a first page of the CMS-2567 ic submission of the POC will tion of compliance. acceptable electronic POC, an refacility may be conducted to compliance with the en attained. It comprehensive Care Plans facility must develop and be then sive person-centered resident, consistent with the corth at §483.10(c)(2) and includes measurable frames to meet a resident's and mental and psychosocial tified in the comprehensive care plan must	F 0	00		1/31/22
		services or specialized es the nursing facility will				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245514	B. WING		12/2) 29/2021	
	PROVIDER OR SUPPLIER	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1001 COLUMBUS AVENUE NORTH NEW PRAGUE, MN 56071			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 656	findings of the PAS rationale in the resi (iv) In consultation or resident's represent (A) The resident's of desired outcomes. (B) The resident's of the resident's properties of the resident's properties of the resident's properties of the resident of t	If a facility disagrees with the ARR, it must indicate its dent's medical record. with the resident and the tative(s)-goals for admission and preference and potential for acilities must document nt's desire to return to the sessed and any referrals to sies and/or other appropriate pose. In the comprehensive care et, in accordance with the orth in paragraph (c) of this to not met as evidenced ation, record review, and staff ews, the facility failed to be ensive plan of care directing and interventions for indwelling and interventions for indwelling and tube inserted into the bladder ne resident (R8) of six dwelling urinary catheters out to 27 residents. This failure is at risk for unmet care needs.	F 656	• R8's comprehensive plan of orinterventions for indwelling urinary catheter has been reviewed and to include risk vs. benefits of catheter use of indwelling urinary catheter comprehensive plan of care interventions have been reviewed updated to include risk vs. benefit catheter use. • Facility will initiate education appropriate staff on development comprehensive plan of care and interventions for indwelling urinary catheter including risks vs. benefit catheter including risks vs. ben	y updated neter use. ntified for eters and and t of to for eters and the formal eters and the forma		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SLIPPI IER/CLIA

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		G (X3	COMPLETED
		245514	B. WING		C 12/29/2021
	PROVIDER OR SUPPLIER	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1001 COLUMBUS AVENUE NORTH NEW PRAGUE, MN 56071	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
F 656	Mental Status (BIM indicated R8 was codecision-making. Tindicated R8 had at Review of R8's conshow a focus, mean for the use of an incomplete of Nursing care plan develope urinary catheter. Syou on that." On 12/29/21 at 10:9 asked if a care plan indwelling urinary countries think he does have but I am not sure, by plan." Parenteral/IV Fluids CFR(s): 483.25(h) § 483.25(h) Parente Parenteral fluids mouth professional staccordance with phase comprehensive per the resident's goals This REQUIREMED by: Based on interview facility failed to enscentral catheter (PI	revealed a "Brief Interview for S)" score of 15 out of 15 which ognitively intact for his "MDS" assessment further in indwelling urinary catheter. Inprehensive care plan did not surable goals, or interventions dwelling urinary catheter. 2/29/21 at 8:10 AM, the (DON) was asked if R8 had a d for the use of an indwelling he stated, "I will get back to 58 AM, the DON was again in had been developed for the atheter. The DON stated, "I a care plan for the catheter, but was told that he had a care seral Fluids. Let a Liuids and preferences and in any sician orders, the son-centered care plan, and and preferences. NT is not met as evidenced and document review, the ure a peripherally inserted CC) was appropriately resident (R29) who received	F 69		1/31/22 d for

