Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 20, 2024

Administrator
Minnesota Masonic Home Care Center
11501 Masonic Home Drive
Bloomington, MN 55437

RE: CCN: 245343
Cycle Start Date: December 18, 2024

Dear Administrator:

On December 18, 2024, a 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 a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Pete Cole, RN Regional Operations Supervisor
Metro Team C District Office
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: peter.cole@state.mn.us
Office/Mobile: (651) 249-1724

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 the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of

the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by March 18, 2025 (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).

In addition, if substantial compliance with the regulations is not verified by June 18, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 **and Minnesota Statute 144A.10 subd 15**, 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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:
https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

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 _____	C 12/18/2024

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
E 000	Initial Comments On 12/16/24 through 12/18/24, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73 was conducted during a standard recertification survey. The facility was in compliance. The facility is enrolled in the electronic Plan of Correction (ePoC) and therefore a signature is not required at the bottom of the first page of the State form. Although no plan of correction is required, it is required that you acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 12/16/24 through 12/18/24, a standard recertification survey was conducted by surveyors from the Minnesota Department of Health (MDH). In addition, a complaint investigation was also completed. Your facility was found not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. In addition to the recertification survey, the following complaint was reviewed with no deficiency issued. H53432660C (MN00108053) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments 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	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/30/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document	F 656		1/21/25

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F 656	Continued From page 2 whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure care-planned interventions to promote appropriate fluid balance were consistently implemented and accurately tracked to promote continuity of care for 1 of 1 resident (R15) reviewed who received hemodialysis and was on a fluid restriction. Findings include: A National Kidney Foundation (NKF) Fluid Overload in a Dialysis Patient feature, dated 2024, identified fluid overload in a dialysis patient occurs when too much water builds up within the body. The feature added, "It can cause swelling, high blood pressure, breathing problems, and heart issues." The feature explained, "When you are on dialysis, your kidneys are no longer able to keep the right balance of fluid in your body ... That's why it's so important to limit how much sodium (salt) and fluid you have between dialysis treatments," adding further, "Follow the fluid guidelines [bolded] given to you ... Most dialysis patients need to limit their fluid intake to 32 ounces per day."	F 656	483.21(b)(1)(3) Develop/Implement a Comprehensive Care Plan 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. It is the policy of Minnesota Masonic Home Care Center to provide resident centered care in accordance with the resident□s preferences and stated goals as outlined in the care plan. R15 was hospitalized from 12/16-12/20/24 due to rib pain and to rule out pulmonary	

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F 656	Continued From page 3 R15's admission Minimum Data Set (MDS), dated 11/16/24, identified R15 had moderate cognitive impairment and had multiple medical conditions including anemia, atrial fibrillation or cardiac dysthymia, heart failure, and end-stage renal disease. Further, the MDS recorded R15 received dialysis treatments while a resident at the center. R15's dialysis care plan, initiated 11/14/24, identified R15 had chronic kidney disease and a history of acute kidney injury (AKI) and received dialysis treatments. The care plan listed multiple goals for R15 including, "Resident's fluid balance will be maintained and complications minimized as evidenced by non-labored breathing and maintenance of target weight ...," along with several interventions to help R15 meet these goal(s) including, "Dialysis: Document intake and output (1500ml [milliliters] fluid restriction)." On 12/16/24 at 2:54 p.m., R15 was observed in her room lying in bed with family member (FM)-E present at the bedside. R15 stated she was on dialysis, which FM-E verified, and on a Tuesday - Thursday - Saturday schedule. On the wall of R15's room, a white-colored cup picture was present which had, "1500," written on it. However, present on R15's bedside table were multiple white Styrofoam cups and a single hard plastic pitcher with water in it. The cups were inspected and each had remaining fluid inside of them. FM-E stated R15 was on a fluid restriction, however, when questioned on if R15 was maintaining that restriction FM-E laughed and pointed at the multiple cups with fluid adding aloud, "I don't know." R15 stated she was unsure how much fluid was given to her at meals or medication pass, nor how it was being tracked if	F 656	embolism. The fluid restriction was discontinued while in the hospital. Our Dietitian noted this on the 12/20/24 readmission, and monitored R15□s status for a potential dietary adjustment. On 12/26/24, the fluid restriction was reordered, and the care plan was updated. An observation was conducted on 12/23/24 for other residents who receive dialysis and are on fluid restrictions. Additional instruction was added to the fluid restriction order. Unit classes began on 12/27/24. Nursing staff were reeducated on the importance of adhering to fluid restrictions and how to accurately document. Nurse will document medication pass fluids directly into the Point of Care module. Dietitian will increase oversight for residents on dialysis with a fluid restriction. A template was created for the orders and care plan to include a more detailed fluid restriction plan for medication pass, meals, as well as separating the order for nurse monitoring of the 24 hour intake. The policy International Dysphagia Diet Standardization Initiative Cup/Plate System Thickened Liquids and Texture Modified Food Guidelines was revised on 12/27/24 to include more detailed instruction for monitoring and documenting fluid intake for residents with	

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F 656	Continued From page 4 at all adding aloud, "I really don't know." FM-E and R15 verified the center' staff provided each of the cups, and R15 denied needing any extra dialysis runs due to fluid overload. When interviewed on 12/17/24 at 1:26 p.m., nursing assistant (NA)-A stated R15 was on dialysis and had been "doing pretty well" with eating but seemed to never drink much adding it was "more just sips [fluids]." NA-A stated they had been trying to offer R15 more fluids, including flavored waters, lately as a result adding, "I want to give her options." NA-A verified R15 was on a current fluid restriction, and stated the aides were tracking the consumed fluid within the point of care (POC) system on their charting. NA-A stated fluid intake should be charted "every shift" to capture fluids at bedside and with meals, and expressed there was no reason fluid for each shift wouldn't be entered into the POC adding aloud, "You always should record." NA-A reiterated the aides were responsible to monitor and track fluid intakes for R15 adding aloud, "I think it's more on us." Further, NA-A stated they were unsure who added it and monitored the totals of fluid to ensure R15 didn't breach her fluid restriction adding aloud, "I really don't know the nursing part of it." R15's POC Response History, printed 12/17/24, identified data collected for the previous 17 days and listed the charting as, "Amount of fluids in cc's." The charting then provided the respective dates, times and amounts recorded by the staff for each day. However, multiple days lacked evidence of three collected totals (i.e., every shift). This included but was not limited to: On 12/1/24 (Sunday), only two collected values	F 656	restrictions. The Interdisciplinary team notification group was revised to include fluid intake/restriction concerns. To enhance current compliant operations and under the direction of the DON, nursing and dietary staff training will occur 1/7-1/8/25, with focuses on care planning, fluid management, and the importance of accurate documentation. Dietitian or designee will audit weekly x 4 weeks, and randomly thereafter. Audits will be reviewed in the Quality Assurance meetings. Person responsible; DON or designee Completion Date 1/21/25	

