DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

					AND TRANSMITTAL		ID: I	
	PART I	TO BE COMPI	LETED BY 1	THE STAT	TE SURVEY AGENCY	1	Facili	ity ID: 00811
MEDICARE/MEDICAID PRO (L1) 245514 2.STATE VENDOR OR MEDICA		3. NAME AND AI (L3) MALA STR (L4) 1001 COLU	ANA CARE &	k REHABII	LITATION CENTER	1. Initia		7 (L8)
(L2) 227432200	AID NO.	(L5) NEW PRAG			(L6) 56071	3. Term 5. Valid 7. On-S	ation 6	l. CHOW 5. Complaint 9. Other
5. EFFECTIVE DATE CHANGE (L9) 07/01/2015	OF OWNERSHIP	7. PROVIDER/SU 01 Hospital	JPPLIER CATEO	GORY 09 ESRD	02 (L7) 13 PTIP 22 CLIA		Survey After Com	
6. DATE OF SURVEY8. ACCREDITATION STATUS:	1/23/2016 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct	06 PRTF 07 X-Ray	10 NF 11 ICF/IID	14 CORF 15 ASC	FISCAL YI	EAR ENDING D	OATE: (L35)
0 Unaccredited 1 TJu 2 AOA 3 Ott		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	0	9/30	
11LTC PERIOD OF CERTIFICA	TION	10.THE FACILITY	IS CERTIFIED	AS:				
From (a):		X A. In Complia	ance With		And/Or Approved Waivers Of	The Following	Requirements:	
To (b):		_	equirements		2. Technical Personne	1 _ 6.	Scope of Service	s Limit
		Compliance	e Based On:		3. 24 Hour RN	7.	Medical Director	ſ
12. Total Facility Beds	90 (L18)	1. A	cceptable POC		4. 7-Day RN (Rural S	NF) 8.	Patient Room Size	e
13.Total Certified Beds	90 (L18) 90 (L17)	B. Not in Comp	liance with Progr	ram	5. Life Safety Code		Beds/Room	
		Requirements	and/or Applied	Waivers:	* Code: A	(L12)		
14. LTC CERTIFIED BED BREAD	KDOWN				15. FACILITY MEETS			
18 SNF 18/19 S 90	SNF 19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):		(L15)	
(L37) (L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY F	REMARKS (IF APPLIC	ABLE SHOW LTC CA	ANCELLATION	DATE):				
See Attached Remarks								
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	Y APPROVAL		Date:
Gayle Lantto, Un	it Supervisor		01/06/2017	(L19)	Mark Meath	、, Enforcem	ent Specialist	01/06/2017 (L20
	PART II - TO BE	COMPLETED I	BY HCFA RI	EGIONAL	OFFICE OR SINGLE S	STATE AGI	ENCY	
19. DETERMINATION OF ELIG	GIBILITY		IPLIANCE WIT	H CIVIL	21. 1. Statement of Fina 2. Ownership/Contr	-	,	CA 1512)
X 1. Facility is Eligible	e to Participate	KIGI	115 AC1:		3. Both of the Abov		iosure Simi (HCF	A-1313)
2. Facility is not Eli	gible (L21)							
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREE	MENT	26. TERMINATION ACTION	I:	(L30)	
OF PARTICIPATION 02/01/1988	BEGINNIN	G DATE	ENDING DA	TE	VOLUNTARY 01-Merger, Closure	0_	INVOLUNTAR 05-Fail to Meet	
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs	sement	06-Fail to Meet	Agreement
25. LTC EXTENSION DATE:		IVE SANCTIONS	. ,		03-Risk of Involuntary Terminati	on	OTHER	
	A. Suspension	n of Admissions:			04-Other Reason for Withdrawal	l	07-Provider Sta	tus Change
(L27)	R Rescind S	uspension Date:	(L44)				00-Active	
	D. Reseniu S	aspension Date.	(L45)					
28. TERMINATION DATE:	2	9. INTERMEDIARY	CARRIER NO.		30. REMARKS			

(L31)

(L33)

DETERMINATION APPROVAL

06201

11/15/2016

32. DETERMINATION OF APPROVAL DATE

(L28)

(L32)

31. RO RECEIPT OF CMS-1539

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00811

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.



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 Weath

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



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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONSTRUCTION		DATE OF REVISIT	Γ
IDENTIFICATION NUMBER	A. Building			
245514 _{Y1}	B. Wing	Y2	11/23/2016	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE		
MALA STRANA CARE & REHABIL	ITATION 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).

ITEI Y4			ATE Y5	ITEM Y4			DATE Y5	ITEM Y4			DATE Y5
ID Prefix Reg. # LSC	F0225 483.13(c)(1)(ii)-(ii - (4)	i), (c)(2) Com	ection pleted /2016	ID Prefix Reg. # LSC	F0226 483.13(c)	Correction Completed 11/11/2016	ID Prefix Reg. # LSC	F0253 483.15(h)(2)		Correction Completed 11/11/2016
ID Prefix Reg. # LSC	F0280 483.20(d)(3), 483 (2)	.10(k) Com	ection pleted /2016	ID Prefix Reg. # LSC	F0285 483.20(m), 483.20(e)	Correction Completed 11/11/2016	ID Prefix Reg. # LSC	F0309 483.25		Correction Completed 11/11/2016
ID Prefix Reg. # LSC	F0356 483.30(e)	Com	ection pleted /2016	ID Prefix Reg. # LSC	F0441 483.65		Correction Completed 11/11/2016	ID Prefix Reg. # LSC			Correction Completed
ID Prefix Reg. # LSC			ection pleted	ID Prefix Reg. # LSC			Correction Completed	ID Prefix Reg. # LSC			Correction Completed
ID Prefix Reg. # LSC			ection	ID Prefix Reg. # LSC			Correction Completed	ID Prefix Reg. # LSC			Correction Completed
REVIEWE STATE AG REVIEWE CMS RO	D BY	REVIEWED BY (INITIALS)	L/mm	DATE 01/06/2		SIGNATURE OF S	15507	WAQ 4 80	WADY OF	DATE 11/23	3/2016
9/30/2010	JP TO SURVEY CO	OMPLETED ON					ED DEFICIENCIES S (CMS-2567) SEN			YES	s 🗆 no

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	ER / SUPPLIER / CLIA /	MULTIPLE CONS	STRUCTION						DATE OF	REVISIT
245514	CATION NUMBER Y1	A. Building 01 B. Wing	- MAIN BUII	LDING 01				Y2	11/15/20)16 _{Y3}
NAME O	F FACILITY				STREET ADD	RESS, CIT	Y, STATE, ZIP	CODE		
MALA S	TRANA CARE & REHABI	LITATION CENTE	ER		1001 COLUM	BUS AVEN	UE NORTH			
					NEW PRAGU	E, MN 5607	71			
program correcte provision	ort is completed by a qual i, to show those deficienci d and the date such corre n number and the identific ey report form).	es previously repo ctive action was a	orted on the accomplishe	CMS-2567, State d. Each deficiend	ement of Deficion	encies and ly identifie	Plan of Cor d using eithe	rection, that have er the regulation or	r LSC	
ITE	EM	DATE	ITEM		DA	ATE	ITEM			DATE
Y	4	Y5	Y4			Y5	Y4			Y5
ID Prefix		Correction	ID Prefix		Cor	rection	ID Prefix			Correction
Reg. #	NFPA 101	Completed	Reg. #	NFPA 101	Con	npleted	Reg. #	NFPA 101		Completed
LSC	K0018	11/11/2016	LSC	K0021	11/1	1/2016	LSC	K0025		11/11/2016
ID Prefix		Correction	ID Prefix		Cor	rection	ID Prefix			Correction
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Reg.#	NFPA 101	Completed	Reg. #	NFPA 101	Con	npleted	Reg. #			Completed
LSC	K0038	11/11/2016	LSC	K0062	11/1	1/2016	LSC			
ID Prefix		Correction	ID Prefix		Cor	rection	ID Prefix			Correction
Reg.#		Completed	Reg. #		Con	npleted	Reg. #			Completed
LSC			LSC				LSC			
ID Prefix		Correction	ID Prefix		Cor	rection	ID Prefix			Correction
Reg.#		Completed	Reg. #		Con	npleted	Reg. #			Completed
LSC		_	LSC				LSC			
ID Prefix		Correction	ID Prefix		Cor	rection	ID Prefix			Correction
Reg. #		Completed	Reg. #		Con	npleted	Reg. #			Completed
LSC		_	LSC				LSC			

(INITIALS) CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF FOLLOWUP TO SURVEY COMPLETED ON UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? 9/28/2016 YES NO

TITLE

DATE

DATE

01/06/2017

X

REVIEWED BY

REVIEWED BY

(INITIALS) TL/mm

REVIEWED BY

REVIEWED BY

CMS RO

STATE AGENCY

SIGNATURE OF SURVEYOR

37008

DATE

DATE

11/15/2016

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: K24X

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

	PART	I - TO BE COM	PLETED BY T	HE STATI	E SURVEY AG	SENCY	F	acility ID: 00811
MEDICARE/MEDICAID PROVIDE (L1)		3. NAME AND ADD (L3) MALA STRA (L4) 1001 COLUM (L5) NEW PRAG	ANA CARE & RE MBUS AVENUE I	EHABILITA		56071	4. TYPE OF ACTION: 1. Initial 3. Termination 5. Validation	2 (L8) 2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF C (L9) 07/01/2015		7. PROVIDER/SUI	05 HHA	09 ESRD	<u>02</u> (L7)) 22 CLIA	7. On-Site Visit 8. Full Survey After Co	9. Other mplaint
6. DATE OF SURVEY 09 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Othe	/30/2016 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE		FISCAL YEAR ENDING 09/30	DATE: (L35)
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12. Total Facility Beds 13. Total Certified Beds 14. LTC CERTIFIED BED BREAKDOV 18 SNF 18/19 SN 90 (L37) (L38) 16. STATE SURVEY AGENCY REMARKS	90 (L18) 90 (L17) WN IF 19 SNF (L39)	X B. Not in Com Requirements :	nce With quirements Based On: Acceptable POC upliance with Program and/or Applied Waiv IID (L43)	n	2. Tech 3. 24 F 4. 7-Da	nnical Personnel Hour RN ay RN (Rural SNF) Safety Code B* MEETS	Following Requirements: 6. Scope of Servi 7. Medical Direc 8. Patient Room S 9. Beds/Room (L12) (L15)	tor
See Attached Remarks								
17. SURVEYOR SIGNATURE Mary Bruess, HFE	NEII	Date :	10/30/2016	(L19)		VEY AGENCY API	Enforcement Special	Date: 11/14/2016 (L20)
	PART II - TO	BE COMPLETE	D BY HCFA RI	EGIONAL	OFFICE OR S	SINGLE STAT	E AGENCY	
DETERMINATION OF ELIGIBIL	Participate		IPLIANCE WITH C	CIVIL	2. (ial Solvency (HCFA-2572) interest Disclosure Stmt (HCFA	-1513)
22. ORIGINAL DATE OF PARTICIPATION 02/01/1988 (L24)	23. LTC AGREEM BEGINNING (L41)		24. LTC AGREEME ENDING DATE (L25)		26. TERMINAT VOLUNTARY 01-Merger, Closu 02-Dissatisfaction	00	INVOLUNT 05-Fail to Mo	ARY eet Health/Safety et Agreement
25. LTC EXTENSION DATE: (L27)	27. ALTERNATIV A. Suspension B. Rescind Sus	of Admissions:	(L44) (L45)		03-Risk of Involu 04-Other Reason	ntary Termination for Withdrawal	OTHER 07-Provider 00-Active	Status Change
28. TERMINATION DATE:	29	O. INTERMEDIARY/C	CARRIER NO.		30. REMARKS			
		06201						
	(L28)			(L31)				
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION (OF APPROVAL DA	TE				
	(L32)			(L33)	DETERMINA	ATION APPRO	VAL	

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00811

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.



