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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 5XI8

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00232

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **12/26/2018** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Eva Loch, Unit Supervisor 12/27/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Douglas Larson, Enforcement Specialist 12/28/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 27, 2018

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

RE: Project Number S5343031

Dear Administrator:

On November 27, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on November 1, 2018. 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 26, 2018, 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 1, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 11, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on November 1, 2018, effective December 11, 2018 and therefore remedies outlined in our letter to you dated November 27, 2018, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division

Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

CMS Certification Number (CCN): 245343

December 27, 2018

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

Dear Administrator:

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 December 11, 2018 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/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Douglas Larson, Enforcement Specialist

Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

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(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 **11/01/2018** (L34)

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2 AOA 3 Other

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03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
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FISCAL YEAR ENDING DATE: (L35)
12/31

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From (a) :
To (b) :

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE — Date:
Lisa Hakanson, HPR Dietary Specialist — 12/13/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Douglas Larson, Enforcement Specialist — 12/27/2018 (L20)

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

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

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2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
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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

Electronically delivered
November 27, 2018

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

RE: Project Number S5343031

Dear Administrator:

NOTE: The health and life safety code survey findings will be processed under separate enforcement cycles.

On November 1, 2018, a standard survey was completed at your facility by the Minnesota Department of Health 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 constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

OPPORTUNITY TO CORRECT - DATE OF CORRECTION

The date by which the deficiencies must be corrected to avoid imposition of remedies is December 11, 2018.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.

- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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

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

- Discretionary denial of payment for new Medicare and Medicaid admissions (42 CFR 88.417 (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 (488.456(b)).

DEPARTMENT CONTACT

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

Eva Loch, Unit Supervisor
Metro D Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: eva.loch@state.mn.us
Phone: (651) 201-3792
Fax: (651) 215-9697

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department

of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

If substantial compliance with the regulations is not verified by February 1, 2019 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by May 1, 2019 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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.

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

Feel free to contact me if you have questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245343	A. BUILDING _____ B. WING _____	11/01/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted on 10/29/18 through 11/01/18, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On 10/29/18 through 11/01/18, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with the requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by:	F 554		12/11/18

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

Electronically Signed | 12/06/2018

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245343	A. BUILDING _____ B. WING _____	11/01/2018

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 554	Continued From page 1 Based on observation, interview and document review, the facility failed to ensure an assessment for safe self-administration of medications was completed for 1 of 1 resident (R98) observed to self-administer medication via nebulizer (a drug delivery device used to administer medication in the form of a mist inhaled into the lungs). Findings include: R98 was observed on 10/31/18, at 8:24 a.m. during medication administration. Licensed practical nurse (LPN)-A set up R98's pulmicort nebulizer (a device used to administer inhaled medication) and offered it to R98. Immediately after R98's nebulizer was turned on LPN-A left R98's room and returned to the medication cart in the hallway. R98 was observed again on 10/31/18, at 8:38 a.m. with the nebulizer mask held to her face while alone in her room without supervision. LPN-A confirmed, on 10/31/18, at 8:46 a.m., R98 had been self-administering the pulmicort nebulizer for "quite a while" and had self-administered the scheduled 8:00 a.m. dose . According to R98's quarterly Minimum Data Set (MDS) assessment dated 10/1/17, R98 was cognitively intact. Additionally, R98's admission record dated 10/31/18, included diagnoses of chronic obstructive pulmonary disease (COPD) and congestive heart failure (CHF). R98's Order Summary Report dated 10/31/18, included orders for pulmicort suspension 1 mg/2 ml (budesonide), inhale orally two times a day related to COPD. R98's Medication Administration Record (MAR) for October 2018, reviewed 10/31/18, indicated	F 554	F554 Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) We are submitting this Credible Allegation of Compliance solely because state and federal law mandate submission of a Credible Allegation of Compliance within ten (10) days of receipt of the Statement of Deficiencies as a condition to participate in the Medicare & Medical Assistance programs. The submission of the Credible Allegation of Compliance within this time frame should in no way be considered or construed as agreement with the allegations of non-compliance or admissions by the facility. It is the policy of Minnesota Masonic Home Care Center to provide care that supports a resident in executing their preference and right to self-administer their medication(s). It is the policy to notify residents of this right on admission and document their preference. R98 has resided in facility since 8/14/2014, is well known to staff and able to make preferences known. A practitioner□s order was in place that stated Pulmicort [&] OK to self-administer neb. Upon notification on 10/31/18, that a self-administration assessment was not located, an interview was immediately conducted with R98 regarding a continued desire to self-administer the nebulizer	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 554	Continued From page 2 R98 had received pulmicort suspension two vials inhaled orally via nebulizer two times daily at 8:00 a.m. on 10/31/18. There was no evidence in R98's medical record of an assessment if R98 could safely self-administer medications. On 10/31/18, at 11:06 a.m. registered nurse (RN) -A stated R98 did not have a medication self-administration assessment completed and should have before self-administered the pulmicort medication. The facility's Self Administration of Medications policy dated 5/2004, included: If a resident takes his/her medications independently after nursing prepared the medications, a physician's order similar to "resident may self-administer medications after nursing sets up" would need be obtained. The policy did not reference resident self-administration of medication assessments.	F 554	treatment after nursing set-up. R98 stated a preference for staff to take over administration of medications at this time because R98 has not been feeling well. An order was obtained on 10/31/18 to discontinue self-administration of nebulizer in support of R98□s newly stated preference. A facility-wide audit was conducted to identify other residents who self-administer medications. Residents identified who self-administer medications have a Self-Administration of Medication Evaluation on record. The Self-Administration of Medication(s) and Treatment(s) Policy was revised. A Self-Administration of Medication Evaluation was revised and computerized. To enhance current compliant operations and under the direction of the Director of Nursing, education emphasized the revised Self-Administration of Medication Evaluation, revised Self-Administration of Medication(s) and Treatment(s) Policy and assessment timing requirements. Nurse Manager education was completed on the Self-Administration of Medication Evaluation and Self-Administration of Medication(s) and Treatment(s) Policy on 12/6/18. MDS Nurse education was provided on Self-Administration of Medication Evaluation and Self-Administration of Medication(s) and Treatment(s) Policy on	

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 _____	11/01/2018

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 554	Continued From page 3	F 554	11/7/18 and 11/29/18. Nursing Staff education was provided on Self-Administration of Medications Policy by verbal instruction and demonstration on 12/5/18, 12/6/18 and is scheduled for 12/7/18. Audits of residents who self-administer medication will be done weekly for three (3) months and randomly thereafter. Audits will be reviewed in the Quality Assurance meetings. Person responsible; Director of Nursing or designee. Compliance date is 12/11/18	
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the call light was within reach for 1 of 2 residents (R 96) reviewed for call lights. Findings include: During an initial interview on 10/29/18, at 1:40 p.m. R96 was seated in his wheelchair outside of	F 558	F558 Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) 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	12/11/18

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	245343	A. BUILDING _____ B. WING _____	11/01/2018

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

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F 558	Continued From page 4 his bathroom entry way and stated; "I am wondering where my table is so I can find my call light." R96 further stated that he was unable to see and "the staff just left me here." R96's call light was observed to be placed on a reclining chair approximately four feet away from R96's reach. Licensed practical nurse (LPN)-B was notified and verified R96's call light was out of his reach. During an observation on 10/29/18, at 5:44 p.m. R96 was heard calling out of his room and yelled "where am I, where am I?" R96 was observed in his wheelchair near entrance of room facing the hallway with the call light out of reach. LPN-C was alerted R96 had asked for help. LPN-C verified R96's call light was out of reach and further stated R96 was legally blind so he would not be able to independently move himself towards the call light or see where it was located. R96's face sheet printed 10/31/18, indicated R96 had diagnoses including generalized muscle weakness. R96's annual Care Area Assessment (CAA) dated 1/11/18, indicated R96 had impaired cognition and "very poor eyesight." R96's CAA further indicated that he required assistance with activities of daily living. R96's care plan, revised on 10/2/18, identified R96 was "blind but does have some vision." The care plan further indicated R96 was at risk for falls, required assistance with toileting and mobility and to "keep call light within reach when resident in room." During an interview on 10/31/18, at 2:56 p.m. registered nurse (RN)-C, also senior clinical manager, stated it was her expectation for all	F 558	Assistance programs. The submission of the Credible Allegation of Compliance within this time frame should in no way be considered or construed as agreement with the allegations of non-compliance or admissions by the facility. It is the policy of Minnesota Masonic Home Care Center to provide services with reasonable accommodation of a resident□s needs and preferences. Upon notification R96 was out of reach from his call light, LPN-B immediately went to R96□s room to assist and ensure call light was accessible. Nursing and Nursing Assistant unit class on Access to Call Lights was started on 11/1/18. Call light placement checks were added to the Nursing Assistant schedule for R96 on 10/31/18. Random audits were conducted for 1 month for R96 to ensure call light accessibility. Random facility-wide audits were conducted to ensure call lights were accessible to residents. Facility-wide installation of alternative call light clips was completed on 12/6/18. To enhance current compliant operations and under the direction of the Director of Nursing, education was provided that	

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F 558	Continued From page 5 resident's to have their call light within reach when they are in their room. A facility call light policy was requested on 10/31/18, but not provided.	F 558	emphasized call light accessibility. Nurse Manager education was provided by unit class. Nursing and Nursing Assistant education was provided by written instruction or demonstration. Staff education was provided by verbal instruction and demonstration on 12/5/18, 12/6/18 and is scheduled for 12/7/18. Random facility wide audits will be done weekly for (3) month and randomly thereafter. Audits will be reviewed in the Quality Assurance meetings. Person responsible; Director of Nursing or designee Compliance date is 12/11/18	
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the	F 585		12/11/18

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F 585	Continued From page 6	F 585		

facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.

