DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: JSZI

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

PART I	- TO BE COMPI	LETED BY T	THE STAT	TE SURVEY AGENCY	Fa	cility ID: 00232
MEDICARE/MEDICAID PROVIDER NO. (L1) 245343 2.STATE VENDOR OR MEDICAID NO. (L2) 511542600	3. NAME AND AL (L3) MINNESOT (L4) 11501 MASO (L5) BLOOMINO	A MASONIC ONIC HOME	HOME CA	ARE CENTER (L6) 55437	4. TYPE OF ACTION 1. Initial 3. Termination 5. Validation	
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)	7. PROVIDER/SU 01 Hospital	JPPLIER CATEC	09 ESRD	02 (L7) 13 PTIP 22 CLIA	7. On-Site Visit 8. Full Survey After C	9. Other
6. DATE OF SURVEY 03/26/2015 (L34) 8. ACCREDITATION STATUS: (L10) 0 Unaccredited	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDING	G DATE: (L35)
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12. Total Facility Beds 214 (L18) 13. Total Certified Beds 214 (L17)	Complianc 1. A B. Not in Com		gram	And/Or Approved Waivers Of 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SN 5. Life Safety Code * Code: A*	6. Scope of Servi 7. Medical Direc	ices Limit etor
14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 19 SNF 214 (L37) (L38) (L39)	ICF (L42)	IID (L43)		15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)	
16. STATE SURVEY AGENCY REMARKS (IF APPLIC Mandatory DOPNA, effective 02/07/15 17. SURVEYOR SIGNATURE Robert Rexeisen, SFMO	, is discontinued Date:		(L19)	18. STATE SURVEY AGENCY Anne Kleppe, Enforce		Date: 04/07/2015 (L20
PART II - TO BE	COMPLETED I	BY HCFA RI	EGIONAI	OFFICE OR SINGLE S	TATE AGENCY	
19. DETERMINATION OF ELIGIBILITY _X 1. Facility is Eligible to Participate 2. Facility is not Eligible (L21)		IPLIANCE WITI HTS ACT:	H CIVIL		ncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (H	
22. ORIGINAL DATE 23. LTC AGREL OF PARTICIPATION BEGINNIN 09/01/1986 (L24) (L41)		4. LTC AGREEM ENDING DA' (L25)		26. TERMINATION ACTION: VOLUNTARY 00 01-Merger, Closure 02-Dissatisfaction W/ Reimburs	INVOLUNT 05-Fail to Me ement 06-Fail to Me	30) ARY eet Health/Safety eet Agreement
A. Suspensi	TIVE SANCTIONS on of Admissions: Suspension Date:	(L44) (L45)		03-Risk of Involuntary Terminatic 04-Other Reason for Withdrawal	OTHER	Status Change
28. TERMINATION DATE: (L28)	29. INTERMEDIARY/	CARRIER NO.	(L31)	30. REMARKS		
31. RO RECEIPT OF CMS-1539 (L32)	32. DETERMINATION 12/29/2014	I OF APPROVAL	L DATE (L33)	DETERMINATION APP	ROVAL	



Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5343

Electronically Delivered: March 27, 2015

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

Dear Ms. Wiggin:

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

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

Effective February 16, 2015 the above facility is certified for:

214 - Skilled Nursing Facility/Nursing Facility Beds

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

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

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination. Please contact me if you have any questions about this electronic notice.

Sincerely,

A 171 F. C

Dire Klegge

Anne Kleppe, Enforcement Specialist Licensing and Certification Program Health Regulation Division

Minnesota Department of Health Email: anne.kleppe@state.mn.us

Telephone: (651) 201-4124 Fax: (651) 215-9697

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number 245343	(Y2) Multiple Cons A. Building B. Wing		IN BUILDING 01	(Y3) Date of Revisit 3/26/2015		
Name of Facility			Street Address, City, State, Zip Code			
MINNESOTA MASONIC HOME CARE	CENTER	11501 MASONIC HOME DRIVE BLOOMINGTON, MN 55437				

(Y4) Item		(Y5) Date	(Y4) Item	(Y5)	Date	(Y4)	Item	(Y5)	Date
ID Prefix		Correction Completed 02/16/2015	D #		Correction Completed		ID Prefix			
-	NFPA 101 K0071		Reg. # LSC				Reg. # LSC			
Reg. #			Reg. #		Correction Completed		ID Prefix			Correction Completed
ID Prefix Reg. # LSC			Reg. #		Correction Completed		ID Prefix Reg. # LSC			Correction Completed
ID Prefix Reg. # LSC			Reg. #		Correction Completed		ID Prefix Reg. # LSC			Correction Completed —
ID Prefix Reg. # LSC			Reg. #		Correction Completed		ID Prefix Reg. # LSC			
Reviewed I	Ву В	eviewed By	Date:	Signature of Sur	veyor:				Date:	
State Agen	су	PS/AK	03/27/2015				28120		03/2	26/2015
Reviewed E	Зу Я	eviewed By	Date:	Signature of Sur	veyor:				Date:	
Followup t	o Survey Comp			Check for any Uncor Uncorrected Defic					YES	NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

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MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

PART I	- TO BE COMPI	LETED BY T	THE STAT	TE SURVEY AGENCY	Fa	cility ID: 00232
MEDICARE/MEDICAID PROVIDER NO. (L1) 245343 2.STATE VENDOR OR MEDICAID NO. (L2) 511542600	3. NAME AND AL (L3) MINNESOT (L4) 11501 MASO (L5) BLOOMINO	A MASONIC ONIC HOME	HOME CA	ARE CENTER (L6) 55437	4. TYPE OF ACTION 1. Initial 3. Termination 5. Validation	2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)	7. PROVIDER/SU 01 Hospital	05 HHA	09 ESRD	02 (L7) 13 PTIP 22 CLIA	7. On-Site Visit 8. Full Survey After C	9. Other complaint
6. DATE OF SURVEY 01/04/2015 (L34) 8. ACCREDITATION STATUS: (L10) 0 Unaccredited	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDING	G DATE: (L35)
11LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 214 (L18) 13.Total Certified Beds 214 (L17)	Complianc 1. A	nce With equirements e Based On: cceptable POC	gram	And/Or Approved Waivers Of 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SN 5. Life Safety Code * Code: B	6. Scope of Servi 7. Medical Direc	ices Limit etor
14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 19 SNF 214 (L37) (L38) (L39)	ICF (L42)	IID (L43)		15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)	
16. STATE SURVEY AGENCY REMARKS (IF APPLIC Mandatory DOPNA continues to be effective of the state of the stat	ective 02/07/15.	ANCELLATION :	DATE):			
Gayle Lantto, Unit Supervisor	Date :	03/23/2015	(L19)	Anne Kleppe, Enforce		Date: 03/27/2015 (L20
PART II - TO BE	COMPLETED I	BY HCFA RI	EGIONAI	OFFICE OR SINGLE S	TATE AGENCY	
19. DETERMINATION OF ELIGIBILITY _X 1. Facility is Eligible to Participate 2. Facility is not Eligible (L21)		IPLIANCE WITI HTS ACT:	H CIVIL		ncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (H e:	
22. ORIGINAL DATE OF PARTICIPATION 09/01/1986 (L24) (L41)		4. LTC AGREEM ENDING DA		26. TERMINATION ACTION: VOLUNTARY 00 01-Merger, Closure 02-Dissatisfaction W/ Reimburse 03-Risk of Involuntary Termination	<u>INVOLUNT</u> 05-Fail to Mo	ARY eet Health/Safety eet Agreement
A. Suspensi	ON OF Admissions: Suspension Date:	(L44) (L45)		04-Other Reason for Withdrawal	OTHER	Status Change
28. TERMINATION DATE: 2	9. INTERMEDIARY/ 03001	CARRIER NO.	(L31)	30. REMARKS		
31. RO RECEIPT OF CMS-1539 (L32)	2. DETERMINATION 12/29/2014	I OF APPROVAL	L DATE (L33)	DETERMINATION APP	ROVAL	



