Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

April 27, 2023

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

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

Dear Administrator:

On April 4, 2023, 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.

Please contact me with any questions regarding this letter.

Sincerely,

Lori Hagen, Compliance Analyst
Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-Mail: Lori.Hagen@state.mn.us

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April 27, 2023

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

Re: Reinspection Results
Event ID: WCHB12

Dear Administrator:

On April 4, 2023, 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 February 24, 2023. At this time these correction orders were found corrected.

Please contact me with any questions regarding this letter.

Sincerely,

Lori Hagen, Compliance Analyst
Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-Mail: Lori.Hagen@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

March 14, 2023

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

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

Dear Administrator:

On February 24, 2023, a survey was completed at your facility by the Minnesota Department 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:

Elizabeth Silkey, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, Minnesota 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, 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 May 24, 2023, (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

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

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

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

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

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

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

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

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

Please contact me with any questions regarding this letter.

Sincerely,

Lori Hagen, Compliance Analyst
Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-Mail: Lori.Hagen@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 02/24/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 2/24/23, a standard abbreviated survey was conducted at your facility. 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. H55148313C (MN90993 and MN91048) with a deficiency issued at F609 and F610. 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.	F 000		
F 609 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	F 609		3/23/23

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

Electronically Signed | 03/23/2023

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

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F 609	Continued From page 1 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 misappropriation of property was reported to the state agency (SA) within 24 hours, in accordance with established policies and procedures, for 1 of 1 residents (R1) reviewed for potential diversion of a narcotic medication. Findings include: R1's facesheet printed on 2/24/23, included diagnoses of chronic pain syndrome, osteoporosis and dorsalgia (back pain). R1's quarterly Minimum Data Set (MDS) assessment dated 1/12/23, indicated R1 was cognitively intact and required extensive assistance of one or two staff for most activities of daily living (ADL's). R1 received scheduled pain medications for infrequent pain.	F 609	R1 orders and plan of care has been reviewed and updated to prevent narcotic drug diversion. R1 was assessed by the Director of Nursing and Administrator to verify that her property has not been missing or misappropriation of property. All like residents who have been identified for potential diversion of narcotic medication were assessed by the Director of Nursing and Administrator to verify their property has not been missing or misappropriation of property. The Director of Nursing or designee will initiate re-education to appropriate staff in regard to reporting alleged violations and the process for reviewing potential diversion of a narcotic medication. Education will be initiated to appropriate staff regarding alleged allegation and	

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F 609	Continued From page 2 R1's care plan initiated on 7/29/21, indicated R1 was at risk for discomfort due to advanced age, decreased mobility, arthritis, back pain and chronic pain syndrome. R1 would have adequate relief from pain as evidenced by freedom from verbal and non-verbal symptoms of pain. R1's physician order dated 2/8/23, included fentanyl (a controlled substance used to treat severe pain) transdermally (application of medicine through the skin) patch 72 hour 12 mcg/hr (microgram per hour). Apply one patch transdermally one time a day every three days for pain and remove per schedule. An order dated 9/17/20, indicated staff were to check the fentanyl patch placement every shift. Progress notes in R1's electronic medical record (EMR) indicated missing fentanyl patches on the following dates: --1/5/23, at 9:18 a.m., registered nurse (RN)-A documented staff were unable to locate R1's fentanyl patch this morning. A new patch [was] to be applied 1/6/23. Family member (FM)-D was contacted who stated she preferred to have the fentanyl patch replaced today. Orders were updated and a new patch was applied to R1's LUB (left upper back). --1/27/23, at 3:45 p.m., licensed practical nurse (LPN)-A documented the TMA had been unable to locate R1's fentanyl patch; the provider was notified and orders were updated to restart the patch; a new patch was applied. --1/31/23, at 2:44 p.m., RN-B documented TMA reported she had not been able to find R1's fentanyl patch that was supposed to be on R1's RUB (right upper back). R1 had a bath that morning and the bath aide did not recall seeing the patch. RN-B looked through R1's pajama's	F 609	misappropriation of property to the state agency within 24hrs. The Director of Nursing or designee will perform audits for current residents that receive narcotic medication to ensure drug diversion is not occurring along with misappropriation of their property. Director of Nursing or designee will interview 3 staff members regarding reporting of allegation of misappropriation of property and when this should be reported to appropriate state agency within 24hrs. Audits will be completed weekly audit x4, monthly x2. Audit will be reviewed by QAPI committee for further recommendation.	

