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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: R90F

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **12/05/2013** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

10.THE FACILITY IS CERTIFIED AS:

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

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

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

At the time of the Standard Survey, the facility was not in substantial compliance with Federal Certification Regulations. 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). Post Certification Revisit to follow.

17. SURVEYOR SIGNATURE Date :
Lisa Hakanson, HFE NEII 01/06/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Colleen B. Leach, Program Specialist 02/06/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7012 3050 0001 9094 7147

December 19, 2013

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

RE: Project Number S5343025

Dear Ms. Wiggin:

On December 5, 2013, 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>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

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 January 14, 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 January 14, 2014 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC 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,

- Include signature of provider and date.

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's PoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. 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 PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

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 March 5, 2014 (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 June 5, 2014 (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 a PoC 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 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
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205
Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4124
Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

PRINTED: 12/19/2013
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245343	A. BUILDING _____ B. WING _____	12/05/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared 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, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced	F 280	F280 R320's care plan was reviewed and determined to be current. The rail should not have been in the upright position. Therefore, the siderails were removed from the bed on December 4, 2013. To ensure ongoing compliance, random audits of the careplan, NAR assignment sheets and actual nursing practice of other residents will be conducted. Results will be reviewed by the Quality Assurance Committee. Person Responsible: Director of Nursing Date of Completion: January 14, 2014	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Sheela Wiggin — TITLE: Administrator — (X6) DATE: 12/30/13

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

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F 280	Continued From page 1 by: Based on observation, interview and record review the facility failed to ensure the care plan was revised for 1 of 4 residents in the sample (R320) whose care plan did not direct staff when side rails should have been used. Findings include: R320's care plan (dated 11/26/13) noted the resident did not utilize rails on her bed, however, one rail was observed in the up position and staff reported the resident utilized the rail during cares. On 12/4/13, at 10:06 a.m. R320's bed was observed to have bilateral quarter rails. The bed was unoccupied at the time of the observation. The rail near the wall was in the low position. The outside rail was in the upright position. After the observation at 10:20 a.m. a registered nurse (RN-A) explained that resident who utilized perimeter mattresses should not have had the rails left in the upright position when the bed was occupied. On 12/4/13, at 1:15 p.m. R320 was lying in bed. A body pillow was positioned on her right side, and the quarter rail was again noted in the upright position. At 2:15 p.m. R320 was again observed lying in bed in the same manner, however, the head of the bed was raised to approximately 30 degrees. The following day at 7:20 a.m. the resident was again observed in bed with the body pillow on her right side and the head of bed raised to approximately 30 degrees.	F 280		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323		

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F 323	Continued From page 2 The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure all side rails attached to beds met Federal Drug Administration (FDA) guidelines to reduce entrapment for 3 of 4 residents in the sample (R320, R384, R120) whose side rails exceeded the recommended dimensional limits. Findings include: R320 had spaces between the bottom of the side rail and the top of her mattress where a body part could have potentially become entrapped. The Guidance for Industry and FDA Staff/Hospital Bed System Dimensional and Guidance to Reduce Entrapment Guidelines (issued 3/10/06) recommended the dimensional limit for Zone 4 (space under the rail and at the end of the rail be fewer than 2 3/8 inches to reduce the risk of neck entrapment. On 12/4/13, at 10:06 a.m. R320's bed was observed to have bilateral quarter rails. The bed was unoccupied at the time of the observation. The rail near the wall was in the low position. The outside rail was in the upright position, and could be moved approximately two inches when tested	F 323	F323 Resident 320 had the siderails removed from the bed. Residents R384 and R214 received new beds which have grab bars that meet the FDA guidelines. This was done immediately on December 5, 2013. A review of the beds in the D building that have siderails attached was conducted. If the rails did not meet the FDA guidelines, the rails were removed (and discarded to prevent ever being attached to another bed). Some of the patients were given new beds that met the new FDA guidelines. We also have implemented a procedure to not allow beds from an outside system such as hospice to further ensure safety of our bed systems. Maintenance staff has been educated on the new FDA standard. Monthly audits will be conducted of the beds and store rooms to ensure that the siderails have been discarded and are no longer available for 3 months and then conducted randomly. All audits will be reviewed by the Quality Assurance Committee for effectiveness. Person Responsible: Director of Guest Services and the Director of Nursing Date of Completion: January 14, 2014	

