Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
September 29, 2025

Administrator
Mala Strana Care & Rehabilitation Center
1001 COLUMBUS AVENUE NORTH
NEW PRAGUE, MN 56071

RE: CCN: 245514
Cycle Start Date: August 6, 2025

Dear Administrator:

On September 12, 2025, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore, no remedies will be imposed.

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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September 29, 2025

Administrator
Mala Strana Care & Rehabilitation Center
1001 COLUMBUS AVENUE NORTH
NEW PRAGUE, MN 56071

Re: Reinspection Results
Event ID: 1D329A-H1

Dear Administrator:

On 09/12/2025 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on 08/06/2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
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Saint Paul, MN 55164-0900
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An equal opportunity employer.

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Electronically delivered

August 13, 2025

Administrator
Mala Strana Care & Rehabilitation Center
1001 COLUMBUS AVENUE NORTH
NEW PRAGUE, MN 56071

RE: CCN:245514
Cycle Start Date: August 6, 2025

Dear Administrator:

On August 6, 2025, a survey was completed at your facility by the Minnesota Departments of Health 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 no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), 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:

LeAnn Huseth, RN, Regional Operations Supervisor
Fergus Falls District Office
Health Regulation Division
Minnesota Department of Health
2312 College Way
Fergus Falls, MN 56537
Email: leann.huseth@state.mn.us

Office: (218) 332-5140 Mobile: (218) 403-1100

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 November 6, 2025, (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 February 6, 2026, (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)

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

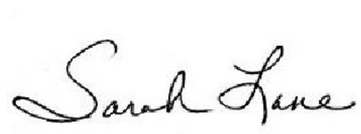
INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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.

Feel free to contact me if you have questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
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August 13, 2025

Administrator
Mala Strana Care & Rehabilitation Center
1001 COLUMBUS AVENUE NORTH
NEW PRAGUE, MN 56071

Re: State Nursing Home Licensing Orders
Event ID: 1D329A-H1

Dear Administrator:

The above facility was surveyed on August 6, 2025, for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a “suggested method of correction” has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction

Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

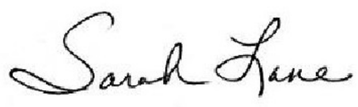
LeAnn Huseth, RN, Regional Operations Supervisor
Fergus Falls District Office
Health Regulation Division
Minnesota Department of Health
2312 College Way
Fergus Falls, MN 56537
Email: leann.huseth@state.mn.us

Office: (218) 332-5140 Mobile: (218) 403-1100

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.

Sincerely,



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 CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245514	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mala Strana Care & Rehabilitation Center	**1001 COLUMBUS AVENUE NORTH , NEW PRAGUE, Minnesota, 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
F0000	INITIAL COMMENTS On 8/6/25, an abbreviated survey was completed by surveyors from the Minnesota Department of Health (MDH) to conduct a complaint investigation. Your facility was found NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed: H55141503C (2579880, 2580710); non-compliance cited at F550, F609. 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 that substantial compliance with the regulations has been attained.	F0000		08/19/2025
F0550 SS = D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding	F0550	F0550 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. R1 was affected by this related to not having care provided with explanation and choices. All residents have the potential to be affected by this. The process of satisfying this requirement has been reviewed and revised as needed, to ensure the facility develops and implements processes and procedures to utilize electronic devices, communication boards and professional interpreter services as needed. All necessary Mala Strana Rehabilitation staff will be educated to devices available to interpreter services per the resident's care plan. All necessary Mala Strana	08/19/2025

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245514	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/06/2025

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F0550 SS = D	Continued from page 1 transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure morning cares were provided in a dignified, courteous manner to prevent complication (i.e., frustration, misunderstanding) for 1 of 1 residents (R1) reviewed who expressed staff had been rough with her during provision of care. Findings include: R1's admission Minimum Data Set (MDS), dated 6/16/25, identified R1 had severe cognitive impairment but demonstrated no delusional thinking during the review period. A submitted Incident Report Summary (i.e., FRI), dated 8/4/25, identified an incident had happened on 8/3/25 where R1 had expressed nursing assistant (NA)-A and NA-B were rough when getting her out of bed in the morning. R1 was found to have a bruise on her left leg after this incident and the FRI outlined R1 had sustained potential mental anguish from it with dictation reading, "Cried during interview." On 8/6/25 at 9:06 a.m., R1 was observed lying in bed while in her room. An interview was attempted with R1 at this time, and R1 nodded responses to verbal questions from the surveyor, however, responded aloud only in Spanish. Following, registered nurse manager	F0550	Continued from page 1 Rehabilitation staff will be educated to slow down while providing care, so they are effectively communicating with each resident in a courteous and dignified manner. The director of nursing and/or designee will complete random audits on a weekly basis for the next four weeks. Results will be reviewed at the monthly Quality Assessment and Performance Improvement meeting for review and recommendations.	

