Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 23, 2023

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

RE: CCN: 245514
Cycle Start Date: May 24, 2023

Dear Administrator:

On May 24, 2023, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Nathan Schreier, Unit Supervisor
Metro B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: nate.schreier@state.mn.us
Office: (651) 201-4348 Mobile (651) 392-2726

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or

Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by August 24, 2023 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by November 24, 2023 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the

dates specified for compliance or the imposition of remedies.

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

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

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245514	A. BUILDING _____ B. WING _____	C 05/24/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On May 21- 24, 2023, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was in compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On May 21-24, 2023, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with NO deficiencies cited: H55142277C (MN86829), H55142289 (MN 91222), H55142275C (MN93015), H55142274C (MN83693) and H55142273C (MN85833). and The following complaint was reviewed: H55142276C (MN91996) with a deficiency cited at F695 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/03/2023

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245514	A. BUILDING _____ B. WING _____	C 05/24/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 1 Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure oxygen tubing was changed according to physician orders and professional standards for 2 of 2 residents (R33, R41) reviewed for oxygen therapy. In addition, the facility failed to ensure oxygen was provided for 1 of 2 residents (R33) whose portable oxygen tank was empty. Findings include: R33's quarterly Minimum Data Set (MDS) dated 4/18/23, indicated R33 had intact cognition, was independent with eating and required extensive assistance with all other activities of daily living (ADLs). R33's diagnoses included congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD resulting in difficulty breathing), and obstructive sleep apnea (periods	F 695	Preparation, submission, and implementation of this plan of correction does not constitute an admission of agreement with the facts and conclusions set forth on this survey report. Our plan of correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Some residents have the potential to be affected by this deficient practice: An audit was done for all residents receiving oxygen therapy. The process for changing oxygen tubing/cannulas and	7/3/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245514	A. BUILDING _____ B. WING _____	C 05/24/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 2 of not breathing during sleep). R33's care plan dated 2/6/23, indicated R33 had an alteration in respiratory status related to COPD. Interventions included R33 preferring to sleep in a recliner and requesting his bed be removed from his room, monitoring R33's oxygen level as ordered and as needed, monitoring for shortness of breath with a goal to keep oxygen levels above 90%. R33's physician orders dated 5/22/23, indicated R33 was on oxygen at 1-3 liters per minute (lpm) to keep oxygen levels above 90%. During an observation on 5/21/23 at 12:03 p.m., R33 was sitting in his room with a nasal cannula (tubing that delivers oxygen through two prongs inserted into the nostrils) that was delivering humidified oxygen. The nasal cannula tubing had a piece of tape labeled "5/8" and the humidified water bottle (bubbler) was dated 3/27/23. During an observation and interview on 5/22/23 at 5:33 p.m., R33 was sitting in his wheelchair in his room. R33's nasal cannula tubing was dated "5/22" but the bubbler remained dated "3/27/23". R33's nasal cannula was attached to a portable oxygen tank that was hanging from the back of his wheelchair. The portable oxygen tank was set to deliver oxygen at 1.5 lpm however, the oxygen tank gage needle was in the red, indicating it was empty. Upon notifying R33, he removed the cannula from his nostrils and verified he could not feel any oxygen coming out. R33 then checked his oxygen saturation level with a personal pulse oximeter which read 90% and denied increased shortness of breath but.stated he was on oxygen continuously and requested staff assistance to	F 695	replacing the bubblers used for humidification was reviewed and tweaked. The audit and process review ensures residents currently receiving oxygen therapy and, in the future, will have clean accessories and will not go without oxygen. The residents that reside at Mala Strana with oxygen orders often use portable oxygen when leaving their room. The portable oxygen tank is to be checked every time to ensure there is oxygen in the tank. When returning to their room, the portable oxygen tank should be turned off and the tubing switched to the large tank of liquid oxygen. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: The Treatment Administration Record identifies what day of the week the oxygen tubing and bubbler is to be changed for each resident on oxygen. Not all residents use a bubbler. The nursing staff have been provided with education regarding the need to ensure this task is completed as scheduled. Audits of residents with oxygen therapy and new admissions/hospital returns/new orders will be included in this sample. Corrective action(s) will be monitored to ensure the deficient practice will not recur.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245514	A. BUILDING _____ B. WING _____	C 05/24/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 3 switch his oxygen tubing to the large "main" tank in his room as they should have when he returned from activities over an hour prior. At 5:41 p.m. licensed practical nurse (LPN)-A entered R33's room, verified his portable oxygen tank was empty, and attached R33's nasal cannula to the large tank. LPN-A stated R33 needed to be on oxygen continuously and should have been switched to the main tank by staff when he was brought back to his room after his activities. LPN-A also verified R33's bubbler was dated 3/27/23, but stated she did not know how often the bubbler or tubing were supposed to be changed because it was done on the night shift. During an observation on 5/23/23 at 7:27 a.m. R33's bubbler was dated 3/27/23. During an interview on 5/23/23 at 7:47 a.m. LPN-B verified the date on R33's bubbler was 3/27/23. LPN-B further stated the date on the oxygen tubing indicated the last time it was changed. LPN-B also stated she was unsure how often the bubbler was to be changed but thought it was every 30 days. R41's quarterly MDS dated 2/22/23, indicated R41 had moderate to severe cognitive deficits, required supervision with eating and bed mobility, limited assistance with transfers, personal hygiene and dressing, and extensive assistance with toileting. R41's diagnoses included dementia, anxiety, diabetes, chronic respiratory failure with low oxygen, a pacemaker,and heart failure. R41's care plan dated 5/23/23, lacked indication R41 was on oxygen or interventions regarding R41's oxygen use.	F 695	Routine monitoring will be put into place: The director of nursing services and/or designee will audit residents receiving oxygen therapy on a weekly basis. This data will be reported at the July and October 2023 Quality Assessment and Process Improvement Committee. The results of the reviews/monitoring tool will be assessed and continued if found necessary.