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: January 5, 2015

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

RE: Project Number S5343026

Dear Ms. Wiggin:

On November 14, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on November 7, 2014. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On January 4, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on November 7, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of November 28, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on November 7, 2014, effective November 28, 2014 and therefore remedies outlined in our letter to you dated November 14, 2014, will not be imposed.

Correction of the Life Safety Code deficiencies cited the time of the November 7, 2014 standard survey, has not yet been verified. Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

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

Sincerely,

Dre Kleese

Anne Kleppe, Enforcement Specialist

Licensing and Certification Program

Health Regulations Division Minnesota Department of Health

Email: anne.kleppe@state.mn.us

Telephone: (651) 201-4124 Fax: (651) 215-9697

Post-Certification Revisit Report

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

(Y1)	Provider / Supplier / CLIA / Identification Number 245343	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 1/4/2015		
Nam	e of Facility		Street Address, City, State, Zip Code			
MINNESOTA MASONIC HOME CARE CENTER			11501 MASONIC HOME DRIVE BLOOMINGTON, MN 55437			

(Y4) Item	(Y	i) Date	(Y4) Item	(Y5)	Date	(Y4)	Item		(Y5)	Date
ID Prefix	F0279	Correction Completed 11/28/2014	ID Prefix	F0325	Correction Completed 11/28/2014		ID Prefix	F0356		Correction Completed 11/19/2014
Reg. # LSC	483.20(d), 483.20(k)(1)	=	Reg. # LSC	483.25(i)	-		Reg. # LSC	483.30(e)		_
ID Prefix Reg. # LSC			ID Prefix Reg. # LSC		Correction Completed					Correction Completed
ID Prefix Reg. # LSC		Correction Completed	Reg. #		Correction Completed		Reg. #			Correction Completed
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Reg. #			Reg. #				D "			
Reviewed E		-	Date:	Signature of Sur	rveyor:				Date:	
State Agend	, GE/112		01/05/201				1.	5507		04/2015
Reviewed E	By Reviewe	а ву	Date:	Signature of Su	rveyor:				Date:	
Followup t	o Survey Completed o 11/7/2014	n:		Check for any Unco Uncorrected Defice					YES	NO

Post-Certification Revisit Report

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(Y1) Provider / Supplier / CLIA / Identification Number 245343	(Y2) Multiple Cons A. Building B. Wing		IN BUILDING 01	(Y3) Date of Revisit 2/10/2015		
Name of Facility			Street Address, City, State, Zip Code			
MINNESOTA MASONIC HOME CARE	CENTER	11501 MASONIC HOME DRIVE BLOOMINGTON, MN 55437				

(Y4) Item		(Y5) Date	(Y4) Item	(Y5)	Date	(Y4)	Item		(Y5)	Date
ID Prefix Rea.#	NFPA 101	Correction Completed 12/08/2014	D #		Correction Completed		ID Prefix			
_	K0147		LSC				LSC _			_ _
Reg. #			Reg. #		Correction Completed		ID Prefix			Correction Completed
ID Prefix Reg. # LSC			Reg. #		Correction Completed		Reg. #			Correction Completed
ID Prefix Reg. # LSC			Reg. #		Correction Completed					Correction Completed —
ID Prefix Reg. # LSC			Reg. #		Correction Completed					
Reviewed E	By Rev	viewed By	Date:	Signature of Sur	veyor:				Date:	
State Agen	cy PS	S/AK	02/13/2015				281	20	02/1	0/2015
Reviewed E	By Rev	riewed By	Date:	Signature of Sur	veyor:				Date:	
Followup t	o Survey Comple 11/11/20			Check for any Uncor Uncorrected Defic					YES	NO

Post-Certification Revisit Report

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(Y1) Provider / Supplier / CLIA / Identification Number 245343	(Y2) Multiple Cons A. Building B. Wing		IN BUILDING 01	(Y3) Date of Revisit 2/10/2015		
Name of Facility			Street Address, City, State, Zip Code			
MINNESOTA MASONIC HOME CARE	CENTER	11501 MASONIC HOME DRIVE BLOOMINGTON, MN 55437				

(Y4) Item		(Y5) Date	(Y4) Item	(Y:	5) Date	(Y4)	Item	(Y5)	Date
ID Prefix	NFPA 101	Correction Completed 02/06/2015		 NFPA 101	Correction Completed 02/06/2015		ID Prefix Reg. #			
_	K0025		-	K0027	_		LSC			
ID Prefix Reg. #			ID Prefix Reg. #		Correction Completed		ID Prefix Rea.#			Correction Completed
ID Prefix Reg. # LSC			Reg. #	_	Correction Completed		Reg. #			Correction Completed
ID Prefix Reg. # LSC			Reg. #		Correction Completed		Б "			Correction Completed
ID Prefix Reg. # LSC			Reg. #							
Reviewed E	By Rev	iewed By	Date:	Signature of S	urveyor:				Date:	
State Agen	cy PS	/AK	02/13/201	5		28	120		02/1	10/2015
Reviewed B	By Rev	iewed By	Date:	Signature of S	urveyor:				Date:	
Followup t	o Survey Complet 12/4/201			Check for any Unc Uncorrected De					YES	NO



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: March 6, 2015

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

RE: Project Numbers: Health S5343026, Life Safety Code F5343023, and FMS F5343024

Please note you are receiving this notice, originally posted February 17, 2015, as the Life Safety Code tag K071 was not posted to ePOC. Please follow the instructions contained in this letter (in bold) and return an electronic plan of correction at your earliest convenience.

Dear Ms. Wiggin:

On November 14, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on November 7, 2014. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On December 4, 2014 a surveyor representing the Minnesota Department of Public Safety completed a Federal Monitoring Survey (FMS) of your facility. As the surveyor informed you during the exit conference, the FMS revealed that your facility continued to not be in substantial compliance. The most serious deficiencies at the time of the FMS were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required. On December 17, 2014, CMS forwarded the results of the Life Safety Code (LSC) FMS and notified you that your facility was not in substantial compliance with the applicable Federal requirements for nursing homes participating in the Medicare and Medicaid programs and that they were imposing the following enforcement remedy:

• Mandatory Denial of Payment for New Admissions effective February 7, 2015 (42 CFR 488.417 (b))

Also, the CMS Region V Office notified you in their letter of December 17, 2014, in accordance with Federal law, as specified in the Act at Sections 1819 (f)(2)(B)(iii)(I)(b) and 1919 (f)(2)(B)(iii)(I)(b), your facility would be prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from February 7, 2015.