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F 656	Continued From page 5 were listed at 1:06 a.m. and 2:21 p.m. The total fluid intake for the entire day was 360 cubic centimeters (cc). On 12/2/24 (Monday), only one collected value was listed at 5:51 a.m. The total fluid intake for the entire day was 60 cc. On 12/6/24 (Friday), only two collected values were listed at 6:49 a.m. and 10:35 p.m. The total fluid intake for the entire day was 360 cc. On 12/8/24 (Sunday), only one collected value was listed at 3:45 a.m. The total fluid intake for the entire day was 60 cc. The POC charting lacked any further dictation or evidence on R15's fluid intakes for the shifts not listed, including fluids provided with meals, happened on those respective shifts. When interviewed on 12/17/24 at 1:38 p.m., licensed practical nurse (LPN)-C verified they were the current nurse assigned to R15's room for care, however, expressed it was not their typical floor to work on adding they had "never worked with her [R15]." LPN-C stated they had, however, worked with other patients on dialysis and explained residents' on a fluid restriction used the smaller Styrofoam cups and staff "don't bring in the big cup [pitcher]." LPN-C the smaller cups were used to better track how much fluid was being consumed and verified the aides were supposed to chart the fluid intakes "under the POC." LPN-C stated the nurse then tracked the fluids in the Treatment Administration Record (TAR) which was more "a running total" of the data collected by the aides but combined with fluids the nurse provided to the patient, too, so	F 656		

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F 656	Continued From page 6	F 656		

the data in the TAR was the cumulative intake for both. LPN-C stated both the TAR data and POC data should be done "every shift" adding aloud, "It's a lot of communication [between nurse and NA]."

R15's TAR, dated 12/2024, identified a nursing order which read, "1500ml fluid restriction. Document Intake ... every shift Total previous 24hrs on PM shift [current shift + previous AM and NOC [night]]," with an order date recorded, "11/18/2024." The TAR listed three shifts along with spacing to record cc (ml) consumed and staff initials. However, the recorded data had multiple days with either blank spaces left, non-discernable amounts, or inaccurately added data. This included but was not limited to:

On 12/2/24, a total fluid intake was recorded as 820 cc. The three shifts used to determine this value were recorded as 60 cc, 400 cc, and 360 cc (total 820 cc). However, the POC charting for the same period had additional fluid amounts recorded which were not included in the total recorded on the TAR.

On 12/6/24, a total fluid intake was recorded as 640 cc. The three shifts used to determine this value were recorded as 60 cc, 300 cc, and 220 cc (total 580 cc). However, the POC charting for the same period had additional fluid amounts recorded which were not included in the total recorded on the TAR.

On 12/13/24, the shift labeled, "11-7," was left blank and not completed.

On 12/18/24, at 9:01 a.m., registered nurse unit manager (RN)-A was interviewed, and verified

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F 656	Continued From page 7 they had reviewed R15's medical record and fluid intakes. RN-A explained the NA was responsible to track the fluid intakes at meals and report the information to the nurse who tracked the fluid provided while giving medications or with ice chips. RN-A verified the TAR data should be the cumulative intake collected from the NA and nurse together which should be added to provide the total amount consumed for a 24 hour period as directed by the TAR directions. RN-A reviewed the POC charting and acknowledged multiple gaps of missing data adding staff "should be charting" it. RN-A reviewed R15's TAR and acknowledged the 'total' amount recorded on multiple days did not add up correctly given all the recorded data points which likely lead to inaccurate amounts recorded. RN-A stated it was important to ensure R15's fluid intake was tracked accurately and consistently "so she's not going over her fluid restriction," adding further R15 was currently hospitalized for another reason but was found also to be "a little dehydrated." A facility Care Plans policy, dated 5/2023, identified the care center provided resident-centered care in accordance with the resident's preferences and stated goals as outlined within the care plan. The policy outlined the comprehensive care plan was developed by the interdisciplinary team (IDT) and would outline interventions to help each resident meet their respective highest physical, social and mental well-being.	F 656		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that	F 684		1/21/25

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F 684	Continued From page 8 applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow physician orders, or notify the provider of resident's refusal for 1 of 1 residents (R88) reviewed for cervical collar use. In addition, the facility failed to implement and reassess an individualized bowel management (BM) protocol for 1 of 1 resident (R60) reviewed for constipation. Findings include: R88's face sheet, printed on 12/17/24, included diagnoses of posterior displaced type II dens fracture (involving the area of the dens between the inferior aspect of the anterior C1 vertebrae {upper neck} which occurs due to forces such as trauma and can be life threatening due to its proximity to the spinal cord and brainstem) , Alzheimer's disease, and dementia. R88's significant change Minimum Data Set, dated 11/12/24, indicated R88 had severe cognitive impairment with delirium including inattention that fluctuates, but no behaviors including rejection of care. In addition it documented R88 required substantial to maximal assistance for transfers, bed mobility, and eating. R88 had one fall with major injury and is receiving pain medications for pain management and R88	F 684	483.25 Quality of Care 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. It is the policy of Minnesota Masonic Home Care Center to provide resident centered care in accordance with the resident's preferences and stated goals as outlined in the care plan. Upon notification on 12/17/24, an intervention was placed for NARs to report to nurse if cervical collar was noted to be off, and if (R88) removes, Nursing to reapply. R88 was enrolled in hospice on 9/16/24. On 12/24/25, hospice ordered the cervical collar as needed for comfort per resident request. R88's responsible party and GNP were updated.	

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F 684	Continued From page 9 was enrolled in hospice. R88's plan of care dated 12/17/24, included medical problems with a history of falls. Care plan interventions included cervical collar on at all time and if R88 removes collar, report to nurse immediately as the nurse needs to place it back on. A separate intervention dated 11/26/24 included to leave cervical collar in place. A hospital Discharge Summary, dated 11/7/24, included discharge diagnoses of traumatic closed fracture of C1 vertebra with minimal displacement with cause of injury accidental fall. A provider order, dated 12/7/24, included cervical collar to be in place at all times. If R88 removes it, nurse to replace collar every shift for cervical fracture. During observation and interview on 12/17/24 at 10:44 a.m., R88 was lying in bed, head of bed at 30 degrees with her cervical neck collar off and located at the top of the mattress to R88's left side. Registered nurse (RN)-B was present in the room giving R88 her pain medication. R88 stated she was having pain in her neck. RN-B stated R88 is supposed to have her cervical collar on at all times but frequently takes it off. RN-B did not request R88 to put on the cervical collar. RN-B indicated she is not sure if R88's hospice team or the provider is aware R88 is removing her cervical collar or refusing to wear it at times. During observation and interview on 12/17/24 at 1:00 p.m., R88 was laying across her bed side ways with no cervical collar on with her neck unsupported by the mattress and feet on the other side of the mattress not touching the floor.	F 684	A facility-wide review was conducted on 12/26/24, for resident refusals of medical devices. No other residents identified. Existing policies were reviewed, Protocol for Routine Nursing Care/Services, Physician Services Guideline, Notification of Changes, no changes were indicated. R60's individualized bowel care plan and constipation care plan were reviewed. No changes were required. On 12/30/24, a facility-wide observation was conducted for all residents and bowel movement status, to ensure bowel protocol is followed. No irregularities were observed. The Bowel Management Protocol and Standing House Orders were reviewed and revised to offer interventions sooner than 9 shifts. To enhance current compliant operations and under the direction of the DON, nursing staff training will occur 1/7-1/8/25, with focus on quality of care, adhering to physician orders and individualized care plans, the revised bowel management protocol, documentation of refusals, and physician notification of changes. Conduct audits weekly x 4 weeks, of R60's bowel status, adjusting the care	