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F 323	Continued From page 3 for stability. There was noticeable space between the bottom of the rail and the top of the perimeter mattress (with defined edges). After the observation at 10:20 a.m. a registered nurse (RN-A) explained that resident who utilized perimeter mattresses should not have had the rails left in the upright position when the bed was occupied. That afternoon at 1:15 p.m. R320 was lying in bed. A body pillow was positioned on her right side, and the quarter rail was again noted in the upright position. An occupational therapist/registered (OTR)-A was interviewed on 12/4/13 at 1:17 p.m. and stated R320 was receiving therapy for core strengthening and positioning, and the resident required assistance from staff for bed mobility. On 12/4/13, at 2:15 p.m. R320 was again observed lying in bed in the same manner, however, the head of the bed was raised to approximately 30 degrees. The following day at 7:20 a.m. the resident was again observed in bed with the body pillow on her right side and the head of bed raised to approximately 30 degrees. At 10:15 a.m. the side rail was in the upright position, and was measured by RN-A. The RN stated the space measured four inches. The RN also stated R320 participated in bed mobility with cuing to use the side rails during cares. However, if the resident was lying in bed, the rails were not supposed to have been left in the upright position when cares were not being performed. The RN stated she was unaware the bed did not meet the FDA guidelines. R320's care plan (dated 11/26/13) noted some of the resident's needs were anticipated due to	F 323		

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F 323	Continued From page 4 impaired insight to her limitations. Her care sheet (printed for 12/4/13) revealed the resident did not utilize side rails. The Minnesota Masonic Home Side Rail Evaluation (dated 11/25/13) also showed no side rails were utilized for R320. The resident's diagnoses included hemiplegia (paralysis on one side of the body) osteoarthritis right shoulder, muscle weakness, scoliosis (curvature of the spine) and dementia. R384 was observed to have quarter side rails on the both sides of her bed. The side rails were in the upright position. The side rails were able to be moved approximately two inches when manipulated, and had the potential for entrapping a body part. On 12/03/13 at 4:48 p.m. R384 was sitting on the edge of the bed, and quarter side rails were in the upright position. The rails were able to be manipulated approximately two inches. The following day at 7:24 a.m. R384 was lying in bed and the bilateral quarter rails were again in the upright position. RN-A stated on 12/04/13 at 10:20 a.m. an assessment to determine the need and safety of side rail use was completed with each Minimum Data Set (MDS) assessment including when a resident significantly changed and/or had returned from a hospital stay. The RN explained that if a mattress had defined edges side rails were not to be left in the upright position. The RN also said she was unaware of the FDA's guidance regarding side rails. On 12/5/13, at 10:15 a.m. RN-A measured R384's mattress and rail ratio and reported the space at Zone 2 between the safety brackets was	F 323		

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F 323	Continued From page 5 6.5 inches, and said the rails "wiggle." The FDA recommendations was for not more than 4 3/4 inches to prevent head entrapment. The RN stated that R384 was using the rails for repositioning. R384's care plan (dated 5/16/13) indicated the resident experienced short term memory loss after five minutes. In addition, the plan directed staff to raise the resident's side rails to promote her impendence with bed mobility. Side rail evaluations dated 10/11/13, 7/19/13, 4/26/13 and 1/25/13 verified R384 used left and right side rails for bed mobility. R124 had quarter side rails on the both sides of her bed. The side rails were in the upright position, and were able to be moved approximately two inches when manipulated, potentially entrapping a body part. On 12/5/13 at 10:15 a.m. R124's quarter bed rails were noted to be in the upright position on both sides of the residents bed, and the bed was unoccupied. RN-A measured Zone 2 from the FDA guidelines and the area between the safety brackets was 6.7 inches. The FDA recommendations were for no more than 4 3/4 inches. RN-A stated the rails attached to R384's bed "wiggle." R124's care sheet indicated the resident independently repositioned in the bed. Side rail evaluations dated 11/15/13, 8/25/13,5/30,12 and 12/14/13 revealed side rails were used for bed mobility. The Minnesota Masonic Home Short Side Rails/Grab Bars--Use of guideline dated 11/13	F 323		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245343	A. BUILDING _____ B. WING _____	12/05/2013

