DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

March 19, 2018

Ms. Beth Schroeder, Administrator
Minnesota Masonic Home Care Center
11501 Masonic Home Drive
Bloomington, MN 55437

Subject: Minnesota Masonic Home Care Center - IDR
CMS Certification Number (CCN) 245343
Project # S5343029

Dear Ms. Schroeder:

This is in response to your letter of November 27, 2017, in regard to your request of an informal dispute resolution (IDR) for the federal deficiency identified at tag F325 S/S-G 483.25(g)(1)(3) issued pursuant to the survey event 56W211, completed on October 26, 2017.

The information presented with your letter, the CMS 2567 dated October 26, 2017 and corresponding Plan of Correction, as well as survey documents and discussion with representatives of Licensing &Certification staff have been carefully considered and the following determination has been made:

F325 Scope and severity (S/S) -G 42 CFR § 483.25 (g)(1)(3) Maintain Nutrition Status Unless Unavoidable: (g) Assisted nutrition and hydration. Based on a resident's comprehensive assessment, the facility must ensure that a resident- (1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's condition demonstrates that this is not possible or resident preferences indicate otherwise; (3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.

Summary of the facility's reason for IDR of this tag.: The facility disputed the findings because they asserted R44's clinical condition demonstrated weight loss was unavoidable; that R44 experienced declining appetite and had a personal preference to refuse meals; R44 had received skilled rehabilitation, skilled nursing and therapeutic nutritional interventions while she was in their Transitional Care Unit (TCU), but since moving to the Long Term Care Unit (LTCU) desired only comfort care, and her family refused use of a tube feeding.

Summary of facts: R44 was admitted 9/6/17, to the facility's TCU following a CVA (stroke) and subsequently to the Long Term Care Unit (LTCU) on 10/18/17. A Palliative Care Consultation note dated 9/6/17, indicated a goal of care: restorative at this point. The care plan goal identified in the LTCU included: The resident will maintain adequate nutritional status as evidence by non-significant weight changes, no signs/symptoms of malnutrition, and consuming at least 50% of meals daily; Resident will maintain weight at 155# +/- with weight restoration desired; needing more assistance at meals related to decrease in strength on right side as needing assist of 1 staff at meals; unplanned weight loss due to poor oral intake at meals, consuming 0%-50% at meals and loss from usual body weight of 160#-164#; prior to stroke. Documentation dated 9/18/17, by the Nurse Practitioner (NP) noted: further discussed goals of care, daughter thought if R44 further declined, she would be interested in comfort cares. Care conference notes indicated during a care conference dated 9/27/17, the family did not

wish to pursue Hospice. A Provider Order for Life-Sustaining Treatment (POLST) updated and signed by the daughter on 9/28/17, indicated a desire for comfort-focused treatment. The Registered Dietitian (RD) documentation identified a significant weight loss on the 9/26/17, Nutritional Assessment. Nursing Progress Notes indicated R44 intermittently refused therapy (speech, physical, occupational) treatments and transferred from the TCU to the LTCU on 10/18/17. Observations during the survey revealed food consumption was 25% on the evening of 10/23/17; staff did not offer breakfast on 10/25/17, and only offered her meals at 11:00 a.m. and 4:30 p.m. Documentation dated 10/19 thru 10/26/17, (8 days) identified that no breakfast meal was consumed nor offered.

Summary of findings: R44's medical condition fluctuated daily, including alertness, fatigue and responsiveness to treatment, with R44 often refusing cares. Upon completion of therapies and subsequent transfer from the TCU to the LTCU, the plan of care lacked revisions related to any refusal to consume breakfast and/or desire to skip breakfast. In addition, there were no interventions identified to direct staff not to offer/assist with breakfast and/or snacks if R44 was asleep. Risks of restricting food with significant unplanned weight loss was not addressed. Documentation, observation and interview revealed R44 was not consistently offered breakfast while in the LTCU. In addition, staff did not attempt to return and/or encourage consumption of breakfast nor afternoon snacks.

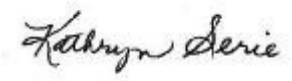
Although the family did indicate a desire for comfort focused treatment, that does not negate staff responsibility to provide and offer planned meals, especially when R44 was experiencing a significant unplanned weight loss.

This is a valid deficiency at this tag and at the correct scope and severity of a "G".

This concludes the Minnesota Department of Health informal dispute resolution process.

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

Sincerely,



Kathryn Serie, Unit Supervisor
Licensing and Certification Program
Health Regulation Division
Telephone: 507-476-4233 Fax: 507-537-7194

cc: Office of Ombudsman for Long-Term Care
Maria King, Assistant Program Manager
Licensing and Certification File
Susan Haben, Metro Team D Unit Supervisor

DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 56W2

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00232

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245343**

2.STATE VENDOR OR MEDICAID NO.
(L2) **511542600**

3. NAME AND ADDRESS OF FACILITY
(L3) **MINNESOTA MASONIC HOME CARE CENTER**
(L4) **11501 MASONIC HOME DRIVE**
(L5) **BLOOMINGTON, MN** (L6) **55437**

4. TYPE OF ACTION: **7** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **12/13/2017** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **214** (L18)

13.Total Certified Beds **214** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	214			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Glenora Souther, HFE NEII 11/28/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 11/29/2017 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
__X__ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
09/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
11/29/2017
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

On October 26, 2017 a standard survey was completed at this facility. The most serious deficiency was cited at a S/S level of G. As a result of the survey findings, the Department imposed the Category 1 remedy of State monitoring, effective November 19, 2017.

In addition, we recommended to the CMS RO the following enforcement remedy for imposition:

- CMP for deficiency cited at F0325

On December 13, 2017, a PCR was completed at this facility and found all deficiencies corrected, effective November 22, 2017. As a result of the revisit findings, the Department discontinued the Category 1 remedy of State monitoring, effective November 22, 2017.