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F 684	Continued From page 10 At 1:02 p.m., nursing assistant (NA)-E entered the room and helped R88 sit on the edge of the bed. R88's cervical collar remained on the top of the mattress. Using an EZ stand (mechanical lift), NA-E got R88 standing and assisted with toileting prior to placing in a Broda chair (specialty chair with head support) at 1:26 p.m. NA-E put on cervical collar and stated R88 removes her collar and doesn't like it on until she is up in her chair. NA-E added R88 frequently refused to wear the cervical collar and the nurses were aware of this. On interview 12/17/24 at 2:46 p.m., licensed practical nurse (LPN)-D, also identified as nurse manager, indicated R88 should have her cervical collar on at all times per provider order and it is not okay to get her up without it on. LPN-D stated if she is refusing, the physician or hospice should be notified. LPN-D confirmed there is no documentation in her electronic medical record at present indicating she has been refusing to wear the cervical collar or that the hospice agency or provider have been notified. On observation and interview 12/18/24 at 7:34 a.m., R88 was lying in bed with cervical collar out of reach on her bedside table. LPN-E entered the room and stated R88 is supposed to have her cervical collar on at all times but frequently refuses to wear it. LPN-E indicated sometimes R88 cooperates with wearing it and other times she refuses. On interview 12/18/24 at 8:52 a.m., registered nurse (RN)-C, hospice nurse, indicated he wasn't aware R88 was refusing to wear her cervical collar. RN-C indicated if the orders states she should wear it at all times, then the facility should	F 684	plan as necessary. Conduct facility-wide random audits weekly for three (3) months and randomly thereafter. Audits include verification of bowel movements and interventions. Conduct weekly audits x 4 weeks and randomly thereafter, of refusals of medical devices and documentation practices to ensure that refusal, intervention, and communication with provider is documented. Audits will be reviewed in the Quality Assurance meetings. Person responsible; DON or designee Completion Date 1/21/25	

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F 684	Continued From page 11 ensure she is wearing it or let hospice or the provider know of the refusal. On interview 12/18/24 at 10:37 a.m., the director of nursing (DON) indicated if the provider order states she is to wear the cervical collar at all times, she should be wearing it. The DON added if she takes it off, staff should notify hospice and see if she if she really needs it or not. A policy on devices, and physician orders was requested and none received. R60's annual Minimum Data Set (MDS) dated 10/10/24, indicated R60 was cognitively intact, had no behaviors, was frequently incontinent of bowel, and didn't have a toileting program. The MDS also indicated, R60 was dependent with toileting, needed maximal assistance with dressing, transfers, bed mobility, showers, set up for eating, and oral hygiene. R60's MDS indicated diagnoses of coronary artery disease (damage or disease in the heart's major blood vessels), heart failure (a chronic condition in which the heart doesn't pump blood as well as it should), hypertension (high blood pressure), hyperlipidemia (high levels of fat particles in the blood), and hemiplegia (paralysis of one side of the body). R60's Diagnosis report dated 12/19/24, indicated diagnoses of slow transit constipation (a condition where the large intestine moves waste too slowly, causing chronic constipation and sometimes uncontrollable soiling), cervicalgia (neck pain), inflammatory poly-arthropathy (a condition in which multiple joints are inflamed) , and left side	F 684		

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F 684	Continued From page 12 hemiparesis (weakness or the inability to move one side of the body) and hemiplegia. R60's medication administration record (MAR) printed on 12/18/24, included the following orders: * Senna-docusate sodium (laxative used for constipation) tablet 8.6-50 milligrams (mg)- give 2 tablets by mouth twice a day, hold for loose stools, order dated 4/10/24. * Miralax packet (laxative used for constipation) give 17 grams (gm) by mouth in the morning for constipation, hold for loose stools, order dated 5/11/22. * Miralax packet 17 gm by mouth as needed (PRN) for constipation daily, order dated 5/11/22. * Offer prune juice every morning, order dated 5/10/22. R60's Bowel/Incontinence care plan printed on 12/19/24, indicated R60 was incontinent with some control, and was dependent on staff for assistance. R60's care plan interventions directed staff to, * Implement Standing House Order for constipation if no BM in 9 shifts. * Dieticians consult as needed. * Provide loose fitting, easy to remove clothing. * Provide pericare after each incontinent episode. R60's Bowel Elimination Task form printed on 12/18/24, contained information completed by the nursing assistants caring for R60 every shift, for a total of 3 shifts a day or morning (AM), evening (PM), and night (NOC) and included documentation as follows: * 11/19/24- BM, AM & PM shifts. * 11/20/24 - no BM * 11/21/24- BM, AM shift * 11/22/24 - no BM	F 684		

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F 684	Continued From page 13	F 684		

* 11/23/24 - no BM
* 11/24/24 - BM, AM shift
* 11/25/24 - no BM
* 11/26/24 - BM, AM shift
* 11/27/24 - no BM
* 11/28/24 - BM, AM shift
* 11/29/24 - BM, AM shift
* 11/30/24 - BM, AM & PM shifts.
* 12/1/24 - no BM
* 12/2/24 - no BM
* 12/3/24 - no BM
* 12/4/24 - BM, AM shift
* 12/5/24 - BM, AM shift
* 12/6/24 - no BM
* 12/7/24 - BM, PM shift
* 12/8/24 - BM, AM shift
* 12/9/24 - BM, AM shift
* 12/10/24- BM, AM shift
* 12/11/24 - no BM
* 12/12/24 - BM, AM shift
* 12/13/24 - No BM
* 12/14/24 - No BM
* 12/15/24 - no BM
* 12/16/24 - BM, PM shift
* 12/17/24 - BM, AM shift

During interview on 12/16/24 at 6:11 p.m., R60 was in his room and sitting in a wheelchair (WC). R60 stated "I would like to visit with you, but I am extremely constipated. I have severe abdominal pain. It must be at least 4 to 5 days since I had the last BM. Please, please call the nurse and let her know I am in pain, I am constipated."