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		245514	B. WING				C 29/2021
	PROVIDER OR SUPPLIER	ABILITATION CENTER		10	TREET ADDRESS, CITY, STATE, ZIP CODE 001 COLUMBUS AVENUE NORTH IEW PRAGUE, MN 56071	1 <i>2/1</i>	25/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 694	Findings include: R29's Admission Rindicated R29 had a staphylococcal arthof the joint). R29's 5-Day Prospondinimum Data Set indicated R29 had a impairment and redicated R29 had a impairment and redicated R29 had a redicated R29 had a R29's Order Summ directed staff to adright (antibiotic) two grar 1/17/22. The order monitor R29's PICO the provider of resist R29's December 20 Record indicated R cefazolin twice daily R29's care plan data R29 had a PICC line Review of R29's proposed and R29 had a PICC line Review of R29's PICO line Review of R29's PICO line Review of R29's PICO line	ecord dated 12/29/21, diagnoses which included ritis of the right knee (infection ective Payment System (MDS) dated 5/24/21, a moderate cognitive eived IV medications at the ge Summary dated 12/14/21, a PICC line. ary Report dated 12/21/21, minister cefazolin sodium ns IV every 12 hours through further directed staff to 2 line for patency and to notify stance. 221 Medication Administration 29 was to be administer at 7:00 a.m. and 7:00 p.m. ded 12/29/21, lacked indication e or related interventions. Degress notes revealed: 2:24 p.m. R29 was found still intibiotic during the morning. Thurse (LPN)-C attempted to the with normal saline,	F 6	594	reviewed and updated to include P line use. • Facility will initiate education to appropriate staff on medication administration through PICC line at documentation of removal of medicing to DON or designee will complete weekly x 4 and monthly x 2. • Audit results will be reviewed by committee for possible further recommendations.	nd cation. audits	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245514	B. WING			C 12/29/2021
	PROVIDER OR SUPPLIER	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COI 1001 COLUMBUS AVENUE NORTH NEW PRAGUE, MN 56071	DE	12/23/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	
F 694	the emergency roor increased creatining on 12/24/21, at 52 hospital around 4:0 medical technicians PICC line had resis on 12/28/21, at 12 to disconnect the IV line at 6:00 a.m. The revealed the IV med 7:00 p.m. LPN-A dia and flushed the PIC centimeters (cc) of patent and flushed During an interview LPN-A stated she hemedication from R2 a.m. LPN-A stated left the IV antibiotic remove it once cominformed by R29's antibiotic was still c LPN-A stated if IV removed after adm PICC line to clot off During an interview pharmacist (P)-A stated in IV removed after adm PICC line to clot off During an interview pharmacist (P)-A stated in IV removed after adm PICC line after the antibiotic should be infusion and infusion The complication from the property of the state of the antibiotic should be infusion and infusion The complication from the property of the state of the antibiotic should be infusion and infusion the complication from the property of the state of the property of the state of the property of the state of the property of	m for evaluation related to an e, CRP, and SED rate (labs). 40 p.m. R29 was sent to the p.m. and emergency (EMTs) were notified R29's tance. 28 p.m. LPN-A was requested medication from R29's PICC e progress note further dication was from 12/27/21, at sconnected the IV medication CC line with 10 cubic normal saline. The IV site was without resistance. on 12/28/21, at 7:00 a.m. ad just removed the IV (19) (from 12/27/21). At 7:45 the night nurse (from 12/27/2) connected to R29 and did not apleted. LPN-A stated she was nursing assistant (NA) the onnected to R29's PICC line. medication was left and not inistration it could cause the	F 6	94		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245514	B. WING			C 29/2021
	PROVIDER OR SUPPLIER	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1001 COLUMBUS AVENUE NORTH NEW PRAGUE, MN 56071	1 12/	20/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORREC' ((EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPRIOR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 694	director of nursing (would be to administ and flush the PICC made aware R28's attached from the particle An untitled letter inc (RN)-B left an antib R29's PICC line on 12/27/21, at 6:09 p. RN-B was provided included the proper medication. A Teachable Mome indicated on 12/27/2 hooked up an antib lacked documentation removed. A Teachable Mome indicated on 12/27/2 hooked up an antib lacked documentation removed. Facility policy titled indicated staff would the use of elastome policy directed staff sphere when infusion	on 12/28/21, at 2:06 p.m. the DON) stated her expectation ster medications as ordered line. The DON stated she was IV medication was still previous evenings dosing. Sicated registered nurse iotic medication connected to 12/24/21, at 3:30 a.m. and m. The letter further indicated competency training which administration of IV Int Form dated 12/28/21, 21, LPN-D documented she iotic to R29's PICC line, but ion the antibiotic was Int Form dated 12/28/21, 21, RN-B documented she iotic to R29's PICC line, but ion the antibiotic was Infusion Therapy dated 4/17, d be knowledgeable regarding eric infusion devices. The to disconnect and dispose of on is finished. Staff are further int the following in the	F6	94		
	resident's medical r Label/Store Drugs a CFR(s): 483.45(g)(l	and Biologicals	F 7	61		1/31/22