§483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.

§483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:
(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for

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F 585	Continued From page 7	F 585		

example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;
(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;
(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and
(vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision.

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F 585	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to respond and resolve reports of missing personal clothing for 1 of 2 resident (R30) who reported missing property in the facility. Findings include: During resident council meeting on 10/30/18, at 3:28 p.m. R30 stated she was missing several items of personal clothing including two new shirts and underwear. R30 stated it "drives me nuts" because nobody had taken any responsibility about the missing items. R30 stated staff just told her they didn't know what happened to her belongings. On 10/30/18, at 4:16 p.m. the facility's grievance log was reviewed. There were no grievances documented regarding R30's missing clothing. On 11/1/18, at 9:27 a.m. R30 stated during the summer a shirt of hers went missing from the laundry. R30 described it as a "sailor shirt" with gold buttons on the shoulders and had blue and white strips. R30 stated it was labeled with her name. R30 stated she went to the laundry room to look for it with the laundry aide (LA) but did not find it. R30 stated nobody followed up with her about her missing shirt. R30 also stated two weeks ago the facility lost a brand new sweater of hers. R30 stated she put it in a bag and gave it to staff at the nurse station to be sent down to laundry to be labeled. R30 stated she asked staff at the nurse station about what happened to it and they told her they did not know. R30 stated nobody helped her try to find it.	F 585	F585 Grievances CFR(s): 483.10(j)(1)-(4) We are submitting this Credible Allegation of Compliance solely because state and federal law mandate submission of a Credible Allegation of Compliance within ten (10) days of receipt of the Statement of Deficiencies as a condition to participate in the Medicare & Medical Assistance programs. The submission of the Credible Allegation of Compliance within this time frame should in no way be considered or construed as agreement with the allegations of non-compliance or admissions by the facility. It is the policy of Minnesota Masonic Home Care Center to provide quality care and be responsive to the needs of those we serve. All residents have the right to voice grievances without fear of discrimination or reprisal, to facility staff, grievance officer or other entity that hears grievances. Such grievances include those with respect to care, staff, missing items, residents or other concerns regarding their stay. We encourage feedback for continued growth, to be proactive in answering questions and to address concerns as they arise. Residents and resident representatives have the right to file their grievance orally in person or by phone, in writing and anonymously. Information about resident rights and grievances is provided to residents by written materials upon admission. The	

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F 585	Continued From page 9 R30 was admitted to the facility on 6/13/18. R30's Significant Change Minimum Data Set dated 8/7/18, indicated that R30 was cognitively intact. On 11/1/18, at 10:43 a.m. the director of social services (DSS) stated staff expectation for missing items was to let the unit social worker or nursing supervisor know when they became aware of missing resident belongings. DSS stated that either the social worker or nursing supervisor would fill out a grievance form regarding the missing items. DSS stated the she was the point of contact with staff in the laundry if they became aware of any missing items. DSS explained the facility had a better chance of locating missing items when they found out about them right away when they were discovered missing. DSS was not aware of any grievances or reports of missing laundry for R30. DSS stated she did not see any grievance for R30 on the facility's grievance log. On 11/1/18, at 12:06 p.m. LA stated that she usually looked for missing clothes per request of nursing staff or social workers. LA also stated that the formal grievance would be completed by social workers. The facility's Grievance Procedure dated January 2017, indicated staff would notify social worker, nurse case manager, nursing supervisor as soon as possible regarding any grievance brought to their attention.	F 585	grievance process was reviewed during resident council meetings on 9/7/18 and 11/2/18. Resident and resident representatives are encouraged to provide input, ask questions and bring up issues or concerns. According to the progress notes and the care conference summaries signed by R30, no issues were voiced during the 8/20/18 and 11/7/18 care conferences. R30 voiced complaint of missing items during survey observed resident council meeting on 10/31/18. R30 was unavailable for further discussion on that day. The Grievance Officer interviewed R30 on 11/1/18 as per the facility Grievance process. A grievance form was initiated according to facility Grievance Policy. Standard on-site searches, for the stated missing items, began immediately and continued throughout grievance process. Communications with facility laundry vendor occurred on 11/13/18 and 11/26/18 without recovery of any items. R30 and facility agreed that R30 would be reimbursed for any stated items that could not be located. R30 was reimbursed at the level requested by R30 on 12/4/18. The Grievance was resolved according to R30□s satisfaction and closed on 12/4/18.	

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F 585	Continued From page 10	F 585	R30 discharged to the community on 12/6/18. A random sample of residents were interviewed to determine if missing items were reported to staff without initiation of a grievance report. The Grievance process will be reviewed on 12/7/18 at the Resident Council meeting. To enhance current compliant operations and under the direction of the Grievance Officer, education was provided to staff on the Grievance Policy. Laundry staff education was completed by written and verbal instruction. Social Services education was completed on 11/21/18 by written and verbal instruction. Staff education was provided by verbal instruction on 12/5/18, 12/6/18 and will be on 12/7/18. Random audits will be done weekly for three (3) months and randomly thereafter. Audits will be reviewed in the Quality Assurance meetings. Person responsible; Grievance Officer or designee Compliance date is 12/11/18	
F 684 SS=D	Quality of Care CFR(s): 483.25	F 684		12/11/18

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F 684	Continued From page 11 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to complete on-going assessment of a resident's bowel elimination status for a resident with a diagnosis of constipation for 1 of 1 resident (R43) reviewed for bowel elimination. Findings include: R43's care plan revised on 8/23/18, revealed R43 had an identified focus of constipation and the goal for R43 was to have had "a medium to large soft, formed bowel movement at least every 2-3 days." The care plan interventions included: administer bowel medication as ordered; update the NP/MD [nurse practitioner/ medical doctor] if not effective in treatment constipation; observe bowel elimination status. Record every shift, notify nurse of any changes noted in bowel pattern and observe for/ document/ report PRN [as needed] signs/symptoms of constipation. During an interview on 10/30/18, at 9:27 a.m. R43 stated "I haven't had a bowel movement in a week; would you be hungry if you hadn't had a bowel movement in six days."	F 684	F684 Quality of Care CFR(s): 483.25 We are submitting this Credible Allegation of Compliance solely because state and federal law mandate submission of a Credible Allegation of Compliance within ten (10) days of receipt of the Statement of Deficiencies as a condition to participate in the Medicare & Medical Assistance programs. The submission of the Credible Allegation of Compliance within this time frame should in no way be considered or construed as agreement with the allegations of non-compliance or admissions by the facility. It is the policy of Minnesota Masonic Home Care Center to provide quality of care in accordance with professional standards and based on a resident□s unique needs and preferences that support them to attain and maintain their highest practicable level. On 11/1/18, a unit class was started on the Bowel Management Protocol. Bowel audits were conducted for unit	

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F 684	Continued From page 12 During an interview on 10/30/18, at 1:55 p.m. NA-G stated resident's bowel elimination status were documented on the computer into the electronic medical record by the NA every shift and the information would then go directly to the nurse. During an interview on 10/31/18, at 1:55 p.m. registered nurse (RN)-D verified during review of R43's medical record that R43 had a bowel movement on 10/30/18. RN-D further revealed R43's last bowel movement prior to 10/30/18, was on 10/24/18. RN-D identified the night shift reviewed all resident's bowel elimination status daily and if a resident hadn't had a bowel movement in three days that resident would be added to the "no bowel movement list." RN-D indicated the resident would stay on the list until they had a bowel movement. RN-D stated the no bowel movement list was an informal tracking paper that would be passed on shift to shift and was not a part of the medical record. RN-D explained R43 was on scheduled Senna S (laxative) and Miralax (laxative) every day, fleet mineral oil enema (laxative) as needed and Milk of Magnesia (laxative) as needed. RN-D further stated R43 "doesn't eat much sometimes so he may not have a bowel movement." RN-D confirmed during review of R43's medication administration record (MAR) that R43 had not received any of his as needed medications for constipation from 10/24/18 through 10/30/18. RN-D further stated an as needed medication should have been administered on day three of no bowel movement. R43's order summary report printed on 11/1/18, identified R43 had active orders which included: Miralax 17 grams (gm) every other day, Senna S	F 684	where R43 resides beginning 11/2/18. Facility bowel audits were conducted to identify residents needing potential Bowel Management. The Bowel Management Program was revised. The Bowel Management Protocol was revised. To enhance current compliant operations and under the direction of Director of Nursing, Nursing education emphasized the Bowel Management Program and Protocol, BM documentation and tracking. Nurse Manager education was completed on 11/6/18. Nursing education was provided on 12/5/18, 12/6/18 and is scheduled for 12/7/18. Facility audits will be done weekly for three (3) months and randomly thereafter. Audits will be reviewed in the Quality Assurance meetings. Person responsible; Director of Nursing or designee Compliance date is 12/11/18	

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one tablet twice daily, fleet mineral oil enema (laxative) as needed for constipation and Milk of Magnesia (laxative) as needed daily for constipation. R43's MAR printed on 11/1/18, identified R43 had received Miralax and Senna S as ordered. R43' MAR lacked evidence of fleet enema and/ or Milk of Magnesia administration during 10/24/18 to 10/30/18.