During interview on 12/16/24 at 6:15 p.m. licensed practical nurse (LPN)-F stated "we [nurses] have a 24-hour report where the evening supervisor writes the names of the residents after not having a BM for 7 shifts. We check this

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F 684	Continued From page 14	F 684		

report, and after not having a BM for 9 shifts, our residents get prune juice or Miralax as needed". LPN-F added "on the 4th day, the residents get a bisacodyl suppository." LPN-F talked to R60, and he requested a suppository. LPN-F verified based on POC BM task report, R60 had last BM on 12/12/24, therefore, there had been 13 shifts since resident had the last BM.

During interview on 12/17/24 at 8:50 a.m., R60 stated yesterday he received a suppository and had a BM. R60 stated he had chronic issues with pain but had decided to stop taking Ultram (pain medication) because of his problems with constipation. R60 stated, "I prefer to have pain rather than being constipated."

Review of R60's MAR, printed on 12/17/24, indicated R60's Ultram had been discontinued on 12/6/24.

During interview on 12/17/24 at 1:28 p.m., nursing assistant (NA)-B stated "R60 sometimes complained of abdominal pain, and when he asks for prune juice, we give it to him, and report to the nurse before the end of her shift."

During interview on 1/17/24 at 1:34 p.m., LPN-G stated R60 received scheduled Miralax and Senna twice a day. LPN-G stated the nurses followed the bowel protocol which directed them to use PRN Miralax. LPN-G added, "we have standing orders for enemas, and we have suppositories as well."

During interview on 12/17/24 at 1:57 p.m., nurse manager/LPN-A stated the 24-hour report was started by the overnight supervisor. The supervisor checks the resident's bowel records

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F 684	Continued From page 15 and writes the names of residents who didn't have a BM for 7 shifts. LPN-A stated if a resident doesn't have a BM in 9 shifts, they receive a suppository. LPN-A stated R60's senna order was increased in April and stated a couple of weeks ago, R60's scheduled Ultram was discontinued per his request because it seemed R60 had increased problems with constipation. During interview on 12/18/24 at 10:09 a.m., LPN-B stated everyday he looked at the bowel records in the computer and the 24-hour report. If a resident hasn't had a BM in 7 shifts, he will use the resident's PRN orders for constipation. LPN-B stated if a resident didn't have a BM for 9 shifts, he will follow the bowel protocol that directs nurses to administer a bisacodyl suppository. LPN-B stated all interventions, effectiveness of interventions and/or residents refusals needed to be documented in the MAR and residents' progress notes. During interview on 12/18/24 at 10:18 a.m., the director of nursing (DON) stated their bowel protocol indicated when a resident doesn't have a BM for 9 shifts, the resident will receive PRN Miralax or Senna. If they refuse these meds, they will receive a bisacodyl suppositories. If a resident refuses all interventions the primary physician needs to be notified. The DON stated all interventions need to be documented. DON verified R60 did not receive any PRN medications or a suppository after not having a BM for 11 shifts between 11/30 and 12/4, and once again after not having a BM for 13 shifts between 12/12 and 12/16. DON stated the nurses should have activated the bowel protocol after the 9th shift. DON also stated, based on documentation and medical history, R60 should have a more	F 684		

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F 684	Continued From page 16 individualized bowel program. Facility's policy titled Bowel Management Protocol dated 12/2018, indicated nurses will routinely check the BM record to ensure residents have bowel movements according to standard of practice or as identified on the individualized care plan. This policy includes the Bowel Management Standing House Orders which read, Bowel Management Standing House Orders Constipation: if no documented BM in last 8 shifts. * Ask Resident when their last BM occurred. If they can accurately report their last BM, place a progress note regarding last BM. * On shift 9 start pushing fluids (unless contraindicated or has a fluid restriction) and give a Bisacodyl suppository 10mg PR, document results. * If no results, then the next shift will give another Bisacodyl suppository 10mg PR, document results. * If no results, by the end of the shift, call practitioner for further orders.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives	F 686		1/21/25

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F 686	Continued From page 17 necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess wounds including measurements weekly for 1 of 3 residents (R52) reviewed for pressure ulcers. Findings include: R52's Diagnosis Report, dated 12/18/24, included diagnoses of infection and inflammatory reaction to internal right knee prosthesis (artificial joint), type 2 diabetes mellitus with neuropathy (nerve pain), osteomyelitis (infection of the bone) of right ankle and foot, methicillin resistant staphylococcus aureus (type of bacteria that many antibiotics don't work on) and peripheral vascular disease (slow and progressive disorder of narrowing of blood vessels, usually in legs). R52's quarterly Minimum Data Set (MDS), dated 11/22/24, identified R52 was cognitively intact, was dependent on staff for toileting, bathing, and required, substantial to maximal assistance with bed mobility and transfers. The MDS documented R52 was high risk for pressure ulcers and currently had one unstageable pressure ulcer due to coverage of wound bed by slough (dead tissue) and/or eschar (thick, black, necrotic tissue that forms as a result of dead tissue). R52's physician orders dated 12/11/24, included wound care to left heel. "Cleanse with wound	F 686	483.25(b)(1)(i)(ii) Treatment/Services to Prevent/Heal Pressure Ulcer 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. It is the policy of Minnesota Masonic Home Care Center to provide a comprehensive Skin Injury Prevention and Wound Management Program to promote its resident's highest level of functioning and well-being. Risk assessment, preventive interventions, skin care, and wound care treatment plans are evidence based best-practice and consistent with resident centered goals as identified in the plan of care. On 12/18/24, upon notification R52 lacked weekly wound measurements, a wound measurement order was added. On 12/18/24, a facility-wide review of all	

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F 686	Continued From page 18 cleanser, pat dry and apply betadine and cover with dry dressing." An order dated 7/25/24, included primary nurse to assess bilateral lower extremity wounds on Wednesdays; enter wound assessment with measurements entered into the progress note. R52's plan of care dated 9/6/24, included R52 had a risk for skin integrity impairment related to being admitted with multiple medical issues ..."and left heel pressure ulcer". Interventions included observe heel integrity daily, float heels off surface of bed, air mattress, ..., follow facility protocols for treatment of injury and observe for signs of infection such as redness, swelling, pain, fever and purulent drainage. Report abnormal findings to provider. On interview and observation 12/16/24 at 3:03 p.m., R52 was lying in her bed with both heels elevated off bed with wedged cushion, on an air mattress. R52 stated she had a pressure ulcer on her left heel that she developed while at this facility. R52 added she has had amputation of several of her toes and had poor circulation. R52 stated her wound has remained unchanged and she has the wound specialist at the facility see her weekly on Wednesdays. R52's Braden scale (tool used to predict pressure ulcer risk) skin assessments were completed monthly beginning 5/1/24 through 11/26/24 with a continued score of 18 indicating at risk for pressure ulcers. Weekly wound assessments and measurements were completed weekly except 5/26/24, 7/4/24, 8/1/24, 8/7/24, 10/2/24, 10/17/24, 11/12/24, and 12/4/24 which were missing.	F 686	residents with pressure ulcers was conducted to ensure orders for weekly measurements was in place and were documented. No issues were identified. On 12/20/24, the Wound Management policy was reviewed, no changes were indicated. A Weekly Wound Rounds electronic form will be created. To enhance current compliant operations and under the direction of the DON, nursing staff training will occur 1/7-1/8/25, with focus on weekly wound measurements and documentation. Conduct weekly audits x 4 weeks and randomly thereafter. Audits include verification that residents with pressure injuries are documented. Audits will be reviewed in the Quality Assurance meetings. Person responsible; DON or designee Completion date is 1/21/25	

