Electronically delivered
September 11, 2019

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

RE: Project Number H5514025C

Dear Administrator:

On August 23, 2019, an abbreviated standard survey was completed at your facility by the Minnesota Department(s) 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 actual harm that was not immediate jeopardy (Level G) as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective November 11, 2019.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective November 11, 2019. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective November 11, 2019.

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

This Department is also recommending to CMS the following for imposition. You will receive a formal

notice from the CMS RO only if CMS agrees with our recommendation.

- Civil money penalty. (42 CFR 488.430 through 488.444)

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $10,483; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by November 11, 2019, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Mala Strana Care & Rehabilitation Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from November 11, 2019. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition remains in effect for the specified period even though selected remedies may be rescinded at a later date if your facility attains substantial compliance. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

DEPARTMENT CONTACT

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

Eva Loch, Unit Supervisor
Metro D Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: eva.loch@state.mn.us
Phone: (651) 201-3792
Fax: (651) 215-9697

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 23, 2020 (six months after the

identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

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

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

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

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.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@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 08/23/2019

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 8/23/19, an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found not to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaint was found to be substantiated: H5514025C The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's 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 on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 684	R1 and R2 have been discharged.	9/23/19

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

Electronically Signed | 09/20/2019

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 684	Continued From page 1 review the facility failed to provide quality care by not implementing interventions to prevent new and worsening skin conditions from occurring for 2 of 3 residents (R1,R2). Findings include: R1's admission Minimum Data Set (MDS) assessment dated 5/10/19, indicated R1 was cognitively intact, required extensive assistance from two staff for bed mobility, toileting and transfers, was occasionally incontinent of bladder and was frequently incontinent of bowel. The MDS further identified R1 had two venous/arterial ulcers (Venous ulcers develop from damage to the veins caused by an insufficient return of blood back to the heart) on admission. R1's care plan dated 5/15/19, indicated an alteration in mobility related to left ankle fracture and an alteration in skin integrity exhibited by venous ulcers. On 7/22/19, the care plan identified current ulcers on the Left lateral calf, right lateral calf; superior and inferior, right lateral calf. Care planned interventions dated 6/10/19, included: R1 to be followed by wound care nurse, pressure redistribution mattress on bed and cushion in wheel chair. Review of Integrated Wound Care Visit Notes dated May 2019 to July 2019, identified the following: 5/9/19: Wound 1) right anterior calf vasculitic ulcer 0.6 centimeters (cm) x .6 cm. Wound 2) Right lateral calf partial thickness venous ulcer 2 cm x 1.4 cm with 26-50% slough (soft moist devitalized (dead) tissue. It may be	F 684	All residents were assessed who currently have identified pressure wounds for appropriate interventions and care plans and physicians updated, as needed. All appropriate staff were educated on how to ensure proper assessment, monitoring, and implementation of pressure reliving interventions for residents with identified pressure concerns. DON or designee will conduct random audits to ensure proper assessment, monitoring, and implementation of pressure relieving interventions for residents with skin integrity issues. Audits will be completed weekly x4, monthly x2. Audit results will be reviewed by QA&A Committee for further recommendations.	

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F 684	Continued From page 2 white, yellow, tan, gray or green, and it may be loose or firmly adherent). 5/28/19: Wound 1) .5 cm x .3 cm. Wound bed 1-25% eschar (thick leathery black or brown devitalized tissue). Wound 2) 1.6 cm x 1.3 cm, non -viable tissue in the wound base. Wound 4) Right anterior calf partial thickness venous ulcer 1 cm x .5 cm. Wound bed 76-100% slough. Wound 5) Right lateral superior calf partial thickness venous ulcer, 2.2 cm x 1.5 cm, 76-100% slough in wound bed. 6/3/19: Wound 1) 1 cm x .5 cm, wound bed 1-25% eschar and 26-50% slough. Eschar debrided from wound base. Wound 2) 1.6 cm x 1.2 cm x .2 cm. Wound bed 76-100% slough. Depth noted today. Wound 4) 1 cm x .8 cm, 76-100% slough. Wound 5) 2.1 cm x 1.5 cm with 76-100% slough. 6/10/19: Wound 1) .4 cm x 0.2 cm, 1-25% eschar and 1-25% slough. Wound 2) 1.5 cm x 1 cm x 0.2 cm, wound bed 76-100% slough. Wound 4) 0.8 cm x 0.8 cm, wound bed 76-100% slough. Wound 5) 2 cm x 1 cm x 0.8 cm. 76-100% slough. Wound 6) left lateral calf venous ulcer. 1.3 cm x 1.5 cm. 6/25/19: Wound 2) 1.5 cm x 1.1 cm, 76-100% slough. Wound 5) 0.5 cm x 0.5 cm, 76-100% slough.	F 684		