R43's bowel elimination history printed on 11/1/18, indicated R43 had a medium bowel movement on 10/24/18, small bowel movement on 10/30/18, and one small and one large bowel movement on 10/31/18.

R43's quarterly Minimum Data Set (MDS) dated 8/16/18, identified R43 had cognitive impairment and had diagnoses which included: dementia and constipation. The MDS identified R43 required staff assistance with activities of daily living (ADL) including transfers and toileting. The MDS further identified R43 was continent of bowel and was not on a toileting program. The MDS lacked evidence of bowel patterns and if constipation was present.

R43's significant change Care Area Assessment (CAA) dated 3/5/18, identified R43 had diagnoses of Alzheimer's disease or other dementia and confusion, disorientation, forgetfulness. The CAA identified R43 was at risk for unmet needs related to dependence on staff.

R43's quarterly bowel and bladder review dated 8/2/18, indicated bowel management program was effective and there was no change to plan at that time.

During an interview on 10/31/18, at 3:15 p.m.

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F 684	Continued From page 14 LPN-B (also nurse manager) stated it was her expectation for a resident to have an assessment with interventions per individual orders if they have not had a bowel movement in three days. The facility "Bowel Management Protocol" not dated indicated "1. Nurses are to check the BM [bowel movement] record to make sure residents/ patients are having BM's according to their care plan."	F 684		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure staff offered the daily walking program as recommended by physical therapy to maintain mobility for 1 of 2 residents (R494) reviewed for ambulation	F 688	F688 Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) We are submitting this Credible Allegation of Compliance solely because state and federal law mandate submission of a	12/11/18

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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 688	Continued From page 15 program. Findings include: R494's face sheet printed on 10/31/18, indicated R494 admitted to the facility on 9/12/18, with diagnoses included: heart failure, difficulty in walking and muscle weakness. R494's Minimum Data Set (MDS) dated 9/12/18, indicated R494 demonstrated no behaviors such as refusals of cares and required assistance with mobility. R494's care plan dated 8/26/18, indicated R494 had limited physical mobility and would ambulate to all meals with wheelchair follow the length of one length of hallway. R494's Therapy Recommendations, ADL[activities of daily living] /Mobility form dated 10/18/18, identified R494 had limited physical mobility and intervention included: "ambulate using gait belt and assist of one staff, patient will walk to all meals with w/c follow, 1 length of hallway." During an interview on 10/30/18, at 8:28 a.m. R494 stated "you know they should be walking me; I've only walked once since I moved up here but they should do it every day and they don't." During an observation on 10/30/18, at 10:00 a.m. R494 was observed being pushed by a facility staff to the dining room while seated in her wheelchair. During an interview on 10/30/18, at 2:05 p.m. nursing assistant (NA)-D verified that R494 had been wheeled to the dining room in her wheelchair for brunch earlier that day. NA-D indicated R494 was to be pushed in wheelchair to	F 688	Credible Allegation of Compliance within ten (10) days of receipt of the Statement of Deficiencies as a condition to participate in the Medicare & Medical Assistance programs. The submission of the Credible Allegation of Compliance within this time frame should in no way be considered or construed as agreement with the allegations of non-compliance or admissions by the facility. It is the policy of Minnesota Masonic Home Care Center to provide care that helps residents attain or maintain their highest level of physical, mental and psychosocial well-being. Upon notification on 10/31/18 that a therapy recommended ambulation program was not completed, a Physical Therapist Assistant immediately re-assessed R494. The Physical Therapist Assistant confirmed R494 had no loss of prior ambulation functioning. R494□s Functional Maintenance Program was adjusted on 10/31/18. R494□s Functional Maintenance Programs were correctly added to the Nursing Assistant tasks schedule and to the Functional Maintenance Program form. The care plan was revised. An audit was conducted for other residents with Functional Maintenance Programs.	

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F 688	Continued From page 16 meals and was unaware of a mealtime walking program. During an interview on 10/31/18, at 2:29 p.m. registered nurse (RN)-C, (also senior clinical care manager) verified R494 had a therapy recommendation from 9/29/18, to ambulate to meals. RN-C stated, "it was never attached to any documentation or charting so nursing wasn't able to document, because it really didn't go anywhere other than the care plan." During an interview on 10/31/18, at 3:24 p.m. licensed practical nurse (LPN)-B, (also nurse manager) stated therapy would enter an ADL/functional maintenance program for a resident into the electronic medical record (EMR) and this would create a notification to alert the nurse manager that there was a new program that needed to be communicated to the nursing staff. LPN-B revealed R494's walking program was entered into the EMR but not under the correct form so it did not create the usual nurse manager notification of a new walking program. LPN-B verified the nursing staff was not aware of R494's walking to meals program. During an interview on 11/1/18, at 8:46 a.m. RN-C indicated that R494 was still able to ambulate the length of the hallway and that the walking program was now in place correctly. RN-C further stated it was her expectation for all walking programs to be implemented immediately. The facility's PCC Therapy Recommendations ADL/ Mobility (old TCU ADL/ Mobility Form) MMHCC February 2017 Functional Maintenance program initiated March 2017 policy indicated "for	F 688	The Functional Maintenance Program Form was revised to include direct scheduling of the program task for Nursing Assistants. The Functional Maintenance Program Guidance was revised. To enhance current compliant operations and under the direction of the Director of Therapy, Therapy and Nursing education will focus on the revised Functional Maintenance Program Form and Nursing Assistant task scheduling. R494□s therapy staff education was completed on 11/6/18. Nurse Manager education was provided on 11/6/18. MDS Coordinator education was provided on 11/29/18. Rehab Team Coordinator education on Revised FMP form and PCC tracking of Functional Maintenance Program was provided on 11/28/18. Therapy education was provided on the revised Functional Maintenance Program Form and process on 12/3/18. Nursing and Therapy education was provided on 12/5/18, 12/6/18 and is scheduled for 12/7/18. Random audits will be done weekly for three (3) months and randomly thereafter.	

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F 688	Continued From page 17 all ambulation programs (TCU and LTC) that are specifically targeted for the NAR's [nursing assistant] to complete, need to complete both forms (ADL/ mobility and functional maintenance program); the intervention activated on the FMP [Functional Maintenance Program] form will trigger the Nurse/ Case Managers to create a task- that leads to NAR tracking when the program is completed."	F 688	Audits will be reviewed in the Quality Assurance meetings. Person responsible; Director of Therapy or designee Compliance date is 12/11/18	
F 730 SS=E	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to complete annual performance evaluations (PE) for 3 of 5 nursing assistants (NA-A, NA-B, NA-C) who had worked at the facility for over a year. Findings include: Review of NA personnel files on 11/1/18, revealed the following: NA-A's date of hire (DOH) with the facility was 6/6/16, and last PE completed by the facility was on 12/1/16. NA-B's DOH with the facility was 2/9/16, and last PE completed by the facility was 2/20/18. PE	F 730	F730 Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) We are submitting this Credible Allegation of Compliance solely because state and federal law mandate submission of a Credible Allegation of Compliance within ten (10) days of receipt of the Statement of Deficiencies as a condition to participate in the Medicare & Medical Assistance programs. The submission of the Credible Allegation of Compliance within this time frame should in no way be considered or construed as agreement with the allegations of non-compliance or admissions by the facility. It is the policy of Minnesota Masonic	12/11/18

