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	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mala Strana Care & Rehabilitation Center	1001 Columbus Avenue North New Prague, MN 56071

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44651 Based on observation, interview, and record review, the facility failed to ensure dignity was maintained for 1 of 1 residents (R44) who was transported through the hallway to the tub room. Findings include: R44's quarterly Minimum Data Set, dated dated dated [DATE], indicated R44 was severely cognitively impaired, had a diagnosis of dementia, and was dependent for bathing, tub transfers, and lower body dressing. R44's care plan reviewed 1/31/24, included R44 received hospice services due to end stage dementia, and directed staff to provide assist on one staff for bathing. During observation on 3/13/24 at 7:18 a.m., R44 was seated sideways on the shower chair as they were being pushed through the hallway from their room to the tub room by nursing assistant (NA)-A. R44 wore a shirt, nothing below the waist, and had a hospital gown over their arms and covering the front side of their body and top of their legs. The sides of their hips and back of their buttocks were visible, as well as approximately four inches of buttocks which were protruding from the hole on the bottom of the shower chair. R44 passed by 10 resident rooms, included two containing residents who were facing the hallway with their doors open. One nurse and one other NA were also present in the hallway. When asked about R44's state of undress, NA-A confirmed R44 was exposed, apologized, and stated usually the gown covered any exposed parts. During observation on 3/13/24 at 7:35 a.m., NA-A transported R44 from the tub room down the hallways past the 10 rooms, including the two residents facing their doors, covered in blankets and towels. A small portion of R44's buttocks were exposed through the bottom of the shower chair during transport. During interview on 3/13/24 at 1:15 p.m., NA-B stated staff made sure resident were covered when going to the tub or shower and would often use a hospital gown. During interview on 3/13/24 at 1:24 p.m., 03/13/24 NA-C stated there was usually one NA who completed residents' showers during the morning and another in the evening, and NA-A was doing them that day. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 3/13/24 at 1:28 p.m., NA-A stated they usually brought residents to the shower room clothed, however it was sometimes easier to prepare R44 for a bath in their room due to behavioral concerns. They stated they usually had a towel underneath residents' covering the hole while being transported in the shower chair, however R44 had a bowel movement so NA_A removed the towel. The stated R44 started to become combative so they wanted to get them to the tub since it helps calm them down. NA-A apologized and confirmed they should have looked more closely at R44's state of undress before transporting through the hallway to avoid exposure. During interview on 3/13/24 at 3:10 p.m., registered nurse (RN)-C stated resident should always be covered for their own privacy, and they wouldn't want their family member or themselves to have body part exposed in the hallways. During interview 3/14/24 at 8:50 a.m., RN-D stated the facility used a tub transport chair to take residents to the shower or tub room, and they had bath blankets with holes in them for their heads like a poncho and they covered everything to protect residents' dignity. They stated residents loved them because they were warm, and the facility had plenty of them. If they were out on the unit, they could ask laundry to bring more. During interview on 3/14/24 at 10:57 a.m., director of nursing stated they expected all residents to be adequately covered in public areas and to be treated with dignity and respect. The Resident choices/Dignity Procedure dated 3/24, included resident dignity will be respected during cares and treatments including bathing.