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

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F 323	Continued From page 6 directed staff to ensure bed equipment was in good operating condition (i. e. side rails/grab bars) were securely fastened, and to notify maintenance staff if necessary.	F 323		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a medication error rate of fewer than 5% for 1 of 5 residents (R360) whose medication administration was observed. The medication error rate was 12%. Findings include: R360 was administered a series of four different eye drops one after the other without proper spacing between drops. On 12/4/13 at 8;11 a.m. a licensed practical nurse (LPN)-D administered eye drops for R360. She administered the drops in succession without waiting in between the drops as follows: 1) Timolol Mal Solution 0.5%, one drop to the left eye for glaucoma; 2) Prednisonlone 1% for corneal transplant, one drop to the left eye; 3) Restasis 0.05% one drop to the left eye for tear film insufficiency; and 4) Refresh liquigel 1%, one drop to the left eye for tear film insufficiency. At 11:12 a.m. the consultant pharmacist was	F 332	F332 The nurse identified as administering the eye drops without waiting the proper period of time was re-educated immediately on proper eye drop administration. In addition education was offered to all nurses and TMAs regarding proper eye drop administration. Weekly audits of the nurse will be conducted for 6 weeks. Audits of other nurses eye drop administration will also be conducted randomly. Results of the audits will be reviewed by the Quality Assurance Committee. Person responsible: Director of Nursing/Director of Education Date completed: January 14, 2014	

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F 332	Continued From page 7 Interviewed. He stated that the proper procedure for administering eye drops was to wait three to five minutes between each eye drop, as the eye was only able to hold a limited amount of fluid. At 12:43 p.m. LPN-D stated that she was running behind and did not want to make the resident late for an appointment. She verified that the usual procedure was to wait two to five minutes between each eye drop. On 12/5/13 at 11:55 a.m. a registered nurse (RN)-B reported that if a resident received multiple eye drops, the staff should have waited five minutes between each drop. The facility policy and procedure for Eye drop Administration Procedure from the contracted Pharmacy directed staff to "wait three to five minutes" between administrations of different eye medications to allow sufficient time for each drug to spread across the surface of the eye and be properly absorbed, rather than diluting or washing out.	F 332		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation,	F 441		

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F 441	Continued From page 8 should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure staff implemented proper hand washing and glove removal for 1 of 2 residents (R155) whose personal cares were observed and 6 of 6 residents (R367, R30, R196, F174, F172, and an unidentified resident) who utilized wash cloths from a communal basin, and to ensure proper disposal of contaminated sharps for 3 of 4 residents who had glucose checks (R189, R196, R113).	F 441	F441 New sharps containers have been purchased for the memory care wing. They consist of an outer locked container which holds the sharps container. This will be attached to the wall in the residents bathrooms. A key is needed to access the new containers. The new containers cannot be tipped upside down and the opening is too small for a hand to reach into it. The identified residents had the new containers installed promptly following survey. The new containers will be installed in all rooms on the memory care wing by January 14, 2014. Re-education for nursing staff on proper hand washing and glove usage with peri care will be completed by January 14, 2014. The involved NAR was re-educated and will be required to have a successful return demonstration of the proper procedure completed by the Education Manager by January 14, 2014. Random audits of peri care, (Continued)	

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F 441	Continued From page 9 Findings include: NA-B performed perineal care for R155 during morning cares, however, she failed to remove the soiled gloves and wash her hands prior to the completion of personal cares and prior to leaving the resident's room. R155 was assisted with morning cares by on 12/5/13, at 7:55 a.m. The resident was assisted by NA-B and the use of an EZ-Stand to use the toilet. The NA donned gloves prior to assisting the resident. When the resident finished urinating and having a bowel movement, the NA cleaned the resident using disposable wipes, using a new cloth each time she wiped. The NA then ran her hands under the water faucet. Without removing her gloves and washing her hands, the NA washed under R155's armpits, applied deodorant, and assisted the resident with her blouse. The NA then removed her gloves and donned a new pair without washing her hands prior to donning the clean gloves. NA-B then assisted R155 to wash her face and wipe her eyes. The resident declined brushing her teeth until after breakfast. NA-B then removed her gloves and again without washing her hands, assisted R155 to the dining room in her wheelchair. In the dining room NA-B was in the process of giving R155 a glass of juice with a straw when she was asked to stop and wash her hands. After the observations at 8:45 a.m. NA-B explained she was newly hired and had only been working independently for two days, however, said she had been tanned regarding appropriate hand washing and glove use. She acknowledged she had not properly washed her hands and changed her gloves during and after cares for	F 441	glove usage and hand washing will be conducted by nursing management. Audit results will be reviewed by the Quality Assurance Committee. Re-education of the nursing staff and the Activity staff on the hand washing procedures with meal services will be completed by January 14, 2014. Audits of the meal service handwashing on the memory care unit will be done weekly times 6 weeks then done randomly. Results of the audit will be reviewed by the Quality Assurance Committee. Person responsible: Director of Nursing Date of completion: January 14, 2014	