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F 684	Continued From page 3 Wound 6) .5 cm x 0.5 cm, 76-100% slough. Wound 10) Left medial ankle vasculitic ulcer 0.8 cm x 0.3 cm. 7/1/19: Wound 1) resolved. Wound 2) 1.5 cm x 1.5 cm, 26-50% slough. Wound 5) 1.2 cm x 1.3 cm, 25-50% slough. Wound 6) 0.3 cm x 0.3 cm, 76-100% slough. Wound 9) resolved. 7/8/19: Wound 2) 1.5 cm x 1.5 cm, 26-50% slough. Wound 5) 1.2 cm x 1.2 cm, 26-50% slough. Wound 6) 0.2 cm x 0.2 cm, wound bed 76-100% slough. Wound 7) resolved. Wound 13) Right lateral ankle partial thickness venous ulcer 1.3 cm x 1.6 cm. Wound bed 76-100% slough. 7/15/19: Wound 2) 1.5 cm x 1 cm, 26-50% slough. Wound 5) 1.9 cm x 1.3 cm, wound bed 26-50% slough. The wound is deteriorating. Wound 6) 0.1 cm x 0.1 cm, 76-100% slough. Wound 10) resolved. Wound 11) resolved. Wound 13) resolved. 7/22/19: Wound 2) 1 cm x .7 cm, 26-50% slough. Wound 5) 1.5 cm x 1 cm, 26-50% slough. Wound 6) 0.1 cm x 0.1 cm, 76-100% slough. An Integrated Wound Care Follow-up Progress note dated 7/29/19, identified the following wounds: Wound 1) left lateral calf ulcer resolved.	F 684		

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F 684	Continued From page 4	F 684		

Wound 2) Right lateral venous calf ulcer 1.2 cm x 0.4 cm.
Wound 3) right lateral calf venous ulcer 1.2 cm x 1 cm,
Wound 4) Right lateral ankle venous ulcer 0.7 cm x 1 cm.

A facility assessment titled Weekly Skin Inspection dated 7/30/19, indicated "no new skin issues noted." A Weekly Skin Inspection dated 8/6/19, indicated "no new concerns."

R1's discharge MDS dated 8/7/19, indicated no venous or arterial ulcers.

R2's quarterly MDS dated 7/31/19, indicated she was moderately cognitively impaired and required extensive assistance for bed mobility and total dependence for transfers and toileting. The MDS indicated R2 was always incontinent of bowel and bladder and had open lesions and moisture associated skin damage (MASD). (Condition caused by moisture from wound drainage, fecal and/or urinary incontinence, and perspiration.)
R2's care plan dated 7/22/19, identified non-healing fissures to buttock area, with non-healing cyst to left buttock. The care plan intervention dated 4/28/17, directed staff to turn and reposition with reminders to off-load every two hours and provide toileting assitance every two hours.

During continuous observation on 8/23/19, at 7:48 a.m. R2 was seated in the dining room. At 8:47 a.m. R2 was escorted to her room by staff and left seated in her wheel chair. At 9:09 a.m R2 remained seated in her wheel chair in her room. At 9:26 a.m. R2 remained in her wheel chair in her room. No staff had entered the room. R2 was