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44651 Based on observation, interview, and document review, the facility failed to ensure a resident had an appropriately sized wheelchair for 1 of 1 residents (R23) reviewed for wheelchair fit, and failed to ensure call lights were accessible for two of three residents (R37, R36) reviewed for call light accessibility. Findings include: Wheelchair R23's significant change Minimum Data Set (MDS) dated [DATE], indicated they were cognitively intact, had diagnoses of cancer, fracture, and arthritis, impairment of one lower extremity, used a wheelchair for mobility, could independently use a manual wheelchair to move 150 feet with two turns, and was receiving hospice services. R23's care plan dated 3/2/24, indicated R24 had history of falls, was able to self-propel in a wheelchair, and frequently self-transferred. A hospice progress note dated 2/20/24, indicated R23 was able to self-propel very short distances/in room in a standard wheelchair but pedal [hospice] chair was ordered within the last few weeks. Due to patient's height, they are unable to self-propel and R23 was switched back to a standard wheelchair. A hospice progress note dated 2/27/24, indicated the facility was still trying to find R23 a standard wheelchair as R23 did not like their pedal [hospice] chair. R23's MHM Incident Review and Analysis dated 3/6/24, included R23 was found on the floor after falling from their wheelchair, had two wheelchairs in their room, and indicated hospice nurse would continue to monitor the need for both wheelchairs. During observation and interview on 3/11/24 at 1:59 p.m., R23 stated their wheelchair clocks, and they could only go around in two-foot circles, and when they stood up from the chair it got caught on their hips and lifted six inches off the ground when they rose. The arm rest were too short, they couldn't rest their wrists, and it wasn't deep enough. R23 stated they were going to land on [their] nose again, and darn tootin', it's too small!. R23's lower body filled the wheelchair seat and the seat depth stopped mid-thigh. The end of the arms of the wheelchair stopped in the middle of R23's forearms. During interview on 3/14/24 at 8:22 a.m., nursing assistant (NA)-C stated R23 had a different chair but did not like it as it restricted movement, so hospice obtained a different one for R23. NA-C stated R23's current chair did not roll well on one side when R23 was seated in it, and it appeared to be too small. They stated R23 completely fills it out and would probably be more comfortable in a larger chair. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 3/14/24 at 8:28 a.m., registered nurse (RN)-D stated R23 was switched back from a hospice-provided wheelchair to a regular wheelchair at R23's request as R23 had a hard time moving around their room in the hospice chair. They stated R23 had fell out of their wheelchair in the past, and hospice managed R23's wheelchair needs, measured for fit, and provide a new one if needed. RN-D stated the placed a maintenance request for any chairs needed to be fixed and was unaware of R23's difficulty moving in their chair or the small size. During interview on 3/14/24 at 8:56 a.m., physical therapist (PT) stated the facility therapy department did not follow residents, including R23, if they were on hospice, and hospice had their own therapists. During interview on 3/14/24 at 9:29 a.m., hospice nurse (HRN) stated R23 tried a different chair but did not like it, so they sent an email to the director of nursing (DON) to see if they could find a regular standard wheelchair for R23. HRN was not sure, but thought it was the same one as before as it looked similar. They stated the facility assessed residents for wheelchair size, and hospice only assessed if it was a specialty chair for hospice purposes. During interview on 3/14/24 at 10:13 a.m., maintenance director (M) stated R23 receive the current wheelchair a month or two prior, and it was 20 inches wide with a standard depth. During interview on 3/14/24 at 10:15 a.m., RN-D stated therapy or the hospice nurse made the wheelchair size determination, but the therapy department was good about completing a quick assessment. They stated if the hospice nurse had noticed R23's wheelchair was too small they would have let the staff know. During interview on 3/14/24 at 10:57 a.m., DON stated R23 had a history of falls and was on hospice. He was switched to a hospice chair but did not like it and requested to move back to a regular wheelchair so he could move independently more easily. DON stated they were not sure how R23 ended up with the small wheelchair, but they needed one that fit, and someone must have grabbed the wrong one. Call lights R37's quarterly Minimum Data Set (MDS) dated [DATE], included R37 was moderately cognitively impaired, had diagnoses of heart failure, respiratory failure, dementia, seizure disorder, depression, and manic depression. R37 was dependent for toileting and transfers and required assistance with bed mobility. R37's care plan dated 8/9/23, included keep call light within reach of resident at all times. During observation and interview on 3/11/24 at 3:45 p.m., R7 was lying in bed with their call light hanging on the bed frame down to the floor out of reach on the right side of the bed. R37 stated it was lost, and staff told her to use the call light when she needed something, but sometimes she had to holler to get the attention of staff. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation and interview on 3/11/24 at 6:47 p.m., R37's call light was wrapped around the right side of the bed frame behind R37 and hanging down to the floor out of reach. R37 called out for staff assistance and registered nurse (RN)-D entered R37 room and left without providing them with the call light. R37 stated they were very uncomfortable and waiting for some pain cream. During observation on 3/11/24 at 6:47 p.m., RN-C entered R37's room with a topical cream and left the room at 6:55 p.m. The call light was still in the same position out of reach. During observation on 3/11/24 at 7:04 p.m., R37 called out hello from her room. Nursing assistant (NA)-F peeked into the room from the doorway, stated they were checking on R37, and left while the call light was still on the floor attached to the bed frame behind R37. During interview on 3/11/24 at 7:05 p.m., NA-F stated staff made sure residents had call lights before leaving the room. NA-F looked around R37's room and was unable to locate the call light, and once they found it, stated, oh, there it is, picked it up off the floor and gave it to R37 who asked NA-F to turn off the room lights. During interview on 3/11/24 at 7:07 p.m., RN-C stated R37 was capable of using the call light, and they did not look at the call light to see where it was when they entered R37's room earlier to apply R37's cream. During interview on 3/11/24 at 7:19 p.m., RN-D stated all call lights should be reachable by the resident to ensure staff responds to resident needs and did not notice the call light location when in R37's room earlier. During interview on 3/14/24 at 10:57 a.m., director of nursing stated they expected call lights to be placed within reach of residents so they could call if they needed assistance with something. 48299 R36's admission Minimum Data Set (MDS) dated [DATE], indicated R36 was cognitively intact and required substantial/maximal to dependent assistance with bed mobility and transfers. R36 had diagnoses of heart failure, cancer, renal insufficiency, renal failure, or end-stage renal disease. The MDS indicated R36 had hospice services. R36's Function Abilities Care Area Assessment Worksheet undated, indicated R36 needed assistance with most activities of daily living tasks, such as hygiene, dressing, and eating. R36's mood and behavior care plan dated 3/14/24, directed staff to keep R36's call light within reach and answer promptly to help reassure resident. During interview and observation on 3/11/24 at 2:04 p.m., R36's call light was on the floor. R36 stated he pressed the round button when he needed help from staff and normally the call light was on the bed or the bedside table. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 3/11/24 at 2:17 p.m., nursing assistant (NA)-E stated call lights were placed where residents could reach them. NA-E confirmed R36's call light was on the floor and clipped the call light to R36's blanket where he could reach it. NA-E stated R36 cannot do much for himself so needed the call light within reach to call for assistance. The Call Light Policy dated 4/24/23, indicated call cords, buttons, or other communication devices must be placed where they are within reach of each resident.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42579 Based on observation, interview, and document review, the facility failed to develop and implement medical device interventions for a ventriculoperitoneal (VP) shunt (implanted tube that drains excess cerebrospinal fluid from ventricles within the brain to the abdomen) in accordance with professional standards of practice for 1 of 1 resident (R21) reviewed for medical devices. Findings include: St. [NAME] Hospital VP Shunt information page dated 9/2022, identified a VP shunt traveled inside the body from the ventricles in the brain down the neck and chest and into the abdominal cavity. Some shunts were programmable and some were not, and warning signs should be monitored that may identify the shunt was not working or infected such as swollen skin along the path of the VP shunt. The name and contact information of the neurosurgeon responsible for shunt malfunctions or infections, the name and kind of shunt, and computed tomography (CT) or magnetic resonance imaging (MRI) images of brain ventricles when the shunt was working, should be available at all times. R21's Pre-Admission Medical Screening dated 1/22/24, identified diagnosis of hydrocephalus (buildup of fluid in cavities called ventricles deep within the brain) and VP shunt placed in 2018. R21's associated Temporary Care Plan lacked