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F 609	Continued From page 3 and bedding and was not able to find the patch. The DON had been informed of the situation. Nurse practitioner (NP) visit note dated 2/7/23, indicated there had been a meeting between social services, nursing, family. R1 had three incidences this month of fentanyl patch holding [sic]. During an interview and observation on 2/24/23, at 9:46 a.m., R1 was in her room in a wheelchair watching TV and reading a newspaper. R1 stated her pain was controlled "pretty good." When asked where her medication patch was located, R1 used her right hand to indicate her upper back, behind her left shoulder. With permission, viewed patch which was very small, approximately 1.5 inches x 1.5 inches, thin and clear. Printing on the patch indicated Fentanyl 12.5 mcg per/hr. The patch was covered with a clear, occlusive dressing with white tab with handwritten date of 2/23/23. During an interview on 2/24/23, at 9:54 a.m., LPN-A stated only licensed nurses could apply fentanyl patches to residents. Location of fentanyl patches were to be rotated, and tegaderm (a clear occlusive dressing) was to be applied over the top of the patch to secure it. LPN-A stated it was not policy to apply the tegaderm, but was what nurses liked to do. LPN-A stated once applied, either the fentanyl patch or the occlusive dressing was dated and initialed by the nurse. When the fentanyl patch was removed by a nurse, it was folded in half and disposed of in the sewer. The nurse who removed the patch along with another nurse, witnessed and signed off on the process on a paper fentanyl destruction log.	F 609		

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F 609	Continued From page 4 During an interview and observation on 2/24/23, at 9:58 a.m., together with LPN-A, went to R1's room and looked at the fentanyl patch. LPN-A confirmed it was dated 2/23/23, and was without nurse initials. LPN-A stated the patch was replaced every three days. Further, LPN-A stated in the past, nurses rotated the patch between the front and back of R1's chest, but then noticed it stuck to her clothing sometimes, so now the patch was applied only to her upper back. During an interview on 2/24/23, at 10:10 a.m., trained medication aide (TMA)-A stated she had observed nurses dispose of R1's fentanyl patch about a month ago when they flushed it down the toilet in the bathroom at the nurses station. TMA-A was not aware of R1's patch ever coming off or getting stuck on her clothing or bedding. During an interview on 2/24/23, at 10:20 a.m., LPN-B stated when a fentanyl patch was removed from R1, the patch along with the tegaderm was removed, folded over and the whole thing flushed down the sewer, adding that another nurse witnessed the disposal and both nurses signed off on the process. The presence of R1's fentanyl patch was assessed every shift to make sure it was still in place and documented on the treatment administration record (TAR). LPN-B had been aware of times when R1's patch was not in place during one of the checks. After this occurred, there had been re-education of staff regarding the process of applying and removing medicated patches. During an interview on 2/24/23, at 10:26 a.m. the director of nursing (DON) stated that on 2/3/23, FM-D talked to her about R1's missing fentanyl patches. During the conversation, FM-D told the	F 609		