Further, the Department is recommended to the CMS RO that the following enforcement remedy be imposed:

- CMP for deficiency cited at F0325

Refer to the notice dated January 17, 2017 for the details of the revisit.

Effective November 22, 2017, the facility is certified for 214 skilled nursing facility beds.

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245343

January 17, 2018

Ms. Beth Schroeder, Administrator
Minnesota Masonic Home Care Center
11501 Masonic Home Drive
Bloomington, MN 55437

Dear Ms. Schroeder:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective November 22, 2017 the above facility is certified for:

214 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 214 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

cc: Licensing and Certification File

Electronically delivered
January 17, 2018

Ms. Beth Schroeder, Administrator
Minnesota Masonic Home Care Center
11501 Masonic Home Drive
Bloomington, MN 55437

RE: Project Number S5343029

Dear Ms. Schroeder:

On November 14, 2017, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective November 19, 2017. (42 CFR 488.422)

On November 14, 2017, the Department recommended to the Centers for Medicare and Medicaid Services (CMS) that the following enforcement remedy be imposed:

- Civil money penalty for the deficiency cited at F0325. (42 CFR 488.430 through 488.444)

This was based on the deficiencies cited by this Department for a standard survey completed on October 26, 2017. The most serious deficiency was found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), whereby corrections were required.

On December 13, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on October 26, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of November 22, 2017. We have determined, based on our visit, that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on October 26, 2017, as of November 22, 2017.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective November 22, 2017.

In addition, this Department recommended to the CMS Region V Office the following action related to the remedy outlined in our letter of November 14, 2017:

- Civil money penalty for deficiency cited at F0325, be imposed. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding the recommended remedy and appeal rights.

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.

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

cc: Licensing and Certification File

DEPARTMENT OF HEALTH AND HUMAN SERVICES **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: 56W2l.,

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00232

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245343**
2.STATE VENDOR OR MEDICAID NO.
(L2) **511542600**

3. NAME AND ADDRESS OF FACILITY
(L3) **MINNESOTA MASONIC HOME CARE CENTER**
(L4) **11501 MASONIC HOME DRIVE**
(L5) **BLOOMINGTON, MN** (L6) **55437**

4. TYPE OF ACTION: **2** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **10/26/2017** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
12/31

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From (a) :
To (b) :

12.Total Facility Beds **214** (L18)
13.Total Certified Beds **214** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	214			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

On October 26, 2017, a standard recertification survey was conducted by MDH surveyors and they cited a deficiency of F-325, Maintain Nutrition Status Unless Avoidable at a s/s of "G", which means this is a no-opportunity-to-correct case. The facility is challenging the G-tag through the Informal Dispute Resolution process.

17. SURVEYOR SIGNATURE Date :
Deanna Novak, HFE-NE II 11/28/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Peterson, Enforcement Specialist 11/29/2017 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
09/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

November 14, 2017

Ms. Beth Schroeder, Administrator
Minnesota Masonic Home Care Center
11501 Masonic Home Drive
Bloomington, MN 55437

RE: Project Number S5343029

Dear Ms. Schroeder:

On October 26, 2017, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety 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 attached CMS-2567, whereby significant corrections are required.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

No Opportunity to Correct - the facility will have remedies imposed immediately after a determination of noncompliance has been made;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);

Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

Potential Consequences - the consequences of not attaining substantial compliance 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

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.

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:

Susie Haben, 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: susie.haben@state.mn.us
Phone: (651) 201-3794
Fax: (651) 215-9697

NO OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

For all surveys completed after September 1, 2016, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when one or more of the following circumstances exist:

- Immediate jeopardy (IJ) (scope and severity levels J, K, and L) is identified on the current survey; OR
- Deficiencies of Substandard Quality of Care (SQC) that are not IJ are identified on the current survey; OR
- Any G level deficiency is identified on the current survey in 42 CFR 483.13, Resident Behavior and Facility Practices, 42 CFR 483.15, Quality of Life, or 42 CFR 483.25 Quality of Care; OR
- Deficiencies of actual harm or above (level G or above) on the current survey as well as having deficiencies of actual harm or above on the previous standard health or Life Safety Code (LSC) survey OR deficiencies of actual harm or above on any type of survey between the current survey and the last standard survey. These surveys must be separated by a period of compliance (i.e., from different noncompliance cycles).; OR
- A facility is classified as a Special Focus Facility (SFF) AND has a deficiency citation at level "F" or higher on its current health survey or "G" or higher for the current LSC survey.

Note: the "current" survey is whatever Health and/or LSC survey is currently being performed, i.e., standard, revisit, or complaint.

Your facility meets one or more criterion and remedies will be imposed immediately. Therefore, this Department is imposing the following remedy:

- State Monitoring effective November 19, 2017. (42 CFR 488.422)

The Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

- Civil money penalty for the deficiency cited at F-325. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding our recommendations, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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 remedy be imposed:

- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable PoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

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 their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. 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 January 26, 2018 (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). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

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 April 26, 2018 (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 Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/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: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions related to this electronic notice.

