Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 27, 2025

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

RE: CCN: 245514
Cycle Start Date: May 21, 2025

Dear Administrator:

On June 9, 2025, we notified you a remedy was imposed. On June 26, 2025 the Minnesota Department of Health 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 June 18, 2025.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective June 24, 2025 did not go into effect. (42 CFR 488.417 (b))

In our letter of June 9, 2025, 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 June 24, 2025 due to denial of payment for new admissions. Since your facility attained substantial compliance on June 18, 2025, 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 Therefore, the NATCEP prohibition is rescinded.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 Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

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June 9, 2025

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

RE: CCN: 245514
Cycle Start Date: May 21, 2025

Dear Administrator:

On May 21, 2025, a survey was completed at your facility by the Minnesota Department(s) 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 isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective June 24, 2025.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective June 24, 2025. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective June 24, 2025.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs

offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $13,343; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by June 24, 2025, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Mala Strana Care & Rehabilitation Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from June 24, 2025. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

The purpose of the ePoC submission is to confirm your allegation of compliance and preparedness for a revisit.

Within ten (10) calendar days after your receipt of this notice, a provider should develop and submit an effective ePOC for the deficiencies cited. A revisit will determine if substantial compliance has been achieved.

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.

DEPARTMENT CONTACT

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

Elizabeth Silkey, Regional Operations Supervisor
Mankato District Office
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, MN 56001

Email: elizabeth.silkey@state.mn.us
Office: (507) 344-2742 Mobile: (651) 368-3593

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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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 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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS location and/or the Minnesota Department of Human Services that your provider agreement be terminated by November 21, 2025 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

tamika.brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A

written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown at (312) 353-1502. Information may also be emailed to tamika.brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 **and Minnesota Statute 144A.10 subd 15**, 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@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 05/21/2025

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 5/19/25 to 5/21/25, a survey for compliance with §483.73, Appendix Z, Emergency Preparedness Requirements for Long Term Care Facilities 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 5/19/25 to 5/21/25, 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: H55144947C (MN00102965) H55144948C (MN00108837) H55144949C (MN00113000) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the	F 000		

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

Electronically Signed | 06/17/2025

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

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F 000	Continued From page 1 regulations has been attained.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically	F 580		5/30/25

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F 580	Continued From page 2 update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to notify the provider, family/resident representative, and hospice of bruising for 1 of 1 resident (R2) reviewed for skin. Findings include: R2's significant change in status Minimum Data Set (MDS) assessment dated 3/19/25, indicated R2 had severe cognitive impairment, dependent on staff for toileting, dressing, personal hygiene, and transfers, utilized a wheelchair, and diagnoses included arthritis, abnormalities of gait and mobility, and hospice care. R2's care plan dated 3/21/25, indicated risk for alteration in skin integrity r/t (related to) impaired mobility and interventions included monitor skin integrity daily during cares, weekly skin inspection by nurse, monitor for skin breakdown for signs/symptoms of infection, report signs/symptoms to provider, and document on skin condition and keep provider informed of changes.	F 580	F580 - Notify of Changes This Plan of Correction constitutes our written allegation of compliance for the deficiency cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. R2 was affected by this. All residents have the potential to be affected by this. Family and Hospice provider were notified of the bruise documented on 5/20/2025. All residents have the potential to be affected by this alleged deficient practice, none were identified as being negatively impacted. Education was started on 5/21/2025, with nursing staff, on the expectation that any bruise will require notification to the	

