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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: 79XJ

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 **11/25/2015** (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

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

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

17. SURVEYOR SIGNATURE — Date :
Gayle Lantto, Unit Supervisor — 11/25/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath, Enforcement Specialist — 01/08/2016 (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
12/03/2015
(L33)

DETERMINATION APPROVAL

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245343

January 8, 2016

Ms. Shelly Wiggin, Administrator
Minnesota Masonic Home Care Center
11501 Masonic Home Drive
Bloomington, Minnesota 55437

Dear Ms. Wiggin:

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 9, 2015 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 eNotice.

Sincerely,

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

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered

Ms. Shelly Wiggin, Administrator
Minnesota Masonic Home Care Center
11501 Masonic Home Drive
Bloomington, MN 55437

RE: Project Number S5343027

Dear Ms. Wiggin:

On October 14, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on October 1, 2015. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On November 25, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on October 1, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of November 10, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on October 1, 2015, effective November 9, 2015 and therefore remedies outlined in our letter to you dated October 14, 2015, will not be imposed.

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.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245343	A. Building B. Wing	11/25/2015

Name of Facility	Street Address, City, State, Zip Code
MINNESOTA MASONIC HOME CARE CENTER	11501 MASONIC HOME DRIVE BLOOMINGTON, MN 55437

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix F0157 Reg. # 483.10(b)(11) LSC	11/09/2015	ID Prefix F0257 Reg. # 483.15(h)(6) LSC	11/09/2015	ID Prefix F0311 Reg. # 483.25(a)(2) LSC	11/09/2015
ID Prefix F0441 Reg. # 483.65 LSC	11/09/2015	ID Prefix F0463 Reg. # 483.70(f) LSC	11/09/2015	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GL/kfd	11/25/2015	15507	11/25/2015
CMS RO				

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
10/1/2015	

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

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(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 **10/01/2015** (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
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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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To (b) :

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A. In Compliance With
Program Requirements
Compliance Based On:
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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):

17. SURVEYOR SIGNATURE
Conrad Simba, HFE NEII
Date : 11/23/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL
Mark Meath
Enforcement Specialist
Date: 12/02/2015 (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
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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)

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02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
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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

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
October 14, 2015

Ms. Shelly Wiggin, Administrator
Minnesota Masonic Home Care Center
11501 Masonic Home Drive
Bloomington, Minnesota 55437

RE: Project Number S5343027

Dear Ms. Wiggin:

On October 1, 2015, 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 widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

> **Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> **Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;**
>
> **Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;**

Potential Consequences - the consequences of not attaining substantial compliance 3 and 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:

Gayle Lantto, Unit Supervisor
Metro D Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: gayle.lantto@state.mn.us

Phone: (651) 201-3794
Fax: (651) 215-9697

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by November 10, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by November 10, 2015 the following remedy will be imposed:

- Per instance civil money penalties. (42 CFR 488.430 through 488.444)

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 remedies be imposed:

• Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

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

Failure to submit an acceptable ePoC 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. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) 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 remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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 1, 2016 (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 1, 2016 (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.

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

Sincerely,

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

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 ______	10/01/2015

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 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 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a	F 157		11/10/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — Electronically Signed
TITLE
(X6) DATE 10/22/2015

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.

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 ______	10/01/2015

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 157	Continued From page 1 change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure provide notice to a responsible party when treatment was altered and medication errors were made for 1 of 1 resident (R229) reviewed for unnecessary medications. Findings include: R229's 9/15, medication administration record (MAR) revealed physician orders for Ativan (anti-anxiety medication) 0.5 milligrams (mg) twice daily and as needed (PRN) in the afternoon. A nurse practitioner (NP) on 9/2/15, wrote an order to decrease to decrease Ativan to 0.5 mg every morning and continue the PRN order. However, the 9/15 MAR revealed R229 continued to receive the additional Ativan twice daily for two weeks until the NP caught the error on 9/15/15. R229's most recent quarterly Minimum Data Set (MDS) dated 8/17/15, indicated the resident had severe cognitive impairment, and required the assistance of one staff to transfer and walk in the room and corridor. R229's nurses' notes from 9/1 to 10/1/15 and	F 157	R229's responsible party was notified on 10/1/2015 that there was a transcription error that occurred 9/2/2015 and was corrected on 9/15/2015. It was reported to the responsible party that Ativan was decreased from twice daily to once daily. The DON and ADON reviewed the procedure related to the Change in Condition Notification and revised it to include updating family with omission errors or any error that results in need for resident monitoring. Documentation of this will be in the Interdisciplinary Note. The DON and ADON reviewed the Medication Error Procedure. A revision was made to this procedure. When a medication error is noted the nurse finding the error will email the findings to our group incident report notification email which includes Nurse Managers, Nurse Supervisors, DON, ADON and Administrator. After report of an error is received an audit of the Interdisciplinary Note will be done to ensure that family was notified about a change in condition	