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F 686	Continued From page 19 On interview 12/18/24 at 7:23 a.m., registered nurse (RN)-E stated the wound care nurse is responsible for wound assessments and measurements weekly but if she is gone, R88's nurse was responsible to complete. On interview 12/18/24 at 8:12 a.m., licensed practical nurse (LPN)-A, also identified as nurse manager, stated the wound nurse is responsible for completing wound assessments and measurements and if she is gone, the wound nurse will put an order in for the nurse to complete. LPN-A was unsure why the above dates were missing and stated R88 has only been on this unit for 3 months and referred to wound care nurse to assist with locating them. On interview 12/18/24 at 8:44 a.m., registered nurse (RN)-D, also identified as wound care manager, stated she does wound rounds on R88 weekly and completes comprehensive wound assessment and measurements. RN-D stated she will place an order for nursing to complete the wound assessments and measurements when she is gone. RN-D added she may forget at times to document the wound assessments as she does a lot of wound care and assessments every day. RN-D indicated R88's left heel pressure wound was present on admission, is likely chronic and was unavoidable due to R88's poor arterial blood flow. RN-D stated the goal is to keep the wound from becoming infected and to keep it stable, which they have been able to do. A request was made for above dates that were missing wound assessments and measurements. On interview 12/18/24 at 11:25 a.m., RN-D indicated on 6/19/24, R88 saw her podiatrist and	F 686		

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F 686	Continued From page 20 measurements and wounds were assessed at that time. RN-D confirmed the rest of the wound assessments and measurements were not able to be located. RN-D stated it was discovered when she was putting the order in for nursing staff to complete in her absence, it was entered incorrectly so it did not flow over as an order for the floor nurse to complete. RN-D confirmed these likely were not completed due to the error, which has now been corrected. On interview 12/18/24 at 10:33 a.m., the director of nursing (DON) confirmed wound assessments and measurements should be completed weekly. The DON indicated in the absence of the wound care nurse, the licensed nurse should be completing these. The DON indicated starting two weeks ago, the unit manager and licensed nurse are supposed to round with the wound care nurse so this should help improve communication. A Skin and Wound Management policy dated 10/23 included chronic wounds, wounds related to pressure, severe wounds and wounds with high microbial bioburden are followed by the wound care manager or designee who assesses the wound weekly. Wound care is coordinated in collaboration with members of the interdisciplinary team, which include the wound care manager, nurse manager, therapy, MDS coordinator, nurse, nursing assistant and/or dietician. At each weekly wound assessment, a progress note is written to document a description of the wound, any changes from the week prior, pain with wound care, and any new interventions or changes in plan of care.	F 686		

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	245343	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/17/2024**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 12/17/2024. At the time of this survey, Minnesota Masonic Home Care Center was found not 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) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC 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. UPON RECEIPT OF AN ACCEPTABLE POC, 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION	K 000		

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

Electronically Signed | 12/30/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 000	Continued From page 1 IS NOT REQUIRED. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. 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	K 000		

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K 000	Continued From page 2 system and has a fire alarm system with smoke detection in the corridors and areas open to corridors, that are monitored for automatic fire department notification. The facility has a capacity of 194 beds and had a census of 159 at the time of the survey.	K 000		
K 345 SS=E	The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by: Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, section 9.6.1.3, and NFPA 72 (2010 edition), National Fire Alarm and Signaling Code section 14.2.1.2.2. This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 12/17/2024 between 08:30 AM and 11:30 AM, it was revealed by a review of available	K 345	K345 Fire Alarm System - Testing and Maintenance On 12/17/24, the vendor who completed the annual fire alarm inspection was contacted to investigate the deficiencies identified on the 1/19/24 report. By 1/9/25, a technician will confirm the following are compliant: 1.) Low Air BLDG E- Panel not responding 2.) Flow/tamper reverse- BLVD D 3.) Warehouse 1ft- remove abandoned smoke det 4.) Replace 4-7 AH Batteries in FACP and NAC panel 5.) Replace Horn	1/21/25

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K 345	Continued From page 3 documentation that the deficiencies listed below were noted on the annual fire alarm inspection report dated 01/19/2024 and at the time of the survey the facility did not have documentation showing that repairs had been made. - Low Air BLDG E- Panel not responding - Flow/tamper reversed- Bldg D - Warehouse 1fl- remove abandoned smoke det - Replace 4-7 AH Batteries in FACP and NAC panel - Replace Horn Strobe- 1FL Hall by Room 128 An interview with the Maintenance Supervisor verified this deficient finding at the time of discovery.	K 345	Strobe- 1FL Hall by Room 128. An annual fire alarm inspection will occur prior to the completion date. To enhance current compliant operations under the direction of the Facilities Director, education was provided to facility maintenance staff on 12/30/24 regarding the requirement to maintain the fire alarm system. Upon completion of future fire alarm system inspections, an internal review will be completed to ensure any identified deficiencies are corrected and documented correctly. Person responsible; Facilities Director or designee. Completion date is 1/21/25.	
K 351 SS=E	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes	K 351		1/21/25

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K 351	Continued From page 4 closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to install the fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.5.1, 19.3.5.4, and 9.7.1.1, and NFPA 13 (2010 edition), Standard for the Installation of Sprinkler Systems, sections 8.3.3.2 and 8.15.10.1. These deficient findings could have an patterned impact on the residents within the facility. Findings include: 1. On 12/17/2024 at 11:00 AM, it was revealed by observation that fire sprinklers were unable to be found to be installed in Electrical Equipment rooms DG 30 and DG-32. 3. On 12/17/2024 between 08:30 AM and 11:30 AM, it was revealed by observation in the DG and E2 corridors there were quick and standard response heads in the same smoke compartment. An interview with the Facilities Director and Interim Administrator verified these deficient findings at the time of discovery.	K 351	K351 Sprinkler System - Installation Upon notification, a vendor was contacted to correct the improper fire sprinkler heads and to add fire sprinkler coverage in DG30 and DG32. On 12/24/24, the vendor conducted an audit, no other issues were identified. Work to correct the identified fire sprinkler heads and add fire sprinkler heads in DG30 and DG32, will occur prior to the completion date. To enhance current compliant operations under the direction of the Facilities Director, education was provided to facility maintenance staff on 12/30/24 regarding correct fire sprinkler head usage and placement. Random visual inspections will be done weekly for 4 weeks, then randomly thereafter. Audits will be reviewed in the Quality Assurance meetings. Person responsible; Facilities Director or designee.	