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:

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Gayle Lantto, Unit Supervisor 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:

Page 3

- 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.

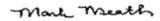
Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

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

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PRINTED: 10/28/2016 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245514	B. WING _	·····	09/	30/2016
	ROVIDER OR SUPPLIER	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1001 COLUMBUS AVENUE NORTH NEW PRAGUE, MN 56071	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 000	as your allegation of Department's accept enrolled in ePOC, y at the bottom of the form. Your electronic be used as verificate Upon receipt of an on-site revisit of you validate that substate regulations has been	of correction (POC) will serve of compliance upon the otance. Because you are your signature is not required of first page of the CMS-2567 ic submission of the POC will	F 00	00		
F 225 SS=E	completed at the tir complaint was subsidered at F225 483.13(c)(1)(ii)-(iii), INVESTIGATE/REFALLEGATIONS/INE The facility must not been found guilty of mistreating residenthad a finding enterer registry concerning of residents or miss and report any known court of law against indicate unfitness for other facility staff to or licensing authorities.	(c)(2) - (4) PORT DIVIDUALS It employ individuals who have f abusing, neglecting, or ts by a court of law; or have ed into the State nurse aide abuse, neglect, mistreatment appropriation of their property; wledge it has of actions by a can employee, which would or service as a nurse aide or the State nurse aide registry ties.	F 22	25		11/11/16
ABOD: 70 -:	involving mistreatm including injuries of	sure that all alleged violations ent, neglect, or abuse, unknown source and		TITLE		(X6) DATE

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

(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.

	ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245514	B. WING		09/30/20)16	
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F 225	immediately to the to other officials in through established State survey and control of the facility must have a survey and control of the facility must have a survey and control of the facility must have a survey and the facility must have a survey and investigation is in pure the facility of all in to the administrator of the facility of the fac	resident property are reported administrator of the facility and accordance with State law diprocedures (including to the ertification agency). Ave evidence that all alleged ughly investigated, and must ential abuse while the rogress. Vestigations must be reported	F 225				
	by: Based on interview facility failed to report potential neglect of complaint investigated approximately 46 research and Little Villa Findings include: E-1's personnel file indicating that on the employee E-1 was although she was residents at the time "Call lights continued"	NT is not met as evidenced and document review, the ort and thoroughly investigate care/supervision for 1 of 1 ted, potentially affecting esidents who resided on the ge units. Tevealed statements are night of 12/1 to 12/2/15, reportedly in resident rooms, not providing care for the e. A staff's statement read, ed to alarm or residents or calling out. Every resident		To ensure all staff is trained regard abuse prohibition an in-service will completed on November 2nd. The president of operations will be comi speak on this date regarding susper maltreatment and reporting procedured we have also implemented a procestress dealing with employees who behaviors that could put our resider risk. While we still have a drug test policy that we use when appropriate are educating staff to report to management or person in charge a behaviors that could be deemed had to residents. Staff members have a been educated to make arrangement.	be vice ng to cted ures. ess to exhibit nts at ing e, we ny rmful also		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIE	R HABILITATION CENTER		10	TREET ADDRESS, CITY, STATE, ZIP CODE 2011 COLUMBUS AVENUE NORTH EW PRAGUE, MN 56071		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
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F 225	on or assisting was underwear, soaked would be with reswith or had already she was working as to when she did night I noticed she againShe had 2 with the same information were mixed in with spilled all over the frequent bathroom there just shortly I down the hall she periods of timeIn night." E-1 was renight, however, the not immediately reagency (SA). On 12/13/15, and Form indicated E-alone in Village" (observed E-1 taking was seen coming Another staff personand then go "Action taken: Co The file also contaregarding an incide from a NA who for room. Employee I about the care leved 5:30 am [E-1] left had left the building would be with the same in the	ange 2 ang on or assisting was checking as soaking wet, pads, or pad underneath them. This ident she was just recently in any completed roundsNoticed on toileting sheet for the night drounds, mid-way through the end was working on the sheets of different toileting sheets going ormationThe clean glasses in dirty glasses and milk was emAppeared she was taking in breaks when she had been before that or when she walked disappeared in rooms for long of this went on throughout the emoved from the schedule that the potential neglect of care was exported to the designated State. Employee/Facility Concerns and unauthorized break and indoors, having been outside. Son wrote a statement indicating die-1 emerging from the break sing back to the break room. Intinue to monitor." Jained a report dated 12/17/15, dent involving E-1, including und E-1 sleeping in a resident's vels provided by [E-1] tonightAt a note on the clipboard that she ing ill. She had not reported her staff person or this writer. There		225	have the employee removed from hany resident contact and to secure means of transport home. The Administrator along with input from and Nurse Managers will then file a and investigate the situation, and determine the best course of action that employee that safeguards our residents. Observational audits will be completensure care is provided according the residents care plans. Audits will be completed weekly for 1 month, follow by biweekly for 2 months and then monthly for 3 months. The audits were reviewed at the Quality Assurance meetings for review to assess on-geneed.	DON VA of for eted to to the owed	

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F 225	not tell this writer sl during the conversa Notice read, "We for said you had left ead did not tell the char was in the building. left the residents	Ther being sick and she did ne was sick moments before ation." An Employee Warning and a note at the desk that arly at 5:30 a.m., ill or sick. You ge nurse or Administrator who This essentially means you This cannot happen taken: Written warning at this at happen again. Leaving the ing is abandonment of esult in immediate termination. ince is considered a voluntary acident was not reported to the acility at approximately 2:16 an non-responsive resident East wing. After the officers a mether resident had do not The nurse expressed concern stance from the officers ged impaired condition. E-1 the schedule for the rest of the incident was not immediately	F 2	25			

	TEMENT OF DEFICIENCIES OPLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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F 225	the East or Little V nurse who worked The director of nur 9/30/16, at 1:21 p.1 although he had w DON but the nurse DON said E-1 was assistant in the but odd statements and He was not fully an aware the former a re-education for E-E-1 should not have work on the nights leaving the resider the surveyor had the report of the surveyor had the report of the surveyor had the surveyor had they be the survey	vas assigned alone on either illage memory care unit with a between the two units. sing (DON) was interviewed on m. The DON indicated that orked with E-1, he was not the manager at the time. The the "most competent nursing ilding," but had been making d was displaying odd behavior. Oprised of the situation, but was administrator provided in the authorist provided in the property of the provided in the provided	, E 2	225			

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F 225	from possible subs misconduct or injur investigatedNotify Department of Head discovery of the ind in accordance with	actions to protect residents equent incidents of y while the matter is being the the Minnesota (MDH) immediately after cidentInvestigation will begin Federal Law."	F 22				
F 226 SS=E	policies and proced mistreatment, negl	, ETC POLICIES evelop and implement written	F 22	26		11/11/16	
	by: Based on interview facility failed to folk thoroughly investig care/supervision for investigated, poten 46 residents who revillage units. Findings include: The facility's undate Prohibition/Vulnera "Immediately, upor will take necessary from possible subsemisconduct or injurinvestigatedNotific Department of Head	tially affecting approximately esided on the East and Little		To ensure all staff is trained regard abuse prohibition an in-service will completed on November 2nd. The president of operations will be comspeak on this date regarding suspensaltreatment and reporting proced. We have also implemented a procestress dealing with employees who behaviors that could put our residerisk. While we still have a drug test policy that we use when appropriate are educating staff to report to management or person in charge a behaviors that could be deemed hat to residents. Staff members have a been educated to make arrangement any resident contact and to secure means of transport home. The	be vice ing to ected ures. ess to exhibit nts at ting e, we any armful also ents to naving		

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F 226	indicating that on the employee E-1 was although she was residents at the time. "Call lights continuate crawling out of beet that I was checking on or assisting was underwear, soaker would be with reside with or had already she was working of as to when she did night I noticed she again She had 2 with the same inforwere mixed in with spilled all over their frequent bathroom there just shortly be down the hall she of periods of time The not immediately reagency (SA). On 12/13/15, an Eform indicated E-1 alone in Village" (nobserved E-1 taking was seen coming in Another staff persons she had witnessed	Federal Law." Perevealed statements the night of 12/1 to 12/2/15, reportedly in resident rooms, not providing care for the the. A staff's statement read, and to alarm or residents or calling out. Every resident of on or assisting was checking as soaking wet, pads, and underneath them. This dent she was just recently in a completed roundsNoticed on toileting sheet for the night of rounds, mid-way through the was working on the sheets different toileting sheets going and mationThe clean glasses dirty glasses and milk was mAppeared she was taking breaks when she had been refore that or when she walked disappeared in rooms for long his went on throughout the moved from the schedule that the potential neglect of care was ported to the designated State of the properties o	F 22	Administrator along with input and Nurse Managers will the and investigate the situation, determine the best course of that employee that safeguard residents Observational audits will be ensure care is provided accoresidents care plans. Audits completed weekly for 1 monthly biweekly for 2 months and monthly for 3 months. The areviewed at the Quality Assumeetings for review to assessineed.	en file a VA , and f action for ds our completed to ording to the will be th, followed d then udits will be irance	

