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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: K24X

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00811

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245514**

2.STATE VENDOR OR MEDICAID NO.
(L2) **227432200**

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

4. TYPE OF ACTION: **7** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **07/01/2015**

6. DATE OF SURVEY **11/23/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **90** (L18)

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

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

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	90			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Gayle Lantto, Unit Supervisor 01/06/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 01/06/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
02/01/1988
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
06201
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
11/15/2016
(L33)

DETERMINATION APPROVAL

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

CCN: 24 5514

On November 23, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on November 15, 2016 the Minnesota Department of Public Safety completed a PCR to verify that the facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on September 30, 2016. Based on their plan of correction, the facility had corrected these deficiencies as of November 11, 2016.

In addition correction of F225 and F226 determines compliance with the complaint number H5514011 investigated at the time of the survey.

Refer to the CMS 2567b forms for both health and life safety code for the results of this visit.

Effective November 11, 2016 the facility is certified for 90 skilled nursing facility beds.

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245514

January 6, 2017

Mr. Jay Wobig, Administrator
Mala Strana Care & Rehabilitation Center
1001 Columbus Avenue North
New Prague, Minnesota 56071

Dear Mr. Wobig:

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

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

Effective November 11, 2016 the above facility is certified for:

90 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
January 6, 2017

Mr. Jay Wobig, Administrator
Mala Strana Care & Rehabilitation Center
1001 Columbus Avenue North
New Prague, Minnesota 56071

RE: Project Number S5514025 and H5514011

Dear Mr. Wobig:

On October 18, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on September 30, 2016. that included an investigation of complaint number H5514011. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On November 23, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on November 15, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on September 30, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of November 11, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on September 30, 2016, effective November 11, 2016 and therefore remedies outlined in our letter to you dated October 18, 2016, will not be imposed.

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

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245514 Y1	A. Building B. Wing Y2	11/23/2016 Y3

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

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4		DATE Y5	ITEM Y4		DATE Y5	ITEM Y4		DATE Y5
ID Prefix	F0225	Correction	ID Prefix	F0226	Correction	ID Prefix	F0253	Correction
Reg. #	483.13(c)(1)(ii)-(iii), (c)(2) - (4)	Completed	Reg. #	483.13(c)	Completed	Reg. #	483.15(h)(2)	Completed
LSC		11/11/2016	LSC		11/11/2016	LSC		11/11/2016
ID Prefix	F0280	Correction	ID Prefix	F0285	Correction	ID Prefix	F0309	Correction
Reg. #	483.20(d)(3), 483.10(k)(2)	Completed	Reg. #	483.20(m), 483.20(e)	Completed	Reg. #	483.25	Completed
LSC		11/11/2016	LSC		11/11/2016	LSC		11/11/2016
ID Prefix	F0356	Correction	ID Prefix	F0441	Correction	ID Prefix		Correction
Reg. #	483.30(e)	Completed	Reg. #	483.65	Completed	Reg. #		Completed
LSC		11/11/2016	LSC		11/11/2016	LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☒	GL/mm	01/06/2017	15507	11/23/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
9/30/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245514 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	11/15/2016 Y3

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

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0018	11/11/2016	LSC K0021	11/11/2016	LSC K0025	11/11/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. #	Completed
LSC K0038	11/11/2016	LSC K0062	11/11/2016	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☒	TL/mm	01/06/2017	37008	11/15/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
9/28/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: K24X

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 **09/30/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **90** (L18)

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

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	90			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

See Attached Remarks

17. SURVEYOR SIGNATURE — Date :
Mary Bruess, HFE NEII — 10/30/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath, Enforcement Specialist — 11/14/2016 (L20)

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

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
__X__ 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

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

CCN: 24 5514

At the time of the September 30, 2016 recertification survey survey the facility was not in substantial compliance with Federal participation requirements. The facility has been given an opportunity to correct before remedies would be imposed. In addition at the time of the survey an investigation of complaint number H 5514011 was conducted and found to be substantiated at deficiencies cited at F225 and F226. The most serious deficiency is a widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections are required. Please refer to the CMS-2567 for both health and life safety code along with the facility's plan of correction. Post Certification Revisit to follow.

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
October 18, 2016

Mr. Jay Wobig, Administrator
Mala Strana Care & Rehabilitation Center
1001 Columbus Avenue North
New Prague, Minnesota 56071

RE: Project Number S5514025, H5514011

Dear Mr. Wobig:

On September 30, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. In addition, at the time of the September 30, 2016 standard survey the Minnesota Department of Health completed an investigation of complaint number H5514011.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the September 30, 2016 standard survey the Minnesota Department of Health completed an investigation of complaint number H5514011 that was found to be substantiated at F225 and F226.

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

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

> **Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> **Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;**

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

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

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

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

DEPARTMENT CONTACT

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

Gayle Lantto, Unit Supervisor
Metro D Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: gayle.lantto@state.mn.us
Phone: (651) 201-3794 Fax: (651) 215-9697

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by November 11, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by November 11, 2016 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by December 30, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was

issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by March 30, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

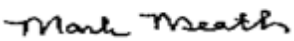
Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division

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

Feel free to contact me if you have questions related to this eNotice.

Sincerely,



Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

.Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

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 _____	09/30/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's 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 on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. An investigation of complaint H5514011 was completed at the time of the federal survey. The complaint was substantiated and deficiencies were cited at F225 and F226.	F 000		
F 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and	F 225		11/11/16

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

Electronically Signed | 10/27/2016

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F 225	Continued From page 1 misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to report and thoroughly investigate potential neglect of care/supervision for 1 of 1 complaint investigated, potentially affecting approximately 46 residents who resided on the East and Little Village units. Findings include: E-1's personnel file revealed statements indicating that on the night of 12/1 to 12/2/15, employee E-1 was reportedly in resident rooms, although she was not providing care for the residents at the time. A staff's statement read, "Call lights continued to alarm or residents crawling out of bed or calling out. Every resident	F 225	To ensure all staff is trained regarding abuse prohibition an in-service will be completed on November 2nd. The vice president of operations will be coming to speak on this date regarding suspected maltreatment and reporting procedures. We have also implemented a process to stress dealing with employees who exhibit behaviors that could put our residents at risk. While we still have a drug testing policy that we use when appropriate, we are educating staff to report to management or person in charge any behaviors that could be deemed harmful to residents. Staff members have also been educated to make arrangements to	

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F 225	Continued From page 2 that I was checking on or assisting was checking on or assisting was soaking wet, pads, underwear, soaker pad underneath them. This would be with resident she was just recently in with or had already completed rounds...Noticed she was working on toileting sheet for the night as to when she did rounds, mid-way through the night I noticed she was working on the sheets again...She had 2 different toileting sheets going with the same information...The clean glasses were mixed in with dirty glasses and milk was spilled all over them...Appeared she was taking frequent bathroom breaks when she had been there just shortly before that or when she walked down the hall she disappeared in rooms for long periods of time...This went on throughout the night." E-1 was removed from the schedule that night, however, the potential neglect of care was not immediately reported to the designated State agency (SA). On 12/13/15, an Employee/Facility Concerns Form indicated E-1 reportedly "Left residents alone in Village" (memory care unit). A nurse observed E-1 taking an unauthorized break and was seen coming indoors, having been outside. Another staff person wrote a statement indicating she had witnessed E-1 emerging from the break room and then going back to the break room. "Action taken: Continue to monitor." The file also contained a report dated 12/17/15, regarding an incident involving E-1, including from a NA who found E-1 sleeping in a resident's room. Employee Notes read, "Multiple complaints about the care levels provided by [E-1] tonight...At 5:30 am [E-1] left a note on the clipboard that she had left the building ill. She had not reported her departure to any staff person or this writer. There	F 225	have the employee removed from having any resident contact and to secure a safe means of transport home. The Administrator along with input from DON and Nurse Managers will then file a VA and investigate the situation, and determine the best course of action for that employee that safeguards our residents. Observational audits will be completed to ensure care is provided according to the residents care plans. Audits will be completed weekly for 1 month, followed by biweekly for 2 months and then monthly for 3 months. The audits will be reviewed at the Quality Assurance meetings for review to assess on-going need.	

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F 225	Continued From page 3	F 225		

was no evidence of her being sick and she did not tell this writer she was sick moments before during the conversation." An Employee Warning Notice read, "We found a note at the desk that said you had left early at 5:30 a.m., ill or sick. You did not tell the charge nurse or Administrator who was in the building. This essentially means you left the residents...This cannot happen again...Action to be taken: Written warning at this time, but this cannot happen again. Leaving the floor and not reporting is abandonment of residents and will result in immediate termination. Leaving without notice is considered a voluntary separation." The incident was not reported to the SA.