On January 4, 2015, the Minnesota Department of Health (MDH) completed a Health Post Certification

Minnesota Masonic Home Care Center March 6, 2015 Page 2

Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on November 7, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of November 28, 2014. Based on our visit, we have determined that your facility has achieved substantial compliance with the health deficiencies issued pursuant to our standard survey, completed on November 7, 2014.

On February 10, 2015, a surveyor representing Minnesota Department of Public Safety completed an FMS PCR of your facility. As the surveyor informed you during the exit conference, the FMS PCR revealed that your facility was found in substantial compliance.

Additionally, on February 10, 2015, the Minnesota Department of Public Safety completed an LSC PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on November 7, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies. Based on this visit, MDH has determined that your facility has not achieved substantial compliance with the LSC deficiencies issued pursuant to our standard survey, completed on November 7, 2014. The most serious LSC deficiencies in your facility at the time of the standard survey were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required. **The deficiency not corrected is as follows:**

K0071 -- S/S: F -- NFPA 101 -- Life Safety Code Standard, Bldg: 01

As a result of our revisit finding that your facility is not in substantial compliance, MDH is implementing:

• The Category 1 remedy of state monitoring effective February 10, 2015

In addition, as a result of our revisit findings, MDH is recommending to CMS the imposition of a Civil Money Penalty effective February 10, 2015. (42 CFR 488.430 through 488.444)

Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, this Department is notifying you of the continuation of the previously imposed remedy:

• Mandatory Denial of payment for new Medicare and Medicaid admissions effective February 7, 2015. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective February 7, 2015. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective February 7, 2015. You should notify

Minnesota Masonic Home Care Center March 6, 2015 Page 3

all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Minnesota Masonic Home Care Center is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective February 7, 2015. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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

DEPARTMENT CONTACT

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

Mr. Patrick Sheehan, Supervisor Health Care Fire Inspections State Fire Marshal Division

Email: pat.sheehan@state.mn.us Telephone: (651) 201-7205

Fax: (651) 215-0525

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that

Minnesota Masonic Home Care Center March 6, 2015 Page 4

solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

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

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

APPEAL RIGHTS

If you disagree with this determination, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40 et seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services at the following address:

Department of Health and Human Services Departmental Appeals Board MS 6132 Civil Remedies Division Attention: Karen R. Robinson, Director 330 Independence Avenue, SW Cohen Building, Room G-644 Washington, DC 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by May 7, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process Minnesota Department of Health Health Regulation Division P.O. Box 64900 St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Sincerely,

Dire Klegge

Anne Kleppe, Enforcement Specialist Licensing and Certification Program Health Regulations Division Minnesota Department of Health

Email: anne.kleppe@state.mn.us

Telephone: (651) 201-4124 Fax: (651) 215-9697

PRINTED: 03/26/2015 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED 5343023 OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING 01 - MAIN BUILDING 01 R B. WING 245343 02/10/2015 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 11501 MASONIC HOME DRIVE MINNESOTA MASONIC HOME CARE CENTER **BLOOMINGTON, MN 55437** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) **TAG** TAG DEFICIENCY) {K 000} {K 000} INITIAL COMMENTS FIRE SAFETY 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 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Minnesota Masonic Home was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY **DEFICIENCIES (K-TAGS) TO:**

Healthcare Fire Inspections State Fire Marshal Division

445 Minnesota St., Suite 145

St. Paul, MN 55101-5145, OR

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

By email to:

TITLE

(X6) DATE

Electronically Signed

03/13/2015

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

Facility ID: 00232

PRINTED: 03/26/2015 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION 01 - MAIN BUILDING 01	СОМ	E SURVEY PLETED
		245343	B. WING			l	੨ 10/2015
	PROVIDER OR SUPPLIER OTA MASONIC HOME	CARE CENTER		1	STREET ADDRESS, CITY, STATE, ZIP CODE 1501 MASONIC HOME DRIVE BLOOMINGTON, MN 55437		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
{K 000}	DEFICIENCY MUS FOLLOWING INFO 1. A description of volto correct the deficition. 2. The actual, or proposed in the second of the second with a basement the and was determine construction. In 198 to the south wing an Type I (332) construction of the south sprinkler protected system with smoke areas open to corrical automatic fire depart of the second of the facility smoke detection. Be and the 1 additions construction type, the second of the facility of the second of the facility smoke detection. The requirement at the second of the second of the facility smoke detection of the facility smoke detection. The second of the facility of the second of the facility smoke detection of the facility smoke detection. The facility of the second of the facility smoke detection of the facility smoke detection of the facility of the second of the facility of the f	RRECTION FOR EACH T INCLUDE ALL OF THE DRMATION: what has been, or will be, done ency. poposed, completion date. r title of the person ection and monitoring to ence of the deficiency. Home is a 3-story building at was constructed in 1965 d to be of Type I (332) for an addition was constructed and was determined to be of action. The facility is fully fire The facility has a fire alarm detection in the corridors and dors that is monitored for rtment notification. All resident have hardwired single station ecause the original building are all of the same ne facility was surveyed as lity has a capacity of 214 and 4 at the time of the survey. 42 CFR, Subpart 483.70(a) is	{K 0				
{K 071} SS=F	NOT MET as evide NFPA 101 LIFE SA	nced by: FETY CODE STANDARD	{K 0	71}	ACCUPATION AND ACCUPA		2/16/15
	Rubbish Chutes, In Chutes:	cinerators and Laundry	•				

Event ID: JSZI22

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 01 - MAIN BUILDING 01	COM	E SURVEY PLETED
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	PROVIDER OR SUPPLIER OTA MASONIC HOME			1	TREET ADDRESS, CITY, STATE, ZIP CODE 1501 MASONIC HOME DRIVE LOOMINGTON, MN 55437		
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{K 071}	pneumatic rubbish directly onto any co construction to prev with a fire door asso	ge 2 on and trash chute, including and linen systems, that opens rridor is sealed by fire resistive vent further use or is provided embly having a fire protection new chutes comply with	{K 0	71}			
	pneumatic rubbish a with automatic extir accordance with 9.7 (3) Any trash chute collection room use protected in accordance (4) Existing flue-fed	discharges into a trash d for no other purpose and ance with 8.4. incinerators are sealed by fire to prevent further use.					
	Based on observat linen chute that doe of Sections 19.5.4, 17 This deficient practi residents. Findings include: On facility tour betwon 11/11/2014, obsesoiled linen chute dehave labels indicatir. This deficient practi	s not met as evidenced by: ions, the facility has a soiled s not meet the requirements 9.5 and 8.4 and NFPA 82. ce could affect some een 10:00 AM and 1:00 PM ervation revealed that the bors in the "D" building do not ng their fire rating. ce was verified by the time of the inspection.			New linen chute doors with the appropriate fire rating labels were in on February 16, 2015. To ensure the deficient practice will not recur, and the fire rating labels on the linen chedoors will be completed monthly for months and randomly thereafter. A will be reviewed by the Quality Assu Committee. Person responsible: Dof Guest Services.	ne lits of ute r 6 udits urance	