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F 730	Continued From page 18 dated 2/20/18, signed by nurse manager (NM)-B and director of nursing (DON) was not signed by NA-B. NA-C's DOH with the facility was 5/23/16, and last PE completed, signed by NA-C and DON, was undated. On 11/1/18, at 1:56 p.m. Human Resources (HR) director stated she sent out the PE notices to nurse managers 90 days after an employee was hired and annually from their anniversary hire date. HR verified NA-A's last PE completed was 12/1/16, and stated another PE should have been completed in 2017. HR verified NA-B's PE was not signed by NA-B and stated should have included NA-B's signature when reviewed. HR verified NA-C's PE was not dated and stated should have included the date the PE was reviewed with NA-C. HR stated after PEs were reviewed with the employees, the PEs were sent back to HR for HR to track and file. HR then made a telephone call and after the call stated there were no additional PEs for NA-A, NA-B, NA-C or any additional information to be provided. On 11/1/18, at 1:04 p.m. DON stated PEs were completed by nurse managers and reviewed with the employees yearly. A policy for PEs was requested from the facility, was not made available.	F 730	Home Care Center to complete annual performance reviews and provide regular in-service education to staff. NA-A□'s, NA-B'□s and NA-C'□s annual performance reviews were completed. An audit of staff performance reviews was conducted. Those identified without an annual review, will be brought up to date. Unavailable staff, including but not limited to those on medical leave or out of the country, will not work until review completion. The Performance Evaluation Policy was revised. Department manager education on Performance Review Policy was completed on 11/28/18. Random audits will be done monthly for three (3) months and randomly thereafter. Audits will be reviewed in the Quality Assurance meetings. Person responsible; Human Resources Director or designee Compliance date is 12/11/18	
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from	F 757		12/11/18

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F 757	Continued From page 19 unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to identify, assess and monitor bruising for 1 of 1 resident (R56) reviewed on an anticoagulant (blood thinner). Findings include: On 10/29/18, at 4:56 p.m. R56 was observed sitting in his room with a large purplish dark bruise approximately 6-7 cm (centimeters) on upper right arm, three small circular bruise on left upper arm, and a dark purple bruise covering most of the top of R56's left hand. R56 stated the bruise on his left hand and right arm were from IVs (Intravenous Therapy) when in the hospital and the bruises on his left arm were because he bruised easily.	F 757	F757 Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) 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.	

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F 757	Continued From page 20 R56's Admission MDS dated 8/28/18, indicated R56's cognition was intact and on an anticoagulant for 7 of the 7 days assessed. R56's Admission Record (AR) printed 11/1/18, indicated R56 was admitted to the facility 8/21/18, and readmitted on 9/17/18. R56's AR included diagnoses (D/X) of Long Term (Current) use of Anticoagulants, Atrial Fibrillation (AF), unspecified, Congestive Heart Failure (CHF) and Anemia. R56's CAA (Care Area Assessment) Worksheet dated 8/31/18, indicated R56 had been recently hospitalized, D/X included CHF, AF, cardiovascular disease, anemia, had skin impairments with possible medication side effects, took an anticoagulant, and was at risk for bleeding/bruising. R56's careplan revised 9/3/18, indicated R56 was to remain free of complications related to thrombus (blood clot) formation. R56's careplan revised 10/17/18, indicated R56 had medical problems including AF, CHF, anemia, would be controlled through observations, prescribed medications and would be monitored for adverse consequences of the medications. R56's careplan dated 8/21/18, indicated R56 had impairment to skin integrity, had fragile skin and skin was to be checked weekly with bath regarding observations of impairment and notable changes. However R56's current careplan printed out 11/1/18, did not indicate R56 was on an anticoagulant and to be monitored for skin bruising and bleeding. R56's Kardex (careplan for NAs) printed out 11/1/18, did not indicate R56 was on an	F 757	It is the policy of Minnesota Masonic Home Care Center to provide care consistent with standards of practice. This includes monitoring medication side effects as condition and orders dictate. Immediately upon notification of undocumented bruise on 10/31/18 on R56, a Head to Toe skin evaluation was completed to document impairments and ascertain cause. R56 confirmed bruising was from a blood draw and IV□s from his hospitalization as was documented on the 8/21/18 and 9/17/18 admission Head to Toe forms. An audit of R56's record confirmed weekly Head To Toe Forms from 10/31/18-12/4/18 note impairments including bruises. On 11/4/18, a care plan intervention ANTI-COAGULANT THERAPY: Observe for bruising/bleeding (i.e., bleeding gums, petechia, nose bleeds, hematuria, tarry stools, coffee ground emesis), was added and visible on the Nursing Assistant Kardex. Side effects monitoring was added to the Treatment Administration Record on 11/7/18. An audit of residents taking anticoagulants was conducted. Side effects monitoring, care plan interventions and Kardex precautions are in place for those residents. The Head to Toe policy was revised and title changed to Skin Evaluation.	

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F 757	Continued From page 21 anticoagulant and needed monitoring for bruising and bleeding. R56's physician order dated 10/15/18, indicated R56 was on Xarelto (anticoagulant) 20 mg (milligrams) to be administered daily for atrial fibrillation. R56's physician order dated 11/1/18, indicated R56 was to be monitored for bleeding and bruising every day and evening shift for prophylaxis. At 9:13 a.m. on 11/1/18, registered (RN)-F verified no order for bleeding and bruising was in R56's record. Consultant Pharmacist reviewed R56's medical chart on 10/30/18, and indicated in progress note "No Recommendations". On 10/30/18, at 1:54 p.m. nursing assistant (NA)-I stated R56 had been hospitalized a couple of times after coming to the facility and stated any bruises she would need to report to the nurse. On 10/31/18, at 1:31 p.m. NA-I stated she checked R56's skin when she got him dressed in the morning, when she toileted him, and in the shower on bath day, and if any new bruises she would notify the nurse. NA-I stated the nurses completed weekly skin checks on bath days. On 10/31/18, at 1:39 p.m. NA-J stated she took care of R56 yesterday, took him to the bathroom and helped him change his "dirty" shirt. NA-J stated she would notify the nurse of any resident' bruising if she had not previously worked with that particular resident, stating the bruises then would be "new" to her. NA-J stated "yesterday was the first time working" with R56. RN-J stated she would let the nurse know of any bruises "right away". NA-J stated she had not noticed R56's	F 757	The Care Plan intervention ANTI-COAGULANT THERAPY: Observe for bruising/bleeding (i.e., bleeding gums, petechia, nose bleeds, hematuria, tarry stools, coffee ground emesis), is visible on the Nursing Assistant Kardex.) An order template was created for daily anticoagulant side effects monitoring. To enhance current compliant operations and under the direction of the Director of Nursing, nursing education will focus on anticoagulant side effects monitoring. R56□s nurse education on the Head to Toe form and follow up was conducted on 11/2/18. Staff education was provided on 12/5/18, 12/6/18 and is scheduled for 12/7/18. Nursing education on anticoagulant side effects monitoring was provided by demonstration and verbal instruction on 12/5/18, 12/6/18 and is scheduled on 12/7/18. Random audits (which includes verification of) will be done weekly for three (3) months and randomly thereafter. Audits will be reviewed in the Quality Assurance meetings. Person responsible; Director of Nursing or designee Compliance date is 12/11/18	

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F 757	Continued From page 22	F 757		

bruises yesterday, did not know why she had not noticed and stated, "we [NAs] are always moving". NA-J stated she had not assisted R56 with a shower yesterday but had just helped R56 change his shirt.

At 2:08 p.m. NA-C stated she had worked with R56 today and had not looked at his skin and was not aware of R56's bruises on his arms and hand. NA-C stated she would notice a bruise when dressing the resident and had not dressed R56 today as he had already been dressed when she started working. NA-C stated she would notify the nurse of any resident bruises and the nurse would come in and look at the bruises, write down the size and location of the bruise, and if new bruise or internal bleeding would circle it and come back in 30 minutes. NA-C stated it is hard to know if bruises are new or old and would ask the resident about it and would double check with the nurse. NA-C stated the nurses completed weekly skin checks after the resident bath. NA-C re-stated she had not looked at R56's hands or arms and did not know if were bruised.

On 10/31/18, at 2:22 p.m. NA-C verified R56's bruise on left antecubital, three small bruises on left upper arm, bruise on top of left hand, and bruise on upper right arm. NA-C asked R56 if the three smaller bruises on left upper arm hurt and R56 stated no. R56 stated the bruise on his left hand and upper right arm were from IVs while in the hospital. R56 stated the left antecubital bruise was from the blood drawn this morning.

On 11/1/18, at 9:02 a.m. registered nurse (RN)-E stated nurses were to identify and assess resident bruises, and measure and monitor any bruises for size, and color and discoloration.