Sincerely,

Anne Peterson

Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
anne.peterson@state.mn.us
Telephone #: 651-201-4206 Fax #: 651-215-9697

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245343	A. BUILDING _____ B. WING _____	10/26/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINNESOTA MASONIC HOME CARE CENTER	11501 MASONIC HOME DRIVE BLOOMINGTON, MN 55437

(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 10/23, 24, 25 and 26, 2017, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. 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 312 SS=D	ADL CARE PROVIDED FOR DEPENDENT RESIDENTS CFR(s): 483.24(a)(2) (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure oral hygiene and grooming needs including nail care, were provided for 1 of 1 resident (R772) reviewed for dependence with activities of daily living (ADLs). Findings include:	F 312	We are submitting this Credible Allegation of Compliance solely because state and federal law mandate submission of a Credible Allegation of Compliance within ten (10) days of receipt of the Statement of Defiencies as a condition to participate in the Medicare & Medical	11/22/17

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

Electronically Signed | 11/22/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245343	A. BUILDING _____ B. WING _____	10/26/2017

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F 312	Continued From page 1 R722's face sheet printed on 10/26/17, indicated the resident had diagnoses including: dementia with behavioral disturbance, displaced intertrochanteric fracture of the left femur, legal blindness, and major depressive disorder. R772's care area assessment (CAA) dated 10/19/17, indicated R722's cognition was severely impaired and that he needed extensive assistance with ADLs which included personal hygiene. The CAA indicated R722 was at risk for unmet needs and further decline due to a recent fracture and increased dependence on others for assistance. R722's care plan dated 8/23/17, directed staff to brush R722's teeth and perform oral hygiene with morning and bedtime cares. R772 was observed on 10/23/17, at 3:13 p.m. to have a brown substance under the finger nails on both hands. In addition, R722 was observed to have brown debris and matter build up on his lower and upper teeth. On 10/24/17, at 8:25 a.m. nursing assistant (NA)-I and NA-J were providing incontinence care for R722 who had been incontinent of bowel and bladder. During the care, R722 was observed to reached his right hand to his buttock area and made contact with the incontinent stool. NA-I and NA-J confirmed the observation and verified R722 does reach back and put his hands in his brief following incontinent episodes. NA-I and NA-J completed the incontinent care and left the room, without offering or assisting the resident to wash his hands. At 9:02 a.m. R722 was observed to have a dark substance under the finger nails of	F 312	Assistance programs. The submission of the Credible Allegation of Compliance within this time frame should in no way be considered or construed as agreement with the allegations of non-compliance or admissions by the facility. An assessment was completed on resident R772 on 10/26/17. Fingernail length did not extend beyond fingertips. Hands were soaked in warm soapy water, nail care with attention to nail beds was completed on R772. Oral hygiene was also completed. Implemented oral hygiene audits for R772, weekly times four (4) weeks, then as needed. Implemented increased monitoring of cleanliness of fingernails to ensure no debris is present prior to meals and PRN. Hands will be washed, with attention to nail beds, before meals with soap and water. A resident specific nail brush has been provided. A fingernail inspection was conducted on Long Term Care residents. Random facility wide bath audits were performed, including inspection of fingernails to ensure residents with recent baths or showers received proper hygiene according to the plan of care and facility policy. No widespread concerns were discovered. Nursing and Nursing Assistant	

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F 312	Continued From page 2 both hands. On 10/25/17, at 8:05 a.m. registered nurse (RN)-E and NA-K entered R722's room. R722 was observed to have his right hand in his groin area. R722's finger nails on both hands continued to have a dark substance under them. R722 put his right hand behind his head and then followed it by placing his right pinky in his mouth running his pinky alongside of his teeth. After incontinence care was completed RN-E offered R722 to brush his teeth and R722 responded "I suppose I could use that". R722 performed oral care and stated "that feels so much better and much fresher". When R722 rinsed his mouth with water and spit it into the basin it contained blood. RN-E then took a wet wash cloth and washed the tops and palms of R722's hands but did not clean under 722's finger nails. On 10/25/17, at 12:56 p.m. NA-L stated R722 had not received a shower since 10/12/17, but received a bed bath. NA-L stated nail care was supposed to be completed with every shower and as needed. NA-L also stated oral care should be completed twice a day. On 10/25/17, at 1:02 p.m. R722 was observed to have his right hand in his brief. R722 then moved his right hand to stroke the back of his head. At 1:52 p.m. licensed practical nurse (LPN) A entered R722's room with a meal tray. R722 continued to have the brown matter under all finger nails on both hands and was observed to run his finger across his teeth. LPN-A stated R722 "digs in his brief all the time". LPN-A confirmed the brown matter under all nails on both hands and stated it could possibly be fecal matter. LPN-A stated she expected staff to	F 312	re-education regarding Nail Care Procedure was provided by written instruction and video. The Nail Care Procedure was revised to note the date and file location on the document. An Oral Hygiene Policy was implemented which provides direction for staff to provide routine oral hygiene to residents. Nursing and Nursing Assistant education was provided on Oral Hygiene Policy by written and verbal instruction. Random bath audits (which includes verification of oral hygiene and fingernail care) will be done weekly for three (3) months and randomly thereafter. Audits will be reviewed in the Quality Assurance meetings. Person responsible; DON Compliance date is 12/10/17	

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F 312	Continued From page 3	F 312		

perform nail care every bath day and as needed. LPN-A confirmed there was not a monitoring system in place to assure R722's nails are clean even though staff are aware of his habit of digging in his brief. LPN-A took a wet wash cloth and washed the tops and palms of R722's hands but did not clean under R722's nails. LPN-A also stated she expected staff to perform oral cares in the morning and evening.

On 10/26/17, at 8:27 a.m. NA-M stated oral care should be completed twice a day and nail care was completed with a resident's bath and as needed. NA-M confirmed R722 had brown matter under both his nails on both hands and stated they needed to be cleaned. At 8:40 a.m. RN-E entered 722's room and confirmed there was brown matter under nails and stated it could possibly be fecal matter as R722 does frequently place his hands in his brief. R722's nails were cleaned at this time. NA-M confirmed oral care had not yet been performed.

On 10/26/17, at 9:01 a.m. RN-E was interviewed and confirmed she had noticed the condition of R722's teeth on 10/25/17 during care. RN-E confirmed there was a build up and bleeding from his gums which was "not good". RN-E stated she needed to re-educate staff on the importance of performing oral care and brushing R722's teeth twice a day in the morning and before bed. RN-E also confirmed that staff should monitor and clean under R722's nails on bath days and as needed.