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F 580	Continued From page 3 R2's progress note dated 5/12/25 at 11:49 p.m., registered nurse (RN)-B indicated new bruises: writer informed by nursing staff of client's skin bruise, two thin fading bruises were noted on clients midback section, writer unable to ascertain the clear cause but suspects could be a result of lift sling straps, on call nurse and DON (director of nursing) notified, monitoring orders placed to monitor bruises. R2's record review lacked documentation the provider, family or hospice had been notified of R2's bruising. On 5/19/25 at 2:57 p.m., during a phone interview family member (FM)-D stated she would expect notification from the facility if R2 was found with new skin concerns including bruising. On 5/20/25 at 10:22 a.m., during observation with RN-C and NA-B, R2's back was examined, revealing a faint discoloration (greenish/darker brown) approximately 2 centimeter by 1 centimeter below the right scapula. RN-C stated she had become aware of R2's bruising the day before (5/19/25) upon reviewing progress notes. On 5/20/25 at 10:29 a.m., RN-C, known as the nurse manger, stated she was not aware of R2's bruising until yesterday (5/19/25), when she reviewed R2's progress notes. RN-C stated she did not recall receiving notification from RN-B or discussion from the DON. RN-C stated the family and provider were expected notification of R2's bruise. On 5/20/25 at 10:36 a.m., the DON stated she was notified on 5/12/25, by phone from RN-B of	F 580	medical providers and families. The educational goal is to ensure other residents are not affected by the past deficient practice. Additional education was provided to nursing staff at the monthly nursing staff meeting on 5/29/2025. Staff were instructed to update the families and the providers for any injuries, change of status and/or medication/treatment changes. Documentation in a progress note is required to show this was completed. Daily huddles conducted by the nurse managers include this expected practice. The DON and/or designee will complete random audits of four residents weekly x 6 weeks. The audits were done by auditing progress notes for bruises and notification of the family and provider. Results will be reviewed at the monthly QAPI meeting for review and recommendations.	

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F 580	Continued From page 4 new back bruising. The DON stated the bruising was assessed and consistent with the transfer sling straps. The DON stated education to staff regarding proper use was provided. The DON confirmed that notification of the family and provider was expected. On 5/20/25 at 1:37 p.m., RN-D, known R2's hospice case manager, stated the facility was expected to notify hospice of new skin conditions including bruising and confirmed the facility had not made hospice aware of R2's bruising. On 5/20/25 at 2:43 p.m., RN-B stated he was informed on 5/12/25, by NA-D of bruising on R2's back. RN-B stated R2's skin was assessed and the bruises were consistent with the transfer sling straps. RN-B stated he contacted by phone the DON and RN-C. RN-B stated did not notify the family or provider, due to the time of day and expected the next shift nurse to follow up with family and the provider. On 5/20/25 at 2:46 p.m., NA-D stated on 5/12/25, when repositioning R2 she observed bruising on R2's back and notified RN-B. NA-D stated the bruising was consistent with the straps of the sling used for transfers. On 5/21/25 at 12:09 p.m., during a telephone interview nurse practitioner (NP)-E stated any new skin condition, including bruising, should be reported to the provider. Facility Skin Assessment and Wound Management policy dated 2/25, indicated When a significant alteration in skin integrity is noted, the following actions will be taken Notify provider/treatment ordered	F 580		

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F 580	Continued From page 5 Notify resident representative Review and update care plan	F 580		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a transfer belt was used to assist with a safe transfer for 1 of 2 residents (R30) reviewed for falls. This resulted in actual harm for R1 who fell when being transferred without a transfer belt, which resulted in a fall with a pelvic fracture. This deficient practice is being cited at past non-compliance related to corrective action taken prior to survey to ensure proper use of transfer belt prior to the survey. Findings include: R30's quarterly Minimum Data Set (MDS) dated 4/29/25, identified R1 had intact cognition, no rejection of care, dependent on staff with toileting hygiene, toilet transfer, sit to stand, chair/bed-to-chair transfer, required substantial/maximal assistance with shower/bath and lower body dressing, required partial/maximal assistance with personal hygiene, utilized a wheelchair, with diagnoses including fracture of	F 689	Past noncompliance: no plan of correction required.	