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F0550 SS = D	Continued from page 2 (RN)-C was approached and expressed R1 knew only a few English words so staff often used a bedside "AI [artificial intelligence] device" or had facility' staff translate. RN-C recommended having the facility' staff translate as R1 could speak fast at times which made it hard for the device to translate. At 9:09 a.m., licensed practical nurse (LPN)-A joined R1 and the surveyor and acted as interpreter for the conversation in Spanish. R1 was unable to recall how long she had lived at the care center but expressed a desire to return home. R1 denied being abused while at the care center, but stated the staff who had helped her "on Sunday [8/3]" had been rough and fast-moving with morning cares adding, per LPN-A, the cares provided, "They didn't get her up good." This was explained further as, "She was laying down and they grabbed her." R1 expressed she didn't like talking about the incident and appeared to become more subdued while speaking to LPN-A at this point. LPN-A stated R1 had expressed, "She wants to just forget about it," adding further that R1 was unsure if the staff who had helped her during this incident understood her (R1) or not due to a potential language barrier. Following, on 8/6/25 at 9:27 a.m., LPN-A was interviewed. LPN-A explained they had heard about the incident R1 had just described but expressed she (LPN-A) returned to work on Monday (8/4) afterward and R1 seemed "really upset" about it. LPN-A stated that is when they had found the bruising on R1's left leg and talked with trained medication aide (TMA)-B about the situation. TMA-B had told LPN-A they had overheard some of the interaction between R1 and NA-A, NA-B on 8/3/25 from outside the room as R1 had been "cursing them [NA-A, NA-B] out in Spanish." LPN-A stated the director of nursing (DON) was informed about the incident on Monday (8/4), and added they were "not sure" what, if any, education for staff had been attempted or started yet as they hadn't seen any be assigned for themselves. When interviewed on 8/6/25 at 9:44 a.m., TMA-B verified they spoke Spanish, and explained staff whom were not able to speak Spanish were supposed to be using the "AI device" to communicate and explain cares to R1. However, TMA-B added they hadn't seen staff using it much at all. TMA-B recalled the incident with R1 on 8/3/25 and verified they were on shift working that day when it happened. TMA-B explained they were in the hallway outside R1's room at the medication cart and overheard R1 yelling to the aides to, "Stop, slow down!" TMA-B stated NA-A then was clearly heard saying, "No commprendo," back to R1 in what TMA-B described as a "kind of sarcastic" manner while giggling aloud. TMA-B stated they then entered R1's room and saw R1	F0550		

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F0550 SS = D	Continued from page 3 "semi-sitting" on the bedside and R1 expressed to her, "They're not giving me time." TMA-B verified they never saw NA-A or NA-B be physically rough with R1. TMA-B stated she didn't approach NA-A about the comment made, however, reiterated they (TMA-B) had clearly heard it adding, "Loud and clear." Further, TMA-B stated since the incident happened on 8/3/25 that management had told staff to give R1 "more time" to do cares, however, had nothing had been educated or sent to them about potentially inappropriate language (i.e., sarcastic comments to residents) use that they had seen yet adding aloud, "No, not yet." R1's care plan, printed 8/6/25, identified R1's current or potential problems along with various goals and interventions to address them. The care plan identified a Focus, dated 6/16/25, which read, "Alteration in communication .. speaks Spanish," along with interventions including, "Speak clearly and distinctly to resident or use resident preferred communication method - use AI translator," and, "Alternate communication method (AI translator and or picture binder in room)." On 8/6/25 at 10:01 a.m., RN-C was interviewed, and verified they were the nurse manager for R1. RN-C explained they were also working on 8/3/25 and TMA-B approached them towards the end of the day to explain some staff had been "moving too fast with [R1]." RN-C stated TMA-B had never mentioned NA-A making potentially sarcastic comments back to R1, and expressed if staff overheard that then it should have been reported immediately. RN-C stated there were multiple staff members working on 8/3/25 who could have communicated with R1 in Spanish if the staff were having issues explaining cares or communicating with her. Following this, on 8/6/25 at 10:20 a.m., TMA-B approached the surveyor and expressed they had forgot to say they had reported the sarcastic comment NA-A made to RN-C on 8/3/25 adding, "I told [RN-C]." When interviewed on 8/6/25 at 11:28 a.m., via telephone, NA-A verified they had helped R1 with morning cares on 8/3/25. NA-A explained they entered R1's room and tapped R1's arm saying aloud in English it was time to get up for the day to which R1 "nodded her head" in response. NA-A stated though, "I could tell she was tired." NA-A stated she started to get R1 up and R1 seemed "very difficult" to move on her own so, as a result, NA-A left to get more help. NA-A and NA-B then both physically attempted to get R1 up from the bed using a gait belt when R1 expressed aloud words in Spanish. NA-A stated both of them (NA-A, NA-B) couldn't understand R1 so then, at that time, they	F0550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245514	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/06/2025