On the night of 1/30 to 1/31/16, E-1 was responsible for the care of residents on the East unit, rooms (110-1 to 131-1). Police were dispatched to the facility at approximately 2:16 a.m. to respond to an non-responsive resident who resided on the East wing. After the officers a nurse informed them the resident had do not resucitate wishes. The nurse expressed concern and asked for assistance from the officers regarding E-1's alleged impaired condition. E-1 was removed from the schedule for the rest of the shift, however, the incident was not immediately reported to the SA.

A log of allegations reported to the SA revealed no incidents related to potential neglect of cares/supervision had been reported and investigated during the months of 12/15 or 1/16.

E-1 was scheduled to work 25 of 29 days (two days unavailable for review) from 1/1/16 to 1/31/16, and although could have been paired on the west unit where two nursing assistants (NAs)

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F 225	Continued From page 4	F 225		

worked together, was assigned alone on either the East or Little Village memory care unit with a nurse who worked between the two units.

The director of nursing (DON) was interviewed on 9/30/16, at 1:21 p.m. The DON indicated that although he had worked with E-1, he was not the DON but the nurse manager at the time. The DON said E-1 was the "most competent nursing assistant in the building," but had been making odd statements and was displaying odd behavior. He was not fully apprised of the situation, but was aware the former administrator provided re-education for E-1. It was the DON's opinion E-1 should not have been allowed to return to work on the nights in question, particularly after leaving the residents unattended. The DON said the surveyor had the entire file, and he knew of no other related reports or investigations. "As for a VA [vulnerable adult] report, I don't think there was anything...Investigation? Only what's in the file." The DON stated in hindsight, he felt the whole situation should have been handled differently.

The administrator was interviewed on 9/30/16, at 3:15 p.m. He reported that since learning of the situation with E-1 (prior to his employment), they had talked between facilities as well as to local law enforcement to determine how to handle future situations. The administrator stated they realized what they had been doing (to address potential concerns with staff) "had not been effective" and they had a responsibility to protect the residents.

The facility's undated Abuse Prohibition/Vulnerable Adult Plan indicated, "Immediately, upon learning of the incident, staff

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F 225	Continued From page 5 will take necessary actions to protect residents from possible subsequent incidents of misconduct or injury while the matter is being investigated...Notify the the Minnesota Department of Health (MDH) immediately after discovery of the incident...Investigation will begin in accordance with Federal Law."	F 225		
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to follow their policy for reporting and thoroughly investigating potential neglect of care/supervision for 1 of 1 complaints investigated, potentially affecting approximately 46 residents who resided on the East and Little Village units. Findings include: The facility's undated Abuse Prohibition/Vulnerable Adult Plan indicated, "Immediately, upon learning of the incident, staff will take necessary actions to protect residents from possible subsequent incidents of misconduct or injury while the matter is being investigated...Notify the the Minnesota Department of Health (MDH) immediately after discovery of the incident...Investigation will begin	F 226	To ensure all staff is trained regarding abuse prohibition an in-service will be completed on November 2nd. The vice president of operations will be coming to speak on this date regarding suspected maltreatment and reporting procedures. We have also implemented a process to stress dealing with employees who exhibit behaviors that could put our residents at risk. While we still have a drug testing policy that we use when appropriate, we are educating staff to report to management or person in charge any behaviors that could be deemed harmful to residents. Staff members have also been educated to make arrangements to have the employee removed from having any resident contact and to secure a safe means of transport home. The	11/11/16

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F 226	Continued From page 6 in accordance with Federal Law." E-1's personnel file revealed statements indicating that on the night of 12/1 to 12/2/15, employee E-1 was reportedly in resident rooms, although she was not providing care for the residents at the time. A staff's statement read, "Call lights continued to alarm or residents crawling out of bed or calling out. Every resident that I was checking on or assisting was checking on or assisting was soaking wet, pads, underwear, soaker pad underneath them. This would be with resident she was just recently in with or had already completed rounds...Noticed she was working on toileting sheet for the night as to when she did rounds, mid-way through the night I noticed she was working on the sheets again...She had 2 different toileting sheets going with the same information...The clean glasses were mixed in with dirty glasses and milk was spilled all over them...Appeared she was taking frequent bathroom breaks when she had been there just shortly before that or when she walked down the hall she disappeared in rooms for long periods of time...This went on throughout the night." E-1 was removed from the schedule that night, however, the potential neglect of care was not immediately reported to the designated State agency (SA). On 12/13/15, an Employee/Facility Concerns Form indicated E-1 reportedly "Left residents alone in Village" (memory care unit). A nurse observed E-1 taking an unauthorized break and was seen coming indoors, having been outside. Another staff person wrote a statement indicating she had witnessed E-1 emerging from the break room and then going back to the break room. "Action taken: Continue to monitor."	F 226	Administrator along with input from DON and Nurse Managers will then file a VA and investigate the situation, and determine the best course of action for that employee that safeguards our residents Observational audits will be completed to ensure care is provided according to the residents care plans. Audits will be completed weekly for 1 month, followed by biweekly for 2 months and then monthly for 3 months. The audits will be reviewed at the Quality Assurance meetings for review to assess on-going need.	

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F 226	Continued From page 7 The file also contained a report dated 12/17/15, regarding an incident involving E-1, including from a NA who found E-1 sleeping in a resident's room. Employee Notes read, "Multiple complaints about the care levels provided by [E-1] tonight...At 5:30 am [E-1] left a note on the clipboard that she had left the building ill. She had not reported her departure to any staff person or this writer. There was no evidence of her being sick and she did not tell this writer she was sick moments before during the conversation." An Employee Warning Notice read, "We found a note at the desk that said you had left early at 5:30 a.m., ill or sick. You did not tell the charge nurse or Administrator who was in the building. This essentially means you left the residents...This cannot happen again...Action to be taken: Written warning at this time, but this cannot happen again. Leaving the floor and not reporting is abandonment of residents and will result in immediate termination. Leaving without notice is considered a voluntary separation." The incident was not reported to the SA. On the night of 1/30 to 1/31/16, E-1 was responsible for the care of residents on the East unit, rooms (110-1 to 131-1). Police were dispatched to the facility at approximately 2:16 a.m. to respond to an non-responsive resident who resided on the East wing. After the officers a nurse informed them the resident had do not resucitate wishes. The nurse expressed concern and asked for assistance from the officers regarding E-1's alleged impaired condition. E-1 was removed from the schedule for the rest of the shift, however, the incident was not immediately reported to the SA.	F 226		

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F 226	Continued From page 8 A log of allegations reported to the SA revealed no incidents related to potential neglect of cares/supervision had been reported and investigated during the months of 12/15 or 1/16. E-1 was scheduled to work 25 of 29 days (two days unavailable for review) from 1/1/16 to 1/31/16, and although could have been paired on the west unit where two nursing assistants (NAs) worked together, was assigned alone on either the East or Little Village memory care unit with a nurse who worked between the two units. The director of nursing (DON) was interviewed on 9/30/16, at 1:21 p.m. The DON indicated that although he had worked with E-1, he was not the DON but the nurse manager at the time. The DON said E-1 was the "most competent nursing assistant in the building," but had been making odd statements and was displaying odd behavior. He was not fully apprised of the situation, but was aware the former administrator provided re-education for E-1. It was the DON's opinion E-1 should not have been allowed to return to work on the nights in question, particularly after leaving the residents unattended. The DON said the surveyor had the entire file, and he knew of no other related reports or investigations. "As for a VA [vulnerable adult] report, I don't think there was anything...Investigation? Only what's in the file." The DON stated in hindsight, he felt the whole situation should have been handled differently. The administrator was interviewed on 9/30/16, at 3:15 p.m. He reported that since learning of the situation with E-1 (prior to his employment), they had talked between facilities as well as to local law enforcement to determine how to handle	F 226		