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C		
		245514	B. WING				29/2021
	PROVIDER OR SUPPLIEF	IABILITATION CENTER		10	TREET ADDRESS, CITY, STATE, ZIP CODE DO1 COLUMBUS AVENUE NORTH EW PRAGUE, MN 56071		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 761	Drugs and biologic labeled in accordary professional principal appropriate accessinstructions, and the applicable. §483.45(h) Storage §483.45(h)(1) In a Federal laws, the biologicals in locket temperature contropersonnel to have §483.45(h)(2) The locked, permanen storage of controll the Comprehensive Control Act of 197 abuse, except whe package drug distributed autility stored is reported by: Based on observation where residents at medications. This potential to affect a facility. Findings include:	and of Drugs and Biologicals cals used in the facility must be not with currently accepted ples, and include the sory and cautionary ne expiration date when e of Drugs and Biologicals coordance with State and facility must store all drugs and ed compartments under properols, and permit only authorized access to the keys. facility must provide separately thy affixed compartments for ed drugs listed in Schedule II of the Drug Abuse Prevention and and other drugs subject to the facility uses single unit ribution systems in which the minimal and a missing dose can	F 7	'61	 All medication carts were imme audited to ensure that they were proceed looked under direct and indirect observation of authorized staff in recare areas. Each medication cart has the proceed to be unlocked and unattended. Facility will initiate education to appropriate staff on labeling and stof drugs and biologicals. DON or designee will continue audit medication carts weekly x 4, 1 	operly esident ootential orage to	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	` ´COMI	E SURVEY PLETED
		245514	B. WING				C 2 9/2021
	PROVIDER OR SUPPLIEF	MABILITATION CENTER		10	REET ADDRESS, CITY, STATE, ZIP CODE 001 COLUMBUS AVENUE NORTH EW PRAGUE, MN 56071		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 761	in the Facility," revas revised 12/27/2 the policy did not a medication carts a under the controlle stated that "medichandling, storage, in accordance wapplicable laws ar Review of the faci had two nurses' at the east wing, with the residents of the Observation on 12 north/west nurses two medication cat he area. Ambulat dietary staff deliver hallways. The surn Registered Nurse room at 4:54 P.M. When asked if the unlocked RN B sare-check a blood at the medication cart shaked about the famedication carts of the cart and cart of the	rised January 2018 and initialed 21 by the DON, revealed that specifically state that the should be locked; however, ed substance section the policy ations are subject to special disposal, and recordkeeping with federal, state, and other and regulations." Lity map revealed that the facility ations, the north/west wing and a four medication carts serving	F 7	761	monthly x 2. • Audit results will be reviewed b committee for possible further recommendations.	y QAPI	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245514	B. WING				29/ 2021
NAME OF PROVIDER OR SUPPLIER MALA STRANA CARE & REHABILITATION CENTER				STREET ADDRESS, CI 1001 COLUMBUS AV NEW PRAGUE, MN	ENUE NORTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	X (EACH CORF	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD RENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 761	should not be unlood before leaving the a During an interview Director of Nursing	d, CNA A verified that the cart cked and locked the cart	F	61			

NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs 245514 B. WING		OF ISOLATED DEFICIENCIES WHICH CAUSE	PROVIDER#	MULTIPLE CONSTRUCTION	DATE SURVEY			
PRESIDENT NAME OF PROVIDER OR SUPPLIER MALA STRANA CARE & REHABILITATION CENTE DEPRETIX TAG 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			1 KO VIDEK#					
NAME OF PROVIDER OR SUPPLIER MALA STRANA CARE & REHABILITATION CENTE ID PREFIX TAG 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	NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs			A. BUILDING:	COMPLETE:			
MALA STRANA CARE & REHABILITATION CENTE DOI			245514	B. WING	12/29/2021			
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			1001 COLUMBUS AVENUE NORTH					
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								
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	PREFIX	SUMMARY STATEMENT OF DEFICIENCE	CIES					
	PREFIX TAG	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect to This REQUIREMENT is not met as eving Based on interview and record review, the (MDS)" assessment for one resident (Resordia total sample of 27 residents. The fact (blood-thinning) medication which places Findings include: Review of R32's quarterly "MDS" assessment assessment for the "Physician Orders," located revealed R32 had an order for Apixaban daily for treatment of Atrial Fibrillation (In an interview on 12/28/21 at 12:43 PM Apixaban during the seven-day assessments assessments.	the resident's statudenced by: the facility failed to sident (R) 32) of cility failed to acced R32 at risk for sment with an Astation was not code at in the "Orders' (Eliquis-a blood-(irregular heart rate, the Director of the cent period and was dication, as order	o ensure the accuracy of the "Minimur 20 residents whose assessments were rurately assess the use of an anticoagula unmet care needs. sessment Reference Date (ARD) of 11 red. 'tab of the electronic medical record (1 thinning medication) 2.5 milligrams (1 te) with a start date of 07/16/19. Nursing (DON) was asked if R32 was as this coded on the assessment corrected, and the assessment should have reference to the sessment of the sessment should have reference to the sessment should	reviewed out ant /30/21, EMR), ngs) twice administered ly. The DON			

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

031099

PRINTED: 01/09/2022 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01			(X3) DATE SURVEY COMPLETED	
		245514	B. WING			12/2	28/2021
NAME OF PROVIDER OR SUPPLIER MALA STRANA CARE & REHABILITATION CENTER				1	STREET ADDRESS, CITY, STATE, ZIP CODE 1001 COLUMBUS AVENUE NORTH NEW PRAGUE, MN 56071		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
K 000	INITIAL COMMENT	ΓS	KO	000			
	FIRE SAFETY						
	conducted by the M Public Safety, State 12/28/2021. At the 12/28/2021. At the 12/28/2021. At the 13/2021. At the 15/2021. At t	apacity of 84 beds and had a					

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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 & REHABI	ILITATION CENTER *K4 12/28/2021					
K6 DATE OF PLAN APPROVAL	K3: MULTIPLE CONSTRUCTION TOTAL NUMBER OF BUILDINGS NUMBER OF THIS BUILDING	1 A BUILDING B WING C FLOOR D APARTMENT UNIT					
12 2786 R	alth Care Form 2012 EXISTING	COMPLETE IF ICF/MR IS SURVEYED UNDER CHAPTER 21 SMALL (16 BEDS OR LESS) 1 PROMPT					
13 2786 R 14 2786 U 15 2786 U	2012 NEW ASC Form 2012 EXISTING 2012 NEW	LARGE 4 PROMPT 5 SLOW					
16 2786 V, W, 17 2786 V, W,		K8: 6 IMPRACTICAL APARTMENT HOUSE					
	OF FORM USED FROM ABOVE are marked as not applicable in the [7, Y and Z.]	K8: 7 PROMPT 8 SLOW 9 IMPRACTICAL					
	K351: 3	ENTER E-SCORE HERE K5: e.g 2.5					
*K9 : FACILITY MEETS LSC A1 X (COMP. WITH ALL PROVISIONS)	C BASED ON: (Check all that apply) A2 A3 (ACCEPTABLE POC) (WA	IVERS) A4 A5 (PERFORMANCE BASED DESIGN)					
FACILITY DOES NOT MEET B.	FULLY SPRINKLE (All required areas are sp		n)				
*MANDATORY	1						