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F 226	regarding an incide from a NA who four room. Employee Nabout the care level 5:30 am [E-1] left a had left the buildin departure to any swas no evidence on tell this writer suring the converse Notice read, "We four said you had left edid not tell the chawas in the building left the residents again Action to be time, but this cann floor and not repor residents and will be Leaving without not separation." The in SA. On the night of 1/3 responsible for the unit, rooms (110-1) dispatched to the found asked for assist regarding E-1's allows removed from	ined a report dated 12/17/15, ent involving E-1, including and E-1 sleeping in a resident's lotes read, "Multiple complaints els provided by [E-1] tonightAt a note on the clipboard that she gill. She had not reported her taff person or this writer. There is ther being sick and she did she was sick moments before ation." An Employee Warning ound a note at the desk that arly at 5:30 a.m., ill or sick. You rge nurse or Administrator who. This essentially means you This cannot happen at taken: Written warning at this of happen again. Leaving the ting is abandonment of result in immediate termination. Since is considered a voluntary incident was not reported to the accuracy of residents on the East to 131-1). Police were accility at approximately 2:16 an non-responsive resident estat wing. After the officers a tem the resident had do not The nurse expressed concern stance from the officers eged impaired condition. E-1 the schedule for the rest of the incident was not immediately	F2	226			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
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F 226	A log of allegations no incidents related cares/supervision hinvestigated during E-1 was scheduled days unavailable for 1/31/16, and althouthe west unit where worked together, with the East or Little Vinurse who worked The director of nurse 9/30/16, at 1:21 p.r. although he had wo DON but the nurse DON said E-1 was assistant in the built odd statements and He was not fully apaware the former a re-education for E-E-1 should not hav work on the nights leaving the residenthe surveyor had the no other related repairs and the surveyor had the surv	reported to the SA revealed to potential neglect of had been reported and the months of 12/15 or 1/16. to work 25 of 29 days (two or review) from 1/1/16 to gh could have been paired on two nursing assistants (NAs) as assigned alone on either lage memory care unit with a between the two units. Sing (DON) was interviewed on n. The DON indicated that orked with E-1, he was not the manager at the time. The the "most competent nursing ding," but had been making d was displaying odd behavior. prised of the situation, but was dministrator provided 1. It was the DON's opinion to been allowed to return to in question, particularly after its unattended. The DON said the entire file, and he knew of corts or investigations. "As for lult] report, I don't think there instigation? Only what's in the entire file and he knew of corts or investigations. "As for lult] report, I don't think there instigation? Only what's in the entire file and he knew of corts or investigations. "As for lult] report, I don't think there is stigation? Only what's in the entire file and he knew of corts or investigations. "As for lult] report, I don't think there is tigation? Only what's in the entire file as well as to local determine how to handle	F 220			

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F 226	future situations. The realized what they have potential concerns	ge 9 ne administrator stated they nad been doing (to address with staff) "had not been nad a responsibility to protect	F 2	26		
F 253 SS=E	maintenance service sanitary, orderly, and This REQUIREMEN		F 2	53		11/11/16
	review, the facility frand bathrooms were and were kept clear 121, 123, 126,128, Findings include: On 9/29/16, at 10:0 were identified durit conducted with the (ESD): Room 160/161 shat the wall was rough edges next to the to stored on the bathrohad a brown dried swas first observed or cleaned and remain observed at the tim ESD explained, "The	ion, interview and document ailed to ensure resident rooms e maintained in good repair in seven resident rooms 120, 160, and 161. 4 a.m. the following concernsing an environmental tour, environmental service director and had sharp, un-sanded oilet. A dusty stool riser was soom floor. The safety hand rail smear on the arm handle. This on 9/23/26 and hand not been need the same when again e of the tour on 9/29/16. The wall was patched last Friday aintenance person should		The affected resident rooms have been repaired and cleaned and le good working condition. All resident rooms and bathrooms been checked for cleanliness and ensure that walls, floors, sinks, et good repair/working condition. On 11/2/16 housekeeping staff wil re-educated on the proper proced cleaning bathrooms and cleaning risers and the importance of docu needed repairs in the maintenance books. Nursing staff will also be educated on documentation of ne repairs in the maintenance log boot 11/7/16. Also on 11/2/16 maintenance staff educated on the process for docu progress or completion of work or the maintenance log books. Environmental Services Director we conduct random audits of houseke staff tasks will monitor the maintenance.	ft in s have to c. are in Il be ures for toilet menting e logs eded oks on f will be menting der in vill eeping	

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F 253	have come back or the work. I know the to cause an injury." housekeepers clea probably picked up floor, and then place The ESD then wet the brown substance stated, "It is feces." Room 123: The was craped and rough radiator next to the reported being una stated, "Yes, the racean be injured from could have been be up and down, catch Room 126: The bast from the wall, leaving should have secure confirmed the probeasily get behind the have to prioritize the repair." Room 120/121 the multiple un-repaired there had previously removed that "nobe surface around the edge which could be stated, "We have a the nursing staff to maintenance persomorning and addressive consideration of the stated of the staff to maintenance persomorning and addressive cleans and the staff to maintenance persomorning and addressive cleans are injured.	n Monday to paint and finished is is unsafe and has a potential. The ESD also stated the ned every day, and they the stool riser to clean the ed it back where they found it. paper towel and cleaned off the from the safety rail and	F 25	log books weekly to make being completed satisfacto Monthly environmental/safe be completed by departme reported to QA committee.	rily and timely. ety audits will nt directors and	

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F 253	Continued From pa	ge 11	F 253			
F 280	read, "It is our inter	ed Facility Maintenance Policy asion to keep our facility safe the keep our equipment in a	F 280		11/11/16	
SS=D	PARTICIPATE PLA	NNÍNG CARE-REVISE CP	1 200		11/11/10	
	incompetent or othe incapacitated unde	r the laws of the State, to ing care and treatment or				
	within 7 days after to comprehensive assinterdisciplinary teat physician, a register for the resident, and disciplines as deter and, to the extent puthe resident, the relegal representative	are plan must be developed the completion of the sessment; prepared by an m, that includes the attending red nurse with responsibility d other appropriate staff in mined by the resident's needs, tracticable, the participation of sident's family or the resident's e; and periodically reviewed am of qualified persons after				
	by: Based on interview facility failed to ens coordinated and re	NT is not met as evidenced and document review the ure the care plan was vised as needed related to esident (R23) reviewed for		Affected resident s care plan was updated to reflect current needs an coordination of care with hospice. All residents , receiving hospice se care plans were reviewed and update reflect current needs and coordinate.	ervices, ated to	

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	PROVIDER OR SUPPLIER	ABILITATION CENTER	1	STREET ADDRESS, CITY, STATE, ZIP CODE 1001 COLUMBUS AVENUE NORTH NEW PRAGUE, MN 56071	•	
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F 280	R23's facility hosp 4/22/15, prior to he "Maintain commur hospice" R23's resident had been 7/23/16. The Heartland Hos reviewed and indica tub bath, shamp shaving, and mois cares. Registered nurse interview on 9/30/1 nurse visited R23 nurse was unsure explained she was hospice disciplines R23 stating "They stated that she did between hospice and services betw. NA visited weekly, extra bath or comf RN-A was unsure scheduled, or wha R23. Communicat and the facility too of visits, or by pho between visits. Facility NAs were at the hospice NA was NA-D stated on 9/3 sure when the hosp m. NA-A indicates or I'm not sure hospice hospice in the hospice NA was NA-D stated on 9/3 sure when the hosp m. NA-A indicates or I'm not sure hospice NA was not sure when the hosp m. NA-A indicates or I'm not sure hospice NA was not sure when the hospice NA was NA-D stated on 9/3 sure when the hospice NA was NA-D stated on 9/3 sure when the hospice NA was NA-D stated on 9/3 sure when the hospice NA was NA-D stated on 9/3 sure when the hospice NA was NA-D stated on 9/3 sure when the hospice NA was NA-D stated on 9/3 sure when the hospice NA was NA-D stated on 9/3 sure when the hospice NA was NA-D stated on 9/3 sure when the hospice NA was NA-D stated on 9/3 sure when the hospice NA was NA-D stated on 9/3 sure when the hospice NA was NA-D stated on 9/3 sure when the hospice NA was NA-D stated on 9/3 sure when the hospice NA was NA-D stated on 9/3 sure when the hospice NA was NA-D stated on 9/3 sure when the hospice NA was NA-D stated on 9/3 sure when the hospice NA was NA-D stated on 9/3 sure when the hospice NA was NA-D stated on 9/3 sure when the hospice NA was NA-D stated on 9/3 sure when the hospice NA was NA-D stated on 9/3 sure when the NA-D stated on 9/3 sure when	ce care plan (CP) (dated pospice start date) included, sication with Heartland physician's orders revealed the receiving hospice care since spice NA care plan was sated the agency staff provided poo, combing hair, mouth care, turizing skin among other. RN)-A indicated during an 6, at 1:24 p.m. the hospice 1-2 times a week, however, the the nurse's schedule. RN-A unaware when various came to provide services for just show up." She further not know of a calendar used and the facility to integrate care seen them. She said the hospice possibly to provide R23 with an ort care such as lotioning. What days the NAs were to other care they provided for ion between the hospice nurse k place face-to-face at the time ne calls if issues arose. asked if they knew what days is scheduled to care for R23. 30/16, at 2:47 p.m. "I'm not pice aide comes." And at 2:55 and, "For [R23] I've not seen one; or often they come to see him." to communication with the	F 280	care with hospice Communication systems have bee reviewed with the administrator of Heartland Hospice. For each reside binder has been put together contact calendar of when services are proven formation will be kept together in binder regarding the care plan of the hospice agency and facility so that easily accessible to all staff. Will complete audits on care plansed days after the comprehensive assessment to ensure state complementary to a complementary and the monthly. Audit results will be reported to QA.	dent a aining vided. the ooth it is seven iance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245514	B. WING			09/:	30/2016
	PROVIDER OR SUPPLIER	ABILITATION CENTER		1001 (ET ADDRESS, CITY, STATE, ZIP CODE COLUMBUS AVENUE NORTH PRAGUE, MN 56071		
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F 280	hospice nurse but r On 9/30/16 at 2:44 a schedule in the re hospice nurse com- yesterday." At 2:11 p.m. a Hear she came "every TI facility staff is she v scheduled time. At keep this calendar calendar indicated is scheduled for each Thursday in 9/16 ar scheduled visits by NA visits was includ also explained that many different area scanned into the fa could not verify if th coordinated with the confirmed this prac it "difficult" to obser and coordinate care RN-B further stated other hospice servic R23. RN-B added, papers at the hospi was good because where it could be ex wanted everything of turned out." R23's hospice serv revealed the reside weekly, and social servers.	stated, "I've talked to [R23's] not to his hospice aide." p.m. RN-E explained, "There's esident's room for when the	F 2	80			

	EMENT OF DEFICIENCIES PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		245514	B. WING _		09	/30/2016	
	PROVIDER OR SUPPLIER	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COI 1001 COLUMBUS AVENUE NORTH NEW PRAGUE, MN 56071	TATE, ZIP CODE IE NORTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AR DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 280 F 285	basis.	age 14 eduled on an "as needed" (e) PASRR REQUIREMENTS	F 28			11/11/16	
SS=D	pre-admission scree program under Me the maximum exter duplicative testing. A nursing facility m January 1, 1989, a (i) Mental illness a (i) of this section, usuathority has deterindependent physic performed by a perstate mental health (A) That, because condition of the individual services, whether the specialized service (ii) Mental retardation or deverbas determined prince (A) That, because condition of the individual services (B) If the individual services (B) If the individual services, whether the services (B) If the individual services (B) If the individual services, whether the services (B) If the individual servic	ust not admit, on or after ny new residents with: as defined in paragraph (m)(2) inless the State mental health mined, based on an cal and mental evaluation reson or entity other than the n authority, prior to admission; se of the physical and mental lividual, the individual requires s provided by a nursing facility; ual requires such level of the individual requires es for mental retardation. In the state mental elopmental disability authority					