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K 351	Continued From page 5	K 351	Completion date is 1/21/25.	
K 353 SS=D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation, a review of available documentation, and staff interview, the facility failed to inspect and maintain the fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.5, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, sections 5.1.1.2, and 5.3.2.1. These deficient findings could have a widespread impact on the residents within the facility. Findings include:	K 353	K353 Sprinkler System □ Maintenance and Testing During the 12/17/24 Fire Marshal visit, documentation was provided to the Healthcare Inspector indicating that the facility had completed the five-year internal pipe inspection on 04/29/22. On 12/24/24, a vendor replaced the fire sprinkler riser gauge. On 12/23/24, an audit of all fire sprinkler riser gauges was conducted and no other violations were noted.	1/21/25

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K 353	Continued From page 6 1. On 12/17/2024 between 08:30 AM and 11:30 AM, it was revealed by observation that the five-year internal pipe inspection was not completed for the main building and building E riser and could not provide documentation showing that it had been completed at the time of the survey. 2. On 12/17/2024 between 08:30 AM and 11:30 AM, it was revealed by observation that the gauge on the fire sprinkler riser for the main building and building E were dated 04/2019. An interview with the Facilities Director and Interim Administrator verified these deficient findings at the time of discovery.	K 353	To enhance current compliant operations under the direction of the Facilities Director, education was provided to facility maintenance staff on 12/30/24 regarding the requirement to replace fire sprinkler gauges every five years. Audits will be done weekly for 4 weeks, then randomly thereafter. Audits will be reviewed in the Quality Assurance meetings. Person responsible; Facilities Director or designee. Completion date is 1/21/25	
K 363 SS=E	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed	K 363		1/21/25

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K 363	Continued From page 7 when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.6.3.5 and 19.3.6.3.10. These deficient findings could have a patterned impact on the residents within the facility. Findings include: On 12/17/2024 between 08:30 AM and 11:30 AM, it was revealed by observation that the double doors to the clean linen closets E261, 253, 226 and E116 were not equipped with a latching device to positivley latch. An interview with the Facilities Director and Interim Administrator verified these deficient findings at the time of discovery.	K 363	K363 Doors On 12/18/24, facility maintenance staff began repairs to the identified doors. On 12/23/24 an audit was conducted on all doors, and no other violations of door deficiencies were noted. On 12/26/24 maintenance finished repairs and the identified doors were functioning properly. To enhance current compliant operations under the direction of the Facilities Director, staff education will occur on 1/7/24 - 1/8/24 regarding automatic closing devices and positive latching mechanisms. Audits will be done weekly for 4 weeks, then randomly thereafter. Audits will be	

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K 363	Continued From page 8	K 363	reviewed in the Quality Assurance meetings. Person responsible; Facilities Director or designee. Completion date is 1/21/25.	
K 521 SS=D	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect fire dampers per NFPA 101 (2012 edition), Life Safety Code, section 8.5.5.4.2, and NFPA 105 (2010 edition), Standard for Smoke Door Assemblies and Other Opening Protectives, sections 6.5.2 and 6.5.4. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 12/17/2024 between 08:30 AM and 11:30 AM, it was revealed by a review of available documentation that the damper inspection report that was provided at the time of the survey listed that damper E1105 was unable to be inspected/tested due to not having access.	K 521	K521 HVAC On 12/23/24, a vendor located the access panel to inspect the smoke damper in room E1105. During the inspection, the smoke damper was confirmed to be in proper working order. An audit of the most recent smoke damper inspection was conducted on 12/17/24 and no other violations were noted. To enhance current compliant operations under the direction of the Facilities Director, education was provided to facility maintenance staff on 12/30/24 regarding the location of the E1105 smoke damper	1/21/25

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K 521	Continued From page 9 An interview with the Maintenance Supervisor verified this deficient finding at the time of discovery.	K 521	access panel. Upon completion of future smoke damper inspections, an internal review will be completed to ensure all smoke dampers were properly inspected. Person responsible; Facilities Director or designee. Completion date is 1/21/25.	
K 920 SS=E	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5	K 920		1/21/25

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MINNESOTA MASONIC HOME CARE CENTER	**11501 MASONIC HOME DRIVE BLOOMINGTON, MN 55437**

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K 920	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the usage of electrical adaptive devices NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.5.2.3.1 and 10.2.4.2.1, NFPA 101 (2012 edition), Life Safety Code, section 9.1.2, NFPA 70, (2011 edition), National Electrical Code, sections 400.8, and UL 1363. These deficient findings could have a patterned impact on the residents within the facility. Findings include: 1. On 12/17/2024 at 10:16 AM, it was revealed by observation that there was an extension cord plugged into a multi-plug adapter in resident room 308. 2. On 12/17/2024 at 11:15 AM, it was revealed by observation in the conference room there was a power strip plugged into a power strip for the projector and other IT equipment. An interview with the Facilities Director and Interim Administrator verified these deficient findings at the time of discovery.	K 920	K920 Electrical Equipment Power Cords and Extension On 12/17/24, the extension cord and multi-plug adapter in D308 was corrected. On 12/17/24, the power strip plugged into a power strip was corrected. An audit was conducted on 12/23/24, and no other violations of incorrect electrical devices were noted. To enhance current complaint operations under the direction of the Facilities Director, staff education will occur on 1/7/24 1/8/24. Education will include the acceptable use of power strips and multi-plug adapters. Resident and family education will also be provided. Audits will be done weekly for 4 weeks, then randomly thereafter. Audits will be reviewed in the Quality Assurance meetings. Person responsible; Facilities Director or designee. Completion date is 1/21/25.	

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 20, 2024

Administrator
Minnesota Masonic Home Care Center
11501 Masonic Home Drive
Bloomington, MN 55437

Re: State Nursing Home Licensing Orders
Event ID: G94K11

Dear Administrator:

The above facility was surveyed on December 16, 2024 through December 18, 2024 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Pete Cole, RN Regional Operations Supervisor
Metro Team C District Office
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: peter.cole@state.mn.us
Office/Mobile: (651) 249-1724

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

Please feel free to call me with any questions.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00232	A. BUILDING: _____ B. WING _____	C 12/18/2024

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 12/16/24 through 12/18/24, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). In addition, a complaint investigation was completed. Your facility was found not in compliance with the MN State Licensure and the following correction orders are issued. Please	2 000		

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2 000	Continued From page 1 indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed. In addition to the recertification survey, the following complaint was reviewed with no licensing orders issued: H53432660C (MN00108053) MDH is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met asevidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.	2 000		