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F 609	Continued From page 5 DON she had been informed of the missing patches by RN-B on 1/31/23. After speaking to FM-D, the DON informed the nurse practitioner (NP) of the missing patches, and scheduled a care conference with R1's family for 2/7/23. A progress note dated 2/7/23, written by the social worker (SW) indicated a family meeting had been held for 30 minutes with FM-D and FM-E in attendance, along with the NP, LPN-A, and the DON. The progress note further indicated R1's pain medications, pain management and options for change to help R1 be more comfortable were discussed. The DON stated it was the expectation that nurses always placed a tegaderm dressing over the fentanyl patch. Following the incidents, a nursing order to "apply a tegaderm over the patch" had been added to R1's TAR to ensure nursing staff applied it. The DON stated it did not cross her mind that a visitor could have removed the patch. The DON stated, "I thought about reporting, but my gut told me it wasn't a diversion incident." The DON admitted she did not consider this to be misappropriation of resident property for possible narcotic diversion which was reportable to the SA. During a telephone interview on 2/24/23, at 12:23 p.m., FM-D stated the following: -- On 1/5/23, FM-D stated RN-A told her they couldn't find the fentanyl patch on R1's back. FM-D stated about five years ago, when R1 lived in another facility, a patch went missing and was found on R1's sweater, adding, "That's why we asked them to put tegaderm over the patch." --On 1/31/23, when at the facility visiting R1, RN-B asked FM-D for permission to apply another fentanyl patch on R1, as R1's patch was missing. That was the first FM-D had heard about it, and told RN-B that the facility was to notify R1's	F 609		

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F 609	Continued From page 6 family when this occurred because it had happened before. FM-D stated she assumed RN-B was referring to the incident that occurred on 1/5/23, to which RN-B replied she was not aware of an incident on 1/5, and had been referring to an incident on 1/27. FM-D stated she was not aware of an incident on 1/27. FM-D stated she had looked for the DON that day to discuss the missing patches with her, but the DON was not there, so she briefly talked to the SW about it. FM-D stated she also left a voicemail message for the DON on 1/31/23, and the DON returned her call on 2/4/23. FM-D stated when she talked to the DON about the three incidents where R1's fentanyl patch was missing, instead of listening, the DON said the patch probably fell off in the laundry, then in the bathtub, then when sleeping...". FM-D stated she felt the DON was dismissive of her concerns. At the end of that conversation, FM-D told the DON she wanted to see documentation in R1's chart going back three months, and that she wanted to meet with the DON by the end of the week. FM-D stated that's when the SW called and set up a meeting. On 2/7/23, FM-D, FM-E, LPN-A, the SW, DON and NP met. The NP did most of the talking, mainly about pain control for R1. The DON informed FM-D and FM-E she had made a report of her investigation and could not determine what happened to the patches. During a telephone interview on 2/24/23, at 1:25 p.m., RN-B stated she wasn't surprised the patch was missing on 1/31/23, as there was no tegaderm over the top of it; the nurse who had applied it told her she couldn't find any tegaderm. When the patch went missing, RN-B stated they looked everywhere - all clothing, bedding and drawers. R1 had a bath that day and the patch	F 609		

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F 609	Continued From page 7 could have come off...it's so small and clear. RN-B stated she had no problem finding tegaderm...she went and found it the same day. RN-B informed the DON of the missing patch. During a telephone interview on 2/24/23, at 1:39 p.m., RN-A stated on 1/5/23, she recalled looking for R1's fentanyl patch to document it was present, but couldn't find it. RN-A stated she informed LPN-A and the NP about the missing patch. RN-A stated staff checked for the patch three times a day; every shift. RN-A stated tegaderm was usually placed over the top, but stated there had been a period of time this year when they were waiting to get tegaderm restocked. During an interview on 2/24/23, at 3:07 p.m., the DON and administrator were informed of findings of failure to report misappropriation of resident property for possible diversion of a narcotic. The DON again stated she did not think it was diversion and therefore had not reported it. Facility policy titled Fentanyl Removal, Application, and Destruction dated 10/13, indicated the purpose was to address safe and secure medication handling of controlled substances, delivery and disposal of fentanyl patches. Remove the fentanyl patch and fold the adhesive sides together so there is no exposed medication. Take the used patch to the locked medication room, complete fentanyl destruction log with two licensed nurses wrapping the used fentanyl patch in toilet paper and flushing down the sewer. Two licensed nurses must verify destruction and sign the paper form for proof of destruction. The policy indicated placing tegaderm over the fentanyl patch was optional.	F 609		