PRINTED: 03/26/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT O AND PLAN OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
		245343	B. WING_		02/10/2015	
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Event ID: JSZI22

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: JSZI

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

	PART I -	TO BE COMPL	ETED BY T	THE STAT	TE SURVEY A	AGENCY		Facili	ty ID: 00232
1. MEDICARE/MEDICAID PROVII (L1) 245343 2.STATE VENDOR OR MEDICAID (L2) 511542600		3. NAME AND AD (L3) MINNESOT (L4) 11501 MASO (L5) BLOOMINO	A MASONIC	HOME CA	ARE CENTER (L6)	55437	4. TYPE OF 1. Initial 3. Terminal 5. Validatio 7. On-Site	2. tion 4. on 6.	2 (L8) Recertification CHOW Complaint
5. EFFECTIVE DATE CHANGE OF (L9)	FOWNERSHIP	7. PROVIDER/SU 01 Hospital	PPLIER CATEG 05 HHA	ORY 09 ESRD	<u>02</u> (L7) 13 PTIP	22 CLIA		vey After Com	
6. DATE OF SURVEY 11/ 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	'07/2014 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/III 12 RHC	14 CORF 15 ASC 16 HOSPICE		FISCAL YEAF		ATE: (L35)
11LTC PERIOD OF CERTIFICATION	ON	10.THE FACILITY	IS CERTIFIED	AS:					
From (a):		A. In Complian	nce With		And/Or Appro	ved Waivers Of	The Following Re		
To (b):			equirements e Based On:		2. Tech 3. 24 H	nical Personnel		be of Services lical Director	Limit
12.Total Facility Beds	214 (L18)	•	eceptable POC		4. 7-Da	y RN (Rural SN Safety Code	_	ent Room Size	:
13.Total Certified Beds	214 (L17)	X B. Not in Com Requireme	pliance with Progents and/or Appli		* Code: B		(L12)		
14. LTC CERTIFIED BED BREAKD	OWN				15. FACILITY M	EETS			
18 SNF 18/19 SNF 214	7 19 SNF	ICF	IID		1861 (e) (1) or	1861 (j) (1):	(L1	5)	
(L37) (L38)	(L39)	(L42)	(L43)						
16. STATE SURVEY AGENCY RE	MARKS (IF APPLICA	BLE SHOW LTC CA	NCELLATION I	DATE):					
17. SURVEYOR SIGNATURE		Date :			18. STATE SUR	VEY AGENCY	APPROVAL		Date:
Shaun Soucek, HPR Soc	ial Work Specia	list 1	2/22/2014	(L19)	Anne Klep	pe, Enforce	ment Special	list	12/26/2014 (L20)
PA	ART II - TO BE (COMPLETED E	BY HCFA RE	EGIONAI	L OFFICE OR	SINGLE S	TATE AGEN	CY	
DETERMINATION OF ELIGIB 1. Facility is Eligible to 2. Facility is not Eligible.	Participate		PLIANCE WITH	I CIVIL	2. O		ncial Solvency (HC Il Interest Disclosu :		A-1513)
22. ORIGINAL DATE	23. LTC AGREEN	MENT 24	LTC AGREEN	MENT	26. TERMINA	ΓΙΟΝ ACTION:		(L30)	
OF PARTICIPATION 09/01/1986	BEGINNING		ENDING DAT	ГЕ	VOLUNTARY 01-Merger, Close			VOLUNTAR -Fail to Meet 1	<u>Y</u>
(L24)	(L41)		(L25)		02-Dissatisfactio			-Fail to Meet	ž
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involu	=	n <u>O</u>	THER_	
	A. Suspension	n of Admissions:			04-Other Reason	for Withdrawal		-Provider Stat	tus Change
(L27)	B. Rescind St	spension Date:	(L44)				00	-Active	
			(L45)						
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS				
		03001							
	(L28)			(L31)					
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	OF APPROVAL	DATE					

(L33)

DETERMINATION APPROVAL

(L32)



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: November 14, 2014

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

RE: Project Number S5343026

Dear Ms. Wiggin:

On November 7, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

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

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

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

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

DEPARTMENT CONTACT

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

Gayle Lantto, Unit Supervisor Minnesota Department of Health P.O. Box 64900 St. Paul, Minnesota 55164-0900

Email: gayle.lantto@state.mn.us
Telephone: (651) 201-3794
Fax: (651) 201-3790

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by December 17, 2014, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by December 17, 2014 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by February 7, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement

of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by May 7, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process Minnesota Department of Health Division of Compliance Monitoring P.O. Box 64900 St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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

Mr. Patrick Sheehan, Supervisor Health Care Fire Inspections State Fire Marshal Division

Email: pat.sheehan@state.mn.us
Telephone: (651) 201-7205

Fax: (651) 215-0525

Please feel free to call me with any questions about this electronic notice.

Sincerely,

Dire Klegge

Anne Kleppe, Enforcement Specialist Licensing and Certification Program Division of Compliance Monitoring Minnesota Department of Health

Email: anne.kleppe@state.mn.us

Telephone: (651) 201-4124 Fax: (651) 215-9697

PRINTED: 12/29/2014 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION		E SURVEY PLETED
		245343	B. WING			11/	07/2014
	PROVIDER OR SUPPLIER OTA MASONIC HOME	E CARE CENTER		1150	EET ADDRESS, CITY, STATE, ZIP CODE 01 MASONIC HOME DRIVE OOMINGTON, MN 55437		
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F 000	INITIAL COMMEN	TS	F 0	00			
F 279 SS=D	as your allegation of Department's acceen rolled in ePOC, yat the bottom of the form. Your electron be used as verificated Upon receipt of an on-site revisit of your validate that substate regulations has be your verification. 483.20(d), 483.20(COMPREHENSIVION A facility must use to develop, review comprehensive plate to develop, review comprehensive plate to develop and time medical, nursing, an eeds that are idented assessment. The care plan must to be furnished to a highest practicable psychosocial well-be §483.25; and any side required under idue to the residented.	acceptable electronic POC, an ur facility may be conducted to antial compliance with the en attained in accordance with k)(1) DEVELOP E CARE PLANS the results of the assessment and revise the resident's in of care. evelop a comprehensive care ent that includes measurable etables to meet a resident's and mental and psychosocial ntified in the comprehensive t describe the services that are attain or maintain the resident's physical, mental, and being as required under services that would otherwise §483.25 but are not provided 's exercise of rights under the right to refuse treatment	F 2	79			11/28/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