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	PROVIDER OR SUPPLIER	ABILITATION CENTER		STREET ADDRESS, CITY, STA 1001 COLUMBUS AVENUE NEW PRAGUE, MN 560	NORTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIV CROSS-REFERENCEI	AN OF CORRECTION 'E ACTION SHOULD D TO THE APPROPF CIENCY)	BE	(X5) COMPLETION DATE
F 285	illness" if the indiviillness defined at § (ii) An individual i retarded" if the ind defined in §483.10 related condition at This REQUIREMED by: Based on interview facility failed to obt documents to dete 1 of 1 resident (R1 screening. Findings include: R101 was admitted another state. Pread Resident Review (Status Change Rehad a development Level II "remains which would have required active treservices, however Level I information (PAS) Results form facility's licensed submitted on 3/11/"no" to questions reconditions, therefore screen when it worreport indicated, "Eprovided for this new the individual individual in the individual individual in the individual in	is section: s considered to have "mental dual has a serious mental	F 2	Affected resident s form was obtained fi facility that the residents in MI/MR diagnosis, has creening in their me Social service s pro Pre-Admission screen on 10/26/16. Social services will of Pre-Admission Screen the health information ensure that all level new admissions with completed and scan record.	rom the previous ent resided and edical record. In the facility, with as a completed edical record. In the facility with edical record. In the facility was revious the check the rening and work on department to 2 screening for h MI/MR diagno	h an level 2 hing iewed a with so all osis is	

	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED				
		245514	B. WING			09/:	30/2016
	PROVIDER OR SUPPLIER	ABILITATION CENTER		10	REET ADDRESS, CITY, STATE, ZIP CODE 001 COLUMBUS AVENUE NORTH EW PRAGUE, MN 56071		
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F 285	DD. Please note fir for further evaluation for further evaluation. In a Board on Aging Se 3/14/16, a box was indications of Ment Developmental Dis OBRA I Level I Scruevel II DD or MI Econsumer." R101's the resident had provided the resident had provided by the Lagrange of the present the SS republication of the SS suggested asking (LSW) who had concurrently unavailable the Level II screen could not be found the electronic recounderstand." The LSW was interested from an lived in a group horanother long term was unsure whether state was consider another one. "Minned to do one." The notes and said sor out to assess the reservices on 4/21/1 not be located in the services of 4/21/1 not be located in the services of 4/21/1 not be located in the services of 4/21/1 not be	nal determination of the need on will be made by Senior letter from the Minnesota inior LinkAge Line dated checked that read, "No ital Illness (MI) or sability (DD) were found on the reening. Therefore, an OBRA evaluation is not needed for this is undated care plan indicated refound DD present at birth.	F 2	285			

			(3) DATE SURVEY COMPLETED		
		245514	B. WING		09/30/2016
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F 285 F 309	might not have a co	ge 17 er to your and my question. We opy of that. That might be	F 285		11/11/16
SS=D	provide the necess or maintain the high mental, and psycho	receive and the facility must ary care and services to attain nest practicable physical, esocial well-being, in a comprehensive assessment			
	by: Based on observative review the facility facare with hospice for reviewed for hospic Findings include: R23 was observed 8:45 a.m. and responded been receiving. During an interview nursing assistant (Noreported the NAs princluding transferring face once in a while frequently. We neemay get upset and She indicated R23 they tried to assign	at breakfast on 9/30/16, at onded minimally to a greeting. rders revealed the resident hospice care since 7/23/16. Ton 9/28/16, at 12:49 p.m. NA)-A (also a bath aide) erformed most of R23's cares, ng. She added, "He'll wash his emand he refuses cares d to constantly reapproach. He combative in the morning." did better with certain staff and		Affected resident s care plan was updated to reflect current needs and coordination of care with hospice. All residents , receiving hospice ser care plans were reviewed and update reflect current needs and coordination care with hospice Communication systems have been reviewed with the administrator of Heartland Hospice. For each resides binder has been put together contain calendar of when services are provide Information will be kept together in the binder regarding the care plan of both hospice agency and facility so that it easily accessible to all staff. Will complete audits on care plans so days after the comprehensive assessment to ensure state complian DON or designee to audit weekly x 4 then monthly. Audit results will be	vices, ed to en of nt a ing led. ne h is even

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245514	B. WING		09/	30/2016
	PROVIDER OR SUPPLIER FRANA CARE & REH/	ABILITATION CENTER	-	STREET ADDRESS, CITY, STATE, ZIP CODE 1001 COLUMBUS AVENUE NORTH NEW PRAGUE, MN 56071	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 309	nurse visited 1-2 tin nurse was unsure the explained she was hospice disciplines R23 stating "They justated that she did between hospice are and services between NA visited weekly, pextra bath or comfor RN-A was unsure with scheduled, or what R23. Communication and the facility took of visits, or by phone between visits. The Heartland Hospic reviewed and indicate a tub bath, shamposhaving, and moistic cares. Facility NAs were an the hospice NA was NA-D stated on 9/3 sure when the hospice NA was NA-D stated on 9/3 sure when the hospice nurse but roon 9/30/16 at 2:44	6, at 1:24 p.m. the hospice nes a week, however, the he nurse's schedule. RN-A unaware when various came to provide services for ust show up." She further not know of a calendar used nd the facility to integrate care en them. She said the hospice possibly to provide R23 with an ort care such as lotioning, what days the NAs were other care they provided for on between the hospice nurse place face-to-face at the time re calls if issues arose pice NA care plan was ated the agency staff provided ro, combing hair, mouth care, rurizing skin among other sked if they knew what days as scheduled to care for R23. 0/16, at 2:47 p.m. "I'm not pice aide comes." And at 2:55 d, "For [R23] I've not seen one; of often they come to see him." communication with the stated, "I've talked to [R23's] not to his hospice aide."	F 309	reported to QA.		

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	NAME OF PROVIDER OR SUPPLIER MALA STRANA CARE & REHABILITATION CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 1001 COLUMBUS AVENUE NORTH NEW PRAGUE, MN 56071						
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F 309	she came "every T facility staff is she was cheduled time. At keep this calendar calendar indicated scheduled for each Thursday in 9/16 at scheduled visits by NA visits was included also explained that many different areas canned into the facould not verify if the coordinated with the confirmed this practit "difficult" to observe and coordinate care RN-B further stated other hospice servi R23. RN-B added, papers at the hospi was good because where it could be ewanted everything turned out." The facility's hospice wanted everything turned out." The facility's hospice servi revealed the reside weekly, and social therapy visits were	rtland Hospice RN-B stated hursday" and called to notify was unable to make the 2:35 p.m. RN-B stated, "We in the resident's room." The hospice RN visits were Tuesday in 8/16 and each and 10/16. However, no other hospice staff, including ded on the calendar. RN-B the hospice care plan was in as (addendums) that were cility's computer, and she he hospice care plan was e facility's plan of care. RN-A tice and said the system made we the complete care plans e because of the addendums. If she was not informed when ces were being provided for "We had used a binder with the lused to work for and that it had everything in one place asily seen. But Heartland electronic and this is how it ce care plan (CP) (dated spice start date) as reviewed attain communication with	F 30	09			

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	PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1001 COLUMBUS AVENUE NORTH NEW PRAGUE, MN 56071					
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F 356 F 356 SS=C	Continued From page 20 483.30(e) POSTED NURSE STAFFING		F 356		11/11/16	
	staffing data for a n	aintain the posted daily nurse ninimum of 18 months, or as aw, whichever is greater.				
	by: Based on interview facility failed to pos	NT is not met as evidenced v and document review, the t daily nursing staff as the potential to affect all 80		The posted nursing staffing hours has been revised to include total nuand actual hours worked by each		

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER MALA STRANA CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1001 COLUMBUS AVENUE NORTH NEW PRAGUE, MN 56071			
(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL	D BE	(X5) COMPLETION DATE	
residents and visito Findings include: During the initial tou 12:30 p.m. the post reviewed. The post and census, as wel total hours for each for each shift for rec practical nurses and totals were noted. The the actual hours and worked those times overlapping shifts. During an interview administrator explainew software progrimad reflected each shift hours worked. Check with corporat facility could best rec working each day of 483.65 INFECTION SPREAD, LINENS The facility must es Infection Control Pr safe, sanitary and of to help prevent the of disease and infect (a) Infection Contro The facility must es Program under whic (1) Investigates, control 10:0000000000000000000000000000000000	ur of the facility on 9/26/16, at red nursing hours was ing included the current date I as the shift start times. The shift and full time equivalents gistered nurses, licensed d "Assistants/Techs," and shift The posting, however, lacked d numbers of staff who is, including short shifts and on 9/30/16, at 2:00 p.m. the ined the facility was using a am. The previous program nursing staff member's actual the further stated he would be staff to determine how the effect the required staff on the nursing postings. I CONTROL, PREVENT tablish and maintain an accomfortable environment and development and transmission ction. I Program tablish an Infection Control ch it -	F 44	discipline. Nursing Scheduler will report daily and conduct periodic a ensure that the posted information accurately reflects daily staffing.	audits to	11/11/16	
	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From paresidents and visito Findings include: During the initial too 12:30 p.m. the post reviewed. The post and census, as wel total hours for each for each shift for re- practical nurses and totals were noted. The the actual hours an worked those times overlapping shifts. During an interview administrator expla new software progri had reflected each shift hours worked. check with corporate facility could best re- working each day of 483.65 INFECTION SPREAD, LINENS The facility must es Infection Control Pr safe, sanitary and of to help prevent the of disease and infe- (a) Infection Control The facility must es Program under whi	TRANA CARE & REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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. 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	PROVIDER OR SUPPLIER TRANA CARE & REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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. 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(a) Infection Control Program The facility must establish an Infection Control Program under which it it. (1) Investigates, controls, and prevents infections	PROVIDER OR SUPPLIER TRANA CARE & REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (LEACH DEFICIENCY MISS TO FLORE CHOCK) REQUILITIES PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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 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. 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	PROVIDER OR SUPPLIEF	MABILITATION CENTER		10	TREET ADDRESS, CITY, STATE, ZIP CODE DO1 COLUMBUS AVENUE NORTH EW PRAGUE, MN 56071		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)		BE	(X5) COMPLETION DATE
F 441	should be applied (3) Maintains a recactions related to (b) Preventing Spi (1) When the Infect determines that a prevent the spread isolate the resider (2) The facility mu communicable disfrom direct contact direct contact will (3) The facility mu hands after each of hand washing is in professional pract (c) Linens Personnel must ha	procedures, such as isolation, to an individual resident; and cord of incidents and corrective infections. Tead of Infection ction Control Program resident needs isolation to d of infection, the facility must at. Ist prohibit employees with a ease or infected skin lesions t with residents or their food, if transmit the disease. It require staff to wash their direct resident contact for which adicated by accepted	F	1441			
	by: Based on observative review, the facility handwashing to make for 1 of resident was observed. In prevention and conformation related and analysis of stadiseases/infection	ENT is not met as evidenced ation, interview and document failed to ensure proper inimize the spread of infection s (R125) whose wound care addition, the facility's infection ntrol program lacked pertinent d to surveillance, investigation, aff and resident s to minimize infections in the the potential to affect all 80			The facility has revised their infection prevention and control program to it an updated infection surveillance, investigation, and analysis form. Reand staff Infections will be discussed at the morning IDT meeting and the will be completed in full by the design infection control nurse. Investigation analysis will be on-going. An all staff in-service will be held on 11/2/16 educating staff on proper in	esident ed daily e form gnated on and	