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F0550 SS = D	Continued from page 4 attempted to use the AI device to help translate her words, however, the device didn't work. NA-A stated they then did a "1-2-3" signal to R1 and attempted to sit her up again which is when TMA-B entered the room. NA-A stated she didn't feel R1 ever told her to stop cares or slow down, however, then added R1 spoke Spanish only so they (NA-A) weren't sure what had all been said. NA-A verified they made a comment aloud at one point of, "No commprendo," however, denied making this in a sarcastic manner. NA-A stated they were trying to tell R1 they didn't understand her but then added, "Maybe she [R1] took that tone as demeaning, I'm not sure." NA-A verified nobody had asked them or talked to them about the comment that day. NA-A expressed some frustration with the AI device and stated they'd never had training on it. NA-A stated "the biggest thing" about the incident on 8/3/25 was the language barrier adding if the device had worked like intended then "maybe it would have gone differently." NA-A added, in hindsight, they knew TMA-B was working that day and they "maybe should have gotten her earlier [to help translate or explain cares]." On 8/6/25 at 12:43 p.m., a group interview was completed with the DON, administrator, regional director of operations (RDO)-A, and assistant director of nursing (ADON). DON verified they were first told of the incident which happened on 8/3/25 the following day, on 8/4/25, and explained R1 alleged two female staff members had "pulled me out of bed." DON stated they visited with TMA-B who had explained to them they overheard R1 yelling at the two aides to "slow down" in Spanish which caused TMA-B to enter the room and tell the two aides to "take your time with her." DON stated nobody had reported NA-A as potentially saying comments to R1 in a sarcastic manner, but acknowledged she didn't clarify that with anyone, either. DON stated if staff overhear that happening, they should immediately report it to, at minimum, their nurse manager so it can be reviewed or addressed. DON added such behavior was "not acceptable here at Mala Strana." DON stated they had been investigating this incident since they were notified of it and expressed from their data collection thus far, the AI device had not been used or attempted until nearly after the cares were completed. DON verified staff should be knocking on the door and explaining "what they're going to do" to a resident prior to starting the care; and she reiterated there were staff members working in the building on the day of the incident whom could have helped interpret and provide communication between the NA(s) and R1 if there had been any confusion. The RDO stated they had started some education already about this incident, and the group all acknowledged the importance of maintaining	F0550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245514	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mala Strana Care & Rehabilitation Center	1001 COLUMBUS AVENUE NORTH , NEW PRAGUE, Minnesota, 56071

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F0550 SS = D	Continued from page 5 the resident rights with the DON expressing aloud, "That appears to be what was missed here." Further, the DON stated some education had been started and the administrator was going to send out an email with some resident' rights material to the staff that day. A facility policy on dignified care or treatment was requested, however, none was received.	F0550		
F0609 SS = D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure an allegation of potential verbal abuse (i.e., mocking, demeaning) was reported to the administrator and, if needed, the state agency (SA) in a timely manner for 1 of 3 residents (R1) reviewed during the abbreviated survey. Findings include:	F0609	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. R1 remains a resident at the facility. The two nursing assistants involved in the allegation were placed on investigatory leave on 8/4/2025 and returned to work after education was completed. R1 has been seen by facility psychologist and her son continues to be involved in her care and visits daily as he has done since her admission. Skin audit completed on like-residents. Abuse audits conducted with like-residents. All residents have the potential to be affected by this deficient practice. Education was started immediately after the allegation on timely reporting to all staff and will continue at monthly staff meetings to ensure staff understand the process and expectations related to abuse. The director of nursing and/or designee will complete random audits on a weekly basis for the next four weeks. Results will be reviewed at the monthly Quality Assessment and Performance Improvement meeting for review and recommendations.	08/19/2025