interventions related to the VP shunt. R21's admission Minimum Data Set (MDS) dated [DATE], identified severe cognitive impairment according to staff assessment. Extensive assistance from two staff was required for bed mobility, transfers, and toileting. R21 had a diagnosis of Parkinson's disease and encephalopathy (a group of conditions that cause brain dysfunction, such as confusion, memory loss or coma). R21's diagnosis information dated 3/14/24, also identified diagnoses of encephalopathy and Parkinson's disease but lacked mention of his VP shunt. R21's active orders dated 1/23/24 through 3/12/24, lacked nursing interventions for his VP shunt. R21's care plan dated 3/12/24, lacked nursing interventions for his VP shunt. During an observation and interview on 3/13/24 at 8:46 a.m., registered nurse (RN)-A assessed R21's skin and stated there was linear swelling above the right collarbone area about three inches in length and about one inch out from the chest wall. RN-A pressed on the area and asked if the area hurt, R21 did not show signs of symptoms of pain and said no. Licensed practical nurse (LPN)-A was also in the room, observed the area and agreed with the abnormal swelling finding. LPN-A stated she worked with R21 routinely and had not noticed this before. LPN-A stated they would update the nurse manager later. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a follow up interview together on 3/13/24 at 9:24 a.m., RN-A and LPN-A stated they were not aware R21 had a VP shunt. They reviewed the St. [NAME] VP Shunt information page and R21's medical record together, and stated the VP shunt was not on R21's diagnosis list, orders or care plan interventions. RN-A and LPN-A stated they were not familiar with VP shunts and would not know what interventions were pertinent, but stated it would be important to know in a nurse-to-nurse report if R21 needed to get transported to the emergency room . RN-A left to notify the director of nursing (DON) on these findings. During an observation and interview on 3/13/24 at 9:28 a.m., the DON assessed R21 and stated he was sweaty. RN-B entered the room and assessed R21's vital signs: temperature was 97.1, pulse was 81, and blood pressure was 165/98 (normal blood pressure should be around 130/80 in the elderly). RN-A stated he would look in the orders to see what medical devices a resident had or the care plan for monitoring of a shunt. RN-A stated he could not find any nursing interventions related to the VP shunt in R21's orders or care plan. During a follow up interview on 3/13/24 at 9:45 a.m., the DON stated she expected VP shunt interventions would include monitoring for changes in cognition from baseline and to assess the site for swelling. During an interview on 3/13/24 at 12:10 p.m., NP-A stated R21 had the VP shunt placed in 2018. NP-A stated nurses should be made aware R21 had a VP shunt and follow appropriate facility policies and procedures related to shunts. NP-A stated, like a pacemaker, nurses caring for patients with medical devices should be aware of the devices and relevant interventions, especially in the case of a change in condition. During an interview on 3/13/24 at 1:06 p.m., the neurosurgical clinical registered nurse specialist (CRNS) stated R21's symptoms sounded like localized inflammation from the VP shunt and nursing could apply heat, but not to worry unless it swelled like a water balloon. If swelling was similar to a water balloon, fluid may have disconnected from the shunt. R21 had normal pressure hydrocephalus (excess fluid in the brain ventricles which can lead to brain damage and symptoms such as walking difficulties, memory loss, and bladder problems) and if the shunt became disconnected he may not become acutely ill, but if issues occurred, nursing could call for advice. Neurological assessments were important also, however, changes in cognition would be difficult to assess in R21 because of his dementia diagnosis. The CRNS stated while there was no specific protocol in place for VP shunts, it was important for nursing staff to be aware if a patient had a VP shunt. For example, since the tubing was superficial and ran over the collarbone (where R21's swelling was noticed), positioning may need to be modified. Additionally, anything that could interfere with programmable devices such as very strong magnets (MRI's, recording studios, some areas of the Minnesota Science Museum) should be avoided. During an interview on 3/13/24 at 1:40 p.m., the facility's regional nurse consultant (RNC), stated R21's care plan was now updated with nursing interventions for the shunt. A policy for medical devices was requested, however the RNC stated a policy was not established.