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F 226	Continued From page 9 future situations. The administrator stated they realized what they had been doing (to address potential concerns with staff) "had not been effective" and they had a responsibility to protect the residents.	F 226		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure resident rooms and bathrooms were maintained in good repair and were kept clean in seven resident rooms 120, 121, 123, 126,128,160, and 161. Findings include: On 9/29/16, at 10:04 a.m. the following concerns were identified during an environmental tour, conducted with the environmental service director (ESD): Room 160/161 shared bathroom: The plaster on the wall was rough and had sharp, un-sanded edges next to the toilet. A dusty stool riser was stored on the bathroom floor. The safety hand rail had a brown dried smear on the arm handle. This was first observed on 9/23/26 and hand not been cleaned and remained the same when again observed at the time of the tour on 9/29/16. The ESD explained, "The wall was patched last Friday [on 9/23/16]. The maintenance person should	F 253	The affected resident rooms have all been repaired and cleaned and left in good working condition. All resident rooms and bathrooms have been checked for cleanliness and to ensure that walls, floors, sinks, etc. are in good repair/working condition. On 11/2/16 housekeeping staff will be re-educated on the proper procedures for cleaning bathrooms and cleaning toilet risers and the importance of documenting needed repairs in the maintenance logs books. Nursing staff will also be educated on documentation of needed repairs in the maintenance log books on 11/7/16. Also on 11/2/16 maintenance staff will be educated on the process for documenting progress or completion of work order in the maintenance log books. Environmental Services Director will conduct random audits of housekeeping staff tasks will monitor the maintenance	11/11/16

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F 253	Continued From page 10 have come back on Monday to paint and finished the work. I know this is unsafe and has a potential to cause an injury." The ESD also stated the housekeepers cleaned every day, and they probably picked up the stool riser to clean the floor, and then placed it back where they found it. The ESD then wet paper towel and cleaned off the brown substance from the safety rail and stated, "It is feces." Room 123: The wall behind the headboard was scraped and rough. The metal cover for heat radiator next to the bed was bent. The ESD reported being unaware of the radiator and stated, "Yes, the radiator is bent. The resident can be injured from that." The ESD explained it could have been bent when staff moved the bed up and down, catching on the radiator. Room 126: The bathroom sink was pulled away from the wall, leaving a space where the sink should have securely attached. The ESD confirmed the problem and said water could easily get behind the sink, and said, "We just have to prioritize the work...it is on our list to repair." Room 120/121 the shared bathroom wall had multiple un-repaired holes. The ESD explained there had previously been a towel bar that was removed that "nobody reported to me...the surface around the hole is rough and has sharp edge which could be hazardous." The ESD also stated, "We have a maintenance request book for the nursing staff to write concerns. The maintenance person will check the book every morning and address the issues. If there are serious issues they will call us right away so it can get fixed."	F 253	log books weekly to make sure repairs are being completed satisfactorily and timely. Monthly environmental/safety audits will be completed by department directors and reported to QA committee.	

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F 253	Continued From page 11 The facility's undated Facility Maintenance Policy read, "It is our intension to keep our facility safe for our resident and keep our equipment in a working order."	F 253		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure the care plan was coordinated and revised as needed related to hospice for 1 of 1 resident (R23) reviewed for hospice care. Findings include:	F 280	Affected resident□s care plan was updated to reflect current needs and coordination of care with hospice. All residents□, receiving hospice services, care plans were reviewed and updated to reflect current needs and coordination of	11/11/16

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	245514	A. BUILDING _____ B. WING _____	09/30/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 280	Continued From page 12 R23's facility hospice care plan (CP) (dated 4/22/15, prior to hospice start date) included, "Maintain communication with Heartland hospice...." R23's physician's orders revealed the resident had been receiving hospice care since 7/23/16. The Heartland Hospice NA care plan was reviewed and indicated the agency staff provided a tub bath, shampoo, combing hair, mouth care, shaving, and moisturizing skin among other cares. Registered nurse (RN)-A indicated during an interview on 9/30/16, at 1:24 p.m. the hospice nurse visited R23 1-2 times a week, however, the nurse was unsure the nurse's schedule. RN-A explained she was unaware when various hospice disciplines came to provide services for R23 stating "They just show up." She further stated that she did not know of a calendar used between hospice and the facility to integrate care and services between them. She said the hospice NA visited weekly, possibly to provide R23 with an extra bath or comfort care such as lotioning. RN-A was unsure what days the NAs were scheduled, or what other care they provided for R23. Communication between the hospice nurse and the facility took place face-to-face at the time of visits, or by phone calls if issues arose between visits. Facility NAs were asked if they knew what days the hospice NA was scheduled to care for R23. NA-D stated on 9/30/16, at 2:47 p.m. "I'm not sure when the hospice aide comes." And at 2:55 p.m. NA-A indicated, "For [R23] I've not seen one; so I'm not sure how often they come to see him." When asked about communication with the	F 280	care with hospice Communication systems have been reviewed with the administrator of Heartland Hospice. For each resident a binder has been put together containing calendar of when services are provided. Information will be kept together in the binder regarding the care plan of both hospice agency and facility so that it is easily accessible to all staff. Will complete audits on care plans seven days after the comprehensive assessment to ensure state compliance. DON or designee to audit weekly x 4 and then monthly. Audit results will be reported to QA.	

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F 280	Continued From page 13	F 280		

hospice aide NA-A stated, "I've talked to [R23's] hospice nurse but not to his hospice aide."

On 9/30/16 at 2:44 p.m. RN-E explained, "There's a schedule in the resident's room for when the hospice nurse comes. They were here yesterday."

At 2:11 p.m. a Heartland Hospice RN-B stated she came "every Thursday" and called to notify facility staff is she was unable to make the scheduled time. At 2:35 p.m. RN-B stated, "We keep this calendar in the resident's room." The calendar indicated hospice RN visits were scheduled for each Tuesday in 8/16 and each Thursday in 9/16 and 10/16. However, no scheduled visits by other hospice staff, including NA visits was included on the calendar. RN-B also explained that the hospice care plan was in many different areas (addendums) that were scanned into the facility's computer, and she could not verify if the hospice care plan was coordinated with the facility's plan of care. RN-A confirmed this practice and said the system made it "difficult" to observe the complete care plans and coordinate care because of the addendums. RN-B further stated she was not informed when other hospice services were being provided for R23. RN-B added, "We had used a binder with papers at the hospice I used to work for and that was good because it had everything in one place where it could be easily seen. But Heartland wanted everything electronic and this is how it turned out."

R23's hospice service contract dated 7/22/16, revealed the resident received NA and RN visits weekly, and social service, spiritual, and music therapy visits were expected monthly. A

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F 280	Continued From page 14 volunteer was scheduled on an "as needed" basis.	F 280		
F 285 SS=D	483.20(m), 483.20(e) PASRR REQUIREMENTS FOR MI & MR A facility must coordinate assessments with the pre-admission screening and resident review program under Medicaid in part 483, subpart C to the maximum extent practicable to avoid duplicative testing and effort. A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental illness as defined in paragraph (m)(2)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission; (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation. (ii) Mental retardation, as defined in paragraph (m)(2)(ii) of this section, unless the State mental retardation or developmental disability authority has determined prior to admission-- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation.	F 285		11/11/16

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F 285	Continued From page 15 For purposes of this section: (i) An individual is considered to have "mental illness" if the individual has a serious mental illness defined at §483.102(b)(1). (ii) An individual is considered to be "mentally retarded" if the individual is mentally retarded as defined in §483.102(b)(3) or is a person with a related condition as described in 42 CFR 1009. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to obtain required screening documents to determine appropriate services for 1 of 1 resident (R101) reviewed for pre-admission screening. Findings include: R101 was admitted to the facility in 3/16, from another state. Preadmission Screening and Resident Review (PASRR) dated 9/3/15, for a Status Change Review Outcome indicated R101 had a developmental disability (DD), and the Level II "remains valid." The Level II screening which would have indicated whether the resident required active treatment or other care and services, however, was not included with the Level I information. A Pre-Admission Screening (PAS) Results form was completed by the facility's licensed social worker (LSW) and was submitted on 3/11/16. The screening indicated "no" to questions regarding DD or related conditions, therefore, did not trigger for a Level II screen when it would have been warranted. The report indicated, "Based on the information provided for this nursing home stay is [sic] appears this person does not meet the criteria for	F 285	Affected resident□s level 2 screening form was obtained from the previous facility that the resident resided and was scanned into the medical record. All other residents in the facility, with an MI/MR diagnosis, has a completed level 2 screening in their medical record. Social service□s process for obtaining Pre-Admission screenings was reviewed on 10/26/16. Social services will check the Pre-Admission Screening and work with the health information department to ensure that all level 2 screening for all new admissions with MI/MR diagnosis is completed and scanned into the medical record.	