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F 609	Continued From page 8 Facility policy titled Discrepancies, Loss and/or Diversion of Medications, dated April 2018, indicated all discrepancies, suspected loss and/or diversion of medications, irrespective of drug type or class, are immediately investigated and a report filed. Facility policy titled Abuse Prohibition/Vulnerable Adult Plan, dated 2/2/23, indicated all staff were responsible for reporting misappropriation of resident property. Suspicion of misappropriation of resident property must be reported to OHFC (Office of Health Facility Complaints) online reporting process not later than two hours if the incident resulted in serious bodily injury. If the suspected misappropriation of resident property did not result in serious bodily injury, the reports must be made within 24 hours. The investigative team including the administrator, DON, nurse manager and social worker would review all incident reports regarding residents including those that indicate misappropriation of resident property no later than the next working day following the incident.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.	F 610		3/23/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245514	A. BUILDING _____ B. WING _____	C 02/24/2023

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F 610	Continued From page 9 §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 conducted a thorough investigation for possible drug diversion after becoming aware of missing narcotic patches for 1 of 1 residents (R1) reviewed for misappropriation of property. Findings include: R1's facesheet printed on 2/24/23, included diagnoses of chronic pain syndrome, osteoporosis and dorsalgia (back pain). R1's quarterly Minimum Data Set (MDS) assessment dated 1/12/23, indicated R1 was cognitively intact and required extensive assistance of one or two staff for most activities of daily living (ADL's). R1 received scheduled pain medications for infrequent pain. R1's care plan initiated on 7/29/21, indicated R1 was at risk for discomfort due to advanced age, decreased mobility, arthritis, back pain and chronic pain syndrome. R1 would have adequate relief from pain as evidenced by freedom from verbal and non-verbal symptoms of pain. R1's physician order dated 2/8/23, included fentanyl (a controlled substance used to treat	F 610	R1 was assess by Director of Nursing and Administrator to verify that there has been no drug diversion or misappropriation of property. A thorough investigation was completed by Director of Nursing & Administrator. All like residents who receive narcotic patches have been thoroughly investigated by the Director of Nursing and Administrator to assure no misappropriation of property. Education was initiated by Director of Nursing or designee with staff addressing circumstances that require reporting and responsibility related to investigation. Audits will be completed weekly audit x4, monthly x2 to assess and interview residents and staff regarding thorough investigation, prevention, and correction of alleged violations. Audit will be reviewed by QAPI committee for further recommendation.	

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F 610	Continued From page 10 severe pain) transdermally (application of medicine through the skin) patch 72 hour 12 mcg/hr (microgram per hour). Apply one patch transdermally one time a day every three days for pain and remove per schedule. An order dated 9/17/20, indicated staff were to check the fentanyl patch placement every shift. Progress notes in R1's electronic medical record (EMR) indicated missing fentanyl patches on the following dates: --1/5/23, at 9:18 a.m., registered nurse (RN)-A documented staff were unable to locate R1's fentanyl patch this morning. A new patch [was] to be applied 1/6/23. Family member (FM)-D was contacted who stated she preferred to have the fentanyl patch replaced today. Orders were updated and a new patch was applied to R1's LUB (left upper back). --1/27/23, at 3:45 p.m., licensed practical nurse (LPN)-A documented the TMA had been unable to locate R1's fentanyl patch; the provider was notified and orders were updated to restart the patch; a new patch was applied. --1/31/23, at 2:44 p.m., (RN)-B documented TMA reported she had not been able to find R1's fentanyl patch that was supposed to be on R1's RUB (right upper back). R1 had a bath that morning and the bath aide did not recall seeing the patch. RN-B looked through R1's pajama's and bedding and was not able to find the patch. The DON had been informed of the situation. Nurse practitioner (NP) visit note dated 2/7/23, indicated there had been a meeting between social services, nursing, family. R1 had three incidences this month of fentanyl patch holding [sic].	F 610		