Following interviews with staff, R722's care plan was updated on 10/26/17, identifying that R722 would "dig" in his bowel movement and smear feces on his hands. The care plan directed staff

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F 312	Continued From page 4 to wash/soak hands and clip nails as needed. An Oral/Dental assessment dated 9/14/17, indicated R722 had inflamed or bleeding gums or loose natural teeth. Further, the assessment identified R722 needed direct staff assist with brushing teeth each morning and evening for approximately 2 minutes. A policy was requested for oral hygiene, however only a dental policy was provided which lacked information regarding direction for staff to provide routine oral hygiene to residents. The facility's undated procedure titled Nail Care Procedure, indicated the purpose was to provide safe hygiene and thorough nail care assistance. The procedure directed staff to complete nail care weekly with the bath schedule. The procedure directed staff to soak resident's hands 2 to 3 minutes and clean nails, under the nails, and to clip nails straight across.	F 312		
F 323 SS=E	FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES CFR(s): 483.25(d)(1)(2)(n)(1)-(3) (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility	F 323		11/22/17

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F 323	Continued From page 5 must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure bed rail/grab bar devices were securely attached in order to prevent falls for 2 of 5 residents (R836, R839) reviewed for accidents and 3 other residents whose environments were randomly reviewed (R68, R483, R844) for potential environmental hazards. Findings include: R836's bilateral quarter side rails were observed in the up position on 10/24/17, at 10:14 a.m. Both side rails were observed to move outward from the mattress about two inches. R836 stated she used the rails to move around in bed and to get in and out of bed. R836 stated she was independent with bed mobility and transfers and that she had noticed the side rails were loose. R836's Evaluation for Use of Side Rails or Grab Bars dated 9/15/17, indicated R836 had side rails on her bed.	F 323	We are submitting this Credible Allegation of Compliance solely because state and federal law mandate submission of a Credible Allegation of Compliance within ten (10) days of receipt of the Statement of Deficiencies as a condition to participate in the Medicare & Medical Assistance programs. The submission of the Credible Allegation of Compliance within this time frame should in no way be considered or construed as agreement with the allegations of non-compliance or admissions by the facility. The grab bars do not have any gaps in FDA identified Zones 1 or 2 that exceed 4.75 inches. R836 discharged to community on 10/28/17. R839 discharged to community on 11/1/17.	

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F 323	Continued From page 6 On 10/25/17, at 8:07 a.m. registered nurse (RN)-C and the surveyor went to R836's room to review the side rails. R836 was sitting in bed with bilateral quarter side rails observed in the up position on her bed. R836 stated she used the side rails for bed mobility and to transfer in and out of bed and pulled on each side rail. Both side rails were observed to move back and forth about 2-3 inches from the mattress outward. R836 stated she knew the side rails were loose, but had not mentioned it to staff. On 10/25/17, at 8:15 a.m. the director of nursing (DON) stated side rails and grab bars were assessed for resident's on the day of admission. The DON stated there were different beds with different side rails and/or grab bars throughout the facility, but stated they utilized them in accordance with the manufacturers' instructions. When asked about R836's side rails, the DON stated she was not aware R836's side rails were loose and stated she would go evaluate and would have them change out the bed with another if the side rails were loose as it would be a safety concern for R836. At 10:50 a.m., the DON informed the survey they had switched out R836's bed. On 10/25/17, at 1:35 p.m. nursing assistant (NA)-E stated R836 was independent with transfers and bed mobility and used the walker to ambulate. NA-E stated all the grab bars and siderails in the facility "wiggle". NA-F standing nearby, stated R836 was independent with transfers and was on "frequent checks, more than hourly" to make sure R836 used her walker. NA-F stated R836 had a history of a fall. At 1:47 p.m. on 10/25/17, R836 was observed	F 323	R844 discharged to community on 11/9/17. R68: The device manufacturer for BAM beds was contacted on 11/15/17. We verified with the device manufacturer that the pivot and assist grab bars were installed according to manufacturers instructions. The device manufacturer stated there have been no previously reported safety concerns. Bolts from the device manufacturer were ordered to replace the pivot and assist grab bar securing pins. The bolts arrived on 11/16/17 and were installed. No movement was observed outward from the mattress. Slight movement of less than 1 inch was observed from the headboard to footboard direction. A new Evaluation for use of Grab Bars / Quarter Rails was conducted for R68. The pivot and assist grab bars were removed. There is no reference to a number R483 on the sample list. The surveyor was not able to identify this resident on a 11/21/17 phone call. There have been no falls or injuries due to grab bars or quarter siderails. We have reviewed the quarter siderails and pivot and assist grab bars throughout the facility on all bed types. They were well within the 2006 FDA dimensional guidance. The device manufacturer for BAM beds was contacted on 11/15/17. The device	