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F 285	Continued From page 16	F 285		

DD. Please note final determination of the need for further evaluation will be made by Senior LinkAge Line." In a letter from the Minnesota Board on Aging Senior LinkAge Line dated 3/14/16, a box was checked that read, "No indications of Mental Illness (MI) or Developmental Disability (DD) were found on the OBRA I Level I Screening. Therefore, an OBRA Level II DD or MI Evaluation is not needed for this consumer." R101's undated care plan indicated the resident had profound DD present at birth.

The social service representative (SS) was interviewed on 9/30/16, at 8:47 a.m.
When asked about the Level I screening completed by the LSW indicating no DD was present the SS replied, "That surprises me." The SS suggested asking the licensed social worker (LSW) who had completed the form, but who was currently unavailable. When informed a copy of the Level II screen from the transferring state could not be found in the scanned documents in the electronic record the SS replied, "That I don't understand."

The LSW was interviewed via telephone on 10/4/16, at 2:00 p.m. The LSW explained R101 transferred from another state where she had lived in a group home and then more recently in another long term care setting. She explained she was unsure whether the PASRR from the other state was considered valid, so she had completed another one. "Minnesota said we really didn't need to do one." The LSW reviewed R101's notes and said someone from the county came out to assess the resident for the need for services on 4/21/16, but the information could not be located in the resident's record. The LSW stated, "That might be something we want...That

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F 285	Continued From page 17 might be the answer to your and my question. We might not have a copy of that. That might be helpful. "	F 285		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure coordination of care with hospice for 1 of 1 resident (R23) reviewed for hospice care. Findings include: R23 was observed at breakfast on 9/30/16, at 8:45 a.m. and responded minimally to a greeting. R23's physician's orders revealed the resident had been receiving hospice care since 7/23/16. During an interview on 9/28/16, at 12:49 p.m. nursing assistant (NA)-A (also a bath aide) reported the NAs performed most of R23's cares, including transferring. She added, "He'll wash his face once in a while...and he refuses cares frequently. We need to constantly reapproach. He may get upset and combative in the morning." She indicated R23 did better with certain staff and they tried to assign him to those NAs. Registered nurse (RN)-A indicated during an	F 309	Affected resident□s care plan was updated to reflect current needs and coordination of care with hospice. All residents□, receiving hospice services, care plans were reviewed and updated to reflect current needs and coordination of care with hospice Communication systems have been reviewed with the administrator of Heartland Hospice. For each resident a binder has been put together containing calendar of when services are provided. Information will be kept together in the binder regarding the care plan of both hospice agency and facility so that it is easily accessible to all staff. Will complete audits on care plans seven days after the comprehensive assessment to ensure state compliance. DON or designee to audit weekly x 4 and then monthly. Audit results will be	11/11/16

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F 309	Continued From page 18 interview on 9/30/16, at 1:24 p.m. the hospice nurse visited 1-2 times a week, however, the nurse was unsure the nurse's schedule. RN-A explained she was unaware when various hospice disciplines came to provide services for R23 stating "They just show up." She further stated that she did not know of a calendar used between hospice and the facility to integrate care and services between them. She said the hospice NA visited weekly, possibly to provide R23 with an extra bath or comfort care such as lotioning. RN-A was unsure what days the NAs were scheduled, or what other care they provided for R23. Communication between the hospice nurse and the facility took place face-to-face at the time of visits, or by phone calls if issues arose between visits. The Heartland Hospice NA care plan was reviewed and indicated the agency staff provided a tub bath, shampoo, combing hair, mouth care, shaving, and moisturizing skin among other cares. Facility NAs were asked if they knew what days the hospice NA was scheduled to care for R23. NA-D stated on 9/30/16, at 2:47 p.m. "I'm not sure when the hospice aide comes." And at 2:55 p.m. NA-A indicated, "For [R23] I've not seen one; so I'm not sure how often they come to see him." When asked about communication with the hospice aide NA-A stated, "I've talked to [R23's] hospice nurse but not to his hospice aide." On 9/30/16 at 2:44 p.m. RN-E explained, "There's a schedule in the resident's room for when the hospice nurse comes. They were here yesterday."	F 309	reported to QA.	

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F 309	Continued From page 19 At 2:11 p.m. a Heartland Hospice RN-B stated she came "every Thursday" and called to notify facility staff is she was unable to make the scheduled time. At 2:35 p.m. RN-B stated, "We keep this calendar in the resident's room." The calendar indicated hospice RN visits were scheduled for each Tuesday in 8/16 and each Thursday in 9/16 and 10/16. However, no scheduled visits by other hospice staff, including NA visits was included on the calendar. RN-B also explained that the hospice care plan was in many different areas (addendums) that were scanned into the facility's computer, and she could not verify if the hospice care plan was coordinated with the facility's plan of care. RN-A confirmed this practice and said the system made it "difficult" to observe the complete care plans and coordinate care because of the addendums. RN-B further stated she was not informed when other hospice services were being provided for R23. RN-B added, "We had used a binder with papers at the hospice I used to work for and that was good because it had everything in one place where it could be easily seen. But Heartland wanted everything electronic and this is how it turned out." The facility's hospice care plan (CP) (dated 4/22/15, prior to hospice start date) as reviewed and included, "Maintain communication with Heartland hospice...." R23's hospice service contract dated 7/22/16, revealed the resident received NA and RN visits weekly, and social service, spiritual, and music therapy visits were expected monthly. A volunteer was scheduled on an "as needed" basis.	F 309		

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F 356	Continued From page 20	F 356		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to post daily nursing staff as required. This had the potential to affect all 80	F 356	The posted nursing staffing hours report has been revised to include total number and actual hours worked by each	11/11/16

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F 356	Continued From page 21 residents and visitors. Findings include: During the initial tour of the facility on 9/26/16, at 12:30 p.m. the posted nursing hours was reviewed. The posting included the current date and census, as well as the shift start times. The total hours for each shift and full time equivalents for each shift for registered nurses, licensed practical nurses and "Assistants/Techs," and shift totals were noted. The posting, however, lacked the actual hours and numbers of staff who worked those times, including short shifts and overlapping shifts. During an interview on 9/30/16, at 2:00 p.m. the administrator explained the facility was using a new software program. The previous program had reflected each nursing staff member's actual shift hours worked. He further stated he would check with corporate staff to determine how the facility could best reflect the required staff working each day on the nursing postings.	F 356	discipline. Nursing Scheduler will post this report daily and conduct periodic audits to ensure that the posted information accurately reflects daily staffing.	
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility;	F 441		11/11/16

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F 441	Continued From page 22 (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure proper handwashing to minimize the spread of infection for 1 of -- residents (R125) whose wound care was observed. In addition, the facility's infection prevention and control program lacked pertinent information related to surveillance, investigation, and analysis of staff and resident diseases/infections to minimize infections in the facility, which had the potential to affect all 80 residents.	F 441	The facility has revised their infection prevention and control program to include an updated infection surveillance, investigation, and analysis form. Resident and staff Infections will be discussed daily at the morning IDT meeting and the form will be completed in full by the designated infection control nurse. Investigation and analysis will be on-going. An all staff in-service will be held on 11/2/16 educating staff on proper infection	

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F 441	Continued From page 23 Findings include: R125's wound care was observed on 9/28/16 at 10:23 a.m. by registered nurse (RN)-D. RN-D performed the "dirty" part of the dressing change after appropriately washing her hands before putting on gloves to prepare the new dressing and remove the old dressing. After removing the old dressing, RN-D removed her used gloves and put on clean ones without using either soap and water or alcohol hand wash before donning the clean pair. She placed the new dressing on the resident's wound, and adjusted the resident's clothing before replacing the bedcovers, then removed those gloves and used alcohol hand wash to clean her hands. RN-D then tied off the wastebasket liner and carried it in one hand, while carrying her clean dressing supplies bin in the other to a dirty utility room. She set the dressing supplies bin on the floor to free her hand to open the door and discarded the trash. She then emerged from the room and picked up the clean supply bin from the floor. RN-D was interviewed at 10:33 a.m. about her procedure during the dressing change and stated, "I should have washed my hands again before re-gloving." She was interviewed again at 1:08 p.m. about placing the clean dressing supplies bin on the floor and admitted, "I shouldn't have done that. You don't know what's on the floor." The facility's handwashing policy was reviewed and indicated, "Handwashing is generally considered the most important single procedure for preventing healthcare associated infection." The procedure directed staff to perform hand washing "...After contact with...wound	F 441	control prevention techniques including handwashing, glove usage and handling of equipment. Random audits will be completed on infection control weekly for 1 month, followed by biweekly for 2 months and then monthly for 3 months. We will re-assess on-going need for audits at the QA committee. DON or designee will audit infection analysis form monthly to ensure all documentation and analysis is completed.	