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F 689	Continued From page 6 superior rim of right pubis (break in the pelvis), displaced intertrochanteric fracture of left femur (hip fracture), and one fall with major injury since admission. R30's care plan dated 2/21/25, indicated alteration in mobility d/t (due to) bilateral leg pain and interventions included follow PT (physical therapy) instructions, assist with transfers A1 (assist of one). R30's care plan dated 5/21/25, indicated alteration in mobility d/t bilateral leg pain and dementia,3/12/25: acute nondisplaced fracture of the right pubic rami that is nonoperative, weight bearing as tolerated and pain control as needed per ED physician and interventions included PT per MD order, follow PT instructions, assist with movement in bed and in/out of bed, assist with transfers, A1 EZ stand (mechanical transfer equipment); fall risk related to diagnosis of cognitive impairment, heart failure, alcoholism, assistance with transfers toileting needs, assistance with ADL's (activity of daily living), gets tired and weak during ambulation r/t to heart failure, 3/12/25: fall from chair, interventions included PT to eval, resident given reacher devices, in PT for ambulation program. R30's fall review evaluation dated 8/3/24, indicated history of one-two falls within last six months, unable to independently come to a standing position, risk factors include impaired mobility r/t weakness and recent fall with hip fracture, fall history, forgetfulness, and daily use of medications that may contribute to fall risk, alert, able to make needs known, 1A (one assist), EZ transfer, staff will follow therapy recommendations and update as needed, current	F 689		

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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 689	Continued From page 7 fall interventions: appropriate footwear with transfers, room to be kept clear of clutter and debris, personal items and call light within reach. Facility document title Incident Review and Analysis dated 3/13/25, indicated on 3/12/25 at 2:10 p.m., R30 was ambulating in the hallway, felt weak tired, and was trying to sit down, NA (nursing assistant) was following behind with wheelchair, R30 missed the wheelchair when she was trying to sit down. IDT (interdisciplinary team) met to review current plan of care and fall care plan and further indicated staff was assisting R30 with walking program, R30 was to complete walking program per PT -BID (two times daily walk 15-20 feet (from room to nursing station) with right platform FWW (front wheel walker, A1, follow with w/c (wheelchair). Staff and R30 reported R30 had walked about 20 feet when R30 because tired and asked to sit down, R30 stated that as she was sitting down, she lost her balance and tipped over to her right side and feel, root cause: R30 appeared to be tired and weak during ambulation and after review walking program discontinue, PT to reassess and treat, son aware, and prefers R30 not to ambulate anymore. R30's document ED (emergency department) encounter summary dated 3/12/25, indicated R30 fell as she was leaning backwards to sit in her wheelchair and lost her balance resulting in a fall, resulting in right hemipelvis pain. R30 ED visit confirmed an acute nondisplaced fracture of the right pubic rami (pelvis fracture), and orthopedics was consulted and confirmed this was a nonoperative weight bearing as tolerated and pain control as needed, will require ongoing pain management and additional assistance at her care facility, and increased support and	F 689		

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F 689	Continued From page 8 nonemergent outpatient physical therapy that maybe benefit to help her with the discomfort and pain. R30's progress note dated 3/12/25 at 3:49 p.m., licensed practical nurse (LPN)-A indicated R30 had a witnessed fall in the hallway on West Wing at 3:30 p.m. R30 was walking in the hallway with staff and fell, new injuries to left temp, skin tear, hematoma, left shoulder shin tear, lower back of head-lump-hematoma, nursing checked R30 for bleeding and applied pressure to her left temp and her left shoulder, bandages applied vital signs taken .... Neuro ok, range of motion per normal with pain 3/10 in right hip that was new, assisted off the floor with a mechanical lift and two staff to her wheelchair then to bed, provider and family notified by RN (registered nurse) manager, sent to hospital due to being on blood thinners and a head strike. R30's progress note dated 3/12/25 at 11:28 p.m., registered nurse (RN)-A indicated phone call from ED nurse identified R30 would be returning to the facility via family, and R30 had a pubic rami fracture that was inoperable. Facility document titled Internal 4 Point Plan of Correction dated 3/19/25, indicated the NA (nursing assistant) was not following the residents (R30) plan of care/not using a transfer belt during ambulation, R30 was sent to ER for evaluation on 3/12/25, complete room audit for transfer belt availability, education was initiated for appropriate staff for the use of the transfer belts for ambulation, spoke with NA who was ambulating R30 and the incident, statement was given, resident interviews initiated for transfer belt use and safe ambulation, observation audits initiated	F 689		