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F 323	Continued From page 7 lying in bed, head of bed up 30 degrees with bilateral grab bars in the up position. R836 stated, "They [grab bars] still move back and forth". R836 stated she had talked to maintenance-A earlier and had been told he could not secure because of a safety pin and they would have alittle play. Both grab bars on R836's bed were observed to move back and forth about 1-2 inches outward from the mattress. R836's Care Area Assessment (CAA) dated 10/21/17, indicated R836 had changing cognitive status and physical limitations included: weakness, limited range of motion, poor coordination, poor balance, visual impairment and pain. The same CAA indicated R836 had been admitted to the facility for rehab and pain management post hospital stay for a fall with compression fracture and rib fracture. R836's Fall Risk Form dated 10/11/17, indicated R836 had fallen within one month prior to admission with a fracture and was unable to understand physical or cognitive limitations. R836's Evaluation for Use of Side Rails or Grab Bars dated 10/10/17, indicated R836 had bilateral grab bars for assist with turning/repositioning, sitting up and transfers left and right sided. The same evaluation indicated R836 was alert and able to follow directions. R836's care plan dated 10/10/17, indicated R836 had limited physical mobility; staff were to anticipate R836's needs, required use of walker, and used bilateral grab bars to maintain ability to participate in bed mobility/transfers. R836's care plan dated 10/23/17, indicated R836 was independent with bed mobility and used left side	F 323	manufacturer stated there have been no previously reported safety concerns. We verified with the device manufacturer that the pivot and assist grab bars were installed according to manufacturers instructions. In addition, the properly installed and maintained pivot assist grab bars had gaps that were well within the 2006 FDA dimensional guidance. Bolts were ordered to replace the pivot and assist grab bar securing pins. The bolts arrived on 11/16/17 and were installed on several beds for testing. No movement was observed outward from the mattress. Slight movement of less than 1 inch was observed from the headboard to footboard direction. All pivot and assist grab bars from BAM beds will be removed and replaced with fixed grab bars. The Evaluation for use of Grab Bars / Quarter Rails form was revised to include the risks and benefits to comply with informed consent requirements. Nursing education, both verbal and written, was initiated on 11/21/17 regarding the revised Evaluation for use of Grab Bars / Quarter Rails form. A new Evaluation for use of Grab Bars / Quarter Rails will be verified and/or obtained upon installation of new fixed grab bars. Maintenance began installation of fixed grab bars on 11/22/17.	

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F 323	Continued From page 8 handrail and was independent with transfers. R836's progress note (PN) dated 10/25/17, indicated R836 was alert, oriented, working with therapy and utilized pain medication. A PN dated 10/20/17, indicated R836 required frequent checks due to self transferring. R839 was observed on 10/23/17, at 3:16 p.m. sitting on the side of her bed with bilateral grab bars in the up position. The grab bars were both observed to move back and forth 2-3 inches from the mattress outward. On 10/24/17, at 2:19 p.m. RN-A stated R839 required contact guard assistance with staff for transfers. On 10/24/17, at 2:31 p.m. R839's bilateral grab bars were observed in the up position and were observed to move back and forth about 2-3 inches from the mattress outward. At 2:57 p.m. R839 was observed lying on top of her bed with her shoes off, lying on her left side, bilateral grab bars on the bed in the up position. A red square was observed with a check mark outside the door (indicating R839 was a fall risk). On 10/25/17, at 7:14 a.m. NA-A stated R839 was contact guard staff assist with transfers and stated R839 put her hand on the grab bar to stand up or sit down. NA-B who was also present stated R839 usually sat on the edge of her bed, and staff had to check on her because R839 had fallen and was confused when she'd first come to the facility. NA-A stated R839 would sometimes use the pancake call light but still had some confusion. NA-B stated R839 required contact guard staff assist for transfers and used the grab	F 323	Maintenance will conduct monthly audits for three months and quarterly thereafter to ensure safe operating condition. Audits will be reviewed in the Quality Assurance meetings. Person responsible; Maintenance Supervisor 12/10/17	

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bars to help stand up. NA-B stated when there were problems with the grab bars, staff would write up a slip for maintenance. NA-B stated R839's grab bars were always to be in the up position and had noticed no movement with them other than when putting them back up in place. Following the interview, NA-B checked and verified there were no maintenance slips in the basket to be picked up.

On 10/25/17, at 8:45 a.m. RN-B stated grab bar and siderail assessments were scheduled quarterly and when staff completed them they check with NAs to see whether residents were still using them. RN-B stated he would check the grab bars and siderails to make sure they were still functioning and stated he had not noticed any movement in the grab bars or side rails, but had only noticed movement when putting the grab bars and side rails back up in place from the down position.

On 10/25/17, at 11:00 a.m. R839's bilateral grab bars were observed in the up position, and still had movement about 2-3 inches from the mattress outward.

On 10/25/17, at 1:17 p.m. NA-C stated grab bar use was identified on resident care plans and that if loose, staff were to contact maintenance. At that time, NA-D also stated if side rails or grab bars were loose they would report it to maintenance staff who would come tighten them. Following the interview, NA-D verified no request slips were in the maintenance basket at the nurse's station to be picked up.

R839's fall risk assessment dated 10/10/17, indicated the provider was unable to determine

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whether R839 had falls prior to admission, indicated R839 had dementia and poor judgement, and related to personal safety, indicated R839 was unable to understand physical or cognitive limitations.

R839's Evaluation for Use of Side Rails or Grab Bars dated 10/10/17, indicated R839's bed had bilateral grab bars used for assist with turning/repositioning, sitting up, transfers left and right side. The evaluation dated 10/10/17, indicated R839 was alert and able to follow directions.

R839's careplan dated 10/10/17, indicated she had limited physical mobility due to deconditioning, impaired cognition and gait/balance problems. Same careplan also indicated R839 was at risk for falls due to deconditioning, gait/balance problems, infection, new environment and impaired cognition with forgetfulness. R839's same care plan indicated R839 used bilateral grab bars to maintain ability to participate in bed mobility/transfers and needed limited assist for bed mobility to turn and reposition and boost up in bed and was able to make some changes in position independently.

A Fall Report dated 10/10/17, indicated R839 had an unwitnessed fall, was found by staff on the floor next to her bed, had not used her call light, was confused, weak and unable to manage self transfer.

R839's PN dated 10/18/17, indicated frequent checks were made on R839 for safety and anticipation of needs, R839 used her call light intermittently and would get up by herself out of bed at bedtime.