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	2) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
		245514	B. WING		09/	30/2016	
	PROVIDER OR SUPPLIER	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1001 COLUMBUS AVENUE NORTH NEW PRAGUE, MN 56071			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDERICIENCY)	D BE	(X5) COMPLETION DATE	
F 441	10:23 a.m. by regis performed the "dirty after appropriately putting on gloves to and remove the old old dressing, RN-D put on clean ones water or alcohol had clean pair. She place resident's wound, a clothing before replaced those glowash to clean her had wastebasket liner a carrying her clean of other to a dirty utility supplies bin on the the door and discare emerged from the supply bin from the RN-D was interview procedure during the "I should have was re-gloving." She was p.m. about placing bin on the floor and done that. You don't have the door and done that the door and done the door and done the door and done the door and	e was observed on 9/28/16 at tered nurse (RN)-D. RN-D y" part of the dressing change washing her hands before o prepare the new dressing I dressing. After removing the removed her used gloves and without using either soap and and wash before donning the ced the new dressing on the and adjusted the resident's facing the bedcovers, then wes and used alcohol hand hands. RN-D then tied off the and carried it in one hand, while dressing supplies bin in the yroom. She set the dressing floor to free her hand to open reded the trash. She then room and picked up the clean floor. Wed at 10:33 a.m. about her ne dressing change and stated, hed my hands again before as interviewed again at 1:08 the clean dressing supplies I admitted, "I shouldn't have it know what's on the floor." Washing policy was reviewed adwashing is generally st important single procedure thcare associated infection." cted staff to perform hand	F 441	control prevention techniques inclinandwashing, glove usage and har of equipment. Random audits will be completed infection control weekly for 1 montrol followed by biweekly for 2 months then monthly for 3 months. We wire-assess on-going need for audit QA committee. DON or designee will audit infection analysis form monthly to ensure a documentation and analysis is controlled.	andling on th, and II s at the		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245514	B. WING			09/	30/2016
	PROVIDER OR SUPPLIER	ABILITATION CENTER		1	TREET ADDRESS, CITY, STATE, ZIP CODE 001 COLUMBUS AVENUE NORTH IEW PRAGUE, MN 56071	,	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	Х	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 441		_	F 4	41			
	1/1/16, to 8/31/16, I such as micro-orga symptoms, etc. In a infection rates, ana Quality Improvement	acked pertinent information nisms, antibiotic use, addition, the form lacked lysis, patterns, etc. The					
	(OHL) and director interviewed on 9/29 and DON explained for infection control responsible for both	ealth and learning director of nursing (DON) were 0/16, at 9:03 a.m. The OHL of they both had responsibility at the facility. The OHL was nemployees and residents, orimarily responsible for the					
	stated infection con an interdisciplinary were compiled and reviewed quarterly reviewed at the qua- said the microorgar identified, but they I the forms provided been documenting very well and do no to what we have be monthly meetings." about infections ear infections were pre-	n/30/16, at 10:56 a.m. the DON atrol concerns were brought to (IDT) meeting. Monthly reports then those reports were infection control issues were arterly by the IDT. The DON nism was "sometimes" and not documented them on to the surveyor. "We have not our follow up on infections thave any documentation as the doing at the daily or The DON said they talked ch morning, and if any new sent, they then isolated the toy having residents eat in					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245514	B. WING			09/	30/2016
	PROVIDER OR SUPPLIER	IABILITATION CENTER		100	EET ADDRESS, CITY, STATE, ZIP CODE 1 COLUMBUS AVENUE NORTH W PRAGUE, MN 56071		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 441	issues at the facilit than formally. Becknow where they a bathrooms. We try relationship with reinfections but it is. During an interview OHL reported they and patient care a completed two aud four weeks. The Cwatch cares and completed two aud four weeks. The Cwatch cares and completed two aud four weeks. The Cwatch cares and completed two aud four weeks. The Cwatch cares and completed two aud four weeks. The Complete two aud four weeks and washing train nursing assistants hand washing train nurse managers wan infection control. The forms were compared to the forms were compared t	ussion of infection control by happened "more informally ause we know the residents we are on wings or if they share or to figure out if there is a legard to similarities between not recorded anywhere." If you on 9/30/16, at 11:01 a.m. they had started conducting staff udits on rotating shifts and had dits per week during the last of the stated, "We follow staff and orrect them immediately." In and peri-care was a focus of in 7/16 and 8/16 for all and all staff had received hing in the past few months. Were responsible for filling out of concern form as appropriate. Of the concern form as appropriate. Of they educated staff on proper they educated staff on proper a peri-care, the OHL "the matter." The OHL stated, "We de documenting what we do not any of the morning what it at the morning about it at the morning	F 4	.41			
	a.m. and stated he to be tracking and which microorgani temperature logs, to 6/16, tracking a "not very inclusive The new forms alle	erviewed on 9/30/16, at 10:27 er would have expected the staff looking at trends such as sms were involved, resident resident symptoms, etc. Prior and trending of infections was and did not documented well." owed for better tracking and the staff were not recording all					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	(X3) DAT COM	(X3) DATE SURVEY COMPLETED		
		245514	B. WING		09/	30/2016		
	ROVIDER OR SUPPLIER	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1001 COLUMBUS AVENUE NORTH NEW PRAGUE, MN 56071				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	FIX (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION DATE		

-5514025

PRINTED: 10/31/2016 FORM APPROVED OMB NO. 0938-0391

(X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 01 - MAIN BUILDING 01 245514 B: WING 09/28/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1001 COLUMBUS AVENUE NORTH **MALA STRANA CARE & REHABILITATION CENTER** NEW PRAGUE, MN 56071 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRFFIX **PRÉFIX** CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 INITIAL COMMENTS K 000 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 LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE (X6) DATE TITLE

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.

If continuation sheet Page 1 of 8

Electronically Signed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A, BUILDING 01 - MAIN BUILDING 01			(X3) DATE SUR COMPLETE		
		245514	B. WING			09/	28/2016	
	PROVIDER OR SUPPLIE	HABILITATION CENTER		100	EET ADDRESS, CITY, STATE, ZIP CODE 1 COLUMBUS AVENUE NORTH W PRAGUE, MN 56071	•		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
K 000	DEFICIENCY MU FOLLOWING INF 1. A description of to correct the defi 2. The actual, or particular and responsible for correvent a reoccur Mala Strana Heal at 2 different time in 1972, it is one-basement and wall(111) construction	estate.mn.us and an@state.mn.us ORRECTION FOR EACH IST INCLUDE ALL OF THE FORMATION: If what has been, or will be, done	K	000				
	constructed and vil(111) construction and the 1 addition construction and allowed for existing surveyed as one. The building is further fire alarm system detection and sparmonitored for authorification. The facility has a census of 80 at the surveyed and the surveyed as one.	was determined to be of Type on. Because the original building on are of the same type of meet the construction type on buildings, the facility was						

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			01 - MAIN BUILDING 01	COMPLETED				
		245514	B. WING		09/28/2016	3		
	PROVIDER OR SUPPLIEF		1	STREET ADDRESS, CITY, STATE, ZIP CODE 1001 COLUMBUS AVENUE NORTH NEW PRAGUE, MN 56071				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLE	TION		
	Doors protecting of required enclosure hazardous areas as those construction core wood, or cap 20 minutes. Clear and floor covering in fully sprinklered required to resist no impediment to open devices that pushed or pulled a provided with a midoor closed. Duto permitted. Door from made of steel or owith 8.2.3.2.1. Ro CMS regulations 19.3.6.3	enced by: AFETY CODE STANDARD corridor openings in other than es of vertical openings, exits, or shall be substantial doors, such ted of 13/4 inch solid-bonded able of resisting fire for at least ance between bottom of door is not exceeding 1 inch. Doors smoke compartments are only the passage of smoke. There is the closing of the doors. Hold release when the door is are permitted. Doors shall be eans suitable for keeping the h doors meeting 19.3.6.3.6 are ames shall be labeled and other materials in compliance liler latches are prohibited by in all health care facilities.	K 000		11/11/	16		
	Doors protecting required enclosur hazardous areas as those construction core wood, or cap 20 minutes. Clear and floor covering in fully sprinklered required to resist no impediment to open devices that pushed or pulled provided with a midoor closed. Duto permitted. Door frimade of steel or of the ste	corridor openings in other than es of vertical openings, exits, or shall be substantial doors, such ted of 13/4 inch solid-bonded bable of resisting fire for at least rance between bottom of door is not exceeding 1 inch. Doors it smoke compartments are only the passage of smoke. There is the closing of the doors. Hold it release when the door is are permitted. Doors shall be leans suitable for keeping the ch doors meeting 19.3.6.3.6 are rames shall be labeled and other materials in compliance aller latches are prohibited by		All four doors have been fixed as 10/26/16. New knobs and latche ordered and installed.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 '	TIPLE CONSTRUCTION ING 01 - MAIN BUILDING 01		MPLETED	
		245514	B. WING		09	/28/2016
	PROVIDER OR SUPPLIER	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP 1001 COLUMBUS AVENUE NORTH NEW PRAGUE, MN 56071	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE LE APPROPRIATE	(X5) COMPLETION DATE
K 018	On facility tour be on Sept. 28,2016, interview revealed Doors in corridor 1. B-8 storage roc 2. B-9 storage roc 3. B-4 Laundry roc 4. North hallway is after closing.	tween 09:00 AM and 1:00 PM based on observation and that the findings include: did not latch when tested. om om on the east wing did not open	K	018		
K 021 SS=D	Facility Maintenar discovery. NFPA 101 LIFE S Doors in an exit p horizontal exit, sm	ctice was confirmed by the nce Director at the time of AFETY CODE STANDARD assageway, stairway enclosure, noke barrier or hazardous area	K	021		11/11/16
	position, unless h complying with 7. all such doors throompartment or equired r (b) Local smoke compartment or expected by Local smoke passing the smoke detection (c) The automatic 18.2.2.2.6, 18.3.1 7.2.1.8.2 Door assemblies approved type with rating. 8.2.3.2.3.1	in vertical openings are of an th appropriate fire protection				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G 01 - Main Building 01		COMPLETED	
		245514	B. WING _		09	/28/2016	
	PROVIDER OR SUPPLIEF	HABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1001 COLUMBUS AVENUE NORTH NEW PRAGUE, MN 56071				
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPRED DEFICIENCY)				(X5) COMPLETION DATE	
K 021	This STANDARD Doors in an exit penclosure, horizor hazardous area et kept in the closed as release device automatically clos the smoke compactivation of: (a) The required nowel (b) Local smoke passing the smoke detection is (c) The automatical 18.2.2.2.6, 18.3.1 7.2.1.8.2 Door assemblies approved type with rating. 8.2.3.2.3.1	doors are kept closed. is not met as evidenced by: bassageway, stairway intal exit, smoke barrier or inclosure are self-closing and position, unless held open by complying with 7.2.1.8.2 that es all such doors throughout intment or entire facility upon manual fire alarm system and letectors designed to detect rough the opening or a required	K 02	All doors in the kitchen were and friction magnetic locks hordered and installation has work will be done by 10/31/1	nave been started. All		
K 025	equipment rooms On facility tour be on Sept. 28, 2016 interview revealed room observed be magnet not connessystem This deficient prathe (80) residents area. This deficient pra Facility Maintenar discovery.	doors are kept closed. tween 09:00 AM and 1:00 PM be based on observation and de that the kitchen door to dining eing held open by a friction ected into the main fire alarm ctice could affect the safety of within that smoke compartment ctice was confirmed by the ence Director at the time of CAFETY CODE STANDARD	K 02	25		11/11/16	