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F0609 SS = D	Continued from page 6 R1's admission Minimum Data Set (MDS), dated 6/16/25, identified R1 had severe cognitive impairment but demonstrated no delusional thinking during the review period. A submitted Incident Report Summary (i.e., FRI), dated 8/4/25, identified an incident had happened on 8/3/25 where R1 had expressed nursing assistant (NA)-A and NA-B were rough when getting her out of bed in the morning. R1 was found to have a bruise on her left leg after this incident and the FRI outlined R1 had sustained potential mental anguish from it with dictation reading, "Cried during interview." On 8/6/25 at 9:06 a.m., R1 was observed lying in bed while in her room. An interview was attempted with R1 at this time, and R1 nodded responses to verbal questions from the surveyor, however, responded aloud only in Spanish. Following, registered nurse manager (RN)-C was approached and expressed R1 knew only a few English words so staff often used a bedside "AI [artificial intelligence] device" or had facility' staff translate. RN-C recommended having the facility' staff translate as R1 could speak fast at times which made it hard for the device to translate. At 9:09 a.m., licensed practical nurse (LPN)-A joined R1 and the surveyor and acted as interpreter for the conversation in Spanish. R1 was unable to recall how long she had lived at the care center but expressed a desire to return home. R1 denied being abused while at the care center but stated the staff who had helped her "on Sunday [8/3]" had been rough and fast-moving with morning cares adding, per LPN-A, the cares provided, "They didn't get her up good." This was explained further as, "She was laying down and they grabbed her." R1 expressed she didn't like talking about the incident and appeared to become more subdued while speaking to LPN-A at this point. LPN-A stated R1 had expressed, "She wants to just forget about it." Following, on 8/6/25 at 9:27 a.m., LPN-A was interviewed. LPN-A explained they had heard about the incident R1 had just described but expressed she (LPN-A) returned to work on Monday (8/4) afterward and R1 seemed "really upset" about it. LPN-A stated that is when they had found the bruising on R1's left leg and talked with trained medication aide (TMA)-B about the situation. TMA-B had told LPN-A they had overheard some of the interaction between R1 and NA-A and NA-B on 8/3/25 from outside the room as R1 had been "cursing them [NA-A, NA-B] out in Spanish." When interviewed on 8/6/25 at 9:44 a.m., TMA-B verified they spoke Spanish and recalled the incident with R1 on	F0609		

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F0609 SS = D	Continued from page 7 8/3/25, and verified they were on shift working that day when it happened. TMA-B explained they were in the hallway outside R1's room at the medication cart and overheard R1 yelling to the aides to, "Stop, slow down!" TMA-B stated NA-A then was clearly heard saying, "No commprendo," back to R1 in what TMA-B described as a "kind of sarcastic" manner while giggling aloud. TMA-B stated they then entered R1's room and saw R1 "semi-sitting" on the bedside and R1 expressed to her, "They're not giving me time." TMA-B verified they never saw NA-A or NA-B be physically rough with R1. TMA-B stated they had never seen NA-A or NA-B be rough or demeaning with someone prior, however, reiterated they heard NA-A make that comment to R1 adding, "Loud and clear." TMA-B explained the comment was made with "sarcasm and like [in a] giggly way," which TMA-B stated made them upset also. TMA-B stated they felt the manner in which they heard NA-A make the comment to R1 was said in a demeaning way. On 8/6/25 at 10:01 a.m., RN-C was interviewed, and verified they were the nurse manager for R1. RN-C explained they were also working on 8/3/25 and TMA-B approached them towards the end of the day to explain some staff had been "moving too fast with [R1]." RN-C stated TMA-B had never mentioned NA-A making potentially sarcastic or demeaning comments back to R1, and expressed if staff overheard that then it should have been reported immediately. RN-C stated there were multiple staff members working on 8/3/25 who could have communicated with R1 in Spanish if the staff were having issues explaining cares or communicating with her. Following this, on 8/6/25 at 10:20 a.m., TMA-B approached the surveyor and expressed they had forgot to say they had reported the comment NA-A made to R1 to RN-C on 8/3/25 adding, "I told [RN-C]." The Centers for Medicare and Medicaid (CMS) iQEIS system was reviewed. This verified the allegation of R1 with rough care was not reported to the state agency (SA) until over 24 hours later on 8/4/25, despite TMA-B hearing staff make comments to R1 which were, in their view, potentially demeaning (i.e., verbally abusive) at the same time of the alleged rough care. When interviewed on 8/6/25 at 11:28 a.m., via telephone, NA-A verified they had helped R1 with morning cares on 8/3/25. NA-A explained they entered R1's room and tapped R1's arm saying aloud in English it was time to get up for the day to which R1 "nodded her head" in response. NA-A stated though, "I could tell she was tired." NA-A stated she started to get R1 up and R1 seemed "very difficult" to move on her own so, as a result, NA-A left to get more help. NA-A and	F0609		