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2 000	Continued From page 2 PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure care-planned interventions to promote appropriate fluid balance were consistently implemented and accurately tracked to promote continuity of care for 1 of 1 resident (R15) reviewed who received hemodialysis and was on a fluid restriction. Findings include: A National Kidney Foundation (NKF) Fluid Overload in a Dialysis Patient feature, dated 2024, identified fluid overload in a dialysis patient occurs when too much water builds up within the body. The feature added, "It can cause swelling, high blood pressure, breathing problems, and heart issues." The feature explained, "When you	2 565	"Corrected"	1/21/25

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2 565	Continued From page 3 are on dialysis, your kidneys are no longer able to keep the right balance of fluid in your body ... That's why it's so important to limit how much sodium (salt) and fluid you have between dialysis treatments," adding further, "Follow the fluid guidelines [bolded] given to you ... Most dialysis patients need to limit their fluid intake to 32 ounces per day." R15's admission Minimum Data Set (MDS), dated 11/16/24, identified R15 had moderate cognitive impairment and had multiple medical conditions including anemia, atrial fibrillation or cardiac dysthymia, heart failure, and end-stage renal disease. Further, the MDS recorded R15 received dialysis treatments while a resident at the center. R15's dialysis care plan, initiated 11/14/24, identified R15 had chronic kidney disease and a history of acute kidney injury (AKI) and received dialysis treatments. The care plan listed multiple goals for R15 including, "Resident's fluid balance will be maintained and complications minimized as evidenced by non-labored breathing and maintenance of target weight ...," along with several interventions to help R15 meet these goal(s) including, "Dialysis: Document intake and output (1500ml [milliliters] fluid restriction)." On 12/16/24 at 2:54 p.m., R15 was observed in her room lying in bed with family member (FM)-E present at the bedside. R15 stated she was on dialysis, which FM-E verified, and on a Tuesday - Thursday - Saturday schedule. On the wall of R15's room, a white-colored cup picture was present which had, "1500," written on it. However, present on R15's bedside table were multiple white Styrofoam cups and a single hard plastic pitcher with water in it. The cups were inspected and each had remaining fluid inside of them.	2 565		

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2 565	Continued From page 4 FM-E stated R15 was on a fluid restriction, however, when questioned on if R15 was maintaining that restriction FM-E laughed and pointed at the multiple cups with fluid adding aloud, "I don't know." R15 stated she was unsure how much fluid was given to her at meals or medication pass, nor how it was being tracked if at all adding aloud, "I really don't know." FM-E and R15 verified the center' staff provided each of the cups, and R15 denied needing any extra dialysis runs due to fluid overload. When interviewed on 12/17/24 at 1:26 p.m., nursing assistant (NA)-A stated R15 was on dialysis and had been "doing pretty well" with eating but seemed to never drink much adding it was "more just sips [fluids]." NA-A stated they had been trying to offer R15 more fluids, including flavored waters, lately as a result adding, "I want to give her options." NA-A verified R15 was on a current fluid restriction, and stated the aides were tracking the consumed fluid within the point of care (POC) system on their charting. NA-A stated fluid intake should be charted "every shift" to capture fluids at bedside and with meals, and expressed there was no reason fluid for each shift wouldn't be entered into the POC adding aloud, "You always should record." NA-A reiterated the aides were responsible to monitor and track fluid intakes for R15 adding aloud, "I think it's more on us." Further, NA-A stated they were unsure who added it and monitored the totals of fluid to ensure R15 didn't breach her fluid restriction adding aloud, "I really don't know the nursing part of it." R15's POC Response History, printed 12/17/24, identified data collected for the previous 17 days and listed the charting as, "Amount of fluids in cc's." The charting then provided the respective	2 565		

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2 565	Continued From page 5 dates, times and amounts recorded by the staff for each day. However, multiple days lacked evidence of three collected totals (i.e., every shift). This included but was not limited to: On 12/1/24 (Sunday), only two collected values were listed at 1:06 a.m. and 2:21 p.m. The total fluid intake for the entire day was 360 cubic centimeters (cc). On 12/2/24 (Monday), only one collected value was listed at 5:51 a.m. The total fluid intake for the entire day was 60 cc. On 12/6/24 (Friday), only two collected values were listed at 6:49 a.m. and 10:35 p.m. The total fluid intake for the entire day was 360 cc. On 12/8/24 (Sunday), only one collected value was listed at 3:45 a.m. The total fluid intake for the entire day was 60 cc. The POC charting lacked any further dictation or evidence on R15's fluid intakes for the shifts not listed, including fluids provided with meals, happened on those respective shifts. When interviewed on 12/17/24 at 1:38 p.m., licensed practical nurse (LPN)-C verified they were the current nurse assigned to R15's room for care, however, expressed it was not their typical floor to work on adding they had "never worked with her [R15]." LPN-C stated they had, however, worked with other patients on dialysis and explained residents' on a fluid restriction used the smaller Styrofoam cups and staff "don't bring in the big cup [pitcher]." LPN-C the smaller cups were used to better track how much fluid was being consumed and verified the aides were supposed to chart the fluid intakes "under the	2 565		

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2 565	Continued From page 6 POC." LPN-C stated the nurse then tracked the fluids in the Treatment Administration Record (TAR) which was more "a running total" of the data collected by the aides but combined with fluids the nurse provided to the patient, too, so the data in the TAR was the cumulative intake for both. LPN-C stated both the TAR data and POC data should be done "every shift" adding aloud, "It's a lot of communication [between nurse and NA]." R15's TAR, dated 12/2024, identified a nursing order which read, "1500ml fluid restriction. Document Intake ... every shift Total previous 24hrs on PM shift [current shift + previous AM and NOC [night]]," with an order date recorded, "11/18/2024." The TAR listed three shifts along with spacing to record cc (ml) consumed and staff initials. However, the recorded data had multiple days with either blank spaces left, non-discernable amounts, or inaccurately added data. This included but was not limited to: On 12/2/24, a total fluid intake was recorded as 820 cc. The three shifts used to determine this value were recorded as 60 cc, 400 cc, and 360 cc (total 820 cc). However, the POC charting for the same period had additional fluid amounts recorded which were not included in the total recorded on the TAR. On 12/6/24, a total fluid intake was recorded as 640 cc. The three shifts used to determine this value were recorded as 60 cc, 300 cc, and 220 cc (total 580 cc). However, the POC charting for the same period had additional fluid amounts recorded which were not included in the total recorded on the TAR. On 12/13/24, the shift labeled, "11-7," was left	2 565		