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F 689	Continued From page 9 related to staff following the residents plan of care r/t ambulation and use of gait (provide support and stability during transfers and ambulation), provider update, like residents interviewed and audited for the use of transfer belts for safe ambulation, interviews initiated with staff on resident gait belt use an safe ambulation process, care plans updated and reviewed for ambulation safety, continued audits related to staff following the residents plan of care r/t use of gait belts and ambulation, education on use of transfer belts with ambulation, the incident review further indicated on 3/19/25, NA-A indicated in an email to the director of nursing, NA-A indicated R30 told me that she was trying to sit down and lost her balance, went into room 162 to asked if she (R30) wanted to walk she said yes I made sure she had good shoes on and forgot a gait belt, had the wheelchair behind her the whole time and we took a little break to rest, she started moving her feet and I thought she was going to start walking again but she lost her balance and fell. On 5/19/25 at 12:56 p.m., R30 was observed seated in a wheelchair in her room. R30 stated about a month ago while staff were helping her walk in the hallway she fell and broke her pelvis. R30 stated she lost her balance and fell, R30 confirmed staff were not using the gait belt when she fell. R30 stated since the fall staff used a mechanical lift for toilet transfers, and stated when staff transferred her now staff always use the gait belt. On 5/20/25 at 10:00 a.m., the director of nursing (DON) stated on 3/12/25 R30 experienced a fall on resulting in a fractured pelvis. The DON reported that during the initial fall review, the facility was unaware that a gait belt had not been	F 689		

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F 689	Continued From page 10	F 689		

used. However, upon completion of a comprehensive fall investigation, it was concluded that nursing assistant (NA)-A did not use the gait belt during the transfer and while assisting R30 to ambulate in the hallway with her walker. The DON confirmed that NA-A acknowledged the gait belt was not applied as expected during the ambulation on 3/12/25. The DON stated that the facility's policy and expectation was that a gait belt be used when transferring and walking residents. The DON further confirmed that following the incident, the facility initiated education for staff regarding the importance of transfer belt use, and ensured all staff received training on proper use of gait belts and safe transfer techniques

On 5/20/25 at 10:16 a.m., NA-C stated a transfer belt should always be used for any resident who required assist with transfers or ambulation, and confirmed the facility provided recent education on resident transfers.

On 5/20/25 at 10:21 a.m., RN-C stated that all facility nursing staff had received training and education on the use of gait belts. RN-C confirmed that it was the facility's policy and expectation that staff use a gait belt during all resident transfers and ambulation to ensure resident safety.

On 5/20/25 at 1:01 p.m., NA-B stated a gait belt was expected for any resident transfer and confirmed the facility provided training on resident transfers and use of gait belt when transfer or ambulating residents.

On 05/20/25 at 2:43 p.m., RN-B stated when someone required assistance with transfers staff

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F 689	Continued From page 11 were expected to always use a transfer belt. A transfer belt was used for stability and safety in case the resident got weak. On 5/20/25 at 2:46 p.m., NA-D stated a transfer belt should always be used when a resident required assistance with transfers. NA-D stated the facility provided recent education on the use of transfer belts with all residents to help prevent falls. On 5/21/25 at 7:36 a.m., during a telephone interview nursing assistant NA-A stated that on 3/12/25, she assisted R30 to ambulate out of her room. R30 used a walker, and NA-A followed behind the resident with a wheelchair while holding the back of R30's pants. NA-A confirmed that a gait belt was not applied to R30's waist during ambulation as required. She stated she "completely forgot" to use the gait belt and stated a gait belt was expected when walking with residents. NA-A stated that while assisting R30 in the hallway, approximately 100 feet from her room, R30 attempted to sit in the wheelchair without verbalizing the intent to do so. As a result, R30 lost her balance and fell. NA-A stated that following the fall, R30 immediately complained of pain to her leg and head, and she observed visible skin tears. NA-A stated she had been trained by the facility to use a gait belt when transferring or ambulating residents. She acknowledged this was the first time she failed to use the gait belt, stating it was an oversight. NA-A confirmed that gait belts are designated and readily available in all resident rooms, including R30's. NA-A stated that a nurse, whose name she could not recall, responded to the incident, assessed the R30, obtained vital signs, and staff used a mechanical lift to transfer R30 to a	F 689		