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245514	A. BUILDING _____ B. WING _____	C 05/24/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 4 R41's physician orders dated 5/22/23, indicated the following: -Change oxygen tubing weekly every night shift on Sunday. -Oxygen at 1-2 lpm by nasal cannula to keep oxygen level above 90%. During an observation and interview on 5/21/23 at 10:14 a.m., R41 was in her wheelchair getting ready to leave with her family for the day. R41 had a nasal cannula on that was dated "4/3" and a bubbler attached to her large main oxygen tank dated 1/30/23. R41 stated she had her oxygen with her all the time "just in case." Trained medical aid (TMA)-A entered R41's room to assist her to get ready and stated oxygen tubing was changed on Sundays but was unsure if it was done every Sunday. TMA-A also stated she thought the tubing and bubbler would be changed at the same time. During an observation on 5/22/23 at 5:11 p.m., R41's nasal cannula tubing was dated "5/22" and her bubbler was dated 1/30/23. During an observation on 5/23/23 at 7:30 a.m., R41 was sitting in her room in a recliner with a nasal cannula delivering humidified oxygen from the main tank. The bubbler was dated 1/30/23. During an interview on 5/23/23 at 7:34 a.m., in R41's room, registered nurse (RN)-A stated she believed the oxygen tubing was changed every Sunday and verified the tubing dated "4/3" indicated that was the last time the tubing had been changed. During an interview on 5/23/23 at 12:58 p.m., the director of nursing (DON) stated nasal cannula	F 695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245514	A. BUILDING _____ B. WING _____	C 05/24/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 5 oxygen tubing was to be changed weekly and the bubblers were to be changed at least monthly and both should be dated each time they were changed. The DON stated a resident on continuous oxygen should be switched from their portable tank to the main tank whenever they were in their room to avoid the portable tank from running out of oxygen and the resident becoming hypoxic (low oxygen). The DON also stated any staff could switch the resident from their portable tank to the main tank if the settings remained the same. The facility uses the Northwest Respiratory Services (NRS) customer handbook as their policy and procedure for oxygen use. The NRS handbook dated 3/2007, indicated to replace nasal cannulas "each week" and the humidifier bottle (bubbler) "once every month." No other policy or procedure regarding oxygen use or delivery was provided.	F 695		
F 804 SS=D	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure food was	F 804	Based on observation, interview, and document review, the facility failed to	7/3/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245514	A. BUILDING _____ B. WING _____	C 05/24/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 804	Continued From page 6 served at a palatable temperature for 3 of 3 residents (R11, R19, R31) reviewed for dining services. Findings include: R11's annual Minimum Data Set (MDS) dated 4/7/23, indicated R11 had intact cognition, was independent with eating. R19's quarterly MDS dated 3/16/23, indicated R19 had severe cognitive deficits, was independent with eating. R31's quarterly MDS dated 5/5/23, indicated R31 had intact cognition, was independent with eating. Review of Resident Council Meeting notes from January 2023 to May 2023 indicated the following: -1/18/23, "Cold meals-especially B-fast [breakfast]" -Response from the culinary director (CD): Residents can eat in the main dining room where food would be served a lot warmer. Food is already covered to help it stay warm and microwaves are available. -5/18/23, "Meal trays sitting in hallway too long. Some still getting cold food; mainly breakfast." -Response from CD: "If come down to main dining room for meals-we can fix issues more quickly. Are using covered tops and bottoms." During an interview on 5/22/23 at 5:16 p.m., R11 stated she ate in her room and breakfast was often cold. R11 stated she had complained about it before, and it would get better for a day or two, but then go back to being cold.	F 804	ensure food was served at a palatable temperature for 3 of 3 residents (R11, R19, R31) reviewed for dining services. The facility is submitting a plan of correction in accordance with the regulatory requirement. Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Some residents have the potential to be affected by this deficient practice: The facility identified residents having the potential to be affected by the same practice and corrective actions have been taken. Foods are prepared, maintained, and served at the proper temperature for palatability. The room trays have the potential of having food served at a deficient temperature. A change was made to the time of delivery of room trays to ensure they were delivered to the residents in a timely manner. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: The Culinary Director provided education to the dietary staff related to the meal	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245514	A. BUILDING _____ B. WING _____	C 05/24/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 804	Continued From page 7 During an observation and interview on 5/23/23 at 8:00 a.m., the last resident meal tray was delivered to a resident's room on the northeast wing of the facility. During observation on 5/23/23 at 8:01 a.m., the CD removed the insulated cover from the test tray and recorded the scrambled eggs to be 122 degrees Fahrenheit. During an observation on 5/23/23 at 8:03 a.m., consumption of the test tray indicated the scrambled eggs were "room temperature" and not warm, decreasing their palatability. During an interview on 5/23/23 at 8:13 a.m., R19 was in his room and had finished eating breakfast. R19 stated the breakfast was good but his scrambled eggs were cold and would have liked them better if they were warmer. During an interview on 5/23/23 at 8:15 a.m., R11 stated the eggs could have been warmer because they tasted better when they were "really warm." Interview on 5/23/23 at 2:59 p.m., R31 indicated he eats all his meals in his room. He indicated he really prefers to have eggs for breakfast when they are on the menu, but they "always come cold", so he eats hot cereal. During an interview on 5/23/23 at 8:23 a.m., the registered dietician (RD) stated scrambled eggs should have been served at a minimum holding temperature of 135 degrees Fahrenheit. The RD further stated eggs served below 135 degrees Fahrenheit could be less appealing to the	F 804	service process and timely delivery to ensure foods are served at the proper temperature. All staff receive reminders through the daily Huddle Sheets to assist in tray delivery and offer residents the option to have their food reheated. Corrective action(s) will be monitored to ensure the deficient practice will not recur. Routine monitoring will be put into place: The Culinary Director or designee will monitor foods temperatures for two room trays on each unit two times weekly. This will be done once the tray has reached the resident. This data will be shared with the Quality Assessment and Performance Improvement Committee (QAPI) at the July 2023 meeting. Continued monitoring will continue based on the recommendations of the committee and this data will be reviewed at the October 2023 meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245514	A. BUILDING _____ B. WING _____	C 05/24/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 804	Continued From page 8 residents. No further policies regarding food service or food palatability were provided.	F 804		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245514	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/24/2023**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 05/24/2023. At the time of this survey, Mala Stranna Care and Rehabilitation Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