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 _____	09/30/2016

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 441	Continued From page 24 dressings...After removing gloves."	F 441		

The facility's Infection Surveillance Tracking and Continuous Quality Improvement logs dated 1/1/16, to 8/31/16, lacked pertinent information such as micro-organisms, antibiotic use, symptoms, etc. In addition, the form lacked infection rates, analysis, patterns, etc. The Quality Improvement Conclusions/Actions/Outcome was blank for each of the forms.

The occupational health and learning director (OHL) and director of nursing (DON) were interviewed on 9/29/16, at 9:03 a.m. The OHL and DON explained they both had responsibility for infection control at the facility. The OHL was responsible for both employees and residents, and the DON was primarily responsible for the residents.

In an interview on 9/30/16, at 10:56 a.m. the DON stated infection control concerns were brought to an interdisciplinary (IDT) meeting. Monthly reports were compiled and then those reports were reviewed quarterly infection control issues were reviewed at the quarterly by the IDT. The DON said the microorganism was "sometimes" identified, but they had not documented them on the forms provided to the surveyor. "We have not been documenting our follow up on infections very well and do not have any documentation as to what we have been doing at the daily or monthly meetings." The DON said they talked about infections each morning, and if any new infections were present, they then isolated the persons on that unit by having residents eat in their rooms and limiting activities on the unit. The

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F 441	Continued From page 25 DON said the discussion of infection control issues at the facility happened "more informally than formally. Because we know the residents we know where they are on wings or if they share bathrooms. We try to figure out if there is a relationship with regard to similarities between infections but it is not recorded anywhere." During an interview on 9/30/16, at 11:01 a.m. the OHL reported they had started conducting staff and patient care audits on rotating shifts and had completed two audits per week during the last four weeks. The OHL stated, "We follow staff and watch cares and correct them immediately." Proper and washing and peri-care was a focus during staff training in 7/16 and 8/16 for all nursing assistants, and all staff had received hand washing training in the past few months. Nurse managers were responsible for filling out an infection control concern form as appropriate. The forms were collected monthly and reviewed quarterly. Because they educated staff on proper hand washing and peri-care, the OHL "the organism doesn't matter." The OHL stated, "We probably should be documenting what we do regarding monitoring and training instead of more informally talking about it at the morning meetings." The DON was interviewed on 9/30/16, at 10:27 a.m. and stated he would have expected the staff to be tracking and looking at trends such as which microorganisms were involved, resident temperature logs, resident symptoms, etc. Prior to 6/16, tracking and trending of infections was "not very inclusive and did not documented well." The new forms allowed for better tracking and trending, however, the staff were not recording all the information.	F 441		

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	245514	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/28/2016**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS FORM-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey dated Sept.28, 2016, Mala Strana Health Care Center was found not to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/27/2016

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

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K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Mala Strana Health Care Center was constructed at 2 different times. The original building was built in 1972, it is one-story in height, with a partial basement and was determined to be of Type II(111) construction. In 2002, a one-story in height addition with no basement was constructed and was determined to be of Type II(111) construction. Because the original building and the 1 addition are of the same type of construction and meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is fully sprinklered. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 90 beds and had a census of 80 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is	K 000		

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K 000	Continued From page 2 NOT MET as evidenced by:	K 000		
K 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3 This STANDARD is not met as evidenced by: Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by	K 018	All four doors have been fixed as of 10/26/16. New knobs and latches were ordered and installed.	11/11/16

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K 018	Continued From page 3 CMS regulations in all health care facilities. 19.3.6.3 On facility tour between 09:00 AM and 1:00 PM on Sept. 28,2016, based on observation and interview revealed that the findings include: Doors in corridor did not latch when tested. 1. B-8 storage room 2. B-9 storage room 3. B-4 Laundry room 4. North hallway in the east wing did not open after closing. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 018		
K 021 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure are self-closing and kept in the closed position, unless held open by as release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: (a) The required manual fire alarm system and (b) Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system and (c) The automatic sprinkler system, if installed 18.2.2.2.6, 18.3.1.2, 19.2.2.2.6, 19.3.1.2, 7.2.1.8.2 Door assemblies in vertical openings are of an approved type with appropriate fire protection rating. 8.2.3.2.3.1 Boiler rooms, heater rooms, and mechanical	K 021		11/11/16

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K 021	Continued From page 4 equipment rooms doors are kept closed. This STANDARD is not met as evidenced by: Doors in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure are self-closing and kept in the closed position, unless held open by as release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: (a) The required manual fire alarm system and (b) Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system and (c) The automatic sprinkler system, if installed 18.2.2.2.6, 18.3.1.2, 19.2.2.2.6, 19.3.1.2, 7.2.1.8.2 Door assemblies in vertical openings are of an approved type with appropriate fire protection rating. 8.2.3.2.3.1 Boiler rooms, heater rooms, and mechanical equipment rooms doors are kept closed. On facility tour between 09:00 AM and 1:00 PM on Sept. 28, 2016, based on observation and interview revealed that the kitchen door to dining room observed being held open by a friction magnet not connected into the main fire alarm system.. This deficient practice could affect the safety of the (80) residents within that smoke compartment area. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 021	All doors in the kitchen were inspected and friction magnetic locks have been ordered and installation has started. All work will be done by 10/31/16.	
K 025	NFPA 101 LIFE SAFETY CODE STANDARD	K 025		11/11/16

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K 025 SS=F	Continued From page 5 Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5 This STANDARD is not met as evidenced by: Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5 On facility tour between 09:00 AM and 1:00 PM on Sept.28,2016, based on observation and interview revealed or based that penetrations were found in smoke barriers above ceilings in corridors. Check all smoke barriers through out facility.. This deficient practice could affect the safety of the (20) residents within the smoke compartment. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 025	The smoke barriers through-out the facility have been inspected. The penetrations spots noted in the inspection have been caulked.	
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Exit access is arranged so that exits are readily	K 038	The security company completed the	11/11/16

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K 038	Continued From page 6 accessible at all times in accordance with section 7.1. 19.2.1 On facility tour between 09:00 AM and 1:00 PM on Sept. 28,2016, based on observation and interview revealed that the delay egress locks did not release after the 15 seconds at: 1. Little Village door #7 2. Kitchen Service door. This deficient practice could affect the safety of the (20) residents within the smoke compartment. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 038	work on 9/29/16 and both doors now release after 15 seconds.	
K 062 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5	K 062		11/11/16
	This STANDARD is not met as evidenced by: Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 On facility tour between 09:00 AM and 1:00 PM on Sept. 28,2016, based on observation and interview revealed that the findings include: Observation revealed that the founding was found with the fire sprinkler system. 1. In Corridor of the Little Village area, mixed matched sprinkler heads were found (standard/ quick response) in the same ceiling area. 2.Ceiling tile in charting room has corner broken		Olympic Fire replaced the old style sprinkler head with a new style head in the hallway on 10/18/16. Both the ceiling tile in charting room as well as the B-9 storage room tile that was missing was replaced on 10/5/16.	

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K 062	Continued From page 7 away. 3. B-9 Storage room has missing ceiling tiles. This deficient practice could affect the safety of the (20) residents within the smoke compartment. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 062		

Electronically delivered
October 18, 2016

Mr. Jay Wobig, Administrator
Mala Strana Care & Rehabilitation Center
1001 Columbus Avenue North
New Prague, Minnesota 56071

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5514025,H5514011

Dear Mr. Wobig:

The above facility was surveyed on September 26, 2016 through September 30, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint number H5514011. that was found to be substantiated at MN Statute 144.651 Subdivision 24 and 26. 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 that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 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 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 deficiency 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 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. 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 after the statement, "This Rule 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 Gayle Lantto at (651) 201-3794 or email: gayle.lantto@state.mn.us**.