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F 689	Continued From page 12 wheelchair. NA-A stated R30 was transferred to the hospital. NA-A stated that after the fall, she experienced a panic attack and left the scene. NA-A stated she accepted full accountability for the incident and, following R30's fall she provided a statement to the facility, received re-education on gait belt use, transfer safety, corrective action, and completed a competency evaluation, including a return demonstration on proper ambulation techniques. On 5/21/25 at 8:28 a.m., NA-E stated that in March 2025, the facility provided staff education on the proper use of gait belts. NA-E reported that gait belts were available in each resident room and confirmed that, per the facility, two staff members were required to assist when ambulating a resident. She further stated that the use of a gait belt during ambulation was expected On 5/21/25 at 8:29 a.m., during an interview NA-F stated that when ambulating a resident, two staff members are expected to assist. One staff member was to walk alongside the resident, holding the gait belt, while the second staff member walks behind the resident pushing a wheelchair for safety. NA-F stated the facility had provided education and training to staff regarding the use of gait belts at all times during transfers and ambulation to ensure resident safety. During the survey resident observations, resident and staff interviews, and review of staff education records identified the facility was using transfer belts during all non-mechanical transfers that required staff assistance, and the facility had corrected the non-compliance of not transferring residents without a transfer belt who required the use of a transfer belt prior to entrance on 5/19/25,	F 689		

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F 689	Continued From page 13 prior to survey entrance. Facility Fall Prevention and Management policy dated 2/24, indicated: The purpose of this protocol is to identify residents at risk for fall implement fall prevention interventions, provide guidelines for assessing a resident after a fall and to assist staff in identifying causes off the fall. Avoidable Accident- means that an accident occurred because the facility failed to : -Identify environmental hazards and/or assess individual resident risk of an accident, including the the need for supervision and/or assitive devices and/or -Implement interventions including adequate supervision and assistive devices consistent with a resident's needs, goals, care plan and current professional standard of practice in order to eliminate the risk, if possible, and, if not, reduce the risk of an accident.	F 689		
F 801 SS=F	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A	F 801		6/9/25

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F 801	Continued From page 14 qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section. (iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law. §483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services. (i) The director of food and nutrition services must at a minimum meet one of the following qualifications- (A) A certified dietary manager; or (B) A certified food service manager; or	F 801		

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F 801	Continued From page 15 (C) Has similar national certification for food service management and safety from a national certifying body; or D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; or (E) Has 2 or more years of experience in the position of director of food and nutrition services in a nursing facility setting and has completed a course of study in food safety and management, by no later than October 1, 2023, that includes topics integral to managing dietary operations including, but not limited to, foodborne illness, sanitation procedures, and food purchasing/receiving; and (ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the acting culinary services director (CS)-D was certified and credentialed to oversee food preparation and service(s) in 1 of 1 main production kitchen. This had potential to affect all residents who consumed food from the kitchen. Findings include: During interview on 5/19/25 at 11:40 a.m., CS-D stated she had worked at the facility for 30 years and was had not completed a qualifying course	F 801	F801 - Qualified Dietary Staff This Plan of Correction constitutes our written allegation of compliance for the deficiency cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. On March 18, 2025, the Cook / Assistant Dietary Services Manager, was enrolled in	