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

Electronically Signed | 07/03/2023

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245514	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/24/2023**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. The nursing home was built in 1972 and had an addition built in 2003 with both buildings being type II construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification and the building is fully sprinklered. The facility has a capacity of 69 beds and had a census of 52 at the time of the survey.	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245514	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/24/2023**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 223 SS=E	Doors with Self-Closing Devices CFR(s): NFPA 101 Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain postive latching devices on doors per NFPA 101 (2012 edition), Life Safety Code sections 19.2.2.2.7 and 19.2.2.2.8. These deficient findings could have a patterned impact on the residents within the facility. Findings include: On 05/24/2023 at 11:00 AM, it was revealed by observation that the positive latching devices were observed to be not functioning properly on the following doors: near resident room 119 and resident room 309.	K 223	The alleged deficient areas are located in facility common areas. Maintenance Director identified all affected fire doors and developed a plan to ensure that the adjustments for the latching would be completed. Targeted date for the completion of each identified fire door is week of 7/3/2023. These observed doors will be tested after the repair to assure they are are functioning properly on the following doors: near resident room 119 and resident room 309. Maintenance Director or designee will audit six (6) doors weekly for one (1)	7/3/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245514	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/24/2023**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 223	Continued From page 3 An interview with the Maintenance Director verified this or these deficient findings at the time of discovery.	K 223	month and thereafter, monthly x two (2) months to ensure positive latching devices are functioning properly. Audit results will be reviewed in quarterly QA meeting.	
K 291 SS=F	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test emergency lights per NFPA 101 (2012 edition), Life Safety Code sections 19.2.9.1 and 7.9.3.1.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 05/24/2023 at 10:00AM, it was revealed by a review of available documentation that test records could not be located to show that the annual 90 minute test was conducted on the emergency lights. An interview with the Mainatance Director verified this deficient finding at the time of discovery.	K 291	This plan of correction constitutes our written compliance for the deficiency cited. Annual 90 minute test was conducted on the emergency lights on 6/18/2023. This tested was completed by the Maintenance Director and documented for NFPA 101 emergency lighting. Annual testing will continue yearly by Maintenance Director or designee.	6/18/23

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 30, 2023

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

RE: CCN: 245514
Cycle Start Date: May 24, 2023

Dear Administrator:

On July 31, 2023, we notified you a remedy was imposed. On August 23, 2023 the Minnesota Department of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of August 10, 2023.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective August 24, 2023 did not go into effect. (42 CFR 488.417 (b))

In our letter of June 23, 2023, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from August 24, 2023 due to denial of payment for new admissions. Since your facility attained substantial compliance on August 10, 2023, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us