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.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

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 _____	09/30/2016

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: 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	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. 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. On September 26, 27, 28, 29 and 30, 2016, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. 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. A complaint investigation of H5514011 was conducted and was susbtantiated at MN Statute 144.651 Subdivision 24 and 26.	2 000		
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal	2 570		11/11/16

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2 570	Continued From page 2 guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to ensure the care plan was coordinated and revised as needed related to hospice for 1 of 1 resident (R23) reviewed for hospice care. Findings include: R23's facility hospice care plan (CP) (dated 4/22/15, prior to hospice start date) included, "Maintain communication with Heartland hospice...." R23's physician's orders revealed the resident had been receiving hospice care since 7/23/16. The Heartland Hospice NA care plan was reviewed and indicated the agency staff provided a tub bath, shampoo, combing hair, mouth care, shaving, and moisturizing skin among other cares. Registered nurse (RN)-A indicated during an interview on 9/30/16, at 1:24 p.m. the hospice nurse visited R23 1-2 times a week, however, the nurse was unsure the nurse's schedule. RN-A explained she was unaware when various hospice disciplines came to provide services for R23 stating "They just show up." She further stated that she did not know of a calendar used between hospice and the facility to integrate care and services between them. She said the hospice NA visited weekly, possibly to provide R23 with an extra bath or comfort care such as lotioning. RN-A was unsure what days the NAs were	2 570	Plan of correction written 10/27/16. Correction to be completed by 11/11/16.	

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2 570	Continued From page 3	2 570		

scheduled, or what other care they provided for R23. Communication between the hospice nurse and the facility took place face-to-face at the time of visits, or by phone calls if issues arose between visits.

Facility NAs were asked if they knew what days the hospice NA was scheduled to care for R23. NA-D stated on 9/30/16, at 2:47 p.m. "I'm not sure when the hospice aide comes." And at 2:55 p.m. NA-A indicated, "For [R23] I've not seen one; so I'm not sure how often they come to see him." When asked about communication with the hospice aide NA-A stated, "I've talked to [R23's] hospice nurse but not to his hospice aide."

On 9/30/16 at 2:44 p.m. RN-E explained, "There's a schedule in the resident's room for when the hospice nurse comes. They were here yesterday."

At 2:11 p.m. a Heartland Hospice RN-B stated she came "every Thursday" and called to notify facility staff is she was unable to make the scheduled time. At 2:35 p.m. RN-B stated, "We keep this calendar in the resident's room." The calendar indicated hospice RN visits were scheduled for each Tuesday in 8/16 and each Thursday in 9/16 and 10/16. However, no scheduled visits by other hospice staff, including NA visits was included on the calendar. RN-B also explained that the hospice care plan was in many different areas (addendums) that were scanned into the facility's computer, and she could not verify if the hospice care plan was coordinated with the facility's plan of care. RN-A confirmed this practice and said the system made it "difficult" to observe the complete care plans and coordinate care because of the addendums. RN-B further stated she was not informed when

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2 570	Continued From page 4 other hospice services were being provided for R23. RN-B added, "We had used a binder with papers at the hospice I used to work for and that was good because it had everything in one place where it could be easily seen. But Heartland wanted everything electronic and this is how it turned out." R23's hospice service contract dated 7/22/16, revealed the resident received NA and RN visits weekly, and social service, spiritual, and music therapy visits were expected monthly. A volunteer was scheduled on an "as needed" basis. SUGGESTED METHOD OF CORRECTION: The director of nursing with the hospice agency could review care plans to ensure consistency. Audits could be conducted and the results brought to the quality committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 570		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed.	2 830		11/11/16

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2 830	Continued From page 5 This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure coordination of care with hospice for 1 of 1 resident (R23) reviewed for hospice care. Findings include: R23 was observed at breakfast on 9/30/16, at 8:45 a.m. and responded minimally to a greeting. R23's physician's orders revealed the resident had been receiving hospice care since 7/23/16. During an interview on 9/28/16, at 12:49 p.m. nursing assistant (NA)-A (also a bath aide) reported the NAs performed most of R23's cares, including transferring. She added, "He'll wash his face once in a while...and he refuses cares frequently. We need to constantly reapproach. He may get upset and combative in the morning." She indicated R23 did better with certain staff and they tried to assign him to those NAs. Registered nurse (RN)-A indicated during an interview on 9/30/16, at 1:24 p.m. the hospice nurse visited 1-2 times a week, however, the nurse was unsure the nurse's schedule. RN-A explained she was unaware when various hospice disciplines came to provide services for R23 stating "They just show up." She further stated that she did not know of a calendar used between hospice and the facility to integrate care and services between them. She said the hospice NA visited weekly, possibly to provide R23 with an extra bath or comfort care such as lotioning. RN-A was unsure what days the NAs were scheduled, or what other care they provided for R23. Communication between the hospice nurse and the facility took place face-to-face at the time	2 830	Plan of correction written 10/27/16. Correction to be completed by 11/11/16.	

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2 830	Continued From page 6 of visits, or by phone calls if issues arose between visits. The Heartland Hospice NA care plan was reviewed and indicated the agency staff provided a tub bath, shampoo, combing hair, mouth care, shaving, and moisturizing skin among other cares. Facility NAs were asked if they knew what days the hospice NA was scheduled to care for R23. NA-D stated on 9/30/16, at 2:47 p.m. "I'm not sure when the hospice aide comes." And at 2:55 p.m. NA-A indicated, "For [R23] I've not seen one; so I'm not sure how often they come to see him." When asked about communication with the hospice aide NA-A stated, "I've talked to [R23's] hospice nurse but not to his hospice aide." On 9/30/16 at 2:44 p.m. RN-E explained, "There's a schedule in the resident's room for when the hospice nurse comes. They were here yesterday." At 2:11 p.m. a Heartland Hospice RN-B stated she came "every Thursday" and called to notify facility staff is she was unable to make the scheduled time. At 2:35 p.m. RN-B stated, "We keep this calendar in the resident's room." The calendar indicated hospice RN visits were scheduled for each Tuesday in 8/16 and each Thursday in 9/16 and 10/16. However, no scheduled visits by other hospice staff, including NA visits was included on the calendar. RN-B also explained that the hospice care plan was in many different areas (addendums) that were scanned into the facility's computer, and she could not verify if the hospice care plan was coordinated with the facility's plan of care. RN-A confirmed this practice and said the system made	2 830		

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2 830	Continued From page 7 it "difficult" to observe the complete care plans and coordinate care because of the addendums. RN-B further stated she was not informed when other hospice services were being provided for R23. RN-B added, "We had used a binder with papers at the hospice I used to work for and that was good because it had everything in one place where it could be easily seen. But Heartland wanted everything electronic and this is how it turned out." The facility's hospice care plan (CP) (dated 4/22/15, prior to hospice start date) as reviewed and included, "Maintain communication with Heartland hospice...." R23's hospice service contract dated 7/22/16, revealed the resident received NA and RN visits weekly, and social service, spiritual, and music therapy visits were expected monthly. A volunteer was scheduled on an "as needed" basis. SUGGESTED METHOD OF CORRECTION: The director of nursing with the hospice agency could review communication systems to ensure facility staff and hospice staff care plans are consistent and involved staff have an understanding when and what to expect from the agency for each resident receiving the hospice benefit. Audits could be conducted and the results brought to the quality committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection	21390		11/11/16

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21390	Continued From page 8 control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure proper handwashing to minimize the spread of infection for 1 of -- residents (R125) whose wound care was observed. In addition, the facility's infection prevention and control program lacked pertinent information related to surveillance, investigation, and analysis of staff and resident diseases/infections to minimize infections in the	21390	Plan of correction written 10/27/16. Correction to be completed by 11/11/16.	

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facility, which had the potential to affect all 80 residents.

Findings include:

R125's wound care was observed on 9/28/16 at 10:23 a.m. by registered nurse (RN)-D. RN-D performed the "dirty" part of the dressing change after appropriately washing her hands before putting on gloves to prepare the new dressing and remove the old dressing. After removing the old dressing, RN-D removed her used gloves and put on clean ones without using either soap and water or alcohol hand wash before donning the clean pair. She placed the new dressing on the resident's wound, and adjusted the resident's clothing before replacing the bedcovers, then removed those gloves and used alcohol hand wash to clean her hands. RN-D then tied off the wastebasket liner and carried it in one hand, while carrying her clean dressing supplies bin in the other to a dirty utility room. She set the dressing supplies bin on the floor to free her hand to open the door and discarded the trash. She then emerged from the room and picked up the clean supply bin from the floor.

RN-D was interviewed at 10:33 a.m. about her procedure during the dressing change and stated, "I should have washed my hands again before re-gloving." She was interviewed again at 1:08 p.m. about placing the clean dressing supplies bin on the floor and admitted, "I shouldn't have done that. You don't know what's on the floor."