11/24/2014

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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NAME OF I	PROVIDER OR SUPPLIE	R		STREET ADDRESS, CITY, STATE, ZIP CODE	1.7	317 2 014
MINNES	OTA MASONIC HON	ME CARE CENTER		11501 MASONIC HOME DRIVE BLOOMINGTON, MN 55437		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 279	Continued From բ	page 1	F 27	9		
	by: Based on intervier facility failed to resignificant weight whose nutritional Findings include: R368's nutritional revealed an alterate to a hip fracture aregular diet was cresident had a gowas identified at 10 provide nutrition changes in oral and update the ph (RD) as needed. R368 experiencee 9% of body weigh The resident's we follows: 1) 9/3/14 10/1/14 144 lbs, and On 11/6/14, at 10 (RN)-B verified R3 updated to reflect the resident had a mood and behaviorefuse meals. On 11/6/14, at 10 not addressed R3 was first made and The RD said she	ew and document review, the vise the care plan after a loss for 1 of 3 residents (R368) status was reviewed. care plan dated 9/18/14 ation in nutritional status related and Alzheimer's disease. A ordered, and it was noted the od appetite. The goal weight 155 +/- 5 lbs. Staff were directed and supplements, monitor and fluid intake, monitor weights have admission on 9/10/14. ights were documented as admission weight of 155 lbs, 2) and 3) 10/22/14 141 lbs. coo a.m. a registered nurse 368's care plan had not been the recent loss. RN-B stated cognitive impairment as well as oral issues, and was known to a state of the problem on 11/5/14. planned to add a Magic Cup are sident's nutritional plan. The		Credible Allegation We are submitting this Credible of Compliance solely because a federal law mandate submission Credible Allegation of Complianten (10) days of receipt of the S of deficiencies as a condition to participate in the Medicare & Medicare and Assistance programs. The subthe Credible Allegation of Compwithin this time frame should in considered or construed as agricultary with the allegations of non-compadmissions by the facility. R368' an utritional status was reported by the clinical dietician. The care R368 was updated with nutrition interventions to address her appweight loss. The Dietician will be reviewing her nutritional risk we stable and changing the care planeded with individualized interventions to meal intake are will be done by the dietician and by the QA committee. Person resist the Dietician. The Director of Nursing, the Rediction and Director of Nutritic Services have reviewed the poliprocedures related to weight lospolicy was updated to reflect cupractices. The form to record with dietician (weight board) has	tate and a of a ce within catement edical mission of liance no way be element oliance or eviewed e plan for al etite and e ekly until an as ventions. d weights reviewed esponsible gistered nal cies and s. The crent eights for	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245343	B. WING			11/0	07/2014
	PROVIDER OR SUPPLIER OTA MASONIC HOME	CARE CENTER		11	TREET ADDRESS, CITY, STATE, ZIP CODE 1501 MASONIC HOME DRIVE LOOMINGTON, MN 55437		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 279	RD provided intake September, October revealed that on a conference of the fewer than 75% of I of food.	records for the months of the rand November. The records daily basis R368 consumed the records and took only bites as policy was requested,	F 2	79	revised to identify the baseline weight prevent the possibility of missing a loss in carryover from the month be An audit of resident weights will be to identify any other residents with loss. A weight change group e-mail was implemented to identify and comm weight loss issues quicker. Nursin will be re-educated on importance accurate weights, re-weigh policy, prompt notification of dietician and IDT using the weight change group e-mail. To prevent future occurrences a maudit will be done on random residents/patients to identify any we changes. These will be reviewed be Dietician and Director of Nutritional Services and then reviewed by the Committee. Date of completion: November 28.	weight efore. done weight unicate g staff of and I the onthly eight by the QA	
F 325 SS=D	Based on a resident assessment, the far resident - (1) Maintains acceptatus, such as bod unless the resident' demonstrates that the state of the sta	t's comprehensive cility must ensure that a stable parameters of nutritional ly weight and protein levels, s clinical condition his is not possible; and apeutic diet when there is a	F3	25	Date of completion. November 26.	, 2014	11/28/14

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	· · · · · · · · · · · · · · · · · · ·	X3) DATE SURVEY COMPLETED
	245343	B. WING		11/07/2014
			11501 MASONIC HOME DRIVE	
(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
Continued From p	age 3	F 325	5	
by: Based on observareview, the facility weight loss for 1 on utritional status with the facility weight loss for 1 on utritional status with the resident's weight loss for body weight loss follows: 1) 9/3/14 10/1/14 144 lbs, and An Initial Admit Fonoted R368 was posterior of the facility of the facil	ation, interview and document failed to address a significant f 3 residents (R368) whose was reviewed. I a 14 pound (Ib) weight loss or since admission on 9/10/14. ghts were documented as admission weight of 155 lbs, 2) and 3) 10/22/14 141 lbs. od Intake form dated 8/30/14, rescribed a regular diet, had nowing difficulties, ate diappetite was described as all assessment dated 8/30 to 's ideal body weight range as and in a side of the side of th		R368 's nutritional status was revie by the clinical dietician. The care plate R368 was updated with nutritional interventions to address her appetite weight loss. The Dietician will be reviewing her nutritional risk weekly stable and changing the care plan as needed with individualized interventional weekly audits of meal intake and we will be done by the dietician and review by the QA committee. Person responsis the Dietician. The Director of Nursing, the Registe Dietician and Director of Nutritional Services have reviewed the policies procedures related to weight loss. Topolicy was updated to reflect current practices. The form to record weight the dietician (weight board) has been revised to identify the baseline weight prevent the possibility of missing a work loss in carryover from the month beform An audit of resident weights will be doto identify any other residents with work loss. A weight change group e-mail was implemented to identify and communication weight loss issues quicker. Nursing will be re-educated on importance of accurate weights, re-weigh policy, and prompt notification of dietician and to	an for e and until s ons. eights ewed onsible red and The its for n t to veight fore. done reight fore. done reight
R368's nutritional	care plan dated 9/18/14		IDT using the weight change group	
	SUMMARY ST (EACH DEFICIENCE REGULATORY OR Continued From p This REQUIREME by: Based on observa review, the facility weight loss for 1 o nutritional status w Findings include: R368 experienced 9% of body weight The resident's wei follows: 1) 9/3/14 10/1/14 144 lbs, at An Initial Admit Fo noted R368 was p chewing or swallow independently, and "good." A nutrition 9/5/14 listed R368 117 to 143 lbs. R368's admission dated 9/10/14, ide with disruptive ber severe cognitive in assistance from st identified with cher The corresponding 9/11/14, addressed for eating patterns significant portion supplements daily	PROVIDER OR SUPPLIER OTA MASONIC HOME CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to address a significant weight loss for 1 of 3 residents (R368) whose nutritional status was reviewed. Findings include: R368 experienced a 14 pound (lb) weight loss or 9% of body weight since admission on 9/10/14. The resident's weights were documented as follows: 1) 9/3/14 admission weight of 155 lbs, 2) 10/1/14 144 lbs, and 3) 10/22/14 141 lbs. An Initial Admit Food Intake form dated 8/30/14, noted R368 was prescribed a regular diet, had no chewing or swallowing difficulties, ate independently, and appetite was described as "good." A nutritional assessment dated 8/30 to 9/5/14 listed R368's ideal body weight range as	DENOTIFICATION NUMBER: 245343 B. WING 245343 B. WING PROVIDER OR SUPPLIER DTA MASONIC HOME CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 3 F 325 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to address a significant weight loss for 1 of 3 residents (R368) whose nutritional status was reviewed. Findings include: R368 experienced a 14 pound (lb) weight loss or 9% of body weight since admission on 9/10/14. The resident's weights were documented as follows: 1) 9/3/14 admission weight of 155 lbs, 2) 10/1/14 144 lbs, and 3) 10/22/14 141 lbs. An Initial Admit Food Intake form dated 8/30/14, noted R368 was prescribed a regular diet, had no chewing or swallowing difficulties, ate independently, and appetite was described as "good." A nutritional assessment dated 8/30 to 9/5/14 listed R368's ideal body weight range as 117 to 143 lbs. R368's admission Minimum Data Set (MDS) dated 9/10/14, identified diagnoses of dementia with disruptive behaviors. The resident had severe cognitive impairment, and required set up assistance from staff to eat. No concerns were identified with chewing, swallowing or weight loss. The corresponding Care Area Assessment dated 9/11/14, addressed the triggered nutritional status for eating patterns where resident did not eat a significant portion of meals, snacks and/or supplements daily, even for a few days.	PROVIDER OR SUPPLIER 245343 REQUIDER OR SUPPLIER DTA MASONIC HOME CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY) REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to address a significant weight loss for 1 of 3 residents (R368) whose nutritional status was reviewed. Findings include: R368 experienced a 14 pound (lb) weight loss or 9% of body weight since admission on 9/10/14. The resident's weights were documented as follows: 1) 9/3/14 admission weight of 155 lbs, 2) 10/1/14 144 lbs, and 3) 10/22/14 141 lbs. An Initial Admit Food Intake form dated 8/30/14, noted R368 was prescribed a regular diet, had no chewing or swallowing difficulties, are independently, and appetite was described as "good." A nutritional assessment dated 9/30/14, identified diagnoses of dementia with disruptive behaviors. The resident had severe cognitive impairment, and required set up assistance from staff to eat. No concerns were identified with chewing, swallowing or weight loss. A weight change group e-mail was implemented to identify any other resident swith will be re-educated on importance of accurate weights, re-weigh policy, are proportion of meals, snacks and/or supplements daily, even for a few days.