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2 565	Continued From page 7 blank and not completed. On 12/18/24, at 9:01 a.m., registered nurse unit manager (RN)-A was interviewed, and verified they had reviewed R15's medical record and fluid intakes. RN-A explained the NA was responsible to track the fluid intakes at meals and report the information to the nurse who tracked the fluid provided while giving medications or with ice chips. RN-A verified the TAR data should be the cumulative intake collected from the NA and nurse together which should be added to provide the total amount consumed for a 24 hour period as directed by the TAR directions. RN-A reviewed the POC charting and acknowledged multiple gaps of missing data adding staff "should be charting" it. RN-A reviewed R15's TAR and acknowledged the 'total' amount recorded on multiple days did not add up correctly given all the recorded data points which likely lead to inaccurate amounts recorded. RN-A stated it was important to ensure R15's fluid intake was tracked accurately and consistently "so she's not going over her fluid restriction," adding further R15 was currently hospitalized for another reason but was found also to be "a little dehydrated." A facility Care Plans policy, dated 5/2023, identified the care center provided resident-centered care in accordance with the resident's preferences and stated goals as outlined within the care plan. The policy outlined the comprehensive care plan was developed by the interdisciplinary team (IDT) and would outline interventions to help each resident meet their respective highest physical, social and mental well-being. SUGGESTED METHOD OF CORRECTION: The	2 565		

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2 565	Continued From page 8 director of nursing (DON), or designee, could review applicable policies and procedures on fluid restriction monitoring; then educate direct care staff and audit to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days	2 565		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess wounds including measurements weekly for 1 of 3 residents (R52) reviewed for pressure ulcers. Findings include:	2 900	"Corrected"	1/21/25

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2 900	Continued From page 9 R52's Diagnosis Report, dated 12/18/24, included diagnoses of infection and inflammatory reaction to internal right knee prosthesis (artificial joint), type 2 diabetes mellitus with neuropathy (nerve pain), osteomyelitis (infection of the bone) of right ankle and foot, methicillin resistant staphylococcus aureus (type of bacteria that many antibiotics don't work on) and peripheral vascular disease (slow and progressive disorder of narrowing of blood vessels, usually in legs). R52's quarterly Minimum Data Set (MDS), dated 11/22/24, identified R52 was cognitively intact, was dependent on staff for toileting, bathing, and required, substantial to maximal assistance with bed mobility and transfers. The MDS documented R52 was high risk for pressure ulcers and currently had one unstageable pressure ulcer due to coverage of wound bed by slough (dead tissue) and/or eschar (thick, black, necrotic tissue that forms as a result of dead tissue). R52's physician orders dated 12/11/24, included wound care to left heel. "Cleanse with wound cleanser, pat dry and apply betadine and cover with dry dressing." An order dated 7/25/24, included primary nurse to assess bilateral lower extremity wounds on Wednesdays; enter wound assessment with measurements entered into the progress note. R52's plan of care dated 9/6/24, included R52 had a risk for skin integrity impairment related to being admitted with multiple medical issues ..."and left heel pressure ulcer". Interventions included observe heel integrity daily, float heels off surface of bed, air mattress, ..., follow facility protocols for treatment of injury and observe for signs of infection such as redness, swelling, pain,	2 900		

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2 900	Continued From page 10 fever and purulent drainage. Report abnormal findings to provider. On interview and observation 12/16/24 at 3:03 p.m., R52 was lying in her bed with both heels elevated off bed with wedged cushion, on an air mattress. R52 stated she had a pressure ulcer on her left heel that she developed while at this facility. R52 added she has had amputation of several of her toes and had poor circulation. R52 stated her wound has remained unchanged and she has the wound specialist at the facility see her weekly on Wednesdays. R52's Braden scale (tool used to predict pressure ulcer risk) skin assessments were completed monthly beginning 5/1/24 through 11/26/24 with a continued score of 18 indicating at risk for pressure ulcers. Weekly wound assessments and measurements were completed weekly except 5/26/24, 7/4/24, 8/1/24, 8/7/24, 10/2/24, 10/17/24, 11/12/24, and 12/4/24 which were missing. On interview 12/18/24 at 7:23 a.m., registered nurse (RN)-E stated the wound care nurse is responsible for wound assessments and measurements weekly but if she is gone, R88's nurse was responsible to complete. On interview 12/18/24 at 8:12 a.m., licensed practical nurse (LPN)-A, also identified as nurse manager, stated the wound nurse is responsible for completing wound assessments and measurements and if she is gone, the wound nurse will put an order in for the nurse to complete. LPN-A was unsure why the above dates were missing and stated R88 has only been on this unit for 3 months and referred to	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00232	A. BUILDING: _____ B. WING _____	C 12/18/2024

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

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2 900	Continued From page 11 wound care nurse to assist with locating them. On interview 12/18/24 at 8:44 a.m., registered nurse (RN)-D, also identified as wound care manager, stated she does wound rounds on R88 weekly and completes comprehensive wound assessment and measurements. RN-D stated she will place an order for nursing to complete the wound assessments and measurements when she is gone. RN-D added she may forget at times to document the wound assessments as she does a lot of wound care and assessments every day. RN-D indicated R88's left heel pressure wound was present on admission, is likely chronic and was unavoidable due to R88's poor arterial blood flow. RN-D stated the goal is to keep the wound from becoming infected and to keep it stable, which they have been able to do. A request was made for above dates that were missing wound assessments and measurements. On interview 12/18/24 at 11:25 a.m., RN-D indicated on 6/19/24, R88 saw her podiatrist and measurements and wounds were assessed at that time. RN-D confirmed the rest of the wound assessments and measurements were not able to be located. RN-D stated it was discovered when she was putting the order in for nursing staff to complete in her absence, it was entered incorrectly so it did not flow over as an order for the floor nurse to complete. RN-D confirmed these likely were not completed due to the error, which has now been corrected. On interview 12/18/24 at 10:33 a.m., the director of nursing (DON) confirmed wound assessments and measurements should be completed weekly. The DON indicated in the absence of the wound care nurse, the licensed nurse should be completing these. The DON indicated starting	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 900	Continued From page 12 two weeks ago, the unit manager and licensed nurse are supposed to round with the wound care nurse so this should help improve communication. A Skin and Wound Management policy dated 10/23 included chronic wounds, wounds related to pressure, severe wounds and wounds with high microbial bioburden are followed by the wound care manager or designee who assesses the wound weekly. Wound care is coordinated in collaboration with members of the interdisciplinary team, which include the wound care manager, nurse manager, therapy, MDS coordinator, nurse, nursing assistant and/or dietician. At each weekly wound assessment, a progress note is written to document a description of the wound, any changes from the week prior, pain with wound care, and any new interventions or changes in plan of care. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to promote healing of pressure ulcers. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to reduce the risk for pressure ulcer development. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days	2 900		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
January 29, 2025

Administrator
Minnesota Masonic Home Care Center
11501 Masonic Home Drive
Bloomington, MN 55437

RE: CCN: 245343
Cycle Start Date: December 18, 2024

Dear Administrator:

On January 27, 2025, the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

January 29, 2025

Administrator
Minnesota Masonic Home Care Center
11501 Masonic Home Drive
Bloomington, MN 55437

Re: Reinspection Results
Event ID: G94K12

Dear Administrator:

On January 27, 2025 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on December 18, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us