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F0609 SS = D	Continued from page 8 NA-B then both physically attempted to get R1 up from the bed using a gait belt when R1 expressed aloud words in Spanish. NA-A stated both of them (NA-A, NA-B) couldn't understand R1 so then, at that time, they attempted to use the AI device to help translate her words, however, the device didn't work. NA-A stated they then did a "1-2-3" signal to R1 and attempted to sit her up again which is when TMA-B entered the room. NA-A stated she didn't feel R1 ever told her to stop cares or slow down, however, then added R1 spoke Spanish only so they (NA-A) weren't sure what had all been said. NA-A verified they made a comment aloud at one point of, "No commprendo," however, denied making this in a sarcastic manner. NA-A stated they were trying to tell R1 they didn't understand her but then added, "Maybe she [R1] took that tone as demeaning, I'm not sure." NA-A verified nobody had asked them or talked to them about the comment that day, and they finished working their shift on that day. On 8/6/25 at 12:43 p.m., a group interview was completed with the DON, administrator, regional director of operations (RDO)-A, and assistant director of nursing (ADON). DON verified they were first told of the incident which happened on 8/3/25 the following day, on 8/4/25, and explained R1 alleged two female staff members had "pulled me out of bed." DON stated they visited with TMA-B who had explained to them they overheard R1 yelling at the two aides to "slow down" in Spanish which caused TMA-B to enter the room and tell the two aides to "take your time with her." DON stated nobody had reported NA-A as potentially saying comments to R1 in a sarcastic manner, but acknowledged she didn't clarify that with anyone, either. DON stated if staff overhear that happening, they should immediately report it to, at minimum, their nurse manager so it can be reviewed or addressed. DON added such behavior was "not acceptable here at Mala Strana." The DON and administrator both acknowledged that demeaning comments could potentially be verbal abuse; but the RDO expressed people could perceive things differently and it was hard to immediately link an overheard comment to a "willful intent of harm." The RDO stated the context of the situation along with how the comment was said mattered to help determine if it was reportable as an allegation of potential verbal abuse or more a "customer service concern." However, all of the group acknowledged the staff who heard that comment, including with their concerns about it, should have reported it to them right away so it could be acted upon. The facility Abuse Prohibition/Vulnerable Adult Policy, dated 4/2025, identified all staff were responsible for	F0609		

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F0609 SS = D	Continued from page 9 reporting, " ... any situation that is considered abuse or neglect ..." The policy directed a supervisor would be notified whom would then assess the situation to determine if any emergency treatment of action was required. The policy outlined, "Notification to the facility Administrator will occur immediately for any incidents of resident abuse, alleged or suspected abuse, injury of unknown origin, neglect, financial exploitation, or involuntary seclusion." The policy listed a definition of abuse which included, " ... It includes verbal abuse, sexual abuse, physical abuse, and mental abuse ... Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm." However, the policy lacked a specific definition of what did or could constitute 'verbal abuse' under their review. The policy directed any suspected abuse would be reported to the SA via the online reporting system not later than 2 hours after the forming of suspicion of potential abuse.	F0609		

Minnesota State Department of Health

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20000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 8/6/25, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing orders were issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed. The following complaints were reviewed: H55141503C	20000		08/19/2025

Office of Primary Care and Health Systems Management

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

Minnesota State Department of Health

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20000	Continued from page 1 (2579880, 2580710); orders issued at 1805. MDH is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	20000		
21805	Patients & Residents of HC Fac.Bill of Rights CFR(s): MN St. Statute 144.651 Subd. 5 Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure morning cares were provided in a dignified, courteous manner to prevent complication (i.e., frustration, misunderstanding) for 1 of 1 residents (R1) reviewed who expressed staff had	21805	Corrected	08/19/2025