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		' '	01 - MAIN BUILDING 01	COMPLETED			
		245514	B. WING		09/2	8/2016	
	PROVIDER OR SUPPLIER	HABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1001 COLUMBUS AVENUE NORTH NEW PRAGUE, MN 56071				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE	
K 025 SS=F	least a one half he constructed in acc barriers shall be patrium wall. Wind fire-rated glazing steel frames. 8.3, 19.3.7.3, 19.3 This STANDARD Smoke barriers sleast a one half he constructed in acc barriers shall be patrium wall. Wind fire-rated glazing steel frames. 8.3, 19.3.7.3, 19.3 On facility tour be on Sept.28,2016, interview revealed.	nall be constructed to provide at our fire resistance rating and cordance with 8.3. Smoke remitted to terminate at an ows shall be protected by or by wired glass panels and 8.7.5 is not met as evidenced by: hall be constructed to provide at our fire resistance rating and cordance with 8.3. Smoke remitted to terminate at an ows shall be protected by or by wired glass panels and	K 025	The smoke barriers through-out facility have been inspected. The penetrations spots noted in the in have been caulked.			
K 038 SS=D	corridors. Check facility. This deficient prathe (20) residents This deficient praficient praficient praficient praficient praficulty Maintenardiscovery. NFPA 101 LIFE SEXIT access is arraccessible at all to 7.1. 19.2.1 This STANDARD	ctice could affect the safety of within the smoke compartment. ctice was confirmed by the nce Director at the time of SAFETY CODE STANDARD anged so that exits are readily imes in accordance with section is not met as evidenced by: ranged so that exits are readily	K 03	The security company complete	d the	11/11/16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,		E CONSTRUCTION O1 - MAIN BUILDING 01	COMPLETED		
		245514	B. WING			09/2	8/2016
	PROVIDER OR SUPPLIER	IABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1001 COLUMBUS AVENUE NORTH NEW PRAGUE, MN 56071				
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	On facility tour bet on Sept. 28,2016, interview revealed not release after the 1. Little Village doc 2. Kitchen Service This deficient practine (20) residents This deficient practine (20) residents This deficient practinuously Maintenant discovery. NFPA 101 LIFE S. Required automatic continuously main condition and are periodically.	ween 09:00 AM and 1:00 PM based on observation and that the delay egress locks did ne 15 seconds at:	K	038	work on 9/29/16 and both doors now release after 15 seconds.	V	11/11/16
	Required automate continuously main condition and are periodically. 19 9.7.5 On facility tour be on Sept. 28,2016, interview revealed. Observation revewith the fire sprint 1. In Corridor of the matched sprinkled quick response) in	is not met as evidenced by: tic sprinkler systems are tained in reliable operating inspected and tested 1.7.6, 4.6.12, NFPA 13, NFPA 25, tween 09:00 AM and 1:00 PM based on observation and that the findings include: aled that the founding was found teler system. The Little Village area, mixed theads were found (standard/ the same ceiling area. The same ceiling area. The same rearranger of the system.			Olympic Fire replaced the old style sprinkler head with a new style heat the hallway on 10/18/16. Both the ceiling tile in charting room well as the B-9 storage room tile the missing was replaced on 10/5/16.	id in n as	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G 01 - Main Building 01		COMPLETED			
	PROVIDER OR SUPPLIE	245514 R HABILITATION CENTER	B. WING _	STREET ADDRESS, CITY, STATE, ZIP CODE 1001 COLUMBUS AVENUE NORTH NEW PRAGUE, MN 56071				
(X4) ID PREFIX TAG	(EACH DEFICIEN	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
K 062	This deficient pra the (20) residents This deficient pra	om has missing ceiling tiles. Inctice could affect the safety of a within the smoke compartment. Inctice was confirmed by the lince Director at the time of	K 06	2				



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: 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 <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the 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

Mala Strana Care & Rehabilitation Center October 18, 2016 Page 2

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

Minnesota Department of Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _____ B. WING _ 00811 09/30/2016

	TRANA CARE & REHARII ITATION CEN 1001 COL	, ,	STATE, ZIP CODE ENUE NORTH 6071	
(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) COMPLET DATE
2 000	Initial Comments	2 000		
	*****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			

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

TITLE

(X6) DATE

Electronically Signed

10/27/16

K24X11

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE	SURVEY LETED
ANDILAN	OF GOTTLEGTION	IDENTIFICATION NOMBER.	A. BUILDING:		OOWII	LLILD
		00811	B. WING		09/3	0/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
MALA ST	TRANA CARE & REH	ARII ITATION CEN	UMBUS AVE GUE, MN 50	ENUE NORTH 6071		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Department of Hea you electronically. is necessary for Sta enter the word "cortext. You must then State licensure procompletion date, the corrected prior to e Minnesota Department on September 26, surveyors of this Deabove provider and	Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be lectronically submitting to the	2 000			
	electronic plan of c reviewed these ord they will be comple Minnesota Departmenthe State Licensing federal software. To assigned to Minneson Nursing Homes. A complaint investign	orrection that you have ers, and identify the date when ted. nent of Health is documenting Correction Orders using ag numbers have been sota state statutes/rules for gation of H5514011 was a susbtantiated at MN Statute				
2 570	Plan of Care; Revision care must be review interdisciplinary tea physician, a register for the resident, and disciplines as deter and, to the extent	5 Subp. 4 Comprehensive sion . A comprehensive plan of wed and revised by an an am that includes the attending ared nurse with responsibility dother appropriate staff in a mined by the resident's needs, practicable, with the resident, the resident's legal	2 570			11/11/16

Minnesota Department of Health

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Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

-	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING.			
		00811	B. WING		09/3	0/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
MALA S	TRANA CARE & REH	A DII ITATIONI CEN	UMBUS AVE GUE, MN 5	ENUE NORTH 6071		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 570	guardian or chosen quarterly and withir	representative at least seven days of the revision of resident assessment required	2 570			
	by: Based on interview facility failed to ens coordinated and rehospice for 1 of 1 rehospice care. Findings include: R23's facility hospice 4/22/15, prior to ho "Maintain communihospice" R23's p	and document review the ure the care plan was vised as needed related to esident (R23) reviewed for the care plan (CP) (dated spice start date) included, cation with Heartland chysician's orders revealed the receiving hospice care since		Plan of correction written 10/27/16 Correction to be completed by 11/		
	reviewed and indicate a tub bath, shampo	pice NA care plan was ated the agency staff provided to, combing hair, mouth care, urizing skin among other				
	interview on 9/30/1 nurse visited R23 1 nurse was unsure t explained she was hospice disciplines R23 stating "They j stated that she did between hospice at and services betwee NA visited weekly, extra bath or comfo	RN)-A indicated during an 6, at 1:24 p.m. the hospice -2 times a week, however, the he nurse's schedule. RN-A unaware when various came to provide services for ust show up." She further not know of a calendar used not the facility to integrate care them. She said the hospice possibly to provide R23 with an ort care such as lotioning.				

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
		00811	B. WING		09/	30/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
		1001 CO	LUMBUS AVE	,		
MALA S	TRANA CARE & REHA	ARII ITATION CEN	AGUE, MN 56			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO		(X5)
PRÉFIX TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)		COMPLETE DATE
2 570	Continued From pa	ge 3	2 570			
	R23. Communication and the facility took	other care they provided for on between the hospice nurse place face-to-face at the time e calls if issues arose				
	the hospice NA was NA-D stated on 9/3 sure when the hosp p.m. NA-A indicated so I'm not sure how When asked about hospice aide NA-A	sked if they knew what days scheduled to care for R23. 0/16, at 2:47 p.m. "I'm not pice aide comes." And at 2:55 d, "For [R23] I've not seen one; often they come to see him." communication with the stated, "I've talked to [R23's] not to his hospice aide."				
		p.m. RN-E explained, "There's esident's room for when the es. They were here				
	she came "every The facility staff is she was scheduled time. At keep this calendar in calendar indicated lascheduled for each Thursday in 9/16 ar scheduled visits by NA visits was included also explained that many different area scanned into the faccould not verify if the coordinated with the confirmed this practit "difficult" to obsert and coordinate care	tland Hospice RN-B stated nursday" and called to notify was unable to make the 2:35 p.m. RN-B stated, "We in the resident's room." The nospice RN visits were Tuesday in 8/16 and each not 10/16. However, no other hospice staff, including ded on the calendar. RN-B the hospice care plan was in as (addendums) that were cility's computer, and she e hospice care plan was as facility's plan of care. RN-A tice and said the system made we the complete care plans as because of the addendums. I she was not informed when				