The facility's handwashing policy was reviewed and indicated, "Handwashing is generally considered the most important single procedure for preventing healthcare associated infection." The procedure directed staff to perform hand

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washing "...After contact with...wound dressings...After removing gloves."

The facility's Infection Surveillance Tracking and Continuous Quality Improvement logs dated 1/1/16, to 8/31/16, lacked pertinent information such as micro-organisms, antibiotic use, symptoms, etc. In addition, the form lacked infection rates, analysis, patterns, etc. The Quality Improvement Conclusions/Actions/Outcome was blank for each of the forms.

The occupational health and learning director (OHL) and director of nursing (DON) were interviewed on 9/29/16, at 9:03 a.m. The OHL and DON explained they both had responsibility for infection control at the facility. The OHL was responsible for both employees and residents, and the DON was primarily responsible for the residents.

In an interview on 9/30/16, at 10:56 a.m. the DON stated infection control concerns were brought to an interdisciplinary (IDT) meeting. Monthly reports were compiled and then those reports were reviewed quarterly infection control issues were reviewed at the quarterly by the IDT. The DON said the microorganism was "sometimes" identified, but they had not documented them on the forms provided to the surveyor. "We have not been documenting our follow up on infections very well and do not have any documentation as to what we have been doing at the daily or monthly meetings." The DON said they talked about infections each morning, and if any new infections were present, they then isolated the persons on that unit by having residents eat in their rooms and limiting activities on the unit. The DON said the discussion of infection control

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issues at the facility happened "more informally than formally. Because we know the residents we know where they are on wings or if they share bathrooms. We try to figure out if there is a relationship with regard to similarities between infections but it is not recorded anywhere."

During an interview on 9/30/16, at 11:01 a.m. the OHL reported they had started conducting staff and patient care audits on rotating shifts and had completed two audits per week during the last four weeks. The OHL stated, "We follow staff and watch cares and correct them immediately." Proper and washing and peri-care was a focus during staff training in 7/16 and 8/16 for all nursing assistants, and all staff had received hand washing training in the past few months. Nurse managers were responsible for filling out an infection control concern form as appropriate. The forms were collected monthly and reviewed quarterly. Because they educated staff on proper hand washing and peri-care, the OHL "the organism doesn't matter." The OHL stated, "We probably should be documenting what we do regarding monitoring and training instead of more informally talking about it at the morning meetings."

The DON was interviewed on 9/30/16, at 10:27 a.m. and stated he would have expected the staff to be tracking and looking at trends such as which microorganisms were involved, resident temperature logs, resident symptoms, etc. Prior to 6/16, tracking and trending of infections was "not very inclusive and did not documented well." The new forms allowed for better tracking and trending, however, the staff were not recording all the information.

SUGGESTED METHOD OF CORRECTION:

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21390	Continued From page 12 The director of nursing (DON) and infection control nurse could ensure staff are trained on infection control prevention techniques. The infection control plan could be reviewed and strengthened consistent with standards of practice. Audits could be conducted and the results brought to the quality committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21390		
21695	MN Rule 4658.1415 Subp. 4 Plant Housekeeping, Operation, & Maintenance Subp. 4. Housekeeping. A nursing home must provide housekeeping and maintenance services necessary to maintain a clean, orderly, and comfortable interior, including walls, floors, ceilings, registers, fixtures, equipment, lighting, and furnishings. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure resident rooms and bathrooms were maintained in good repair and were kept clean in seven resident rooms 120, 121, 123, 126,128,160, and 161. Findings include: On 9/29/16, at 10:04 a.m. the following concerns were identified during an environmental tour, conducted with the environmental service director (ESD): Room 160/161 shared bathroom: The plaster on	21695	Plan of correction written 10/27/16. Correction to be completed by 11/11/16.	11/11/16

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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) COMPLETE DATE
21695	Continued From page 13	21695		

the wall was rough and had sharp, un-sanded edges next to the toilet. A dusty stool riser was stored on the bathroom floor. The safety hand rail had a brown dried smear on the arm handle. This was first observed on 9/23/26 and hand not been cleaned and remained the same when again observed at the time of the tour on 9/29/16. The ESD explained, "The wall was patched last Friday [on 9/23/16]. The maintenance person should have come back on Monday to paint and finished the work. I know this is unsafe and has a potential to cause an injury." The ESD also stated the housekeepers cleaned every day, and they probably picked up the stool riser to clean the floor, and then placed it back where they found it. The ESD then wet paper towel and cleaned off the brown substance from the safety rail and stated, "It is feces."

Room 123: The wall behind the headboard was scraped and rough. The metal cover for heat radiator next to the bed was bent. The ESD reported being unaware of the radiator and stated, "Yes, the radiator is bent. The resident can be injured from that." The ESD explained it could have been bent when staff moved the bed up and down, catching on the radiator.

Room 126: The bathroom sink was pulled away from the wall, leaving a space where the sink should have securely attached. The ESD confirmed the problem and said water could easily get behind the sink, and said, "We just have to prioritize the work...it is on our list to repair."

Room 120/121 the shared bathroom wall had multiple un-repaired holes. The ESD explained there had previously been a towel bar that was removed that "nobody reported to me...the

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	00811	A. BUILDING: _____ B. WING _____	09/30/2016

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21695	Continued From page 14 surface around the hole is rough and has sharp edge which could be hazardous." The ESD also stated, "We have a maintenance request book for the nursing staff to write concerns. The maintenance person will check the book every morning and address the issues. If there are serious issues they will call us right away so it can get fixed." The facility's undated Facility Maintenance Policy read, "It is our intension to keep our facility safe for our resident and keep our equipment in a working order." SUGGESTED METHOD OF CORRECTION: The director of maintenance could ensure a reporting system is in place and necessary repairs are made. Audits could be conducted to ensure staff are cleaning and making timely repairs. The results could be brought to the quality committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21695		
21990	MN St. Statute 626.557 Subd. 4 Reporting - Maltreatment of Vulnerable Adults Subd. 4. Reporting. A mandated reporter shall immediately make an oral report to the common entry point. Use of a telecommunications device for the deaf or other similar device shall be considered an oral report. The common entry point may not require written reports. To the extent possible, the report must be of sufficient content to identify the vulnerable adult, the caregiver, the nature and extent of the suspected maltreatment, any evidence of previous maltreatment, the name and address of the	21990		11/11/16

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21990	Continued From page 15 reporter, the time, date, and location of the incident, and any other information that the reporter believes might be helpful in investigating the suspected maltreatment. A mandated reporter may disclose not public data, as defined in section 13.02, and medical records under section 144.335, to the extent necessary to comply with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to report and thoroughly investigate potential neglect of care/supervision for 1 of 1 complaint investigated, potentially affecting approximately 46 residents who resided on the East and Little Village units. Findings include: E-1's personnel file revealed statements indicating that on the night of 12/1 to 12/2/15, employee E-1 was reportedly in resident rooms, although she was not providing care for the residents at the time. A staff's statement read, "Call lights continued to alarm or residents crawling out of bed or calling out. Every resident that I was checking on or assisting was checking on or assisting was soaking wet, pads, underwear, soaker pad underneath them. This would be with resident she was just recently in with or had already completed rounds...Noticed she was working on toileting sheet for the night as to when she did rounds, mid-way through the night I noticed she was working on the sheets again...She had 2 different toileting sheets going with the same information...The clean glasses were mixed in with dirty glasses and milk was spilled all over them...Appeared she was taking frequent bathroom breaks when she had been	21990	Plan of correction written 10/27/16. Correction to be completed by 11/11/16.	

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21990	Continued From page 16	21990		

there just shortly before that or when she walked down the hall she disappeared in rooms for long periods of time...This went on throughout the night." E-1 was removed from the schedule that night, however, the potential neglect of care was not immediately reported to the designated State agency (SA).

On 12/13/15, an Employee/Facility Concerns Form indicated E-1 reportedly "Left residents alone in Village" (memory care unit). A nurse observed E-1 taking an unauthorized break and was seen coming indoors, having been outside. Another staff person wrote a statement indicating she had witnessed E-1 emerging from the break room and then going back to the break room. "Action taken: Continue to monitor."