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F 323	Continued From page 11 R839's PN dated 10/24/17, indicated R839 was assist of one with transfers, used w/c and walker for transfers and destinations and continued with therapy. R839's PN dated 10/25/17, indicated R839 had minor forgetfulness. R839's PN dated 10/24/17, indicated R839 continued to make good progress with therapy and remained a stand by assist for transfers with staff and supervision with mobility due to safety needs. Random observations of other resident's grab bars not securely attached to the bed: R68's bilateral grab bars were observed in the up position on 10/23/17, at 3:47 p.m. Both grab bars were observed to move from the mattress outward about two inches. R68 stated she used the grab bars to get out of bed and if she had to go to the bathroom and staff did not come fast enough, she would transfer herself out of bed to her wheelchair to go to the bathroom, and stated she was taking a diuretic. R483's bilateral grab bars were observed in the up position on 10/24/17, at 10:20 a.m. Both grab bars were observed to move from the mattress outward about 2 inches. R483 stated she used the grab bars to reposition herself in bed and to get in and out of bed. R844's bilateral grab bars were observed in the up position on 10/23/17, at 2:48 p.m. Both grab bars were observed to move from the mattress outward about 1-2 inches. R844 told the surveyor	F 323		

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	245343	A. BUILDING _____ B. WING _____	10/26/2017

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F 323	Continued From page 12	F 323		

and RN-C that she used the grab bars to pull herself up with.

On 10/25/17, at 7:30 a.m. RN-C stated all the transitional care unit beds had grab bars on them and stated assessments for them were completed within the first two hours of admission. RN-C stated the admitting nurse completed the assessment and the grab bars were identified on resident care plans. RN-C stated maintenance checked the grab bars for safety.

During interview with maintenance supervisor (MS) on 10/26/17, at 8:59 a.m. MS stated maintenance checked the grab bars and side rails in the facility for function and to ensure they were not broken. Also at that time, the Guest Services Manager (GSM) stated housekeeping put the grab bars on and took them off beds. GSM stated he had measured all the grab bars the day before and there was 3/8 inch play at the bottom where he had measured. GSM also verified there was more movement toward the top of the grab bar "substantially more," the further you go up. GSM stated they had the manufacturers' instructions for the grab bars. The GSM and MS both stated the facility had purchased these grab bars in the last few years and had been told by the manufacturer that the grab bars met federal regulations.

The facility's policy Short Siderails/Grab Bars-Use from November 2013 included: "...Short siderails or grab bars will be used for bed mobility: ... As indicated by nursing assessment ... Ensure that the the bed equipment is in good operating condition (i.e. siderails/ grab bars are on securely). Notify maintenance if repairs are necessary... Evaluation of short siderails/ grab

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F 323	Continued From page 13 bars usage is done: Anytime an unusual incident occurs when using short siderails/ grab bars ... and as needed."	F 323		
F 325 SS=G	MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE CFR(s): 483.25(g)(1)(3) (g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- (1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; (3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a resident was provided assistance with eating to ensure adequate nutrition was maintained for 1 of 4 residents (R44) reviewed for nutrition. As a result R44 sustained harm, a significant weight loss of 10% in 30 days. Findings include: R44 was admitted to facility on 9/13/17, according	F 325	We are submitting this Credible Allegation of Compliance solely because state and federal law mandate submission of a Credible Allegation of Compliance within ten (10) days of receipt of the Statement of Defiencies as a condition to participate in the Medicare & Medical Assistance programs. The submission of the Credible Allegation of Compliance within this time frame should in no way be considered or construed as agreement	11/22/17

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F 325	Continued From page 14 to admission sheet. R44's medical diagnoses included: cerebral infarction (stroke), right sided weakness following stroke, aphasia (difficulty speaking) and dysphagia (difficulty swallowing) following stroke. According to current physician orders, R44's diet order was for a pureed texture diet, nectar consistency liquid with dietary supplement with each meal. R44 was observed eating in the dining room on 10/23/17, at 5:26 p.m. A nursing assistant (NA) was feeding her. R44 ate approximately 25% of meal, 1/4 of the milk, 3/4 apple juice, and bites of a fruit puree. R44 was observed continuously on 10/25/17, from 7:08 a.m. to 10:05 a.m. During that timeframe, R44 was not offered breakfast. On 10/25/17, at 10:58 a.m. the speech therapist (ST) was observed feeding R44. At 11:18 a.m. the ST stated R44 consumed about 50 milliliters of her beverage and a half cup of yogurt. The ST stated at this time she would not recommend advancing R44's diet to non-pureed foods. On 10/25/17, at 1:33 p.m. NA-G brought a serving of pureed fruit into R44's room and set it at her bedside. During interview with NA-G at 2:16 p.m., NA-G verified she brought afternoon snacks in for R44 but said "if she is sleeping, I will not wake her up to offer it to her." During interview on 10/26/17, at 8:15 a.m. registered nurse (RN)-D confirmed R44 received two meals per day, brunch and dinner. RN-D stated R44 is not fed an additional meal in her	F 325	with the allegations of non-compliance or admissions by the facility. R44 Care focus changed on 9/21/17 to comfort cares. R44□s routine was to have breakfast with Speech Therapy usually between 10a.m.-11a.m. as resident was more awake later in the day. Unit class was conducted on 11/15/17 with Long Term Care (LTC) staff, where R44 currently resides. Class content included instruction on offering meals and snacks, honoring resident preferences outlined in the plan of care, assisting with feeding and accurate recording of intake. The nursing manager spoke with R44□s daughter on 11/15/17 regarding continued weight loss and declining appetite. They discussed, a waiver to allow R44 a more liberal diet for improved quality of life and Hospice options. The nursing manager, local daughter and daughter from out of state scheduled a meeting 11/24/17 to discuss further plan of care and options. The resident was approached on 11/20/17 in an attempt to reevaluate meal and care preferences. Resident did not respond to attempts at communication keeping eyes closed. Resident was re-approached on 11/22/17, again with no response, keeping eyes closed. The nursing manager spoke with R44□s daughter on 11/22/17. Daughter indicated she was with R44 yesterday evening and resident did not eat during the meal. The	