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F 610	Continued From page 11 During an interview and observation on 2/24/23, at 9:46 a.m., R1 was in her room in a wheelchair watching TV and reading a newspaper. R1 stated her pain was controlled "pretty good." When asked where her medication patch was located, R1 used her right hand to indicate her upper back, behind her left shoulder. With permission, viewed patch which was very small, approximately 1.5 inches x 1.5 inches, thin and clear. Printing on the patch indicated Fentanyl 12.5 mcg per/hr. The patch was covered with a clear, occlusive dressing with white tab with handwritten date of 2/23/23. During an interview on 2/24/23, at 10:26 a.m. the director of nursing (DON) stated it wasn't until after the third incident of R1's missing fentanyl patch on 1/31/23, that it had been brought to her attention by RN-B. Once informed, the DON stated she launched an investigation. During the investigation, the DON stated staff had reported there had been no tegaderm to cover the fentanyl patch which the DON stated could have allowed the fentanyl patch to rub off. However, the DON admitted she did not confirm for herself if the facility was in fact out of tegaderm patches. The DON stated after being notified of the incidents, she audited nursing staff schedules, medication administration records (MARs), TARs, and the narcotic book and found no inconsistencies or patterns indicative of narcotic diversion. The DON stated she talked to some nursing staff but did not conduct formal interviews of staff who were involved in applying the fentanyl patches, staff who identified the patches as missing and staff who subsequently replaced the patches. The DON stated she spoke to FM-D but did not conduct a formal interview. The DON admitted she did not take notes of conversations with staff	F 610		

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F 610	Continued From page 12 or R1's family members during her investigation or ask for written statements. The DON had not considered the possibility of visitors removing the patch and did not check the visitor log for patterns. The only notes documented for the investigation of R1's missing fentanyl patches where documented on a paper form titled "Investigation Documentation" and included: --Under a heading titled "investigation" dated 2/3/23, the DON wrote: DON investigated situation. Audited electronic MAR and TAR, audited schedules from days [patch] reported missing for any discrepancies. Audited narcotic book. --Under a heading titled "plan of correction/resolution" dated 2/9/23, the DON wrote: completed education during all staff meetings on 2/9/23 on medicated patches. --Under a heading titled "follow up comments, reviewed with concerned party" undated, the DON wrote that she spoke with FM-D via phone on 2/3/23, and informed her the facility was investigating. Held family meeting with SW, LPN-A, NP, DON, FM-D and FM-E. During an interview on 2/24/23, at 3:07 p.m., the DON and administrator were informed of the findings of failure to conduct a thorough investigation following the identification of R1's missing fentanyl patches. A thorough investigation would include interviews with all staff who had involvement in applying, removing, and observing R1's fentanyl patches, and family members who expressed concerns, and then thoroughly documenting the interviews. The DON acknowledged this had not been done.	F 610		

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F 610	Continued From page 13 Facility policy titled Discrepancies, Loss and/or Diversion of Medications, dated April 2018, indicated immediately upon the discovery or suspicion of a discrepancy, suspected loss or diversion, the administrator, DON and consultant pharmacist were to be notified and an investigation conducted. The DON lead the investigation. Facility policy titled Abuse Prohibition/Vulnerable Adult Plan, dated 2/2/23, indicated the investigation team including the administrator, DON, nurse manager and social worker would review all incident reports regarding misappropriation of resident property. The investigation may include interviewing staff, residents or other witnesses to the incident. Corrective action would be based on the investigation would be completed.	F 610		

Electronically delivered

March 14, 2023

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

Re: State Nursing Home Licensing Orders
Event ID: WCHB11

Dear Administrator:

The above facility was surveyed on February 24, 2023, through February 24, 2023, 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:

Elizabeth Silkey, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, Minnesota 56001
Email: elizabeth.silkey@state.mn.us
Office: (507) 344-2742 Mobile: (651) 368-3593

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 contact me with any questions regarding this letter.