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	245343	A. BUILDING ______ B. WING ______	10/01/2015

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F 157	Continued From page 2 revealed no documentation to indicate the resident's responsible party had been notified of either the dosage reduction or the medication errors, nor that the resident was monitored for potential adverse consequences. The notes revealed two entries related to sedation: On 9/13/15, at 9:55 p.m. R229 was sleepy most of the shift, ambulated with extensive assist of one to dining, and was confused at times. On 9/14/15, at 11:08 p.m. R229 continued to be lethargic until after dinner. She slept through her hair appointment and son's visit, continued to be weaker, received scheduled Ativan. During an interview on 10/1/15, at 9:15 a.m. a registered nurse (RN)-C confirmed there had been a medication error that she became aware of when the "NP pointed it out on 9/15/15." RN-C also confirmed that a medication error report filed had not been filed, nor was R229's responsible party notified of the dosage change or the medication errors. RN-C stated her expectation was that the nurse who identified the medication errors should have filed a report and updated the family. RN-C explained that normally with a medication error "like this, we file a medication error report, notify the [physician/NP] and family, then we continue monitoring the resident." Later that day at 1:21 p.m. RC-C explained that with every fall, the fall committee and the interdisciplinary team (IDT) reviewed resident medications and see if medications could have contributed to the fall. RN-C confirmed that she had not, however, reviewed R229's medications prior to the fall committee meeting on 9/9/15. She stated, "I should have checked on the medication order. I would have caught the error." RN-C stated that all medication errors were supposed	F 157	related to a medication error. To prevent further occurrences a nightly audit of Telephone Orders from the previous day are reviewed to assure the processing of the orders were completed. Education is being provided to licensed nursing staff regarding updates to the Change in Condition Notification Procedure and Medication Error Procedure. Audits will be reviewed by the Quality Assurance Committee. Person responsible: DON/ADON. Date of Completion: November 10, 2015	

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F 157	Continued From page 3 be filed as medication errors, "but honestly I don't know what happened on this situation. I spoke with the director of nursing and the assistant director of nursing [ADON] and they both agreed that a medication error report should have been filed." The ADON stated on 10/1/15, at 1:49 p.m. her expectations was that nurses would have filed a medication error report and notified the family of change in dosage and the medication errors. The ADON explained that the IDT and fall committee reviewed resident's medications with every fall. The ADON further stated, "Since the survey team brought this into our attention, we are now having night shift staff go through all charts to check for any new orders."	F 157		
F 257 SS=E	483.15(h)(6) COMFORTABLE & SAFE TEMPERATURE LEVELS The facility must provide comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 - 81° F This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure comfortable temperatures were maintained in 2 of 6 dinning rooms, having the potential to affection 54 residents. Findings include: R459 stated in an interview on 9/28/15, at 4:53 p.m. that most of the time the building	F 257	Daily temperatures are taken throughout the buildings and recorded for 4 weeks. The identified residents as well as a random selection of other residents who are still residing in our facility, will be interviewed daily on comfort for 4 weeks and randomly thereafter. Maintenance staff will adjust temperatures based on any temperature recordings or interviews that imply a need for temperature change.	11/9/15

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F 257	Continued From page 4 temperature was cold, especially the dining room where he ate meals. R81 reported in an interview on 9/28/15, at 6:22 p.m. that the "hallways can be cold." R788 said on 9/28/15, at 6:38 p.m. that the "dining room is cold." During the evening meal on 9/28/15, at 5:06 p.m. when the surveyor stepped into the dining room on the 2nd floor transitional care unit (TCU), an immediate very strong cool breeze was felt, and the dining room felt cold. The dining room capacity was for 28 residents, and at the time of the observation 20 residents were eating their meal. All but three of the 20 residents were wearing layers of clothing. For example, R255 was dressed in a T-shirt, with a long-sleeved pull over sweater and a knitted shawl draped around and her shoulders and pulled close to her body. R90 wore a T-shirt and sweat shirt. Multiple residents entered the dining room with sweaters. R228 reported it was always cold in the dining room no matter what day or time, and "That's why I bring my sweater." When asked how they felt about the temperature in the dining room, 17 of the 20 residents reported it was always cold. On 9/30/15, at 11:13 a.m. it was again noticeably cooler than the rest of the building, and residents again had layers of clothing. An environmental tour was conducted with the environmental maintenance supervisor (EMS) and the administrative intern (AI) on 10/1/015, at 9:00 a.m. The EMS explained he liked to keep the temperature in the hallways and corridors at 72 degrees Fahrenheit (°F). The dining room on	F 257	Logs and interviews will be reviewed by the Quality Assurance Committee. Completion date of compliance: November 9, 2015. Person responsible: Director of Guest Services.	