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F 325	Continued From page 15 room because she requires assistance eating and needs to sit upright. RN-D further stated R44's cognition was intact but R44 had difficulty communicating her needs due to aphasia from a stroke. RN-D also stated R44 seemed to be more awake in the evening. During interview on 10/26/17, at 8:49 a.m. NA-H confirmed R44 did not eat breakfast because she needed help eating and needed to be fed in the dining room. NA-H stated R44 liked to drink a lot and can hold her own cup to drink if it is given to her. NA-H stated sometimes R44 would look like she was sleeping but was really was awake with her eyes closed and would respond if you talked to her. During interview on 10/26/17, at 9:34 a.m. RN-C stated she was unsure whether breakfast or an evening snack were being sent up and offered to R44. RN-C stated she thought R44 would eat better sitting up in a chair. RN-C further stated she expected nursing staff to assist R44 with eating in her room for the meals and snacks not served in the dining room. During interview on 10/26/17, at 9:44 a.m. dietician (D)-A explained the meal plan available for R44 included a continental breakfast from 6:30-9:00 a.m. which was usually a pureed pastry or fruit and not served in the dining room; brunch at 10:30 a.m. served in the dining room; a snack of pureed fruit at 1:30 p.m. not served in the dining room; dinner at 4:30 p.m. in the dining room; and a 7:30 p.m. pureed snack, such as a pureed tuna and pasta salad, not served in the dining room. D-A stated pureed foods are automatically sent up for R44 but verified the resident would be dependent on staff for deciding	F 325	daughter stated she believes the resident is choosing to not eat because she believes resident would like to die. The daughter repeated R44 never wanted to live in a nursing home and R44 was very independent. Daughter restated her belief R44 would never want to be dependent on others for cares, eating etc. The daughter stated she believes R44 closes her eyes often because resident does not want to look at who is taking care of her. R44□s daughter stated she is a nurse and believes the resident should be allowed to choose to not eat. Daughter does not wish the staff to wake her for continental breakfast or snacks if she is asleep, and would like staff to continue to get the resident up for brunch and supper. Daughter also stated if her mother refuses to get up for those two meals she feels it is okay to let R44 stay in bed. The daughter would like to pursue hospice care and wants to address this during our meeting on 11/24/17. The Care Plan was updated to reflect preferences and adjustment of nutritional goals. Implemented increased monitoring and communication between all disciplines of R44□s refusal to get up or refusal to eat. All LTC residents will be reviewed monthly using a Nutritional Risk Tool to identify those residents who may require further interventions. The tool notes resident sleep/wake preferences, who does not eat continental breakfast, who does not eat a protein HS snack, who requires feeding	

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F 325	Continued From page 16 whether or not to feed it to her. D-A referenced a transfer sheet from D-B to D-A which had been completed when the resident moved to long term care however, verified no new assessments or interventions were in place to address continued weight loss. R44's weights were reviewed from the medical record: On 9/19/17, R44 weighted 152 pounds and as of 10/20/17, R44's weight was 138 pounds indicating a 10% loss in 30 days. A progress note from RD-B dated 10/6/17, indicated RD-B was aware R44's weight was decreasing and that the RD had suggested adjustments to R44's dietary supplements. R44's nutritional intake log from 10/19/17-10/26/17, indicated a morning meal was not consumed. R44's care plan dated 9/21/17, indicated the resident was at risk for altered nutritional status and required more assistance at meals. Goals included: "The resident will maintain adequate nutritional status as evidenced by non-significant weight changes, no signs/symptoms of malnutrition, and consuming at least 50% of meals daily" and, "Resident will maintain wt (weight) at 155# +/- 5# with wt restoration desired."	F 325	assist and who has had weight loss. Clinical communication improvement: When a resident transfers to LTC from Transitional Care (TCU), the TCU and LTC dietitians will communicate regarding the resident□s nutritional needs. The LTC dietitian will conduct an admission visit within 3 days to explain the LTC dining, menus, and gather information such as food preferences, dislikes, mealtime preferences, special requests, etc. and create a care plan. The Continental Breakfast and Snacks menu was expanded to include more protein options. A new picture menu was created to simplify choosing. Some additions: yogurt cup, cheese stick, pudding, hard-boiled egg, English muffin, high protein shake. The Not Applicable option was removed from the Nursing Assistant Point of Care documentation. Nursing and Nursing Assistant re-education regarding meal and snack delivery was provided by written and verbal instruction. Nursing re-education regarding use of weight change notification email was provided. Facility will ensure that Comprehensive Care planning meets requirements as outlined in the State Operations Manual. Facility will ensure that there is no more	

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F 325	Continued From page 17	F 325	than 14 hours between evening and morning meal or 16 hours if chosen by resident group. Nutritional Risk Tool will be reviewed in the Quality Assurance meetings. CASPER reporting weight loss trends will be reviewed by Quality Assurance nurse and reviewed in the Quality Assurance meetings. Person responsible; DON Compliance date is 12/10/17	
F 368 SS=D	FREQUENCY OF MEALS/SNACKS AT BEDTIME CFR(s): 483.60(f)(1)-(3) (f) Frequency of Meals (f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. (f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. (f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the	F 368		11/22/17