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		245343	B. WING		11/0	07/2014
	PROVIDER OR SUPPLIER OTA MASONIC HOME	CARE CENTER	1	STREET ADDRESS, CITY, STATE, ZIP CODE 11501 MASONIC HOME DRIVE BLOOMINGTON, MN 55437	,	.,
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 325	to a hip fracture an regular diet was or resident had a goo was identified at 15 to provide nutritions changes in oral and and update the phy (RD) as needed. On 11/6/14, at 8:45 breakfast. The resportion of her breakliquids provided. Tinterviewed. On 11/6/14, at 10:0 (RN)-B verified shewight loss, nor hat to the physician or not been updated the stated the resident well as mood and known to refuse mediated the resident well as mood and known to refuse mediated the resident well as mood and known to refuse mediated the resident well as mood and known to refuse mediated the resident well as mood and known to refuse mediated the resident well as mood and known to refuse mediated the resident well as mood and known to refuse mediated the resident well as mood and known to refuse mediated the resident well as mood and known to refuse mediated the resident well as mood and known to refuse mediated the resident well as mood and known to refuse mediated the resident was first made aways first made aw	ion in nutritional status related d Alzheimer's disease. A dered, and it was noted the d appetite. The goal weight 55 +/- 5 lbs. Staff were directed al supplements, monitor d fluid intake, monitor weights vician and registered dietitian and registered dietitian and sa.m. R368 was observed at dident had consumed a large kfast and was drinking the he resident was unable to be a not addressed R368's d she communicated the loss RD. The care plan had also o reflect the recent loss. RN-B had cognitive impairment as behavioral issues, and was	F 325	e-mail. To prevent future occurrences a maudit will be done on random residents/patients to identify any wichanges. These will be reviewed I Dietician and Director of Nutritional Services and then reviewed by the Committee. Date of completion: November 28	reight by the Il QA	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	TIPLE CONSTRUCTION	` '	TE SURVEY MPLETED
		245343	B. WING		11/	/07/2014
	PROVIDER OR SUPPLIER OTA MASONIC HOME	CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP COL 11501 MASONIC HOME DRIVE BLOOMINGTON, MN 55437		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR X (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 325	Continued From pa	ige 5	F 3	25		
F 356 SS=C	however, was not p	oss policy was requested, provided. D NURSE STAFFING	F3	356		11/19/14
	a daily basis: o Facility name. o The current date. o The total number by the following cat unlicensed nursing resident care per sl - Registered nu - Licensed prace	and the actual hours worked egories of licensed and staff directly responsible for nift: rses. tical nurses or licensed as defined under State law). e aides.				
	specified above on of each shift. Data o Clear and readab	ace readily accessible to				
	make nurse staffing	pon oral or written request, g data available to the public not to exceed the community				
	staffing data for a n	aintain the posted daily nurse ninimum of 18 months, or as law, whichever is greater.				
	This REQUIREME	NT is not met as evidenced				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245343	B. WING			11/0	7/2014
	PROVIDER OR SUPPLIER OTA MASONIC HOME	CARE CENTER		1150	EET ADDRESS, CITY, STATE, ZIP CODE D1 MASONIC HOME DRIVE DOMINGTON, MN 55437		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 356	daily posted nursing visible, having the presidents residing in staff. Findings include: Upon entering the fram. the 24-hour nuin place readily visil staff. The nursing larea traversed by rewere on the back stacross from a staffinot easily visible wharea. On 11/07/14, at 11:: (RN)-A explained thalways been posted office, located off the	tion and staff interview, the g hours were not readily potential to affect the 212 in the facility, visitors and/or acility on 11/4/14, at 11:40 ursing hours were not posted ple to residents, visitors, and mours were not located in an esidents and visitors, rather ide of a wall partition and ing office door. The area was nen entering the 24 hour lobby 25 a.m. a registered nurse nat the nursing hours had don the wall by the staffing ine 24-hour lobby. RN-A said it blem in the past and the RN	F3	1	The nurse staffing information has moved to the pillar directly inside the door. On environmental rounds the will audit to ensure the hours are pron that pillar. Person responsible: Director of Nur Date of completion: 11/19/2014	ne front e team osted	

PRINTED: 11/25/2014 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A: BUILDING 01 - MAIN BUILDING 01 B. WING 11/11/2014 245343 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 11501 MASONIC HOME DRIVE MINNESOTA MASONIC HOME CARE CENTER BLOOMINGTON, MN 55437 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 K 000 INITIAL COMMENTS **FIRE SAFETY** 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 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Minnesota Masonic Home was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY **DEFICIENCIES (K-TAGS) TO:** Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to:

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

11/24/2014

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.