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F 441	Continued From page 10 R155. On 12/5/13, at 1:30 p.m. the infection control registered nurse (RN)-C explained that she would have expected staff to wash hands after performing perineal care and between glove changes. RN-C stated employees were trained on appropriate hand washing and glove use during orientation and annually. Minnesota Masonic Home Hand washing (dated 5/01) directed staff to perform a 15-20 second hand washing before providing residents' cares; before applying gloves; after removing gloves; before preparing food or serving food or medications; after handling toilet facilities; and before leaving a resident's room. The Perineal Care policy (dated 2/10) directed staff to remove gloves immediately after perineal care was complete, and to wash hands and apply a new pair of gloves as necessary. "Hand washing is also conducted as per recommendations from the CDC [Centers for Disease Control] guidelines." Staff did not properly clean hands between resident to resident contact. On 12/2/13, at 5:38 p.m. a nursing assistant (NA)-A was assisted residents to wash their faces and hands following the evening meal. Wearing gloves, the NA used a basin containing wet washcloths, and took a cloth from the basin and assisted R367 to wipe her hands. The NA then took another cloth and handed it to an unknown resident. The NA then obtained another washcloth and washed off R30's face (including nose) and hands. The NA then wheeled R30 to the activity room. While wearing the same gloves, the NA retrieved another washcloth from	F 441		

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F 441	Continued From page 11 the basin and wiped off R196's face (including nose) and hands. The resident was then walked to the activity room. With the original gloves, the NA retrieved another washcloth from basin and wiped off R174's face (including nose) and hands, and assisted the resident to the activity room. Another washcloth was obtained from the basin and R172's face (including nose) and hands were wiped. At 5:44 p.m. NA-A explained that she had prepared the basin of washcloths by pouring warm water over the cloths. The facility Hand washing policy (dated 11/13) directed staff to perform a 15-20 second hand washing prior to providing resident cares. The facility failed to ensure disposable sharps were maintained in a sanitary manner and were inaccessible. On 12/4/13, at 10:09 a.m. LPN-A checked R189's blood glucose level with a glucometer unit (device used to check blood sugar). LPN-A was observed to place the lancet (pricking needle to obtain drops of blood) into a mobile sharps container (puncture resistant container) located in R189's unlocked closet. At 10:29 a.m. the LPN administered R189's insulin and attempted to place the insulin syringe into the same sharps container, however, the container was full. The opening was large enough for lancets to fall through the opening if it was tipped upside down, and was large enough to place a finger into the opening. LPN-A explained that R316, R196 and R113 also had glucose monitoring supplies and a mobile sharps containers in their unlocked closets. LPN-B escorted and observed the closets of	F 441		

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F 441	Continued From page 12 R316, R196, and R113 on 12/4/13, at 10:36 a.m. R316's closet revealed a glucometer unit and lancets on top shelf of closet, however, no sharps container was found in the room. At 10:39 a.m. R196's closet revealed glucometer unit, lancets, and sharps container that was approximately 1/4 full was in the closet. The container had a plastic lid shut that was shut but easily opened on the top, and was large enough for lancets to be placed in the container. At 10:37 a.m. R113's closet revealed a glucometer unit, lancets and sharps container in the closet. The sharps container was observed to be 1/2 full and was without a lid. The opening was large enough for lancets for fall through. After the observations LPN-B removed the two sharps containers from the resident rooms. The quality assurance director was interviewed on 12/5/13, at 3:30 p.m. She stated she did not feel there was a risk of needle stick as the facility used all retractable sharps, but she did remove the containers from the unit.	F 441		

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	245343	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	12/04/2013

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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, State Fire Marshal Division, on December 4, 2013. At the time of this survey, Minnesota Masonic Home Care Center was found not to be 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: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101-5145, or	K 000	We are submitting this Credible Allegation of Compliance solely because state and federal law mandate submission of a Credible Allegation of Compliance within ten (10) days of receipt of the Statement of deficiencies as a condition to participate in the Medicare & Medical Assistance programs. The submission of the Credible Allegation of Compliance within this time frame should in no way be considered or construed as agreement with the allegations of non-compliance or admissions by the facility. POC ok FS 1-6-14	

DC: 1-14-14

EXIT: 12-5-13

RECEIVED
DEC 30 2013
MN DEPT. OF PUBLIC SAFETY
STATE FIRE MARSHAL DIVISION

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Shelly Wagner — TITLE: Administrator — (X6) DATE: 12/30/13