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F 801	Continued From page 16 for her position. CS-D further stated she was not interested in further schooling. CS-D stated cook (C)-A was enrolled in a certified dietary manager (CDM) course through North Dakota University but had not completed the course yet. CS-D was not aware of the facility ever having a qualified by certification dietary manager and further stated she was unsure when C-A wound complete the course. CS-D stated she consulted with the registered dietician (RD), but the registered dietician was not at the facility full time. During interview on 5/21/25 at 10:36 a.m., RD stated CS-D had worked at the facility for many years and based on experience was qualified for the position, but did not want to complete classes to become certified in dietary management. RD further stated C-A was enrolled in the CDM class in February 2023, and had one year to complete the course through University of North Dakota. RD stated C-A did not complete the course on time and was reenrolled for an additional year in March of 2025. RD stated C-A has submitted two modules and is making progress. RD stated it would be beneficial for residents to have a CDM at the facility. During interview on 5/20/25 at 2:41 p.m., administrator stated CS-D had worked at the facility for 30 years but was not interested in CDM classes. Administrator further stated C-A was taking classes through University of North Dakota but had not completed them in the allowed year. Administrator stated C-A was enrolled in the class again on 3/2025, and her preceptor was RD. Administrator stated she was aware the facility did not have a qualified certified dietary manager according to current regulation.	F 801	the Certified Dietary Manager program at the University of North Dakota. The online course began 3/21/2025 and is a One year course. On June 9, 2025, the Dietary Services Manager, was enrolled in the Certified Dietary Manager program at the University of North Dakota. The online course began 6/12/2025 and is a One year course. Both individuals will be monitored by the Consultant Registered Dietician or the Administrator to ensure timely completion of the course and successful examination for certification occurs as scheduled. Facility and Dietary Manager will continue to have regional dietician support the facility while culinary manager finishes CDM course, dietician will provide additional oversight. How the facility will identify other residents having the potential to be affected by the same deficient practice : All residents have the potential to be affected by the deficient practice. The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not recur : The facility has enrolled the culinary manager in an approved Certified Dietary Manager course. Quality Assurance plans to monitor facility	

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F 801	Continued From page 17 Review of facility provided email titled Welcome to the Nutrition and Foodservice Professional Training from UND Courses addressed to RD dated 1/19/23, indicated C-A had been enrolled in a Nutrition and Foodservice Professional training course and RD would be her preceptor. Review of facility provided email titled Welcome to the Nutrition and Foodservice Professional Training from UND Courses addressed to RD dated 2/10/24, indicated a different cook (C)-B had been enrolled in a Nutrition and Foodservice Profession training course and RD would be her preceptor. Review of a facility provided email dated 3/18/25, indicated C-A had again been enrolled in a course titled Nutrition and Foodservice Professional Training Program through University of North Dakota. In addition, the email stated the following regarding C-B: We regret to inform you that your enrollment in the Nutrition and Foodservice Professional Training Program has been canceled due to not completing your course in the timeframe that was provided to you. Your course end date was: 2/23/25. During review of email provided by administrator on 5/21/25, administrator indicated C-A had started CDM classes on 1/2023, and did not complete the classes in the required year. Administrator further indicated C-B had started courses in 2/2024, after C-A failed to complete her classes. C-B also did not complete her classes in the required year and her enrollment was canceled by the university. Administrator indicated C-A was then reenrolled in the class again in 3/2025. Administrator confirmed the facility did not have a qualified CDM on staff.	F 801	performance to ensure that corrections are achieved and maintained : The facility will review the progress of the culinary managers CDM course during Quarterly QAPI meetings.	