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F 257	Continued From page 5 2nd floor TCU temperature registered 72.7 °F, however, two residents reported to the EMS, "It's too cold in here everyday." Another resident stated she was also cold but did not know whom to report her concern. Later, at 9:28 a.m. R90 reported she always wore a sweater at mealtime, but was discouraged by staff when she wanted to bring a blanket to meals, as well. When the EMS and the surveyor entered the dining room where R90 ate meals the EMS immediately stated, "I feel that cold air--absolutely." A temperature reading was recorded at 70 °F. When the AI entered the dining room she also confirmed she felt it was cold. Both the EMS and AI said residents should not have to be uncomfortable while eating. The EMS then explained that he had not received any complaints of cold temperatures in the dining rooms and voiced his disappointment stating, "I wish staff would of brought this to my attention." A policy and procedure for maintaining dining room temperatures was requested but not provided.	F 257		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure nail care was provided for 1 of 1 resident (R459) reviewed for activities of daily living (ADL's).	F 311	R459's toenails were cut on 9/25/2015. The DON and ADON reviewed the procedure for Bath-Shower. The	11/10/15

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F 311

Continued From page 6

Findings include:

R459 reported during an interview on 9/28/15, at 5:53 p.m. his toe nails had not been cut since his admission. He wanted them cut because they felt long and were pushing against his socks. R459 explained that when he was at home he had his toe nails cut twice a month by a podiatrist, and he was unable to see his podiatrist or cut his toenails on his own.

R459 was admitted to the facility on 8/20/15, with a diagnosis of acute post-operative pain. R459's Minimum Date Set (MDS) dated 9/9/15, indicated he was cognitively intact and did not refuse care. The initial care plan for R459 care plan dated 8/20/15, indicated he was a risk for alteration of skin integrity and required assistance from staff with ADL's. Staff interventions were to inspect skin daily with cares and report any concerns to the nurse. R459's Daily ADL Performance sheet dated 8/24/15, indicated the need for weight bearing assistance from staff during showers which were Mondays and Thursdays.

During an interview on 9/30/15, at 9:32 a.m. a registered nurse (RN)-B explained that each time the nursing assistants (NAs) gave a bath/shower they fill out a sheet titled, Head to Toe Skin Evaluation. RN-B stated the last time R459 received a bath/shower was on 9/28/15, at which time no skin issues noted and the form was signed off by a nurse. RN-B stated that R459 had not reported to her that his toe nails needed cutting and she only cut toe nails of the residents who had diabetes.

During an interview on 9/30/15, at 9:32 a.m. NA-A

F 311

procedure was updated to include the use of Bath-day Checklists which are to be filled out after weekly bath. The Bath-day Checklist includes boxes where the Nursing Assistant checks off whether nail care has been provided. If nail care is not provided the reason will be indicated on the Bath-day Checklist and nurse to be notified.

To prevent further occurrence random weekly audits will be conducted.

Education on use of Bath-day Checklist and updated Bath-Shower Procedure is being provided to nursing staff.

Person Responsible: DON/ADON

Date of Completion: November 10, 2015

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F 311	Continued From page 7 stated that when residents were given a bath or shower she normally cut their finger and toe nails if it was needed and if they did not have diabetes. NA-A explained the unit used to have a sheet of paper where the NAs could check off what bathing cares had been provided for residents, but NA said she had not seen the sheets "for a while." R459 was then re-interviewed at approximately 9:40 a.m. and reported he had asked a NA "yesterday (9/29/15) if he could get his toe nails cut, but was told the staff would instead cut them on his next bath/shower day. R459 stated, "I would of like them to have been done, but its too late now--I'm going home tomorrow." RN-A explained on 9/30/15, at 9:45 a.m. all residents were given a bath/shower twice a week and on one of the two days the nurse filled out a sheet titled Head to Toe Skin Evaluation. RN-A stated she expected staff to check to see if nail care was needed, and to inform the nurse if the resident was diabetic. RN-A explained each resident had an ADL sheet kept in the mediation administration record on the medication cart that would indicated when nail care was provided. RN-A, however, was unable to find the sheets where the NAs documented when nail care had been provided. NA-A then stated she noted when nail care was provided by writing it on the Bath-Day Checklist, but the sheets were unavailable on the unit where R459 resided. RN-A verified having knowledge of the Bath-Day Checklist NA-A referred to, and was unsure why the sheets were not being utilized on the unit. R459 toe nails were observed that same day, and RN-A verified the resident's nails were long and had sharp and jagged edges. RN-A asked R459 if	F 311		