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

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K 000	Continued From page 1 By eMail to: Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Minnesota Masonic Home Care Center was constructed as follows: The original building was constructed in 1965, is three-stories in height, has a full basement, is fully fire sprinkler protected, and was determined to be of Type I (332) construction; The 1995 building addition is three-stories in height, has a partial basement, is fully fire sprinkler protected, and was determined to be of Type I (332) construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to corridors, which is monitored for automatic fire department notification. Because the original building and the one building addition are of the same construction type, the facility was surveyed as one building, and one (1) Form CMS 2786R booklet was completed. The facility has a licensed capacity of 214 and had a census of 195 at time of the survey.	K 000		

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K 000	Continued From page 2 The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 011 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 19.1.1.4.1, 19.1.1.4.2 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain a required 2-hour fire separation between the nursing home and an attached assisted living facility, in accordance with the requirements at NFPA 101 (2000), Chapter 19, Sections 19.1.1.4 and 19.1.2.3. In a fire emergency, this deficient practice could adversely affect the safety of 30 of 214 residents, staff and visitors. FINDINGS INCLUDE: On 12/04/2013 at 2:20 PM, observation revealed a 2-hour fire wall on the E1 North Corridor, separating the nursing home from an attached assisted living facility. The communicating opening through the 2-hour wall was equipped with a set of factory labeled 20-minute fire doors - not the required 90-minute doors - and the required 2-hour occupancy separation was not maintained.	K 011	K011 The doors will be replaced with doors that meet the required 90 minute fire rating by January 6, 2014. Completion Date of Compliance: January 6, 2014 Person Responsible: Director of Guest Services.	

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K 011	Continued From page 3 This finding was verified with the Director of Guest Services at the time of discovery.	K 011		
K 061 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems have valves supervised so that at least a local alarm will sound when the valves are closed. NFPA 72, 9.7.2.1 This STANDARD is not met as evidenced by: Based upon observation, not all components of the facility's automatic fire sprinkler system were equipped with required electrically interconnected supervisory attachments. In a fire emergency, this deficient practice could adversely affect 214 of 214 residents, staff and visitors. FINDINGS INCLUDE: On 12/04/2013 at 12:15 PM, observation revealed a gate valve installed on a section of fire sprinkler branch line, which was located in the Mechanical Penthouse of the original building. Upon examination, it was revealed that both the tamper switch on the valve - and the adjacent flow switch - were not electrically interconnected to the building fire alarm system. This existing arrangement was not in accordance with the requirements at NFPA 101 [2000] Chapter 9, Sections 9.7.2.1 and 9.7.2.2 and NFPA 72 [1999]. This finding was confirmed with the Director of Guest Services at the time of discovery.	K 061	K061 The tamper switch on the gate valve and the adjacent flow switch were electrically interconnected to the building fire alarm system by fire alarm system vendor on December 18, 2013 Completion Date: December 18, 2013 Person Responsible: Director of Guest Services.	
K 144	NFPA 101 LIFE SAFETY CODE STANDARD	K 144		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245343	A. BUILDING 01 - MAIN BUILDING 01 B. WING	12/04/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 144 SS=F	Continued From page 4 Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based upon a review of available records, the facility failed to properly maintain Emergency Generators in accordance with the requirements at NFPA 99 (1999 edition) and NFPA 110 (1999 edition). In a fire or other emergency, this deficient practice could adversely affect 214 of 214 residents, staff and visitors. FINDINGS INCLUDE: On 12/04/2013 at 9:55 AM, it was learned that the facility was equipped with three (3) emergency generators, known as Emergency Generators 1, 2, 3. During a review of the facility's Emergency Generator Monthly Test Logs, it could not be determined whether emergency generators 1, 2 or 3 had been exercised for not less than 30 minutes during each month of the previous year, nor, that they had been exercised at not less than 30% of their EPS nameplate ratings, during each month of the previous year. This deficient practice was not in conformance with the requirements at NFPA 110 (1999), Chapter 6, Section 6-4.2 and NFPA 99 (1999), Chapter 3, Section 3-6.4.1.1(b).	K 144	K144 Maintenance staff was educated on the requirement of documenting the monthly testing of the generators for not less than 30 minutes and exercising at not less than 30% of their EPS nameplate ratings. New form will be implemented to comply with above listed requirements. Audits will be completed by Supervisor bi-weekly for 3 months and randomly after that. Audits will be reviewed by the Quality Assurance Committee. Completion date: January 14, 2014. Person Responsible: Director of Guest Services.	

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K 144	Continued From page 5 This deficient practice was confirmed with the facility's chief building engineer.	K 144		