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F 801	Continued From page 18 A facility policy on requiring a CDM was requested but not received.	F 801		

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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 05/21/2025. At the time of this survey, Mala Strana 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		06/18/2025

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 _____	**05/21/2025**

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. Mala Strana Care and Rehabilitation Center The facility has a capacity of 69 beds and had a census of 65 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K 000		

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K 324	Continued From page 2	K 324		
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain proper inspection and safety measures associated to cooking devices in accordance with NFPA 101 (2012 edition), Life Safety Code, section 19.3.2.5, 19.3.2.5.3(9), 19.3.2.5.4, 19.3.2.5.5, 9.2.3. This deficient finding could have a isolated impact on the residents within the	K 324	K324 - Cooking Facilities This Plan of Correction constitutes our written allegation of compliance for the deficiency cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is	6/18/25

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K 324	Continued From page 3 facility. Findings include: On 05/21/2025 at 12:06 PM, it was revealed by observation that the residential stove located in the Center Therapy room does not have a switch located in a restricted location, that is on a timer, not exceeding a 120-minute capacity, that automatically deactivates the cook top or range, independent of staff action. This deficient finding was confirmed by the Maintenance Director at the time of discovery.	K 324	submitted to meet requirements established by state and federal law. Mala Strana Rehabilitation takes the safety of our residents very seriously in accordance with the requirements of Medicare/Medicaid. On June 18, 2025, our local Electrician installed the necessary switch, on a timer, not exceeding a 120-minute capacity, that automatically deactivates the cook top or range, independent of staff action. There were no residents affected. It could have had an isolated impact on the residents residing in the facility. The Administrator or Maintenance Director will complete weekly audits x4 weeks to ensure the residential stove switch and timer are working appropriately. Audits will continue until the August 2025 Quality Assurance and Performance Improvement Committee (QAPI) meeting. The administrator will share audit results with the QAPI committee for further recommendations. The Administrator is responsible for compliance with this requirement.	
K 372 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING	K 372		6/12/25

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K 372	Continued From page 4 Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke barriers per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.1, 19.3.7.3, 8.5.2.2 and 8.5.4. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 05/21/2025 at 11:47 AM, it was revealed by observation that the fire doors located at the East South barrier entering the Little Village had been completely removed. This deficient finding was confirmed by the Maintenance Director at the time of discovery.	K 372	K372 - Subdivision of Building Spaces - This Plan of Correction constitutes our written allegation of compliance for the deficiency cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. Mala Strana Rehabilitation takes the safety of our residents very seriously in accordance with the requirements of Medicare/Medicaid. On June 12, 2025, the fire doors located at the East South barrier entering the Little Village are now reinstalled in the correct place, tested, and working correctly. There were no residents affected. It could have had an isolated impact on the residents residing in the facility. The Administrator or Maintenance Director will complete weekly audits x4	

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K 372	Continued From page 5	K 372	weeks to ensure fire doors are working appropriately. Audits will continue until the August 2025 Quality Assurance and Performance Improvement Committee (QAPI) meeting. The administrator will share audit results with the QAPI committee for further recommendations. The Administrator is responsible for compliance with this requirement.	
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills under varied times and conditions per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.6, 4.7.4, and 4.6.1.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include:	K 712	K712 - Fire Drills - This Plan of Correction constitutes our written allegation of compliance for the deficiency cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements	5/21/25

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K 712	Continued From page 6 On 05/21/2025 at 11:12 AM, it was revealed by a review of available documentation that the facility was not varying times for fire drills. This deficient finding was confirmed by the Maintenance Director at the time of discovery.	K 712	established by state and federal law. Mala Strana Rehabilitation takes the safety of our residents very seriously in accordance with the requirements of Medicare/Medicaid. The facility failed to conduct fire drills under varied times and conditions in the past and Plant Operations was Educated by Administrator on 5/21/25 that drills must be conducted under varied times, varied shifts, and varied conditions. This will ensure that staff are familiar with procedures on all shifts and times. There were no residents affected. It could have had an isolated impact on the residents residing in the facility. The Administrator or designee will complete monthly audits x3 months to ensure fire drills are held under varied times and conditions. Audits will continue until the September 2025 Quality Assurance and Performance Improvement Committee (QAPI) meeting. The administrator will share audit results with the QAPI committee for further recommendations. The Administrator is responsible for compliance with this requirement.	