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F 757	Continued From page 23 On 11/1/18, at 9:13 a.m. RN-F verified R56's comprehensive risk data collection dated 10/15/18, identified incisions and edema with no bruising noted for R56. RN-F stated there should be a nursing order to monitor R56 for bruising since he was taking a blood thinner and then initialed off the Treatment Administration Record to show it was completed. RN-F verified there was no nursing order for R56's skin to be monitored for bruising and/or bleeding. RN-F stated the nurses should document any new bruises or changes, identify, assess for color, changes in pain and document in a progress note. RN-F verified R56's comprehensive risk data collection dated 8/21/18, indicated "bruises on [BUE]". RN-F stated, "I am thinking BUE stands for bilateral upper extremities." RN-F stated the bruises should have been documented on the assessment for where the bruises are located, color, if healing or hematoma, and size and should be put on the TAR to monitor. RN-F stated if all this identification and assessment of the bruises were on the assessment there would not have to be an additional progress note. RN-F verified R56's progress notes did not include any bruise identified since admission for R56. RN-F verified R56's record had no skin evaluation completed identifying and assessing R56's bruises. Nursing progress notes dated 9/17/18, and 10/15/18, indicated R56 was readmitted to the facility from the hospital and had IVs administered in his upper right arm while in the hospital. No bruising for R56 was noted in the progress notes. R56's Head to Toe skin evaluation dated 10/30/18, did not identify any bruising for R56.	F 757		

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F 757	Continued From page 24 On 11/1/18, at 10:35 a.m. the medical director (MD) stated R56 was on an anticoagulant (Xarelto) and should be monitored for signs and symptoms of bleeding and bruising, and weekly skin checks completed. MD stated Xarelto was a medication that was not able to have blood tests done to ensure proper dosing and depended on staff monitoring for signs and symptoms of bleeding and bruising because of the potential for bleeding and need for dosage change. On 11/1/18, at 12:37 p.m. director of nursing (DON) stated weekly head to toe evaluations by the nurses should be completed and should include resident bruising, where the bruise was located, such as upper right arm, and top of left hand and a nursing order to monitor bruises weekly on bath day until resolved. DON stated the nurse should look at the bruise, see if the bruise is fading and document any new bruises with location and monitor them weekly until resolved. DON stated the facility must have "missed it [monitoring for R56] by switching software" and therefore was not put in the Treatment Administration Record to monitor. DON stated the NAs should report any skin impairment to the nurse. Facility policy Skin Evaluation - Head to Toe dated 10/04, indicated the Skin Evaluation was to be completed weekly for all residents on a weekly basis with the bath, and residents observed for any reddened areas or skin breakdown and documented. Policy requested from facility for monitoring of bruising was not made available.	F 757		

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F 880	Continued From page 25	F 880		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections;	F 880		12/11/18

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 _____	11/01/2018

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 880	Continued From page 26 (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which 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; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure consistent and comprehensive monthly surveillance data was gathered to identify trends and patterns, as a way to reduce the spread of illness and infection. This had the potential to affect all 197 residents residing in the facility, staff and visitors. Findings include:	F 880	F880 Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) 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	

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F 880	Continued From page 27 The August 2018, Infection Control (IC) log identified 26 residents in the facility with 10 skin, 4 urine, 1 lung, 1 stool, 1 blood, and 14 unidentified infections. The "Culture" heading with columns for "Date, Organism, Antibiotic Resistant ?" were blank. The column under Antibiotic Infection Criteria Met was blank with no signs and symptoms identified on the log. The column under Infection for "Indication for use/diagnosis" was blank. The September 2018, IC log identified 28 residents in the facility with 5 sepsis, 5 UTIs (urinary tract infections), 4 cellulitis, 2 wound, 2 clostridium (c) difficile, 2 sinusitis, 1 pneumonia, 1 skin, and 3 other unidentified infections. The "Culture" heading with columns for "Date, Organism, Antibiotic Resistant ?" were blank. The column under Antibiotic Infection Criteria Met was blank with no signs and symptoms identified on the log. The October 2018, IC log identified 45 residents in the facility with 2 skin, 1 bacteremia, 11 UTIs, 3 wound, 2 MRSA, 3 ulcer, 5 c. difficile, 1 colitis, 1 liver abscess, 2 osteomyelitis, 2 septic, 1 sepsis, 1 bone/joint, 1 acute respiratory failure, 1 pneumonia, 1 acute cystitis, 2 cellulitis, 1 diverticulosis, 1 endocarditis, 1 strep bacteremia, and 3 unidentified infections. The Culture heading with columns for "Date, Organism, and Antibiotic Resistant ?" were blank. Antibiotic Infection Criteria Met and signs and symptoms were not identified on the log. On 11/1/18, at 10:25 a.m. the Infection Preventionist (IP) stated she monitored signs and symptoms of residents' infections daily Monday	F 880	Assistance programs. The submission of the Credible Allegation of Compliance within this time frame should in no way be considered or construed as agreement with the allegations of non-compliance or admissions by the facility. It is the policy of Minnesota Masonic Home Care Center to have a system for preventing, identifying, reporting, investigating and controlling infections and communicable diseases. The Infection Preventionist documented previously reviewed hospital cultures on current tracking form. Infection Preventionist performed a review of records of currently tracked residents on antibiotic therapy. Of five culture results□, no trends were observed. The Infection Prevention Surveillance Policy was expanded to specify Surveillance Elements, Process, Outcome and Systems. Lab templates were created to assist with trend tracking. Applications were filed for Electronic Health Record access from referring hospital systems to expedite location of cultures. The Infection Preventionist will adhere to the Surveillance Policy. Random audits will be done weekly for	

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F 880	Continued From page 28 through Friday at the IDT (Interdisciplinary team meetings). IP stated every morning she would pull the report from PCC (Point Click Care) and look at residents newly started on antibiotics and review the antibiotic order for dosage accuracy and start and end dates for the antibiotic. IP stated pharmacy sent a monthly lab report of all cultures completed in the facility for the previous month. IP stated she reviewed the culture results, but did not log the culture results, but rather looked at the individual resident culture results for trends with same bacteria and then re-educated staff on peri care hand hygiene if any with same bacteria. IP stated because the bacteria in the infection could have been transmitted from staff to resident to resident. IP stated the TCU (Transition Care Unit) residents go to the clinic and cultures are performed at the clinic. IP stated she did not get a copy of the culture results completed outside of the facility at clinics or hospitals. IP stated she would have to call the clinic or the hospital to get the culture results as the results did not typically come back from the clinic with the resident or with the resident upon admission from the hospital or re-admission. IP verified on the August, September and the October 2018, IC log the columns for Culture, date, organism, and antibiotic resistant were blank. IP confirmed she looked at the individual cultures completed in the facility when the culture results came back from lab but did not track and trend them on the log. IP stated she and the nurse managers kept a close eye on the infections, but verified there was no tracking log completed for culture results with organisms identified. IP stated she had no additional reports or records to show for tracking and trending of microorganisms. IP stated she had been focused on antibiotic tracking and not on culture tracking	F 880	three (3) months and randomly thereafter. Audits will be reviewed in the Quality Assurance meetings. Person responsible; Infection Preventionist or designee Compliance date is 12/11/18	

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F 880	Continued From page 29 with the organism identified to be able to identify trending patterns. IP stated she had not been trained to track and trend all microorganisms but stated she could and would need more assistance to implement this as it was a large facility. The facility's Infection Prevention and Control Plan dated February 2017, indicated, "... The program is designed to help prevent the development and transmission of communicable diseases and infection..." The facility's Antibiotic Stewardship Program dated November 2017, indicated, " ...will include an evaluation process, use of evidence-based criteria, efforts to identify the microbe responsible for disease ..."	F 880		

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	245343	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/20/2018**

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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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on November 20, 2018. At the time of this survey, Minnesota Masonic Home Care Center was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, the Health Care Facilities Code. Minnesota Masonic Home Care Center is a 3-story building with a basement that was constructed in 1965 and was determined to be of Type I (332) construction. In 1995 an addition was constructed to the south wing and was determined to be of Type I (332) construction. The facility is fully protected throughout by an automatic fire sprinkler system and has a fire alarm system with smoke detection in the corridors and areas open to corridors that is monitored for automatic fire department notification. Because the original building and the addition are both of the same construction type, the facility was surveyed as 1-building. The facility has a capacity of 214 beds and had a census of 190 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

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

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 29, 2018

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

RE: Project Number F5343029

NOTE: The health and life safety code survey findings will be processed under separate enforcement cycles.

Dear Administrator:

On November 20, 2018, a standard survey was completed at your facility by the Minnesota Department of 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.

We are pleased to inform you that this survey resulted in no deficiencies being issued.

The Federal Form CMS-2567 is being electronically delivered.

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

Feel free to contact me if you have questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00232	A. BUILDING: _____ B. WING _____	11/01/2018

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

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2 000	Continued From page 1 The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 10/29/18 through 11/1/18, surveyors of this Department's staff visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. 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 out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS	2 000		

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2 000	Continued From page 2 APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 335	MN Rule 4658.0130 Employees' Personnel Records A current personnel record must be maintained for each employee and be stored in a confidential manner. The personnel records for at least the most recent three-year period must be maintained by the nursing home. The records must be available to representatives of the department and must contain: A. the person's name, address, telephone number, gender, Minnesota license, certification, or registration number, if applicable, and similar identifying data; B. a list of the individual's training, experience, and previous employment; C. the date of employment, type of position currently held, hours of work, and attendance records; and D. the date of resignation or discharge. Employee health information, including the record of all accidents and those illnesses reportable under part 4605.7040, must be maintained and stored in a separate employee medical record. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to complete annual performance	2 335	Corrected	12/11/18

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2 335	Continued From page 3	2 335		

evaluations (PE) for 3 of 5 nursing assistants (NA-A, NA-B, NA-C) who had worked at the facility for over a year.