The file also contained a report dated 12/17/15, regarding an incident involving E-1, including from a NA who found E-1 sleeping in a resident's room. Employee Notes read, "Multiple complaints about the care levels provided by [E-1] tonight...At 5:30 am [E-1] left a note on the clipboard that she had left the building ill. She had not reported her departure to any staff person or this writer. There was no evidence of her being sick and she did not tell this writer she was sick moments before during the conversation." An Employee Warning Notice read, "We found a note at the desk that said you had left early at 5:30 a.m., ill or sick. You did not tell the charge nurse or Administrator who was in the building. This essentially means you left the residents...This cannot happen again...Action to be taken: Written warning at this time, but this cannot happen again. Leaving the floor and not reporting is abandonment of residents and will result in immediate termination. Leaving without notice is considered a voluntary separation." The incident was not reported to the

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21990	Continued From page 17 SA. On the night of 1/30 to 1/31/16, E-1 was responsible for the care of residents on the East unit, rooms (110-1 to 131-1). Police were dispatched to the facility at approximately 2:16 a.m. to respond to an non-responsive resident who resided on the East wing. After the officers a nurse informed them the resident had do not resucitate wishes. The nurse expressed concern and asked for assistance from the officers regarding E-1's alleged impaired condition. E-1 was removed from the schedule for the rest of the shift, however, the incident was not immediately reported to the SA. A log of allegations reported to the SA revealed no incidents related to potential neglect of cares/supervision had been reported and investigated during the months of 12/15 or 1/16. E-1 was scheduled to work 25 of 29 days (two days unavailable for review) from 1/1/16 to 1/31/16, and although could have been paired on the west unit where two nursing assistants (NAs) worked together, was assigned alone on either the East or Little Village memory care unit with a nurse who worked between the two units. The director of nursing (DON) was interviewed on 9/30/16, at 1:21 p.m. The DON indicated that although he had worked with E-1, he was not the DON but the nurse manager at the time. The DON said E-1 was the "most competent nursing assistant in the building," but had been making odd statements and was displaying odd behavior. He was not fully apprised of the situation, but was aware the former administrator provided re-education for E-1. It was the DON's opinion E-1 should not have been allowed to return to	21990		

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21990	Continued From page 18	21990		

work on the nights in question, particularly after leaving the residents unattended. The DON said the surveyor had the entire file, and he knew of no other related reports or investigations. "As for a VA [vulnerable adult] report, I don't think there was anything...Investigation? Only what's in the file." The DON stated in hindsight, he felt the whole situation should have been handled differently.

The administrator was interviewed on 9/30/16, at 3:15 p.m. He reported that since learning of the situation with E-1 (prior to his employment), they had talked between facilities as well as to local law enforcement to determine how to handle future situations. The administrator stated they realized what they had been doing (to address potential concerns with staff) "had not been effective" and they had a responsibility to protect the residents.

The facility's undated Abuse Prohibition/Vulnerable Adult Plan indicated, "Immediately, upon learning of the incident, staff will take necessary actions to protect residents from possible subsequent incidents of misconduct or injury while the matter is being investigated...Notify the the Minnesota Department of Health (MDH) immediately after discovery of the incident...Investigation will begin in accordance with Federal Law."

SUGGESTED METHOD OF CORRECTION:
The DON or designee, could ensure all staff are trained regarding abuse prohibition. Management staff could review procedures to ensure an understanding and methods developed to ensure policies are operationalized. Observational audits of cares could be made on all shifts to ensure care is provided according to residents' care

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21990	Continued From page 19 plans. The audits could be brought to the quality committee for review. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21990		
21995	MN St. Statute 626.557 Subd. 4a Reporting - Maltreatment of Vulnerable Adults Subd. 4a. Internal reporting of maltreatment. (a) Each facility shall establish and enforce an ongoing written procedure in compliance with applicable licensing rules to ensure that all cases of suspected maltreatment are reported. If a facility has an internal reporting procedure, a mandated reporter may meet the reporting requirements of this section by reporting internally. However, the facility remains responsible for complying with the immediate reporting requirements of this section. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to follow their policy for reporting and thoroughly investigating potential neglect of care/supervision for 1 of 1 complaints investigated, potentially affecting approximately 46 residents who resided on the East and Little Village units. Findings include: The facility's undated Abuse Prohibition/Vulnerable Adult Plan indicated, "Immediately, upon learning of the incident, staff will take necessary actions to protect residents from possible subsequent incidents of misconduct or injury while the matter is being	21995	Plan of correction written 10/27/16. Correction to be completed by 11/11/16.	11/11/16

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21995	Continued From page 20	21995		

investigated...Notify the the Minnesota Department of Health (MDH) immediately after discovery of the incident...Investigation will begin in accordance with Federal Law."

E-1's personnel file revealed statements indicating that on the night of 12/1 to 12/2/15, employee E-1 was reportedly in resident rooms, although she was not providing care for the residents at the time. A staff's statement read, "Call lights continued to alarm or residents crawling out of bed or calling out. Every resident that I was checking on or assisting was checking on or assisting was soaking wet, pads, underwear, soaker pad underneath them. This would be with resident she was just recently in with or had already completed rounds...Noticed she was working on toileting sheet for the night as to when she did rounds, mid-way through the night I noticed she was working on the sheets again...She had 2 different toileting sheets going with the same information...The clean glasses were mixed in with dirty glasses and milk was spilled all over them...Appeared she was taking frequent bathroom breaks when she had been there just shortly before that or when she walked down the hall she disappeared in rooms for long periods of time...This went on throughout the night." E-1 was removed from the schedule that night, however, the potential neglect of care was not immediately reported to the designated State agency (SA).

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21995	Continued From page 21 room and then going back to the break room. "Action taken: Continue to monitor." The file also contained a report dated 12/17/15, regarding an incident involving E-1, including from a NA who found E-1 sleeping in a resident's room. Employee Notes read, "Multiple complaints about the care levels provided by [E-1] tonight...At 5:30 am [E-1] left a note on the clipboard that she had left the building ill. She had not reported her departure to any staff person or this writer. There was no evidence of her being sick and she did not tell this writer she was sick moments before during the conversation." An Employee Warning Notice read, "We found a note at the desk that said you had left early at 5:30 a.m., ill or sick. You did not tell the charge nurse or Administrator who was in the building. This essentially means you left the residents...This cannot happen again...Action to be taken: Written warning at this time, but this cannot happen again. Leaving the floor and not reporting is abandonment of residents and will result in immediate termination. Leaving without notice is considered a voluntary separation." The incident was not reported to the SA. On the night of 1/30 to 1/31/16, E-1 was responsible for the care of residents on the East unit, rooms (110-1 to 131-1). Police were dispatched to the facility at approximately 2:16 a.m. to respond to an non-responsive resident who resided on the East wing. After the officers a nurse informed them the resident had do not resucitate wishes. The nurse expressed concern and asked for assistance from the officers regarding E-1's alleged impaired condition. E-1 was removed from the schedule for the rest of the shift, however, the incident was not immediately reported to the SA.	21995		

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21995	Continued From page 22 A log of allegations reported to the SA revealed no incidents related to potential neglect of cares/supervision had been reported and investigated during the months of 12/15 or 1/16. E-1 was scheduled to work 25 of 29 days (two days unavailable for review) from 1/1/16 to 1/31/16, and although could have been paired on the west unit where two nursing assistants (NAs) worked together, was assigned alone on either the East or Little Village memory care unit with a nurse who worked between the two units. The director of nursing (DON) was interviewed on 9/30/16, at 1:21 p.m. The DON indicated that although he had worked with E-1, he was not the DON but the nurse manager at the time. The DON said E-1 was the "most competent nursing assistant in the building," but had been making odd statements and was displaying odd behavior. He was not fully apprised of the situation, but was aware the former administrator provided re-education for E-1. It was the DON's opinion E-1 should not have been allowed to return to work on the nights in question, particularly after leaving the residents unattended. The DON said the surveyor had the entire file, and he knew of no other related reports or investigations. "As for a VA [vulnerable adult] report, I don't think there was anything...Investigation? Only what's in the file." The DON stated in hindsight, he felt the whole situation should have been handled differently. The administrator was interviewed on 9/30/16, at 3:15 p.m. He reported that since learning of the situation with E-1 (prior to his employment), they had talked between facilities as well as to local law enforcement to determine how to handle	21995		

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21995	Continued From page 23 future situations. The administrator stated they realized what they had been doing (to address potential concerns with staff) "had not been effective" and they had a responsibility to protect the residents. SUGGESTED METHOD OF CORRECTION: The DON or designee, could ensure all staff are trained regarding abuse prohibition. Management staff could review procedures to ensure an understanding and methods developed to ensure policies are operationalized. Observational audits of cares could be made on all shifts to ensure care is provided according to residents' care plans. The audits could be brought to the quality committee for review. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21995		