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	08/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mala Strana Care & Rehabilitation Center	1001 Columbus Avenue North New Prague, 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. (continued on next page)

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.

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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure morning cares were provided in a dignified, courteous manner to prevent complication (i.e., frustration, misunderstanding) for 1 of 1 residents (R1) reviewed who expressed staff had been rough with her during provision of care. Findings include: R1's admission Minimum Data Set (MDS), dated [DATE], identified R1 had severe cognitive impairment but demonstrated no delusional thinking during the review period. A submitted Incident Report Summary (i.e., FRI), dated 8/4/25, identified an incident had happened on 8/3/25 where R1 had expressed nursing assistant (NA)-A and NA-B were rough when getting her out of bed in the morning. R1 was found to have a bruise on her left leg after this incident and the FRI outlined R1 had sustained potential mental anguish from it with dictation reading, Cried during interview. On 8/6/25 at 9:06 a.m., R1 was observed lying in bed while in her room. An interview was attempted with R1 at this time, and R1 nodded responses to verbal questions from the surveyor, however, responded aloud only in Spanish. Following, registered nurse manager (RN)-C was approached and expressed R1 knew only a few English words so staff often used a bedside AI [artificial intelligence] device or had facility' staff translate. RN-C recommended having the facility' staff translate as R1 could speak fast at times which made it hard for the device to translate. At 9:09 a.m., licensed practical nurse (LPN)-A joined R1 and the surveyor and acted as interpreter for the conversation in Spanish. R1 was unable to recall how long she had lived at the care center but expressed a desire to return home. R1 denied being abused while at the care center, but stated the staff who had helped her on Sunday [8/3] had been rough and fast-moving with morning cares adding, per LPN-A, the cares provided, They didn't get her up good. This was explained further as, She was laying down and they grabbed her. R1 expressed she didn't like talking about the incident and appeared to become more subdued while speaking to LPN-A at this point. LPN-A stated R1 had expressed, She wants to just forget about it, adding further that R1 was unsure if the staff who had helped her during this incident understood her (R1) or not due to a potential language barrier. Following, on 8/6/25 at 9:27 a.m., LPN-A was interviewed. LPN-A explained they had heard about the incident R1 had just described but expressed she (LPN-A) returned to work on Monday (8/4) afterward and R1 seemed really upset about it. LPN-A stated that is when they had found the bruising on R1's left leg and talked with trained medication aide (TMA)-B about the situation. TMA-B had told LPN-A they had overheard some of the interaction between R1 and NA-A, NA-B on 8/3/25 from outside the room as R1 had been cursing them [NA-A, NA-B] out in Spanish. LPN-A stated the director of nursing (DON) was informed about the incident on Monday (8/4), and added they were not sure what, if any, education for staff had been attempted or started yet as they hadn't seen any be assigned for themselves. When interviewed on 8/6/25 at 9:44 a.m., TMA-B verified they spoke Spanish, and explained staff whom were not able to speak Spanish were supposed to be using the AI device to communicate and explain cares to R1. However, TMA-B added they hadn't seen staff using it much at all. TMA-B recalled the incident with R1 on 8/3/25 and verified they were on shift working that day when it happened. TMA-B explained they were in the hallway outside R1's room at the medication cart and overheard R1 yelling to the aides to, Stop, slow down! TMA-B stated NA-A then was clearly heard saying, No commprendo, back to R1 in what TMA-B described as a kind of sarcastic manner while giggling aloud. TMA-B stated they then entered R1's room and saw R1 semi-sitting on the bedside and R1 expressed to her, They're not giving me time. TMA-B verified they never saw NA-A or NA-B be physically rough with R1. TMA-B stated she didn't approach NA-A about the comment made, however, reiterated they (TMA-B) had clearly heard it adding, Loud and clear. Further, TMA-B stated since the incident happened on 8/3/25 that management had told staff to give R1 more time to do cares, however, had nothing had been educated or sent to them about potentially inappropriate language (i.e., sarcastic comments to residents) use that they had seen yet adding aloud, No, not yet. R1's care plan, printed 8/6/25, identified R1's current or potential problems along with various goals and interventions to address them. The care plan identified a Focus, dated 6/16/25, which read, Alteration in communication speaks Spanish, along with interventions including, Speak clearly and distinctly to resident or use resident preferred communication method - use AI translator, and, Alternate communication method (AI translator and or picture binder in room). On 8/6/25 at 10:01 a.m., RN-C was interviewed, and verified they were the nurse manager for R1. RN-C explained they were also working on 8/3/25 and TMA-B approached them towards the end of the day to explain some staff had been moving too fast with [R1]. RN-C stated TMA-B had never mentioned NA-A