Findings include:

Review of NA personnel files on 11/1/18, revealed the following:

NA-A's date of hire (DOH) with the facility was 6/6/16, and last PE completed by the facility was on 12/1/16.

NA-B's DOH with the facility was 2/9/16, and last PE completed by the facility was 2/20/18. PE dated 2/20/18, signed by nurse manager (NM)-B and director of nursing (DON) was not signed by NA-B.

NA-C's DOH with the facility was 5/23/16, and last PE completed, signed by NA-C and DON, was undated.

On 11/1/18, at 1:56 p.m. Human Resources (HR) director stated she sent out the PE notices to nurse managers 90 days after an employee was hired and annually from their anniversary hire date. HR verified NA-A's last PE completed was 12/1/16, and stated another PE should have been completed in 2017. HR verified NA-B's PE was not signed by NA-B and stated should have included NA-B's signature when reviewed. HR verified NA-C's PE was not dated and stated should have included the date the PE was reviewed with NA-C. HR stated after PEs were reviewed with the employees, the PEs were sent back to HR for HR to track and file. HR then made a telephone call and after the call stated there were no additional PEs for NA-A, NA-B, NA-C or any additional information to be

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2 335	Continued From page 4 provided. On 11/1/18, at 1:04 p.m. DON stated PEs were completed by nurse managers and reviewed with the employees yearly. A policy for PEs was requested from the facility, was not made available. SUGGESTED METHODS OF CORRECTION: The director of nursing (DON) or designee could review and /or revise policies and procedures to ensure the facility evaluated staff performance. The DON or designee could develop monitoring systems to ensure ongoing compliance and report the results to the quality assurance committee for further recommendations. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 335		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed.	2 830		12/11/18

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2 830	Continued From page 5 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to complete on-going assessment of a resident's bowel elimination status for a resident with a diagnosis of constipation for 1 of 1 resident (R43) reviewed for bowel elimination. Findings include: R43's care plan revised on 8/23/18, revealed R43 had an identified focus of constipation and the goal for R43 was to have had "a medium to large soft, formed bowel movement at least every 2-3 days." The care plan interventions included: administer bowel medication as ordered; update the NP/MD [nurse practitioner/ medical doctor] if not effective in treatment constipation; observe bowel elimination status. Record every shift, notify nurse of any changes noted in bowel pattern and observe for/ document/ report PRN [as needed] signs/symptoms of constipation. During an interview on 10/30/18, at 9:27 a.m. R43 stated "I haven't had a bowel movement in a week; would you be hungry if you hadn't had a bowel movement in six days." During an interview on 10/30/18, at 1:55 p.m. NA-G stated resident's bowel elimination status were documented on the computer into the electronic medical record by the NA every shift and the information would then go directly to the nurse. During an interview on 10/31/18, at 1:55 p.m. registered nurse (RN)-D verified during review of R43's medical record that R43 had a bowel movement on 10/30/18. RN-D further revealed	2 830	Corrected	

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2 830	Continued From page 6 R43's last bowel movement prior to 10/30/18, was on 10/24/18. RN-D identified the night shift reviewed all resident's bowel elimination status daily and if a resident hadn't had a bowel movement in three days that resident would be added to the "no bowel movement list." RN-D indicated the resident would stay on the list until they had a bowel movement. RN-D stated the no bowel movement list was an informal tracking paper that would be passed on shift to shift and was not a part of the medical record. RN-D explained R43 was on scheduled Senna S (laxative) and Miralax (laxative) every day, fleet mineral oil enema (laxative) as needed and Milk of Magnesia (laxative) as needed. RN-D further stated R43 "doesn't eat much sometimes so he may not have a bowel movement." RN-D confirmed during review of R43's medication administration record (MAR) that R43 had not received any of his as needed medications for constipation from 10/24/18 through 10/30/18. RN-D further stated an as needed medication should have been administered on day three of no bowel movement. R43's order summary report printed on 11/1/18, identified R43 had active orders which included: Miralax 17 grams (gm) every other day, Senna S one tablet twice daily, fleet mineral oil enema (laxative) as needed for constipation and Milk of Magnesia (laxative) as needed daily for constipation. R43's MAR printed on 11/1/18, identified R43 had received Miralax and Senna S as ordered. R43' MAR lacked evidence of fleet enema and/ or Milk of Magnesia administration during 10/24/18 to 10/30/18. R43's bowel elimination history printed on 11/1/18, indicated R43 had a medium bowel movement on 10/24/18, small bowel movement	2 830		

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2 830	Continued From page 7 on 10/30/18, and one small and one large bowel movement on 10/31/18. R43's quarterly Minimum Data Set (MDS) dated 8/16/18, identified R43 had cognitive impairment and had diagnoses which included: dementia and constipation. The MDS identified R43 required staff assistance with activities of daily living (ADL) including transfers and toileting. The MDS further identified R43 was continent of bowel and was not on a toileting program. The MDS lacked evidence of bowel patterns and if constipation was present. R43's significant change Care Area Assessment (CAA) dated 3/5/18, identified R43 had diagnoses of Alzheimer's disease or other dementia and confusion, disorientation, forgetfulness. The CAA identified R43 was at risk for unmet needs related to dependence on staff. R43's quarterly bowel and bladder review dated 8/2/18, indicated bowel management program was effective and there was no change to plan at that time. During an interview on 10/31/18, at 3:15 p.m. LPN-B (also nurse manager) stated it was her expectation for a resident to have an assessment with interventions per individual orders if they have not had a bowel movement in three days. The facility "Bowel Management Protocol" not dated indicated "1. Nurses are to check the BM [bowel movement] record to make sure residents/ patients are having BM's according to their care plan." SUGGESTED METHODS OF CORRECTION: The director of nursing (DON) or designee could	2 830		

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2 830	Continued From page 8 develop, review, and /or revise policies and procedures to ensure the facility properly assessed residents with constipation, and interventions were developed and implemented. The DON or designee could develop monitoring systems to ensure ongoing compliance and report the results to the quality assurance committee for further recommendations. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 885	MN Rule 4658.0525 Subp. 1 Rehabilitation Nursing Care; Program required Subpart 1. Program required. A nursing home must have an active program of rehabilitation nursing care directed toward assisting each resident to achieve and maintain the highest practicable physical, mental, and psychosocial well-being according to the comprehensive resident assessment and plan of care described in parts 4658.0400 and 4658.0405. Continuous efforts must be made to encourage ambulation and purposeful activities. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure staff offered the daily walking program as recommended by physical therapy to maintain mobility for 1 of 2 residents (R494) reviewed for ambulation program. Findings include: R494's face sheet printed on 10/31/18, indicated	2 885	Corrected	12/11/18

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2 885	Continued From page 9	2 885		

R494 admitted to the facility on 9/12/18, with diagnoses included: heart failure, difficulty in walking and muscle weakness. R494's Minimum Data Set (MDS) dated 9/12/18, indicated R494 demonstrated no behaviors such as refusals of cares and required assistance with mobility. R494's care plan dated 8/26/18, indicated R494 had limited physical mobility and would ambulate to all meals with wheelchair follow the length of one length of hallway.

R494's Therapy Recommendations, ADL[activities of daily living] /Mobility form dated 10/18/18, identified R494 had limited physical mobility and intervention included: "ambulate using gait belt and assist of one staff, patient will walk to all meals with w/c follow, 1 length of hallway."

During an interview on 10/30/18, at 8:28 a.m. R494 stated "you know they should be walking me; I've only walked once since I moved up here but they should do it every day and they don't."

During an observation on 10/30/18, at 10:00 a.m. R494 was observed being pushed by a facility staff to the dining room while seated in her wheelchair.

During an interview on 10/30/18, at 2:05 p.m. nursing assistant (NA)-D verified that R494 had been wheeled to the dining room in her wheelchair for brunch earlier that day. NA-D indicated R494 was to be pushed in wheelchair to meals and was unaware of a mealtime walking program.

During an interview on 10/31/18, at 2:29 p.m. registered nurse (RN)-C, (also senior clinical care manager) verified R494 had a therapy

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recommendation from 9/29/18, to ambulate to meals. RN-C stated, "it was never attached to any documentation or charting so nursing wasn't able to document, because it really didn't go anywhere other than the care plan."