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING 01 - MAIN BUILDIN O	G 01	(X3) DATE SURVEY COMPLETED
		245343	B. WING			11/11/2014
	PROVIDER OR SUPPLIER	CARE CENTER		STREET ADDRESS, CI 11501 MASONIC HO BLOOMINGTON, M	ME DRIVE	•
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x (EACH CORE	R'S PLAN OF CORRECTION RECTIVE ACTION SHOUL RENCED TO THE APPROI DEFICIENCY)	D BE COMPLET
K 000	DEFICIENCY MUS FOLLOWING INFO	tate.mn.us RRECTION FOR EACH IT INCLUDE ALL OF THE DRMATION:	K	000	Ti di	
	to correct the deficit 2. The actual, or pr 3. The name and/oresponsible for corrected a reoccurred Minnesota Masonic with a basement the and was determined to the south wing a Type I (332) construction. In 198 to the south wing a Type I (332) construction type I (332) construction with smoke areas open to corriginate open	oposed, completion date.				
K 071 SS=F	NOT MET as evide NFPA 101 LIFE SA	t 42 CFR, Subpart 483.70(a) is enced by: FETY CODE STANDARD acinerators and Laundry	K	071	* در	12/22/1

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
		245343	B. WING		11/	11/2014	
	PROVIDER OR SUPPLIER	CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP COI 11501 MASONIC HOME DRIVE BLOOMINGTON, MN 55437	DE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
K 071	(1) Any existing line pneumatic rubbish directly onto any co-construction to previous a fire door assignating of 1 hour. Alsection 9.5. (2) Any rubbish chup neumatic rubbish with automatic extinaccordance with 9. (3) Any trash chute collection room use protected in accordance (4) Existing flue-feet	en and trash chute, including and linen systems, that opens orridor is sealed by fire resistive went further use or is provided embly having a fire protection I new chutes comply with ute or linen chute, including and linen systems, is provided nguishing protection in 7. discharges into a trash ed for no other purpose and lance with 8.4. I incinerators are sealed by fire on to prevent further use.	ΚO	71			
	Based on observationen chute that does of Sections 19.5.4, This deficient pract residents. Findings include: On facility tour betwon 11/11/2014, obssoiled linen chute dhave labels indication. This deficient pract	s not met as evidenced by: tions, the facility has a soiled es not meet the requirements 9.5 and 8.4 and NFPA 82. ice could affect some veen 10:00 AM and 1:00 PM ervation revealed that the loors in the "D" building do not ng their fire rating. ice was verified by the etime of the inspection.		Credible Allegation We are submitting this Credible of Compliance solely because federal law mandate submiss Credible Allegation of Compliaten (10) days of receipt of the of deficiencies as a condition participate in the Medicare & Assistance programs. The subthe Credible Allegation of Committee within this time frame should considered or construed as a with the allegations of non-committee.	e state and ion of a ance within Statement to Medical ubmission of npliance in no way be greement		

PRINTED: 11/25/2014 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARI	= & MEDICAID SERVICES				OND NO.	0000
TATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION 1 - MAIN BUILDING 01		E SURVEY PLETED
		245343	B. WING			11/	11/2014
	PROVIDER OR SUPPLIER			115	REET ADDRESS, CITY, STATE, ZIP CODE 501 MASONIC HOME DRIVE COMINGTON, MN 55437		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	ILD BE	(X5) COMPLETIO DATE
K 071 K 147 SS=E	Electrical wiring ar	AFETY CODE STANDARD and equipment is in accordance tional Electrical Code. 9.1.2	K 0		admissions by the facility. We were unable to acquire new labels for the soiled linen chute of New doors have been ordered to with the fire rating requirements, audits of our soiled linen chutes conducted for six months and rathereafter to ensure compliance, will be reviewed by the Quality A. Committee. Completion date of Compliance: December 22, 201 Responsible: Director of Guest S.	loors. comply Monthly will be ndomly Audits ssurance 4. Person	12/8/14
	Based on observation failed to comply with Electric Code. This some residents. Findings include: On facility tour betton 11/11/2014, observension cords are the resident rooms.	is not met as evidenced by: ation and interview, the facility th NFPA 70, The National is deficient practice could affect ween 10:00 AM and 1:00 PM servation revealed several and multiplug adaptors in use in is of the "D" building. tice was verified by the time of the inspection.	e:		Extension cords and multiplug a will be removed from D building rooms. Letters were sent to fami Long term Care Residents to sur compliance. Housekeepers, Maintenance, and Nursing staff a educated on this requirement. Waudits will be completed for three and randomly thereafter. Audits reviewed by the Quality Assurant Committee. Completion Date of Compliance: December 8, 2014. Responsible: Director of Guest States.	resident lies of oport are being reekly e months will be ce	

Facility ID: 00232



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: November 14, 2014

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5343026

Dear Ms. Wiggin:

The above facility was surveyed on November 4, 2014 through November 7, 2014 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 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 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 <u>only a suggestion</u> 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 deficiency 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted 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 after the statement, "This Rule

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 me.

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

Please feel free to call me with any questions about this electronic notice.

Sincerely,

Dire Klegge

Anne Kleppe, Enforcement Specialist

Licensing and Certification Program

Division of Compliance Monitoring

Minnesota Department of Health

Email: anne.kleppe@state.mn.us

Telephone: (651) 201-4124 Fax: (651) 215-9697

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
	00000		B. WING		44/0	44/07/0044	
		00232		D. WING		11/0	7/2014
NAME OF	PROVIDER OR SUPPLIER			, ,	STATE, ZIP CODE		
MINNES	OTA MASONIC HOME	CARE CENTER		SONIC HOM IGTON, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE	S FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 000	Initial Comments			2 000			
	*****ATTE	NTION*****					
	NH LICENSING	CORRECTION ORD	DER				
	144A.10, this correct pursuant to a surve found that the defic herein are not corrected shall	Minnesota Statute, section order has been y. If, upon reinspectiency or deficiencies ected, a fine for each be assessed in accordines promulgated by artment of Health.	issued tion, it is cited violation ordance				
	corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has compliance with all rule provided at the alle number indicated as several items, fail the items will be con Lack of compliance ny item of multi-part ment of a fine even uring the initial inspen	tag below. ure to sidered upon rule will if the item				
	that may result from orders provided tha the Department with	hearing on any assent non-compliance wint a written request is thin 15 days of receipent for non-compliance.	th these made to ot of a				
	receipt of State lice the Minnesota Depa Informational Bullet http://www.health.st	participate in the ele nsure orders consist artment of Health in 14-01, available a tate.mn.us/divs/fpc/p e licensing orders ar	tent with t profinfo/inf				