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F 311	Continued From page 8 he would wanted a foot soak and his toenails cut and R459 replied, "Yes very much." Later that day at 2:30 p.m. NA-A stated she cut R459 toe nails and said his toenails were long and had some jagged and rough edges. During an interview on 10/1/15, at 8:23 NA-B who worked on unit D explained when baths were given on the unit, the Bath-Day Checklist was filled out for each resident. The Bath-Day Checklist had boxes where the NA was to check whether nail care had been provided. A trained medication aide (TMA)-A then verified the NAs on the unit filled out the checklist when bathing was provided and noted whether or not nail care was completed. The facility's undated Bath-Tub Bath policy provided step by step-by-step instructions for staff to follow. Step 5 read, "Unless resident is a diabetic, cut the resident's toenails and fingernails, ensuring the edges of the nails are smooth."	F 311		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an	F 441		11/9/15

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F 441	Continued From page 9 Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document	F 441	Laundry staff were reeducated on the	

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F 441	Continued From page 10 review the facility failed to ensure preventative measures were utilized to minimize the risk for the spread of infection during laundry handling. The practice had the potential to affect all 206 resident who resided at the facility. Finding include: An tour of the laundry area was conducted with the environmental maintenance supervisor (EMS) and the administrative intern (AI) on 10/1/15, at 9:42 a.m. Soiled laundry was observed in a large square wheeled bin on wheels. The edge of the bin was approximately three feet high, requiring staff to bend to reach soiled laundry on the bottom of the bin. A laundry aide (LA)-A explained she picked up soiled laundry from each floor, and brought it back to the laundry room where it was then sorted. LA-A stated when sorting soiled laundry she wore gloves, but did not wear a gown. Her reasoning was, "I don't like the way it fits or the color of it." LA-A stated she had never been instructed she was required to wear a gown when sorting soiled laundry. During an interview on 10/1/15, at 10:53 a.m. LA-B stated when sorting the soiled laundry she donned gloves and an apron/gown. LA-B stated she had been instructed she was required to wear a apron/gown when sorting soiled laundry. LA-B said, however, she was aware LA-A did not wear a gown when sorting soiled laundry, but was unsure why. The facility's 1/10, Processing of Resident Clothing policy directed staff as follows: "Laundry employees, wearing gown and gloves, will sort laundry in the soiled room by separating garments by color, fabric, and soil content."	F 441	laundry sorting policy. Reminder signs to wear gloves and gowns while sorting soiled laundry have been posted in the laundry sorting area. Daily audits will be conducted for 4 weeks and randomly thereafter to ensure that staff are wearing gowns. Audits will be reviewed by the Quality Assurance Committee. Completion date of compliance: November 9, 2015. Person responsible: Guest Services Manager.	

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F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure a call light was functioning for 1 of 1 resident (R107) reviewed for environmental concerns. Findings include: R107's call light was activated, but was found non-functional during an initial observation on 9/28/15, at 5:49 p.m. A licensed practical nurse (LPN)-A was summoned tot he room to check on the light. LPN_A also was unable to get the light to activate. LPN-A stated R107 was legally blind, and staff usually placed the call light close to her chest so it was available should she have needed staffs' assistance. LPN-A stated R107 used her call light at times, and if staff noted a call light not working they should have contacted maintenance right away to have it repaired. On 9/28/15, at 6:10 p.m. the director of guest services (DGS) reported the facility maintenance completed call light audits every other month alternating between the "D and E" buildings. DGS stated if staff found a call light was not working, they were to notify maintenance staff immediately to have it fixed. On 9/28/15, at 7:02 p.m. R107's call light was	F 463	Facility-wide call light audits will continue to be conducted monthly, alternating between buildings D and E each month. Testing the call lights has been added to the housekeepers' daily cleaning routine in resident rooms. Random audits will be conducted as part of our environmental rounds process. If an issue is found, maintenance staff will be notified and the issue will be resolved immediately. Staff will be reeducated to immediately communicate to maintenance if a light is found to be not working properly. Audits will be reviewed by the Quality Assurance Committee. Completion date of compliance: November 6, 2015. Person responsible: Director of Guest Services.	11/9/15

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F 463	Continued From page 12 observed placed on top of her bed and was functioning when tested. On 9/29/15, at approximately 10:00 a.m. the DGS provided call light audit logs which indicated a call audit for building "E" (where R107 resided) was completed on 8/21/15. The audit revealed, "Call lights OK." The DGS stated the next call light audit for building E was scheduled for October 2015. A call light policy was requested but was not provided.	F 463		

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

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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
K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, Minnesota Masonic Home was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. Minnesota Masonic Home 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 fire sprinkler protected. The facility has a fire alarm system with smoke detection in the corridors and areas open to corridors that is monitored for automatic fire department notification. All resident rooms of the facility have hardwired single station smoke detection. Because the original building and the 1 additions are all of the same construction type, the facility was surveyed as 1-building. The facility has a capacity of 214 and had a census of 202 at the 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.