During an interview on 10/31/18, at 3:24 p.m. licensed practical nurse (LPN)-B, (also nurse manager) stated therapy would enter an ADL/functional maintenance program for a resident into the electronic medical record (EMR) and this would create a notification to alert the nurse manager that there was a new program that needed to be communicated to the nursing staff. LPN-B revealed R494's walking program was entered into the EMR but not under the correct form so it did not create the usual nurse manager notification of a new walking program. LPN-B verified the nursing staff was not aware of R494's walking to meals program.

During an interview on 11/1/18, at 8:46 a.m. RN-C indicated that R494 was still able to ambulate the length of the hallway and that the walking program was now in place correctly. RN-C further stated it was her expectation for all walking programs to be implemented immediately.

The facility's PCC Therapy Recommendations ADL/ Mobility (old TCU ADL/ Mobility Form) MMHCC February 2017 Functional Maintenance program initiated March 2017 policy indicated "for all ambulation programs (TCU and LTC) that are specifically targeted for the NAR's [nursing assistant] to complete, need to complete both forms (ADL/ mobility and functional maintenance program); the intervention activated on the FMP [Functional Maintenance Program] form will trigger the Nurse/ Case Managers to create a

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2 885	Continued From page 11 task- that leads to NAR tracking when the program is completed." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could devise a communication system with the Director of Therapy or designee to ensure communication processes regarding nursing rehabilitation programs. The director of nursing (DON) or designee could inservice nursing staff regarding implementation of the care plan to include completing walking programs as directed, and then audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 885		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure consistent and comprehensive monthly surveillance data was gathered to identify trends and patterns, as a way to reduce the spread of illness and infection. This had the potential to affect all 197 residents residing in the facility, staff and visitors. Findings include: The August 2018, Infection Control (IC) log	21375	Corrected	12/11/18

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21375	Continued From page 12	21375		

identified 26 residents in the facility with 10 skin, 4 urine, 1 lung, 1 stool, 1 blood, and 14 unidentified infections. The "Culture" heading with columns for "Date, Organism, Antibiotic Resistant ?" were blank. The column under Antibiotic Infection Criteria Met was blank with no signs and symptoms identified on the log. The column under Infection for "Indication for use/diagnosis" was blank.

The September 2018, IC log identified 28 residents in the facility with 5 sepsis, 5 UTIs (urinary tract infections), 4 cellulitis, 2 wound, 2 clostridium (c) difficile, 2 sinusitis, 1 pneumonia, 1 skin, and 3 other unidentified infections. The "Culture" heading with columns for "Date, Organism, Antibiotic Resistant ?" were blank. The column under Antibiotic Infection Criteria Met was blank with no signs and symptoms identified on the log.

The October 2018, IC log identified 45 residents in the facility with 2 skin, 1 bacteremia, 11 UTIs, 3 wound, 2 MRSA, 3 ulcer, 5 c. difficile, 1 colitis, 1 liver abscess, 2 osteomyelitis, 2 septic, 1 sepsis, 1 bone/joint, 1 acute respiratory failure, 1 pneumonia, 1 acute cystitis, 2 cellulitis, 1 diverticulosis, 1 endocarditis, 1 strep bacteremia, and 3 unidentified infections. The Culture heading with columns for "Date, Organism, and Antibiotic Resistant ?" were blank. Antibiotic Infection Criteria Met and signs and symptoms were not identified on the log.

On 11/1/18, at 10:25 a.m. the Infection Preventionist (IP) stated she monitored signs and symptoms of residents' infections daily Monday through Friday at the IDT (Interdisciplinary team meetings). IP stated every morning she would pull the report from PCC (Point Click Care) and

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21375	Continued From page 13 look at residents newly started on antibiotics and review the antibiotic order for dosage accuracy and start and end dates for the antibiotic. IP stated pharmacy sent a monthly lab report of all cultures completed in the facility for the previous month. IP stated she reviewed the culture results, but did not log the culture results, but rather looked at the individual resident culture results for trends with same bacteria and then re-educated staff on peri care hand hygiene if any with same bacteria. IP stated because the bacteria in the infection could have been transmitted from staff to resident to resident. IP stated the TCU (Transition Care Unit) residents go to the clinic and cultures are performed at the clinic. IP stated she did not get a copy of the culture results completed outside of the facility at clinics or hospitals. IP stated she would have to call the clinic or the hospital to get the culture results as the results did not typically come back from the clinic with the resident or with the resident upon admission from the hospital or re-admission. IP verified on the August, September and the October 2018, IC log the columns for Culture, date, organism, and antibiotic resistant were blank. IP confirmed she looked at the individual cultures completed in the facility when the culture results came back from lab but did not track and trend them on the log. IP stated she and the nurse managers kept a close eye on the infections, but verified there was no tracking log completed for culture results with organisms identified. IP stated she had no additional reports or records to show for tracking and trending of microorganisms. IP stated she had been focused on antibiotic tracking and not on culture tracking with the organism identified to be able to identify trending patterns. IP stated she had not been trained to track and trend all microorganisms but stated she could and would need more	21375		

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21375	Continued From page 14 assistance to implement this as it was a large facility. The facility's Infection Prevention and Control Plan dated February 2017, indicated, "... The program is designed to help prevent the development and transmission of communicable diseases and infection..." The facility's Antibiotic Stewardship Program dated November 2017, indicated, " ...will include an evaluation process, use of evidence-based criteria, efforts to identify the microbe responsible for disease ..." SUGGESTED METHODS OF CORRECTION: The director of nursing (DON) or designee could review and /or revise policies and procedures to ensure the facility track and trend resident infection. The DON or designee could develop monitoring systems to ensure ongoing compliance and report the results to the quality assurance committee for further recommendations. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21375		
21540	MN Rule 4658.1315 Subp. 2 Unnecessary Drug Usage; Monitoring Subp. 2. Monitoring. A nursing home must monitor each resident's drug regimen for unnecessary drug usage, based on the nursing home's policies and procedures, and the pharmacist must report any irregularity to the resident's attending physician. If the attending physician does not concur with the nursing home's recommendation, or does not provide	21540		12/11/18

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21540	Continued From page 15 adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the Quality Assurance and Assessment (QAA) committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist shall refer the matter directly to the QAA. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to identify, assess and monitor bruising for 1 of 1 resident (R56) reviewed on an anticoagulant (blood thinner). Findings include: On 10/29/18, at 4:56 p.m. R56 was observed sitting in his room with a large purplish dark bruise approximately 6-7 cm (centimeters) on upper right arm, three small circular bruise on left upper arm, and a dark purple bruise covering most of R56's top of left hand. R56 stated the bruise on his left hand and right arm were from IVs (Intravenous Therapy) when in the hospital and the bruises on his left arm were because he bruised easily. R56's Admission MDS dated 8/28/18, indicated R56's cognition was intact and on an anticoagulant for 7 of the 7 days assessed.	21540	Corrected	

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R56's Admission Record (AR) printed 11/1/18, indicated R56 was admitted to the facility 8/21/18, and readmitted on 9/17/18. R56's AR included diagnoses (D/X) of Long Term (Current) use of Anticoagulants, Atrial Fibrillation (AF), unspecified, Congestive Heart Failure (CHF) and Anemia.

R56's CAA (Care Area Assessment) Worksheet dated 8/31/18, indicated R56 had been recently hospitalized, D/X included CHF, AF, cardiovascular disease, anemia, had skin impairments with possible medication side effects, took an anticoagulant, and was at risk for bleeding/bruising.

R56's careplan revised 9/3/18, indicated R56 was to remain free of complications related to thrombus (blood clot) formation. R56's careplan revised 10/17/18, indicated R56 had medical problems including AF, CHF, anemia, would be controlled through observations, prescribed medications and would be monitored for adverse consequences of the medications. R56's careplan dated 8/21/18, indicated R56 had impairment to skin integrity, had fragile skin and skin was to be checked weekly with bath regarding observations of impairment and notable changes. However R56's current careplan printed out 11/1/18, did not indicate R56 was on an anticoagulant and to be monitored for skin bruising and bleeding.

R56's Kardex (careplan for NAs) printed out 11/1/18, did not indicate R56 was on an anticoagulant and needed monitoring for bruising and bleeding.

R56's physician order dated 10/15/18, indicated R56 was on Xarelto (anticoagulant) 20 mg (milligrams) to be administered daily for atrial

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fibrillation. R56's physician order dated 11/1/18, indicated R56 was to be monitored for bleeding and bruising every day and evening shift for prophylaxis. At 9:13 a.m. on 11/1/18, registered (RN)-F verified no order for bleeding and bruising was in R56's record.

Consultant Pharmacist reviewed R56's medical chart on 10/30/18, and indicated in progress note "No Recommendations".

On 10/30/18, at 1:54 p.m. nursing assistant (NA) -I stated R56 had been hospitalized a couple of times after coming to the facility and stated any bruises she would need to report to the nurse.