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21805	Continued from page 2 been rough with her during provision of care. Findings include: R1's admission Minimum Data Set (MDS), dated 6/16/25, identified R1 had severe cognitive impairment but demonstrated no delusional thinking during the review period. A submitted Incident Report Summary (i.e., FRI), dated 8/4/25, identified an incident had happened on 8/3/25 where R1 had expressed nursing assistant (NA)-A and NA-B were rough when getting her out of bed in the morning. R1 was found to have a bruise on her left leg after this incident and the FRI outlined R1 had sustained potential mental anguish from it with dictation reading, "Cried during interview." On 8/6/25 at 9:06 a.m., R1 was observed lying in bed while in her room. An interview was attempted with R1 at this time, and R1 nodded responses to verbal questions from the surveyor, however, responded aloud only in Spanish. Following, registered nurse manager (RN)-C was approached and expressed R1 knew only a few English words so staff often used a bedside "AI [artificial intelligence] device" or had facility' staff translate. RN-C recommended having the facility' staff translate as R1 could speak fast at times which made it hard for the device to translate. At 9:09 a.m., licensed practical nurse (LPN)-A joined R1 and the surveyor and acted as interpreter for the conversation in Spanish. R1 was unable to recall how long she had lived at the care center but expressed a desire to return home. R1 denied being abused while at the care center, but stated the staff who had helped her "on Sunday [8/3]" had been rough and fast-moving with morning cares adding, per LPN-A, the cares provided, "They didn't get her up good." This was explained further as, "She was laying down and they grabbed her." R1 expressed she didn't like talking about the incident and appeared to become more subdued while speaking to LPN-A at this point. LPN-A stated R1 had expressed, "She wants to just forget about it," adding further that R1 was unsure if the staff who had helped her during this incident understood her (R1) or not due to a potential language barrier. Following, on 8/6/25 at 9:27 a.m., LPN-A was interviewed. LPN-A explained they had heard about the incident R1 had just described but expressed she (LPN-A) returned to work on Monday (8/4) afterward and R1 seemed "really upset" about it. LPN-A stated that is when they had found the bruising on R1's left leg and talked with trained medication aide (TMA)-B about the	21805		

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21805	Continued from page 3 situation. TMA-B had told LPN-A they had overheard some of the interaction between R1 and NA-A, NA-B on 8/3/25 from outside the room as R1 had been "cursing them [NA-A, NA-B] out in Spanish." LPN-A stated the director of nursing (DON) was informed about the incident on Monday (8/4), and added they were "not sure" what, if any, education for staff had been attempted or started yet as they hadn't seen any be assigned for themselves. When interviewed on 8/6/25 at 9:44 a.m., TMA-B verified they spoke Spanish, and explained staff whom were not able to speak Spanish were supposed to be using the "AI device" to communicate and explain cares to R1. However, TMA-B added they hadn't seen staff using it much at all. TMA-B recalled the incident with R1 on 8/3/25 and verified they were on shift working that day when it happened. TMA-B explained they were in the hallway outside R1's room at the medication cart and overheard R1 yelling to the aides to, "Stop, slow down!" TMA-B stated NA-A then was clearly heard saying, "No commprendo," back to R1 in what TMA-B described as a "kind of sarcastic" manner while giggling aloud. TMA-B stated they then entered R1's room and saw R1 "semi-sitting" on the bedside and R1 expressed to her, "They're not giving me time." TMA-B verified they never saw NA-A or NA-B be physically rough with R1. TMA-B stated she didn't approach NA-A about the comment made, however, reiterated they (TMA-B) had clearly heard it adding, "Loud and clear." Further, TMA-B stated since the incident happened on 8/3/25 that management had told staff to give R1 "more time" to do cares, however, had nothing had been educated or sent to them about potentially inappropriate language (i.e., sarcastic comments to residents) use that they had seen yet adding aloud, "No, not yet." R1's care plan, printed 8/6/25, identified R1's current or potential problems along with various goals and interventions to address them. The care plan identified a Focus, dated 6/16/25, which read, "Alteration in communication .. speaks Spanish," along with interventions including, "Speak clearly and distinctly to resident or use resident preferred communication method - use AI translator," and, "Alternate communication method (AI translator and or picture binder in room)." On 8/6/25 at 10:01 a.m., RN-C was interviewed, and verified they were the nurse manager for R1. RN-C explained they were also working on 8/3/25 and TMA-B approached them towards the end of the day to explain some staff had been "moving too fast with [R1]." RN-C stated TMA-B had never mentioned NA-A making potentially sarcastic comments back to R1, and	21805		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **08/06/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mala Strana Care & Rehabilitation Center	**1001 COLUMBUS AVENUE NORTH , NEW PRAGUE, Minnesota, 56071**