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure an allegation of potential verbal abuse (i.e., mocking, demeaning) was reported to the administrator and, if needed, the state agency (SA) in a timely manner for 1 of 3 residents (R1) reviewed during the abbreviated survey. Findings include: R1's admission Minimum Data Set (MDS), dated [DATE], identified R1 had severe cognitive impairment but demonstrated no delusional thinking during the review period. A submitted Incident Report Summary (i.e., FRI), dated 8/4/25, identified an incident had happened on 8/3/25 where R1 had expressed nursing assistant (NA)-A and NA-B were rough when getting her out of bed in the morning. R1 was found to have a bruise on her left leg after this incident and the FRI outlined R1 had sustained potential mental anguish from it with dictation reading, Cried during interview. On 8/6/25 at 9:06 a.m., R1 was observed lying in bed while in her room. An interview was attempted with R1 at this time, and R1 nodded responses to verbal questions from the surveyor, however, responded aloud only in Spanish. Following, registered nurse manager (RN)-C was approached and expressed R1 knew only a few English words so staff often used a bedside AI [artificial intelligence] device or had facility' staff translate. RN-C recommended having the facility' staff translate as R1 could speak fast at times which made it hard for the device to translate. At 9:09 a.m., licensed practical nurse (LPN)-A joined R1 and the surveyor and acted as interpreter for the conversation in Spanish. R1 was unable to recall how long she had lived at the care center but expressed a desire to return home. R1 denied being abused while at the care center but stated the staff who had helped her on Sunday [8/3] had been rough and fast-moving with morning cares adding, per LPN-A, the cares provided, They didn't get her up good. This was explained further as, She was laying down and they grabbed her. R1 expressed she didn't like talking about the incident and appeared to become more subdued while speaking to LPN-A at this point. LPN-A stated R1 had expressed, She wants to just forget about it. Following, on 8/6/25 at 9:27 a.m., LPN-A was interviewed. LPN-A explained they had heard about the incident R1 had just described but expressed she (LPN-A) returned to work on Monday (8/4) afterward and R1 seemed really upset about it. LPN-A stated that is when they had found the bruising on R1's left leg and talked with trained medication aide (TMA)-B about the situation. TMA-B had told LPN-A they had overheard some of the interaction between R1 and NA-A and NA-B on 8/3/25 from outside the room as R1 had been cursing them [NA-A, NA-B] out in Spanish. When interviewed on 8/6/25 at 9:44 a.m., TMA-B verified they spoke Spanish and recalled the incident with R1 on 8/3/25, and verified they were on shift working that day when it happened. TMA-B explained they were in the hallway outside R1's room at the medication cart and overheard R1 yelling to the aides to, Stop, slow down! TMA-B stated NA-A then was clearly heard saying, No commprendo, back to R1 in what TMA-B described as a kind of sarcastic manner while giggling aloud. TMA-B stated they then entered R1's room and saw R1 semi-sitting on the bedside and R1 expressed to her, They're not giving me time. TMA-B verified they never saw NA-A or NA-B be physically rough with R1. TMA-B stated they had never seen NA-A or NA-B be rough or demeaning with someone prior, however, reiterated they heard NA-A make that comment to R1 adding, Loud and clear. TMA-B explained the comment was made with sarcasm and like [in a] giggly way, which TMA-B stated made them upset also. TMA-B stated they felt the manner in which they heard NA-A make the comment to R1 was said in a demeaning way. On 8/6/25 at 10:01 a.m., RN-C was interviewed, and verified they were the nurse manager for R1. RN-C explained they were also working on 8/3/25 and TMA-B approached them towards the end of the day to explain some staff had been moving too fast with [R1]. RN-C stated TMA-B had never mentioned NA-A making potentially sarcastic or demeaning comments back to R1, and expressed if staff overheard that then it should have been reported immediately. RN-C stated there were multiple staff members working on 8/3/25 who could have communicated with R1 in Spanish if the staff were having issues explaining cares or communicating with her. Following this, on 8/6/25 at 10:20 a.m., TMA-B approached the surveyor and expressed they had forgot to say they had reported the comment NA-A made to R1 to RN-C on 8/3/25 adding, I told [RN-C].The Centers for Medicare and Medicaid (CMS) iQEIS system was reviewed. This verified the allegation of R1 with rough care was not reported to the state agency (SA) until over 24 hours later on 8/4/25, despite TMA-B hearing staff make comments to R1 which were, in their view, potentially demeaning (i.e., verbally abusive) at the same time of the alleged rough care. When interviewed on 8/6/25 at 11:28 a.m., via telephone, NA-A verified they had helped R1 with morning cares on 8/3/25. NA-A explained they entered R1's room and tapped R1's arm saying aloud in English it was time to