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F 684	Continued From page 5 seated with her head down, left foot on the foot pedal and right foot on the floor. At 10:20 a.m. licensed practical nurse (LPN)-A and registered nurse (RN)-A entered R2's room and assisted her to lay down on the bed. As R2 was placed into the mechanical lift a strong foul odor was noted. LPN-A and RN-A removed R2's incontinent product and cleaned a large amount of dark stool. R2's buttock was noted to have a dressing on the left side and two fissures around her peri-anal area. The dressing was removed and wound packing was noted in the left fissure. During interview at 10:42 a.m. nursing assistant (NA)-A stated she had gotten R2 up between 7:00 a.m. and 7:30 a.m. NA-A stated she had repositioned R2 at 9:15 a.m,. however, during continuous observations NA-A had not entered R2's room. During interview at 12:20 p.m. the interim director of nursing (DON) stated R2 had non-healing wounds. The interim DON stated R2 had fissures as well. She stated surgical interventions had been discussed but neither R2 or her family wanted to do that. The interim DON stated the goal was to make sure the wounds did not get infected and stated staff were to turn and reposition and toilet R2 every two and a half to three hours.	F 684		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with	F 686		9/23/19

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F 686	Continued From page 6 professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide quality care by not implementing interventions to prevent new and worsening skin conditions from occurring for 1 of 3 residents (R1) and failed to assess open areas for 1 of 3 residents (R3). This resulted in actual harm for R1 who had new and worsening skin ulcers throughout her stay at the facility. Findings include: R1's admission Minimum Data Set (MDS) assessment dated 5/10/19, indicated R1 was cognitively intact, required extensive assistance from two staff for bed mobility, toileting and transfers, was occasionally incontinent of bladder and was frequently incontinent of bowel. The MDS further identified R1 had a stage I pressure ulcer (An observable, pressure related alteration of intact skin, whose indicators as compared to an adjacent or opposite area on the body may include a defined area of persistent redness). R1's care plan dated 5/15/19, indicated an alteration in mobility related to left ankle fracture and an alteration in skin integrity exhibited by a sacral pressure ulcer. On 7/22/19, the care plan identified current ulcers on the sacrum, and	F 686	R1 and R3 have been discharged. All like residents who have been identified for pressure ulcers or at risk for pressure ulcers, their assessments, interventions and plan of care have reviewed and updated to reflect pressure ulcer interventions. The DON or designee will provide re-education to all appropriate staff on initial skin assessments and pressure ulcer interventions to reduce risk of skin breakdown. Wound Care Procedure has been reviewed with the appropriate staff. The DON or designee will complete audits for 3 current residents with pressure ulcers for proper pressure ulcer interventions in place. Audits will be conducted weekly X 4, and then monthly X 2. Audit results will be reviewed by QA&A Committee for further recommendation.	

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F 686	Continued From page 7	F 686		

inside of left heel. Care planned interventions dated 6/10/19, included: R1 to be followed by wound care nurse, pressure redistribution mattress on bed and cushion in wheel chair. On 7/24/19, the care plan was updated to include shoes only when transferring or ambulating.

Review of Integrated Wound Care Visit Notes dated May 2019 to July 2019, identified the following:

5/9/19:
Wound 3) Sacral stage II pressure ulcer 2.5 cm x 1.5 cm, 50-75% slough.

5/28/19:
Wound 3) Stage III, 3 cm x 1.5 cm 26-50% slough, non -viable tissue in wound base.

6/3/19:
Wound 3) 3 cm x 1.5 cm with undermining noted at 12:00, maximum distance of 3 cm. Wound bed has 1-25% slough.

6/10/19:
Wound 3) 3 cm x 1.5 cm, undermining 4 cm. Wound bed 1-25% slough.
Wound 7) Left heel suspected deep tissue injury (SSDTI), (A pressure-related injury to subcutaneous tissues under intact skin). 3.5 cm x 4 cm.
Wound 8) Left lateral foot SSDTI measuring 2 cm x 1.5 cm.

6/25/19:
Wound 3) 3 cm x 2 cm x 0.7 cm. 1-25% slough, Wound improving. Undermining at 12:00, 2 cm and 3:00 1.5 cm.
Wound 7) 0.6 cm x 0.6 cm, wound improving.