Sincerely,

Lori Hagen, Compliance Analyst
Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-Mail: Lori.Hagen@state.mn.us

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 2/24/23, 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	2 000		

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2 000	Continued From page 1 identify the date when they will be completed. The following complaints were reviewed. H55148313C (MN90993 and MN91048) with a licensing orders issued at 1980. 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 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 https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html 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	2 000		

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2 000	Continued From page 2 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.	2 000		
21980	MN St. Statute 626.557 Subd. 3 Reporting - Maltreatment of Vulnerable Adults Subd. 3. Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a	21980		3/23/23

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21980	Continued From page 3 reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure an allegation of misappropriation of property was reported to the state agency (SA) within 24 hours, in accordance with established policies and procedures, for 1 of 1 residents (R1) reviewed for potential diversion of a narcotic medication. Findings include: R1's facesheet printed on 2/24/23, included diagnoses of chronic pain syndrome, osteoporosis and dorsalgia (back pain). R1's quarterly Minimum Data Set (MDS) assessment dated 1/12/23, indicated R1 was cognitively intact and required extensive	21980	The Director of Nursing or designee will initiate re-education to appropriate staff in regard to reporting alleged violations and the process for reviewing potential diversion of a narcotic medication. Education will be initiated to appropriate staff regarding alleged allegation and misappropriation of property to the state agency within 24hrs. The Director of Nursing or designee will perform audits for current residents that receive narcotic medication to ensure drug diversion is not occurring along with misappropriation of their property. Director of Nursing or designee will interview 3 staff members regarding reporting of	

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21980	Continued From page 4 assistance of one or two staff for most activities of daily living (ADL's). R1 received scheduled pain medications for infrequent pain. R1's care plan initiated on 7/29/21, indicated R1 was at risk for discomfort due to advanced age, decreased mobility, arthritis, back pain and chronic pain syndrome. R1 would have adequate relief from pain as evidenced by freedom from verbal and non-verbal symptoms of pain. R1's physician order dated 2/8/23, included fentanyl (a controlled substance used to treat severe pain) transdermally (application of medicine through the skin) patch 72 hour 12 mcg/hr (microgram per hour). Apply one patch transdermally one time a day every three days for pain and remove per schedule. An order dated 9/17/20, indicated staff were to check the fentanyl patch placement every shift. Progress notes in R1's electronic medical record (EMR) indicated missing fentanyl patches on the following dates: --1/5/23, at 9:18 a.m., registered nurse (RN)-A documented staff were unable to locate R1's fentanyl patch this morning. A new patch [was] to be applied 1/6/23. Family member (FM)-D was contacted who stated she preferred to have the fentanyl patch replaced today. Orders were updated and a new patch was applied to R1's LUB (left upper back). --1/27/23, at 3:45 p.m., licensed practical nurse (LPN)-A documented the TMA had been unable to locate R1's fentanyl patch; the provider was notified and orders were updated to restart the patch; a new patch was applied. --1/31/23, at 2:44 p.m., RN-B documented TMA reported she had not been able to find R1's fentanyl patch that was supposed to be on R1's	21980	allegation of misappropriation of property and when this should be reported to appropriate state agency within 24hrs. Audits will be completed weekly audit x4, monthly x2. Audit will be reviewed by QAPI committee for further recommendation.	

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21980	Continued From page 5 RUB (right upper back). R1 had a bath that morning and the bath aide did not recall seeing the patch. RN-B looked through R1's pajama's and bedding and was not able to find the patch. The DON had been informed of the situation. Nurse practitioner (NP) visit note dated 2/7/23, indicated there had been a meeting between social services, nursing, family. R1 had three incidences this month of fentanyl patch holding [sic]. During an interview and observation on 2/24/23, at 9:46 a.m., R1 was in her room in a wheelchair watching TV and reading a newspaper. R1 stated her pain was controlled "pretty good." When asked where her medication patch was located, R1 used her right hand to indicate her upper back, behind her left shoulder. With permission, viewed patch which was very small, approximately 1.5 inches x 1.5 inches, thin and clear. Printing on the patch indicated Fentanyl 12.5 mcg per/hr. The patch was covered with a clear, occlusive dressing with white tab with handwritten date of 2/23/23. During an interview on 2/24/23, at 9:54 a.m., LPN-A stated only licensed nurses could apply fentanyl patches to residents. Location of fentanyl patches were to be rotated, and tegaderm (a clear occlusive dressing) was to be applied over the top of the patch to secure it. LPN-A stated it was not policy to apply the tegaderm, but was what nurses liked to do. LPN-A stated once applied, either the fentanyl patch or the occlusive dressing was dated and initialed by the nurse. When the fentanyl patch was removed by a nurse, it was folded in half and disposed of in the sewer. The nurse who removed the patch along with another nurse, witnessed and signed off on	21980		