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed 11/24/14

TITLE

Minnesota Department of Health

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING:	COMPLETED		
00232		B. WING	B. WING		
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	11/07/2014
MINNES	OTA MASONIC HOME	CARE CENTER	SONIC HOM		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE
	you electronically. is necessary for State enter the word "corrected. You must then State licensure procompletion date, the corrected prior to el Minnesota Departm On Novemeber 4, 5 this Department's sand the following correction that you and identify the date	Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be electronically submitting to the nent of Health. 5, 6 and 7, 2014, surveyors of taff, visited the above provider orrection orders are issued. our electronic plan of have reviewed these orders, e when they will be completed.	2 000		
	the State Licensing federal software. Ta assigned to Minnes Nursing Homes. The assigned tag n column entitled "ID statute/rule out of c "Summary Stateme and replaces the "T correction order. The findings which are in after the statement, evidence by." Followare the Suggested Time period for Correction Foundation of the Suggested Time period for Correction order. The Suggested Time period for Correction for Correction order. The Suggested Time period for Correction for Correction for Correction for Correction for Correction order. The Suggested Time period for Correction for Correctio	RD THE HEADING OF THE			

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Minnesota Department of Health STATE FORM

Minnesota Department of Health

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00232	B. WING		11/07/2014	
			DRESS, CITY, S	STATE, ZIP CODE	1	
MINNESOTA MASONIC HOME CARE CENTER 11501 MASONIC HOME DRIVE BLOOMINGTON, MN 55437						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
2 000	Continued From pa	ge 2	2 000			
	THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.					
2 570	MN Rule 4658.0405 Plan of Care; Revis	5 Subp. 4 Comprehensive ion	2 570			11/28/14
	Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B.					
	by: Based on interview facility failed to revis	and document review, the se the care plan after a less for 1 of 3 residents (R368) atus was reviewed.		Corrected		
	Findings include:					
	revealed an alteration to a hip fracture and regular diet was orderesident had a good was identified at 15 to provide nutritional	are plan dated 9/18/14 on in nutritional status related d Alzheimer's disease. A dered, and it was noted the d appetite. The goal weight 5 +/- 5 lbs. Staff were directed al supplements, monitor I fluid intake, monitor weights				

Minnesota Department of Health STATE FORM

Minnesota Department of Health

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00232	B. WING		11/07/20	14
	PROVIDER OR SUPPLIER OTA MASONIC HOME	CARE CENTER 11501 MA	DRESS, CITY, S SONIC HOM IGTON, MN		-	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COM	(X5) MPLETE DATE
2 570	and update the phy (RD) as needed. R368 experienced a 9% of body weight of the resident's weight of follows: 1) 9/3/14 at 10/1/14 144 lbs, an On 11/6/14, at 10:0 (RN)-B verified R36 updated to reflect the resident had comood and behavior refuse meals. On 11/6/14, at 10:1 not addressed R36 was first made awa The RD said she plus supplement to the rRD provided intake September, October evealed that on a confewer than 75% of I of food. A nutrition/weight long however, was not public said and director current policies and residents who expetite their care plans reflus appropriate goals at the resident's care and audits could be	sician and registered dietitian a 14 pound (lb) weight loss or since admission on 9/10/14. hts were documented as dmission weight of 155 lbs, 2) d 3) 10/22/14 141 lbs. 0 a.m. a registered nurse is care plan had not been he recent loss. RN-B stated gnitive impairment as well as al issues, and was known to 5 a.m. the RD verified she had is weight loss, and said she re of the problem on 11/5/14. anned to add a Magic Cup esident's nutritional plan. The records for the months of and November. The records daily basis R368 consumed her meals and took only bites is spolicy was requested, rovided. CHOD OF CORRECTION: of nursing could review a procedures regarding rienced weight loss to ensure ect the change and approaches are added to plan. Staff could be educated a conducted. The results of brought to the quality	2 570			

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AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					3) DATE SURVEY COMPLETED		
	00232		B. WING			11/07/2014	
			DRESS, CITY, S	STATE, ZIP CODE	•		
MINNES	OTA MASONIC HOME	CARE CENTER	IGTON, MN				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 570	Continued From pa	ge 4	2 570				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one					
2 965	MN Rule 4658.0600 -Nutritional Status) Subp. 2 Dietary Service	2 965			11/28/14	
	Subpart. 2. Nutritional status. The nursing home must ensure that a resident is offered a diet which supplies the caloric and nutrient needs as determined by the comprehensive resident assessment. Substitutes of similar nutritive value must be offered to residents who refuse food served.						
	This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to address a significant weight loss for 1 of 3 residents (R368) whose nutritional status was reviewed.			Corrected			
	Findings include:						
	R368 experienced a 14 pound (lb) weight loss or 9% of body weight since admission on 9/10/14. The resident's weights were documented as follows: 1) 9/3/14 admission weight of 155 lbs, 2) 10/1/14 144 lbs, and 3) 10/22/14 141 lbs.						
	noted R368 was pre chewing or swallow independently, and "good." A nutritional	d Intake form dated 8/30/14, escribed a regular diet, had no ing difficulties, ate appetite was described as all assessment dated 8/30 to a ideal body weight range as					

Minnesota Department of Health STATE FORM

Minnesota Department of Health

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
00232		B. WING		11/0	11/07/2014	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE	•	
MINNES	OTA MASONIC HOME	CARE CENTER	ASONIC HON NGTON, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 965	Continued From pa	ge 5	2 965			
	dated 9/10/14, iden with disruptive behasevere cognitive im assistance from state identified with chew. The corresponding 9/11/14, addressed for eating patterns a significant portion of supplements daily, R368's nutritional correvealed an alteration a hip fracture and regular diet was orderesident had a good was identified at 15 to provide nutritional changes in oral and	Minimum Data Set (MDS) tified diagnoses of dementia aviors. The resident had pairment, and required set up iff to eat. No concerns were ring, swallowing or weight loss Care Area Assessment dated the triggered nutritional status where resident did not eat a if meals, snacks and/or even for a few days. are plan dated 9/18/14 on in nutritional status related d Alzheimer's disease. A dered, and it was noted the d appetite. The goal weight 5 +/- 5 lbs. Staff were directed al supplements, monitor d fluid intake, monitor weights sician and registered dietitian				
	breakfast. The resi portion of her break	a.m. R368 was observed at ident had consumed a large sfast and was drinking the ne resident was unable to be				
	(RN)-B verified she weight loss, nor had to the physician or I not been updated to stated the resident well as mood and b known to refuse me					
	On 11/6/14, at 10:1	5 a.m. the RD verified she had				

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PRINTED: 12/29/2014 FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _ B. WING 00232 11/07/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 11501 MASONIC HOME DRIVE MINNESOTA MASONIC HOME CARE CENTER **BLOOMINGTON, MN 55437** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 2 965 Continued From page 6 2 965 not addressed R368's weight loss, and said she was first made aware of the problem on 11/5/14. The RD said she planned to add a Magic Cup supplement to the resident's nutritional plan. The RD provided intake records for the months of September, October and November. The records revealed that on a daily basis R368 consumed fewer than 75% of her meals and took only bites of food. The RD explained the normal

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A nutrition/weight loss policy was requested, however, was not provided.

communication method at the facility was for nursing to notify the RD if a weight loss concern was identified, but she had not been notified in

SUGGESTED METHOD OF CORRECTION: The RD and director of nursing could review current policies and procedures regarding residents who experienced weight loss to ensure their nutritional needs met and the changes in weight are recognized in a timely manner. Staff could be educated and audits could be conducted. The results of the audits could be brought to the quality committee for review.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days.

this case.