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 08/23/2019

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 686	Continued From page 8 Wound 9) Left plantar foot unstageable pressure injury 2 cm x 2 cm. 7/1/19: Wound 3) 2.5 cm x 1.5 cm x .7 cm, undermining 3.5 cm. Wound bed 1-25% slough. Wound 7) 0.8 cm x 0.6 cm, scab and bruising on heel. Wound 12) Right lateral ankle blister measuring 1 cm x 0.5 cm. 7/8/19: Wound 3) 3 cm x 1 cm wound bed 25-50% slough. Wound 7) resolved. 7/15/19: Wound 3) 3 cm x 1 cm, 26-50% slough. Wound 12) partial thickness blister, 1 cm x 1.6 cm, 76-100% slough. 7/22/19: Wound 3) 3 cm x 1 cm with undermining noted at 12:00 with a distance of 3.5 cm 1-25% slough in wound bed. Wound 12) 0.8 cm x 1.5 cm , wound bed 76-100% slough. Wound 14) Left heel SSDTI. 2.5 cm x 4 cm. An Integrated Wound Care Follow-up Progress note dated 7/29/19, identified the following wounds: Wound 5) Sacral pressure ulcer unstageable 2.5 cm x 1 cm. 50% slough, 50% granulation. Wound 6) Left heel deep tissue injury 2 cm x 2 cm. No further description of wounds provided on this assessment. A facility assessment titled Weekly Skin	F 686		

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F 686	Continued From page 9 Inspection dated 7/30/19, indicated "no new skin issues noted." A Weekly Skin Inspection dated 8/6/19, indicated "no new concerns." R1's discharge MDS dated 8/7/19, indicated she had one unstageable pressure ulcer, one unstageable due to SSDTI. Review of a report dated 8/9/19, identified R1 was admitted to the hospital due to sepsis. On the morning of admission to the hospital the patient complained of significant pain in lower extremities, back, and coccyx. Upon assessment with doctor many wounds were noted on coccyx area and lower extremities. Patient had significant pain with touch and movement. Wounds included: Coccyx wound 3 cm x 2 cm x 6 cm necrotic foul smelling unstageable pressure ulcer with 2 cm undermining at 1200. Stage II pressure injury (Partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed) left gluteal cleft/buttocks, proximal. Stage II pressure injury, left gluteal cleft/buttocks distal. Stage II right gluteal cleft/buttocks. Right lower extremity, Stage II pressure injury right lateral ankle, Deep tissue injury right ankle. Deep tissue injury left heel. Left posterior ankle deep tissue injuries. Left unstageable medial pressure ulcer. Severity and number of wounds, added to the type of wounds appeared that patient had been left in one position for an extended period of time. The deep tissue injuries on the back of her legs would mirror where a wheelchair leg rest would put pressure on her. When ask if the patient was left in her wheelchair for periods of time, she acknowledged that she indeed was. There are deep tissue injuries on the bottoms of her feet and the back of her ankles, these would also indicate pressure from being in one spot for too lo	F 686		

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F 686	Continued From page 10 R3's admission MDS dated 8/12/19, indicated he was cognitively intact and required assistance for bed mobility, transfers and toileting. The MDS indicated R3 was continent of bowel and bladder and had no skin concerns identified. R3's care plan dated 8/8/19, indicated a potential alteration in nutrition and identified a chronic ulcer to left foot, heal, mid foot and right buttock. The care plan further identified an alteration in skin integrity related to wounds to left foot, ankle and heel. An Admission/Initial Data Collection dated 8/6/19, indicated R1 had a 1 cm x 1.5 cm open area on his right buttock. Review of R3's facility Progress Notes indicated on 8/14/19, hospice RN wrote, R3 had a wound on his coccyx that was being covered by a foam dressing. R3's medical record lacked evidence of assessment of his right buttocks open area. Review of Integrated Wound Care assessments dated 8/15/19 and 8/19/19, identified wounds to R3's left foot, heel and ankle. The assessments did not address R3's buttocks. During interview at 12:25 p.m. the interim DON stated R3 had diabetic ulcers and that Integrated Wound Care come in weekly to assess. In regard to R3's buttocks, the interim DON stated she was not aware of anything. She further stated all wounds were followed by Integrated Wound Care and they should be doing a full skin check every week. The DON stated she was going to look at R3's buttocks and surveyor requested to go with for the assessment, however at 1:15 p.m. R3 was leaving the facility with a visitor.	F 686		

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F 686	Continued From page 11 Interview with the interim DON at 1:37 p.m. the interim DON stated she had seen R3's skin and stated "I forgot we were going to see it together." The DON stated, "he does have something open now, looks like hospice has been following."	F 686		

Electronically Delivered

September 11, 2019

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

Re: State Nursing Home Licensing Orders - Complaint Number H5514025C

Dear Administrator:

A complaint investigation was completed on August 23, 2019. At the time of the investigation, the investigator assessed compliance with Minnesota Department of Health Nursing Home Rules. The investigator from the Minnesota Department of Health noted one or more violations of these rules. These state licensing orders are issued in accordance with Minnesota Statute section 144.653 and/or Minnesota Statute Section 144A.10. If, upon reinspection, it is found that the violations cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the licensing 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 violation. 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 violation within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

The State licensing orders are delineated on the Minnesota Department of Health order form. The Minnesota Department of Health is documenting the state licensing 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 after the statement, "This Rule is not met as evidenced by." Following investigator's 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.

When all licensing orders are corrected, the form should be signed and returned electronically to:

Eva Loch, Unit Supervisor
Metro D Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: eva.loch@state.mn.us
Phone: (651) 201-3792
Fax: (651) 215-9697

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

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

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00811	A. BUILDING: _____ B. WING _____	C 08/23/2019

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MALA STRANA CARE & REHABILITATION CEN	1001 COLUMBUS AVENUE NORTH NEW PRAGUE, MN 56071

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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 8/23/19, surveyors of this Department's staff visited the above provider and the the facility was found NOT IN COMPLIANCE. A complaint investigation was conducted to investigate complaint H5514025C.	2 000		

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2 000	Continued From page 1 As a result the following correction orders are issued. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to provide quality care by not implementing interventions to prevent new and worsening skin conditions from occurring for 1 of 3 residents (R1) and failed to assess open areas for 1 of 3 residents (R3). This resulted in actual harm for R1 who had new and worsening skin ulcers throughout her stay at the facility.	2 830	Corrected.	9/23/19

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2 830	Continued From page 2 Findings include: R1's admission Minimum Data Set (MDS) assessment dated 5/10/19, indicated R1 was cognitively intact, required extensive assistance from two staff for bed mobility, toileting and transfers, was occasionally incontinent of bladder and was frequently incontinent of bowel. The MDS further identified R1 had a stage I pressure ulcer (An observable, pressure related alteration of intact skin, whose indicators as compared to an adjacent or opposite area on the body may include a defined area of persistent redness). R1's care plan dated 5/15/19, indicated an alteration in mobility related to left ankle fracture and an alteration in skin integrity exhibited by a sacral pressure ulcer. On 7/22/19, the care plan identified current ulcers on the sacrum, and inside of left heel. Care planned interventions dated 6/10/19, included: R1 to be followed by wound care nurse, pressure redistribution mattress on bed and cushion in wheel chair. On 7/24/19, the care plan was updated to include shoes only when transferring or ambulating. Review of Integrated Wound Care Visit Notes dated May 2019 to July 2019, identified the following: 5/9/19: Wound 3) Sacral stage II pressure ulcer 2.5 cm x 1.5 cm, 50-75% slough. 5/28/19: Wound 3) Stage III, 3 cm x 1.5 cm 26-50% slough, non -viable tissue in wound base. 6/3/19: Wound 3) 3 cm x 1.5 cm with undermining noted	2 830		

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2 830	Continued From page 3 at 12:00, maximum distance of 3 cm. Wound bed has 1-25% slough. 6/10/19: Wound 3) 3 cm x 1.5 cm, undermining 4 cm. Wound bed 1-25% slough. Wound 7) Left heel suspected deep tissue injury (SSDTI), (A pressure-related injury to subcutaneous tissues under intact skin). 3.5 cm x 4 cm. Wound 8) Left lateral foot SSDTI measuring 2 cm x 1.5 cm. 6/25/19: Wound 3) 3 cm x 2 cm x 0.7 cm. 1-25% slough, Wound improving. Undermining at 12:00, 2 cm and 3:00 1.5 cm. Wound 7) 0.6 cm x 0.6 cm, wound improving. Wound 9) Left plantar foot unstageable pressure injury 2 cm x 2 cm. 7/1/19: Wound 3) 2.5 cm x 1.5 cm x .7 cm, undermining 3.5 cm. Wound bed 1-25% slough. Wound 7) 0.8 cm x 0.6 cm, scab and bruising on heel. Wound 12) Right lateral ankle blister measuring 1 cm x 0.5 cm. 7/8/19: Wound 3) 3 cm x 1 cm wound bed 25-50% slough. Wound 7) resolved. 7/15/19: Wound 3) 3 cm x 1 cm, 26-50% slough. Wound 12) partial thickness blister, 1 cm x 1.6 cm, 76-100% slough. 7/22/19:	2 830		