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21805	Continued from page 4 expressed if staff overheard that then it should have been reported immediately. RN-C stated there were multiple staff members working on 8/3/25 who could have communicated with R1 in Spanish if the staff were having issues explaining cares or communicating with her. Following this, on 8/6/25 at 10:20 a.m., TMA-B approached the surveyor and expressed they had forgot to say they had reported the sarcastic comment NA-A made to RN-C on 8/3/25 adding, "I told [RN-C]." When interviewed on 8/6/25 at 11:28 a.m., via telephone, NA-A verified they had helped R1 with morning cares on 8/3/25. NA-A explained they entered R1's room and tapped R1's arm saying aloud in English it was time to get up for the day to which R1 "nodded her head" in response. NA-A stated though, "I could tell she was tired." NA-A stated she started to get R1 up and R1 seemed "very difficult" to move on her own so, as a result, NA-A left to get more help. NA-A and NA-B then both physically attempted to get R1 up from the bed using a gait belt when R1 expressed aloud words in Spanish. NA-A stated both of them (NA-A, NA-B) couldn't understand R1 so then, at that time, they attempted to use the AI device to help translate her words, however, the device didn't work. NA-A stated they then did a "1-2-3" signal to R1 and attempted to sit her up again which is when TMA-B entered the room. NA-A stated she didn't feel R1 ever told her to stop cares or slow down, however, then added R1 spoke Spanish only so they (NA-A) weren't sure what had all been said. NA-A verified they made a comment aloud at one point of, "No commprendo," however, denied making this in a sarcastic manner. NA-A stated they were trying to tell R1 they didn't understand her but then added, "Maybe she [R1] took that tone as demeaning, I'm not sure." NA-A verified nobody had asked them or talked to them about the comment that day. NA-A expressed some frustration with the AI device and stated they'd never had training on it. NA-A stated "the biggest thing" about the incident on 8/3/25 was the language barrier adding if the device had worked like intended then "maybe it would have gone differently." NA-A added, in hindsight, they knew TMA-B was working that day and they "maybe should have gotten her earlier [to help translate or explain cares]." On 8/6/25 at 12:43 p.m., a group interview was completed with the DON, administrator, regional director of operations (RDO)-A, and assistant director of nursing (ADON). DON verified they were first told of the incident which happened on 8/3/25 the following day, on 8/4/25, and explained R1 alleged two female staff members had "pulled me out of bed." DON stated they visited with TMA-B who had explained to them they	21805		

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Mala Strana Care & Rehabilitation Center	**1001 COLUMBUS AVENUE NORTH , NEW PRAGUE, Minnesota, 56071**

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21805	Continued from page 5 overheard R1 yelling at the two aides to "slow down" in Spanish which caused TMA-B to enter the room and tell the two aides to "take your time with her." DON stated nobody had reported NA-A as potentially saying comments to R1 in a sarcastic manner, but acknowledged she didn't clarify that with anyone, either. DON stated if staff overhear that happening, they should immediately report it to, at minimum, their nurse manager so it can be reviewed or addressed. DON added such behavior was "not acceptable here at Mala Strana." DON stated they had been investigating this incident since they were notified of it and expressed from their data collection thus far, the AI device had not been used or attempted until nearly after the cares were completed. DON verified staff should be knocking on the door and explaining "what they're going to do" to a resident prior to starting the care; and she reiterated there were staff members working in the building on the day of the incident whom could have helped interpret and provide communication between the NA(s) and R1 if there had been any confusion. The RDO stated they had started some education already about this incident, and the group all acknowledged the importance of maintaining the resident rights with the DON expressing aloud, "That appears to be what was missed here." Further, the DON stated some education had been started and the administrator was going to send out an email with some resident' rights material to the staff that day. A facility policy on dignified care or treatment was requested, however, none was received. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review applicable policies and procedures on explanation of care prior to initiation and courteous language to ensure accuracy; then educate direct care staff and audit care to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: 21 Days	21805		