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-	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00811	B. WING		09/3	0/2016
	PROVIDER OR SUPPLIER	ARII ITATION CEN 1001 COL		STATE, ZIP CODE ENUE NORTH 6071		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 570	other hospice serving R23. RN-B added, papers at the hospi was good because where it could be examted everything of turned out." R23's hospice serving revealed the reside weekly, and social atherapy visits were volunteer was schebasis. SUGGESTED MET The director of nurse could review care particular and the quality TIME PERIOD FOR (21) days. MN Rule 4658.0520 Proper Nursing Carcustodial care, and individual needs and the comprehensive plan of care as des 4658.0405. A nursiof bed as much as written order from to the standard transport of the same than the comprehensive plan of care as des 4658.0405. A nursiof bed as much as written order from to the same than the comprehensive plan of care from the same than the comprehensive plan of care as des 4658.0405. A nursiof bed as much as written order from the same than the comprehensive plan of care and the comprehensive plan of care as des 4658.0405. A nursion of the same than the comprehensive plan of care as des 4658.0405. A nursion of the same than the comprehensive plan of care as des 4658.0405. The same than the comprehensive plan of care as des 4658.0405. A nursion of the same than the same than the comprehensive plan of care as des 4658.0405. A nursion of the same than the s	ces were being provided for "We had used a binder with ce I used to work for and that it had everything in one place asily seen. But Heartland electronic and this is how it ice contract dated 7/22/16, nt received NA and RN visits service, spiritual, and music expected monthly. A duled on an "as needed" THOD OF CORRECTION: sing with the hospice agency plans to ensure consistency. Inducted and the results ty committee for review. If CORRECTION: Twenty-one of Subp. 1 Adequate and re; General general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ing home resident must be out possible unless there is a he attending physician that the in in bed or the resident	2 570			11/11/16

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Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00811	B. WING		09/3	80/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY.	STATE, ZIP CODE	-	
		1001 COL		ENUE NORTH		
MALAS	TRANA CARE & REHA	ABILITATION CEN NEW PRA	AGUE, MN 5	6071		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ae 5	2 830			
	This MN Requirements: Based on observation review the facility factories with hospice for reviewed for hospic Findings include: R23 was observed 8:45 a.m. and response R23's physician's of had been receiving. During an interview nursing assistant (Noreported the NAs poincluding transferring face once in a while frequently. We need may get upset and She indicated R23 of they tried to assign	ent is not met as evidenced on, interview and document illed to ensure coordination of or 1 of 1 resident (R23) e care. at breakfast on 9/30/16, at onded minimally to a greeting. Index revealed the resident hospice care since 7/23/16. on 9/28/16, at 12:49 p.m. JA)-A (also a bath aide) erformed most of R23's cares, inc. She added, "He'll wash his emand he refuses cares d to constantly reapproach. He combative in the morning." did better with certain staff and him to those NAs.		Plan of correction written 10/27/16 Correction to be completed by 11/		
	interview on 9/30/16 nurse visited 1-2 tin nurse was unsure ti explained she was	RN)-A indicated during an 5, at 1:24 p.m. the hospice nes a week, however, the he nurse's schedule. RN-A unaware when various				
	R23 stating "They justated that she did between hospice ar and services between NA visited weekly, pextra bath or comfor RN-A was unsure wischeduled, or what R23. Communication	came to provide services for ust show up." She further not know of a calendar used and the facility to integrate care en them. She said the hospice possibly to provide R23 with an ort care such as lotioning. What days the NAs were other care they provided for on between the hospice nurse place face-to-face at the time				

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Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00811	B. WING		09/	30/2016
	PROVIDER OR SUPPLIER	ARII ITATION CEN 1001 COI	DDRESS, CITY, S'LUMBUS AVE	NUE NORTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
2 830	of visits, or by phon between visits. The Heartland Hosp reviewed and indicated a tub bath, shampor shaving, and moistic cares. Facility NAs were at the hospice NA was NA-D stated on 9/3 sure when the hospice so I'm not sure how When asked about hospice aide NA-A hospice nurse but in the respective of the came "every The facility staff is she was calendar indicated in the scheduled time. At keep this calendar indicated is scheduled for each Thursday in 9/16 ar scheduled visits by NA visits was included also explained that many different area scanned into the facould not verify if the coordinated with the series and the coordinated with the coordinated with the series and the coordinated with	e calls if issues arose pice NA care plan was ated the agency staff provided o, combing hair, mouth care, urizing skin among other sked if they knew what days a scheduled to care for R23. 0/16, at 2:47 p.m. "I'm not pice aide comes." And at 2:55 d., "For [R23] I've not seen one; often they come to see him." communication with the stated, "I've talked to [R23's] not to his hospice aide." p.m. RN-E explained, "There's esident's room for when the				

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NAME OF PROVIDER OR SUPPLIER MALA STRANA CARE & REHABILITATION CEN (X4) ID PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) 2 830 Continued From page 7 STREET ADDRESS, CITY, STATE, ZIP CODE 1001 COLUMBUS AVENUE NORTH NEW PRAGUE, MN 56071 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	MPLETED
MALA STRANA CARE & REHABILITATION CEN 1001 COLUMBUS AVENUE NORTH NEW PRAGUE, MN 56071 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 1001 COLUMBUS AVENUE NORTH NEW PRAGUE, MN 56071 ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	9/30/2016
MALA STRANA CARE & REHABILITATION CEN NEW PRAGUE, MN 56071 (X4) ID PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) NEW PRAGUE, MN 56071 NEW PRAGUE, MN 56071 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	
2 830 Continued From page 7	(X5) COMPLETE DATE
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.	
21390 MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection	11/11/16

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMPI	
			B. WING		2010	0/00/10
		00811	b. Willia		09/3	0/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
MALA S	TRANA CARE & REHA	ARII ITATION CEN	UMBUS AVE GUE, MN 5	ENUE NORTH 6071		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21390	procedures which p A. surveillance collection to identify residents; B. a system for control of outbreaks C. isolation and reduce risk of trans D. in-service ed prevention and con E. a resident he immunization progr defined in part 465 procedures of resid the prevention and F. the developr employee health po practices, including defined in part 4658 G. a system for H. a system for products which affed disinfectants, antise incontinence produ I. methods for	ust include policies and provide for the following: based on systematic data of nosocomial infections in a detection, investigation, and is of infectious diseases; disprecautions systems to mission of infectious agents; ducation in infection trol; ealth program including an am, a tuberculosis program as 8.0810, and policies and treatment of infections; ment and implementation of policies and infection control a tuberculosis program as 3.0815; reviewing antibiotic use; review and evaluation of the infection control, such as eptics, gloves, and	21390			
	by: Based on observati review, the facility f handwashing to min for 1 of residents was observed. In a prevention and con	on, interview and document ailed to ensure proper nimize the spread of infection (R125) whose wound care ddition, the facility's infection trol program lacked pertinent to surveillance, investigation, f and resident		Plan of correction written 10/27/16 Correction to be completed by 11/		

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		00811	B. WING		09/3	30/2016
	PROVIDER OR SUPPLIER	ARII ITATION CEN 1001 COL		ETATE, ZIP CODE ENUE NORTH 6071		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21390	facility, which had the residents. Findings include: R125's wound care 10:23 a.m. by regist performed the "dirty after appropriately with putting on gloves to and remove the old old dressing, RN-D put on clean ones with water or alcohol had clean pair. She place resident's wound, a clothing before replaced those glow wash to clean her had wastebasket liner a carrying her clean cother to a dirty utility supplies bin on the the door and discare merged from the resupply bin from the RN-D was interview procedure during the "I should have wash re-gloving." She was p.m. about placing bin on the floor and done that. You don' The facility's handward indicated, "Har considered the most for preventing health."	was observed on 9/28/16 at tered nurse (RN)-D. RN-D /" part of the dressing change washing her hands before operate the new dressing dressing. After removing the removed her used gloves and without using either soap and not wash before donning the ced the new dressing on the and adjusted the resident's acing the bedcovers, then we and used alcohol hand hands. RN-D then tied off the and carried it in one hand, while dressing supplies bin in the yroom. She set the dressing floor to free her hand to open ded the trash. She then from and picked up the clean	21390			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE	SURVEY LETED
71112 1 12711	01 0011112011011	is a manufacture of the second	A. BUILDING:			
		00811	B. WING		09/3	0/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MALA S	TRANA CARE & REH	ARII ITATION CEN	LUMBUS AVE AGUE, MN 50	ENUE NORTH 6071		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21390	washing "After codressingsAfter redressingsAfter redressi	ontact withwound moving gloves." Ion Surveillance Tracking and Improvement logs dated lacked pertinent information anisms, antibiotic use, addition, the form lacked llysis, patterns, etc. The				

Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: 00811 B. WING ___ 09/30/2016

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

MALA ST	TRANA CARE & REHARII ITATION CEN	UMBUS AVE	ENUE NORTH 6071	
(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
21390	Continued From page 11	21390		
	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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Minnesota Department of Health

	AND DUAN OF CODDECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00811	B. WING		09/3	0/2016
	PROVIDER OR SUPPLIER	ARII ITATION CEN 1001 COI		STATE, ZIP CODE ENUE NORTH 6071		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
21390	control nurse could infection control pre infection control pla strengthened consipractice. Audits couresults brought to the review.	ge 12 sing (DON) and infection ensure staff are trained on evention techniques. The un could be reviewed and stent with standards of uld be conducted and the ne quality committee for R CORRECTION: Twenty-one	21390			
21695	Subp. 4. Houseke provide housekeep necessary to mainta comfortable interior ceilings, registers, f and furnishings. This MN Requirements: Based on observation review, the facility for and bathrooms were and were kept clear	eration, & Maintenance eping. A nursing home must ing and maintenance services ain a clean, orderly, and r, including walls, floors, rixtures, equipment, lighting, ent is not met as evidenced on, interview and document ailed to ensure resident rooms re maintained in good repair n in seven resident rooms 120		Plan of correction written 10/27/16. Correction to be completed by 11/1		11/11/16
	were identified during conducted with the (ESD):	160, and 161. 4 a.m. the following concerns ng an environmental tour, environmental service director red bathroom: The plaster on				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00811	B. WING		09/3	0/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	•	
MALA ST	RANA CARE & REHA	ARII ITATION CEN	UMBUS AVE	ENUE NORTH 6071		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21695	edges next to the to stored on the bathrhad a brown dried swas first observed of cleaned and remain observed at the time ESD explained, "The [on 9/23/16]. The make come back on the work. I know this to cause an injury." housekeepers cleat probably picked up floor, and then place The ESD then wet the brown substance stated, "It is feces." Room 123: The was craped and rough radiator next to the reported being unare stated, "Yes, the radiator next to the reported being unare stated,	and had sharp, un-sanded bilet. A dusty stool riser was soom floor. The safety hand rail smear on the arm handle. This on 9/23/26 and hand not been ned the same when again e of the tour on 9/29/16. The ne wall was patched last Friday naintenance person should a Monday to paint and finished is is unsafe and has a potential. The ESD also stated the ned every day, and they the stool riser to clean the ed it back where they found it. paper towel and cleaned off ce from the safety rail and all behind the headboard was. The metal cover for heat bed was bent. The ESD ware of the radiator and diator is bent. The resident that." The ESD explained it ent when staff moved the bed	21695			