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2 830	Continued From page 4 Wound 3) 3 cm x 1 cm with undermining noted at 12:00 with a distance of 3.5 cm 1-25% slough in wound bed. Wound 12) 0.8 cm x 1.5 cm , wound bed 76-100% slough. Wound 14) Left heel SSDTI. 2.5 cm x 4 cm. An Integrated Wound Care Follow-up Progress note dated 7/29/19, identified the following wounds: Wound 5) Sacral pressure ulcer unstageable 2.5 cm x 1 cm. 50% slough, 50% granulation. Wound 6) Left heel deep tissue injury 2 cm x 2 cm. No further description of wounds provided on this assessment. A facility assessment titled Weekly Skin Inspection dated 7/30/19, indicated "no new skin issues noted." A Weekly Skin Inspection dated 8/6/19, indicated "no new concerns." R1's discharge MDS dated 8/7/19, indicated she had one unstageable pressure ulcer, one unstageable due to SSDTI. Review of a report dated 8/9/19, identified R1 was admitted to the hospital due to sepsis. On the morning of admission to the hospital the patient complained of significant pain in lower extremities, back, and coccyx. Upon assessment with doctor many wounds were noted on coccyx area and lower extremities. Patient had significant pain with touch and movement. Wounds included: Coccyx wound 3 cm x 2 cm x 6 cm necrotic foul smelling unstageable pressure ulcer with 2 cm undermining at 1200. Stage II pressure injury (Partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed) left gluteal cleft/buttocks, proximal. Stage II pressure injury, left gluteal cleft/buttocks distal.	2 830		

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2 830	Continued From page 5 Stage II right gluteal cleft/buttocks. Right lower extremity, Stage II pressure injury right lateral ankle, Deep tissue injury right ankle. Deep tissue injury left heel. Left posterior ankle deep tissue injuries. Left unstageable medial pressure ulcer. Severity and number of wounds, added to the type of wounds appeared that patient had been left in one position for an extended period of time. The deep tissue injuries on the back of her legs would mirror where a wheelchair leg rest would put pressure on her. When ask if the patient was left in her wheelchair for periods of time, she acknowledged that she indeed was. There are deep tissue injuries on the bottoms of her feet and the back of her ankles, these would also indicate pressure from being in one spot for too lo R3's admission MDS dated 8/12/19, indicated he was cognitively intact and required assistance for bed mobility, transfers and toileting. The MDS indicated R3 was continent of bowel and bladder and had no skin concerns identified. R3's care plan dated 8/8/19, indicated a potential alteration in nutrition and identified a chronic ulcer to left foot, heal, mid foot and right buttock. The care plan further identified an alteration in skin integrity related to wounds to left foot, ankle and heel. An Admission/Initial Data Collection dated 8/6/19, indicated R1 had a 1 cm x 1.5 cm open area on his right buttock. Review of R3's facility Progress Notes indicated on 8/14/19, hospice RN wrote, R3 had a wound on his coccyx that was being covered by a foam dressing. R3's medical record lacked evidence of assessment of his right buttocks open area. Review of Integrated Wound Care assessments	2 830		

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2 830	Continued From page 6 dated 8/15/19 and 8/19/19, identified wounds to R3's left foot, heel and ankle. The assessments did not address R3's buttocks. During interview at 12:25 p.m. the interim DON stated R3 had diabetic ulcers and that Integrated Wound Care come in weekly to assess. In regard to R3's buttocks, the interim DON stated she was not aware of anything. She further stated all wounds were followed by Integrated Wound Care and they should be doing a full skin check every week. The DON stated she was going to look at R3's buttocks and surveyor requested to go with for the assessment, however at 1:15 p.m. R3 was leaving the facility with a visitor. Interview with the interim DON at 1:37 p.m. the interim DON stated she had seen R3's skin and stated "I forgot we were going to see it together." The DON stated, "he does have something open now, looks like hospice has been following." SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to reduce the risk for pressure ulcer development. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		