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	00811	A. BUILDING: _____ B. WING _____	C 02/24/2023

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21980	Continued From page 6 the process on a paper fentanyl destruction log. During an interview and observation on 2/24/23, at 9:58 a.m., together with LPN-A, went to R1's room and looked at the fentanyl patch. LPN-A confirmed it was dated 2/23/23, and was without nurse initials. LPN-A stated the patch was replaced every three days. Further, LPN-A stated in the past, nurses rotated the patch between the front and back of R1's chest, but then noticed it stuck to her clothing sometimes, so now the patch was applied only to her upper back. During an interview on 2/24/23, at 10:10 a.m., trained medication aide (TMA)-A stated she had observed nurses dispose of R1's fentanyl patch about a month ago when they flushed it down the toilet in the bathroom at the nurses station. TMA-A was not aware of R1's patch ever coming off or getting stuck on her clothing or bedding. During an interview on 2/24/23, at 10:20 a.m., LPN-B stated when a fentanyl patch was removed from R1, the patch along with the tegaderm was removed, folded over and the whole thing flushed down the sewer, adding that another nurse witnessed the disposal and both nurses signed off on the process. The presence of R1's fentanyl patch was assessed every shift to make sure it was still in place and documented on the treatment administration record (TAR). LPN-B had been aware of times when R1's patch was not in place during one of the checks. After this occurred, there had been re-education of staff regarding the process of applying and removing medicated patches. During an interview on 2/24/23, at 10:26 a.m. the director of nursing (DON) stated that on 2/3/23, FM-D talked to her about R1's missing fentanyl	21980		

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21980	Continued From page 7 patches. During the conversation, FM-D told the DON she had been informed of the missing patches by RN-B on 1/31/23. After speaking to FM-D, the DON informed the nurse practitioner (NP) of the missing patches, and scheduled a care conference with R1's family for 2/7/23. A progress note dated 2/7/23, written by the social worker (SW) indicated a family meeting had been held for 30 minutes with FM-D and FM-E in attendance, along with the NP, LPN-A, and the DON. The progress note further indicated R1's pain medications, pain management and options for change to help R1 be more comfortable were discussed. The DON stated it was the expectation that nurses always placed a tegaderm dressing over the fentanyl patch. Following the incidents, a nursing order to "apply a tegaderm over the patch" had been added to R1's TAR to ensure nursing staff applied it. The DON stated it did not cross her mind that a visitor could have removed the patch. The DON stated, "I thought about reporting, but my gut told me it wasn't a diversion incident." The DON admitted she did not consider this to be misappropriation of resident property for possible narcotic diversion which was reportable to the SA. During a telephone interview on 2/24/23, at 12:23 p.m., FM-D stated the following: -- On 1/5/23, FM-D stated RN-A told her they couldn't find the fentanyl patch on R1's back. FM-D stated about five years ago, when R1 lived in another facility, a patch went missing and was found on R1's sweater, adding, "That's why we asked them to put tegaderm over the patch." --On 1/31/23, when at the facility visiting R1, RN-B asked FM-D for permission to apply another fentanyl patch on R1, as R1's patch was missing. That was the first FM-D had heard about it, and told RN-B that the facility was to notify R1's	21980		