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F 368	Continued From page 18 resident plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 4 residents (R44) reviewed for nutrition was provided at least 3 meals daily. Findings include: R44 was observed continuously on 10/25/17, from 7:08 a.m. to 10:05 a.m. During that timeframe R44 was not offered any meal. On 10/25/17, at 10:58 a.m. a speech therapist (ST) was observed feeding R44. At 11:18 a.m. the ST stated R44 had consumed about 50 milliliters of her beverage and half a cup of yogurt. The ST stated at this time she would not recommend advancing R44's diet to non-pureed foods. On 10/25/17, at 1:33 p.m. nursing assistant (NA)-G was observed to take a dish of pureed fruit into R44's room and set it on the bedside table. At 2:16 p.m. NA-G verified she brought R44 an afternoon snack, but stated when R44 was sleeping she would not wake her up to offer it to her. R44 record indicated she had been admitted to facility on 9/13/17, with medical diagnoses including: cerebral infarction (stroke), right sided weakness following stroke, aphasia (difficulty speaking) and dysphagia (difficulty swallowing) following stroke. The current physician orders indicated R44 required a pureed texture diet, with nectar consistency liquids and a dietary supplement with each meal.	F 368	We are submitting this Credible Allegation of Compliance solely because state and federal law mandate submission of a Credible Allegation of Compliance within ten (10) days of receipt of the Statement of Defiencies as a condition to participate in the Medicare & Medical Assistance programs. The submission of the Credible Allegation of Compliance within this time frame should in no way be considered or construed as agreement with the allegations of non-compliance or admissions by the facility. We will continue to provide multiple meal and snack options as resident accepts. Daughter does not wish the staff to wake her for continental breakfast or snacks if she is asleep, and would like staff to continue to get the resident up for brunch and supper. We have added preferences to R44□s care plan to offer continental breakfast if awake and increased monitoring of refusal to get up or refusal to eat. A Unit class was conducted on 11/15/17 with Long Term Care (LTC)staff, where R44 currently resides. Class content included instruction on offering meals and snacks, honoring resident preferences in the plan of care, assisting with feeding and accurate recording of intake.	

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F 368	Continued From page 19 R44's nutritional intake log from 10/19/17-10/26/17, indicated a morning meal was not consumed. During interview on 10/26/17, at 8:15 a.m. registered nurse (RN)-D confirmed R44 only received two meals per day which were brunch and dinner. RN-D stated R44 is not fed an additional meal in her room because she needed assistance eating and needed to sit upright. RN-D stated R44's cognition appeared to be intact but she had difficulty communicating her needs due to aphasia from her stroke. RN-D stated R44 seemed to be more awake in the evening. During interview on 10/26/17, at 8:49 a.m. NA-H confirmed R44 did not eat a continental breakfast because she needed help eating and needed to be fed in the dining room. NA-H stated R44 liked to drink a lot and can hold her own cup to drink if it is given to her. NA-H stated sometimes R44 would look like she was sleeping but was really was awake with her eyes closed and would respond if you talked to her. During interview on 10/26/17, at 9:34 a.m. RN-C stated she was unsure whether a breakfast or evening snack were being sent up and offered to R44. RN-C stated she thought R44 would eat better sitting up in a chair. RN-C further stated she expected nursing staff to assist R44 with eating in her room for the meals and snacks not served in the dining room. During interview on 10/26/17, at 9:44 a.m. dietician (D)-A explained the meal plan available for R44 included a continental breakfast from 6:30-9:00 a.m. which was usually a pureed pastry	F 368	Our Five meal plan was reviewed on 11/16/17. The Five meal plan provides residents with frequent nutritious meal options throughout the day. Any residents waking early are offered optional Continental breakfast. Brunch, Dinner and HS protein snack meet meal requirements. The Registered Dietician attended the Resident Council on 11/3/17 to get feedback on resident satisfaction with meal and snack times. Findings concluded that residents are satisfied with the meal and snack times. All LTC residents will be reviewed monthly using a Nutritional Risk Tool to identify those residents who require further interventions. The tool notes resident sleep/wake preferences, who does not eat continental breakfast, who does not eat a high protein HS snack and those who require feeding assist. We will reevaluate LTC resident preferences for wake/sleep times and preferred eating schedule and care plan according to facility policy. The Continental Breakfast and Snacks menu was expanded to include more protein options. A new picture menu was created to simplify choosing. Some additions: yogurt cup, cheese stick, pudding, hard-boiled egg, English muffin, high protein shake. The Not Applicable option was removed	

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F 368	Continued From page 20 or fruit and not served in the dining room; brunch at 10:30 a.m. served in the dining room; a snack of pureed fruit at 1:30 p.m. not served in the dining room; dinner at 4:30 p.m. in the dining room; and a 7:30 p.m. pureed snack, such as a pureed tuna and pasta salad, not served in the dining room. D-A stated pureed foods are automatically sent up for R44 but verified the resident would be dependent on staff for deciding whether or not to feed it to her.	F 368	from the Nursing Assistant Point of Care documentation. Implemented Point of Care documentation of meal and snack intake. Random audits will be conducted on meal intake documentation. Nursing and Nursing Assistant re-education regarding meal and snack delivery was provided by written and verbal instruction. The Dietary Services Resident Meal Times Policy was revised on 11/21/17. The Dietary Services 5 Meal Plan Policy was revised on 11/21/17. The Nutritional Risk Tool will be reviewed in the Quality Assurance meetings. Audits of meal intake documentation will be reviewed in the Quality Assurance meetings. Person responsible; Director of Nutritional Services 12/10/17	

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	245343	A. BUILDING **01 - MAIN BUILDING 01** B. WING	**10/25/2017**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on October 25, 2017. At the time of this survey, Minnesota Masonic Home Care Center was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, the Health Care Facilities Code. Minnesota Masonic Home Care Center is a 3-story building with a basement that was constructed in 1965 and was determined to be of Type I (332) construction. In 1995 an addition was constructed to the south wing and was determined to be of Type I (332) construction. The facility is fully protected throughout by an automatic fire sprinkler system and has a fire alarm system with smoke detection in the corridors and areas open to corridors that is monitored for automatic fire department notification. Because the original building and the addition are both of the same construction type, the facility was surveyed as 1-building. The facility has a capacity of 214 beds and had a census of 199 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

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

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.