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STATEMENT OF DEFICIENCIES (X1)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE SURVEY COMPLETED	
71110 1 27111	or connection	BERTIN ION HONOR HOMBER.	A. BUILDING:		001111		
		00811	B. WING		09/3	0/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
MALA S	TRANA CARE & REHA	ARII ITATION CEN	UMBUS AVE GUE, MN 50	NUE NORTH 6071			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE	
21695	surface around the edge which could be stated, "We have a the nursing staff to maintenance persomorning and addreserious issues they get fixed." The facility's undate read, "It is our intenfor our resident and working order." SUGGESTED MET The director of maintenance reporting system is repairs are made. A ensure staff are cle repairs. The results quality committee for the staff are sure staff are cle repairs.	hole is rough and has sharp be hazardous." The ESD also maintenance request book for write concerns. The on will check the book every ss the issues. If there are will call us right away so it can ed Facility Maintenance Policy asion to keep our facility safe d keep our equipment in a THOD OF CORRECTION: antenance could ensure a in place and necessary Audits could be conducted to eaning and making timely secould be brought to the	21695				
21990	Maltreatment of Vu Subd. 4. Reportin immediately make a entry point. Use of for the deaf or othe considered an oral point may not requiextent possible, the content to identify the caregiver, the nature maltreatment, any entry to the content of the care of th	inerable Adults ag. A mandated reporter shall an oral report to the common a telecommunications device in similar device shall be report. The common entry in written reports. To the export must be of sufficient he vulnerable adult, the re and extent of the suspected evidence of previous name and address of the	21990			11/11/16	

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1) I

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING:	·		
		00811	B. WING		09/3	0/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MALA S	TRANA CARE & REH	ARII ITATION CEN	.UMBUS AVE .GUE, MN 5	ENUE NORTH 6071		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21990	reporter, the time, of incident, and any of reporter believes me the suspected malt reporter may disclosin section 13.02, ar section 144.335, to comply with this sufficient of the suspection 144.335, to comply with this sufficient of the suspection of the suspecti	date, and location of the ther information that the light be helpful in investigating reatment. A mandated se not public data, as defined and medical records under the extent necessary to bdivision. Lent is not met as evidenced and document review, the lort and thoroughly investigate care/supervision for 1 of 1 ted, potentially affecting esidents who resided on the	21990	Plan of correction written 10/27/16 Correction to be completed by 11/		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	00811	B. WING		09/3	0/2016
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
MALA STRANA CARE & REHABILIT	ΓΔΤΙΟΝ CEN	UMBUS AVE	NUE NORTH		
(X4) ID SUMMARY STATEMEN PREFIX (EACH DEFICIENCY MUST TAG REGULATORY OR LSC IDEN	NT OF DEFICIENCIES BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
5:30 am [E-1] left a note of had left the building ill. She departure to any staff per was no evidence of her be not tell this writer she was during the conversation." Notice read, "We found a	that or when she walked beared in rooms for long nt on throughout the from the schedule that ntial neglect of care was it to the designated State. The dee/Facility Concerns redly "Left residents y care unit). A nurse unauthorized break and s, having been outside. The a statement indicating emerging from the break on the break room. The diplomatical in a resident's lead, "Multiple complaints wided by [E-1] tonightAt on the clipboard that she he had not reported her reson or this writer. There being sick and she did as sick moments before "An Employee Warning a note at the desk that 5:30 a.m., ill or sick. You arse or Administrator who essentially means you annot happen in: Written warning at this pen again. Leaving the abandonment of	21990	BELLICITY		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00811	B. WING		09/3	30/2016
	PROVIDER OR SUPPLIER	ARII ITATION CEN 1001 CO	DDRESS, CITY, S LUMBUS AVE AGUE, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21990	SA. On the night of 1/30 responsible for the unit, rooms (110-1) dispatched to the fa a.m. to respond to who resided on the nurse informed the resucitate wishes. and asked for assis regarding E-1's alle was removed from shift, however, the reported to the SA. A log of allegations no incidents related cares/supervision hinvestigated during E-1 was scheduled days unavailable fo 1/31/16, and althouthe west unit where worked together, with East or Little Vinurse who worked The director of nurse 9/30/16, at 1:21 p.m. although he had wo DON but the nurse DON said E-1 was assistant in the buil odd statements and He was not fully ap aware the former a re-education for E-1	ge 17 O to 1/31/16, E-1 was care of residents on the East to 131-1). Police were acility at approximately 2:16 an non-responsive resident East wing. After the officers arm the resident had do not The nurse expressed concernstance from the officers ged impaired condition. E-1 the schedule for the rest of the incident was not immediately reported to the SA revealed to potential neglect of the months of 12/15 or 1/16. To work 25 of 29 days (two review) from 1/1/16 to gh could have been paired on two nursing assistants (NAs) as assigned alone on either lage memory care unit with a between the two units. Sing (DON) was interviewed on the DON indicated that orked with E-1, he was not the manager at the time. The the "most competent nursing ding," but had been making the was displaying odd behavior. prised of the situation, but was dministrator provided 1. It was the DON's opinion to been allowed to return to				

PRINTED: 10/28/2016 **FORM APPROVED** Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: __ B. WING 00811 09/30/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1001 COLUMBUS AVENUE NORTH **MALA STRANA CARE & REHABILITATION CEN NEW PRAGUE, MN 56071** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 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

Minnesota Department of Health

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00811	B. WING		09/3	0/2016	
	PROVIDER OR SUPPLIER	ARII ITATION CEN 1001 COL		STATE, ZIP CODE ENUE NORTH 6071			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE	
21990	committee for revie	ould be brought to the quality	21990				
21995	Maltreatment of Vul Subd. 4a. Interna (a) Each facility shat ongoing written pro- applicable licensing of suspected maltre- facility has an internal mandated reporter requirements of this internally. However responsible for com- reporting requirements.	I reporting of maltreatment. all establish and enforce an ocedure in compliance with rules to ensure that all cases eatment are reported. If a nal reporting procedure, a may meet the reporting section by reporting r, the facility remains aplying with the immediate	21995			11/11/16	
	facility failed to follo thoroughly investigated, potentially for investigated, potentially for experimental to the facility's undated and the prohibition/Vulneral "Immediately, upon will take necessary from possible subse	ed Abuse learning of the incident, staff actions to protect residents		Plan of correction written 10/27/16 Correction to be completed by 11/			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00811	B. WING		09/3	30/2016
	PROVIDER OR SUPPLIER	ABILITATION CEN 1001 CO	DDRESS, CITY, S LUMBUS AVE AGUE, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21995	discovery of the incin accordance with E-1's personnel file indicating that on the employee E-1 was although she was no residents at the time. "Call lights continued crawling out of bed that I was checking on or assisting was underwear, soaker would be with resid with or had already she was working or as to when she did night I noticed she was working or as to when she did night I noticed she was againShe had 2 dwith the same infort were mixed in with spilled all over them frequent bathroom there just shortly be down the hall she did periods of timeThe night." E-1 was remnight, however, the not immediately repagency (SA). On 12/13/15, an Enform indicated E-1 alone in Village" (mobserved E-1 taking was seen coming in	the the Minnesota Ith (MDH) immediately after identInvestigation will begin Federal Law." revealed statements be night of 12/1 to 12/2/15, reportedly in resident rooms, ot providing care for the e. A staff's statement read, ed to alarm or residents or calling out. Every resident on or assisting was checking	21995			

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AND BLAN OF CORRECTION . IDENTIFICATION NUMBER:		A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00811	B. WING		09/3	30/2016
	PROVIDER OR SUPPLIER	ARII ITATION CEN 1001 COL		ETATE, ZIP CODE ENUE NORTH 6071		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
21995	room and then goin "Action taken: Cont "Action taken: Cont The file also contain regarding an incide from a NA who four room. Employee No about the care leve 5:30 am [E-1] left a had left the building departure to any stawas no evidence of not tell this writer shad uring the conversa Notice read, "We for said you had left eadid not tell the charmwas in the building. left the residents" againAction to be time, but this cannot floor and not report residents and will releaving without not	g back to the break room. inue to monitor." med a report dated 12/17/15, nt involving E-1, including and E-1 sleeping in a resident's otes read, "Multiple complaints is provided by [E-1] tonightAt note on the clipboard that she ill. She had not reported her aff person or this writer. There her being sick and she did ne was sick moments before ation." An Employee Warning bund a note at the desk that rly at 5:30 a.m., ill or sick. You ge nurse or Administrator who This essentially means you	21995			
	responsible for the unit, rooms (110-1 the dispatched to the far a.m. to respond to a who resided on the nurse informed their resucitate wishes. It and asked for assist regarding E-1's alle	o to 1/31/16, E-1 was care of residents on the East to 131-1). Police were acility at approximately 2:16 an non-responsive resident East wing. After the officers a m the resident had do not The nurse expressed concernstance from the officers ged impaired condition. E-1 the schedule for the rest of the				

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Minnesota Department of Health

STATEMEN	AND DUAN OF CODDECTION IDENTIFICATION NUMBER.					(3) DATE SURVEY COMPLETED	
00811		B. WING		09/3	0/2016		
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE			
MALA S	TRANA CARE & REH	ARII ITATION CEN		NUE NORTH			
(V4) ID	SLIMMARV STA	TEMENT OF DEFICIENCIES	GUE, MN 50	PROVIDER'S PLAN OF CORRECTION)N	(X5)	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROL DEFICIENCY)	D BE	COMPLETE DATE	
21995	Continued From pa	ge 22	21995				
	no incidents related cares/supervision hinvestigated during E-1 was scheduled days unavailable for 1/31/16, and althouthe west unit where worked together, with East or Little Vinurse who worked The director of nurs 9/30/16, at 1:21 p.m although he had wo DON but the nurse DON said E-1 was assistant in the buil odd statements and He was not fully ap aware the former a re-education for E-E-1 should not have work on the nights leaving the residenthe surveyor had the no other related regalia VA [vulnerable act was anythingInvestile." The DON state whole situation should fiferently.	reported to the SA revealed of to potential neglect of had been reported and the months of 12/15 or 1/16. to work 25 of 29 days (two or review) from 1/1/16 to gh could have been paired on two nursing assistants (NAs) as assigned alone on either lage memory care unit with a between the two units. Sing (DON) was interviewed on in. The DON indicated that orked with E-1, he was not the manager at the time. The the "most competent nursing ding," but had been making d was displaying odd behavior. prised of the situation, but was dministrator provided 1. It was the DON's opinion to been allowed to return to in question, particularly after its unattended. The DON said the entire file, and he knew of ports or investigations. "As for lult] report, I don't think there estigation? Only what's in the ed in hindsight, he felt the uld have been handled was interviewed on 9/30/16, at					
	3:15 p.m. He report situation with E-1 (place had talked between	vas interviewed on 9/30/16, at rted that since learning of the prior to his employment), they a facilities as well as to local determine how to handle					

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(14) days.

TIME PERIOD FOR CORRECTION: Fourteen