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21980	Continued From page 8 family when this occurred because it had happened before. FM-D stated she assumed RN-B was referring to the incident that occurred on 1/5/23, to which RN-B replied she was not aware of an incident on 1/5, and had been referring to an incident on 1/27. FM-D stated she was not aware of an incident on 1/27. FM-D stated she had looked for the DON that day to discuss the missing patches with her, but the DON was not there, so she briefly talked to the SW about it. FM-D stated she also left a voicemail message for the DON on 1/31/23, and the DON returned her call on 2/4/23. FM-D stated when she talked to the DON about the three incidents where R1's fentanyl patch was missing, instead of listening, the DON said the patch probably fell off in the laundry, then in the bathtub, then when sleeping...". FM-D stated she felt the DON was dismissive of her concerns. At the end of that conversation, FM-D told the DON she wanted to see documentation in R1's chart going back three months, and that she wanted to meet with the DON by the end of the week. FM-D stated that's when the SW called and set up a meeting. On 2/7/23, FM-D, FM-E, LPN-A, the SW, DON and NP met. The NP did most of the talking, mainly about pain control for R1. The DON informed FM-D and FM-E she had made a report of her investigation and could not determine what happened to the patches. During a telephone interview on 2/24/23, at 1:25 p.m., RN-B stated she wasn't surprised the patch was missing on 1/31/23, as there was no tegaderm over the top of it; the nurse who had applied it told her she couldn't find any tegaderm. When the patch went missing, RN-B stated they looked everywhere - all clothing, bedding and drawers. R1 had a bath that day and the patch could have come off...it's so small and clear.	21980		

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21980	Continued From page 9 RN-B stated she had no problem finding tegaderm...she went and found it the same day. RN-B informed the DON of the missing patch. During a telephone interview on 2/24/23, at 1:39 p.m., RN-A stated on 1/5/23, she recalled looking for R1's fentanyl patch to document it was present, but couldn't find it. RN-A stated she informed LPN-A and the NP about the missing patch. RN-A stated staff checked for the patch three times a day; every shift. RN-A stated tegaderm was usually placed over the top, but stated there had been a period of time this year when they were waiting to get tegaderm restocked. During an interview on 2/24/23, at 3:07 p.m., the DON and administrator were informed of findings of failure to report misappropriation of resident property for possible diversion of a narcotic. The DON again stated she did not think it was diversion and therefore had not reported it. Facility policy titled Fentanyl Removal, Application, and Destruction dated 10/13, indicated the purpose was to address safe and secure medication handling of controlled substances, delivery and disposal of fentanyl patches. Remove the fentanyl patch and fold the adhesive sides together so there is no exposed medication. Take the used patch to the locked medication room, complete fentanyl destruction log with two licensed nurses wrapping the used fentanyl patch in toilet paper and flushing down the sewer. Two licensed nurses must verify destruction and sign the paper form for proof of destruction. The policy indicated placing tegaderm over the fentanyl patch was optional. Facility policy titled Discrepancies, Loss and/or	21980		

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21980	Continued From page 10 Diversion of Medications, dated April 2018, indicated all discrepancies, suspected loss and/or diversion of medications, irrespective of drug type or class, are immediately investigated and a report filed. Facility policy titled Abuse Prohibition/Vulnerable Adult Plan, dated 2/2/23, indicated all staff were responsible for reporting misappropriation of resident property. Suspicion of misappropriation of resident property must be reported to OHFC (Office of Health Facility Complaints) online reporting process not later than two hours if the incident resulted in serious bodily injury. If the suspected misappropriation of resident property did not result in serious bodily injury, the reports must be made within 24 hours. The investigative team including the administrator, DON, nurse manager and social worker would review all incident reports regarding residents including those that indicate misappropriation of resident property no later than the next working day following the incident. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), administrator or designee could develop/revise policies or procedures to ensure timely reporting of all allegations of misappropriation of property are within appropriate timeframe's for reporting. The facility could re-educate staff to policies and procedures, and audit all f allegations of misappropriation of property . The results of those audits could be taken to the Quality Assurance Performance Improvement (QAPI) committee to determine the need for further monitoring or compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21980		

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