On 10/31/18, at 1:31 p.m. NA-I stated she checked R56's skin when she got him dressed in the morning, when she toileted him, and in the shower on bath day, and if any new bruises she would notify the nurse. NA-I stated the nurses completed weekly skin checks on bath days.

On 10/31/18, at 1:39 p.m. NA-J stated she took care of R56 yesterday, took him to the bathroom and helped him change his "dirty" shirt. NA-J stated she would notify the nurse of any resident' bruising if she had not previously worked with that particular resident, stating the bruises then would be "new" to her. NA-J stated "yesterday was the first time working" with R56. RN-J stated she would let the nurse know of any bruises "right away". NA-J stated she had not noticed R56's bruises yesterday, did not know why she had not noticed and stated, "we [NAs] are always moving". NA-J stated she had not assisted R56 with a shower yesterday but had just helped R56 change his shirt.

At 2:08 p.m. NA-C stated she had worked with

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21540	Continued From page 18 R56 today and had not looked at his skin and was not aware of R56's bruises on his arms and hand. NA-C stated she would notice a bruise when dressing the resident and had not dressed R56 today as he had already been dressed when she started working. NA-C stated she would notify the nurse of any resident bruises and the nurse would come in and look at the bruises, write down the size and location of the bruise, and if new bruise or internal bleeding would circle it and come back in 30 minutes. NA-C stated it is hard to know if bruises are new or old and would ask the resident about it and would double check with the nurse. NA-C stated the nurses completed weekly skin checks after the resident bath. NA-C re-stated she had not looked at R56's hands or arms and did not know if were bruised. On 10/31/18, at 2:22 p.m. NA-C verified R56's bruise on left antecubital, three small bruises on left upper arm, bruise on top of left hand, and bruise on upper right arm. NA-C asked R56 if the three smaller bruises on left upper arm hurt and R56 stated no. R56 stated the bruise on his left hand and upper right arm were from IVs while in the hospital. R56 stated the left antecubital bruise was from the blood drawn this morning. On 11/1/18, at 9:02 a.m. registered nurse (RN)-E stated nurses were to identify and assess resident bruises, and measure and monitor any bruises for size, and color and discoloration. On 11/1/18, at 9:13 a.m. RN-F verified R56's comprehensive risk data collection dated 10/15/18, identified incisions and edema with no bruising noted for R56. RN-F stated there should be a nursing order to monitor R56 for bruising since he was taking a blood thinner and then initialed off the Treatment Administration Record	21540		

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(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) COMPLETE DATE
21540	Continued From page 19	21540		

to show it was completed. RN-F verified there was no nursing order for R56's skin to be monitored for bruising and/or bleeding. RN-F stated the nurses should document any new bruises or changes, identify, assess for color, changes in pain and document in a progress note. RN-F verified R56's comprehensive risk data collection dated 8/21/18, indicated "bruises on [BUE]". RN-F stated, "I am thinking BUE stands for bilateral upper extremities." RN-F stated the bruises should have been documented on the assessment for where the bruises are located, color, if healing or hematoma, and size and should be put on the TAR to monitor. RN-F stated if all this identification and assessment of the bruises were on the assessment there would not have to be an additional progress note. RN-F verified R56's progress notes did not include any bruise identified since admission for R56. RN-F verified R56's record had no skin evaluation completed identifying and assessing R56's bruises.

Nursing progress notes dated 9/17/18, and 10/15/18, indicated R56 was readmitted to the facility from the hospital and had IVs administered in his upper right arm while in the hospital. No bruising for R56 was noted in the progress notes.

R56's Head to Toe skin evaluation dated 10/30/18, did not identify any bruising for R56.

On 11/1/18, at 10:35 a.m. the medical director (MD) stated R56 was on an anticoagulant (Xarelto) and should be monitored for signs and symptoms of bleeding and bruising, and weekly skin checks completed. MD stated Xarelto was a medication that was not able to have blood tests done to ensure proper dosing and depended on staff monitoring for signs and symptoms of

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	00232	A. BUILDING: _____ B. WING _____	11/01/2018

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21540	Continued From page 20 bleeding and bruising because of the potential for bleeding and need for dosage change. On 11/1/18, at 12:37 p.m. director of nursing (DON) stated weekly head to toe evaluations by the nurses should be completed and should include resident bruising, where the bruise was located, such as upper right arm, and top of left hand and a nursing order to monitor bruises weekly on bath day until resolved. DON stated the nurse should look at the bruise, see if the bruise is fading and document any new bruises with location and monitor them weekly until resolved. DON stated the facility must have "missed it [monitoring for R56] by switching software" and therefore was not put in the Treatment Administration Record to monitor. DON stated the NAs should report any skin impairment to the nurse. Facility policy Skin Evaluation - Head to Toe dated 10/04, indicated the Skin Evaluation was to be completed weekly for all residents on a weekly basis with the bath, and residents observed for any reddened areas or skin breakdown and documented. Policy requested from facility for monitoring of bruising was not made available. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) and/or designee could review policies and procedures related to monitoring side effects for anticoagulants. The DON or designee could educate staff and develop a system of compliance with anticoagulation therapy side effecting monitoring. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21540		

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21565	MN Rule 4658.1325 Subp. 4 Administration of Medications Self Admin Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure an assessment for safe self-administration of medications was completed for 1 of 1 resident (R98) observed to self-administer medication via nebulizer (a drug delivery device used to administer medication in the form of a mist inhaled into the lungs). Findings include: R98 was observed on 10/31/18, at 8:24 a.m. during medication administration. Licensed practical nurse (LPN)-A set up R98's pulmicort nebulizer (a device used to administer inhaled medication) and offered it to R98. Immediately after R98's nebulizer was turned on LPN-A left R98's room and returned to the medication cart in the hallway. R98 was observed again on 10/31/18, at 8:38 a.m. with the nebulizer mask held to her face while alone in her room without supervision. LPN-A confirmed, on 10/31/18, at 8:46 a.m., R98 had been self-administering the pulmicort nebulizer for "quite a while" and had self-administered the scheduled 8:00 a.m. dose . According to R98's quarterly Minimum Data Set	21565	Corrected	12/11/18

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21565	Continued From page 22 (MDS) assessment dated 10/1/17, R98 was cognitively intact. Additionally, R98's admission record dated 10/31/18, included diagnoses of chronic obstructive pulmonary disease (COPD) and congestive heart failure (CHF). R98's Order Summary Report dated 10/31/18, included orders for pulmicort suspension 1 mg/2 ml (budesonide), inhale orally two times a day related to COPD. R98's Medication Administration Record (MAR) for October 2018, reviewed 10/31/18, indicated R98 had received pulmicort suspension two vials inhaled orally via nebulizer two times daily at 8:00 a.m. on 10/31/18. There was no evidence in R98's medical record of an assessment if R98 could safely self-administer medications. On 10/31/18, at 11:06 a.m. registered nurse (RN) -A stated R98 did not have a medication self-administration assessment completed and should have before self-administered the pulmicort medication. The facility's Self Administration of Medications policy dated 5/2004, included: If a resident takes his/her medications independently after nursing prepared the medications, a physician's order similar to "resident may self-administer medications after nursing sets up" would need be obtained. The policy did not reference resident self-administration of medication assessments. SUGGESTED METHODS OF CORRECTION: The director of nursing (DON) or designee could develop, review, and /or revise policies and procedures to ensure the facility properly assessed residents for safe SAM procedures. The DON or designee could develop monitoring	21565		

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21565	Continued From page 23 systems to ensure ongoing compliance and report the results to the quality assurance committee for further recommendations. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21565		
21810	MN St. Statute 144.651 Subd. 6 Patients & Residents of HC Fac.Bill of Rights Subd. 6. Appropriate health care. Patients and residents shall have the right to appropriate medical and personal care based on individual needs. Appropriate care for residents means care designed to enable residents to achieve their highest level of physical and mental functioning. This right is limited where the service is not reimbursable by public or private resources. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the call light was within reach for 1 of 2 residents (R 96) reviewed for call lights. Findings include: During an initial interview on 10/29/18, at 1:40 p.m. R96 was seated in his wheelchair outside of his bathroom entry way and stated; "I am wondering where my table is so I can find my call light." R96 further stated that he was unable to see and "the staff just left me here." R96's call light was observed to be placed on a reclining chair approximately four feet away from R96's reach. Licensed practical nurse (LPN)-B was	21810	Corrected	12/11/18

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21810	Continued From page 24 notified and verified R96's call light was out of his reach. During an observation on 10/29/18, at 5:44 p.m. R96 was heard calling out of his room and yelled "where am I, where am I?" R96 was observed in his wheelchair near entrance of room facing the hallway with the call light out of reach. LPN-C was alerted R96 had asked for help. LPN-C verified R96's call light was out of reach and further stated R96 was legally blind so he would not be able to independently move himself towards the call light or see where it was located. R96's face sheet printed 10/31/18, indicated R96 had diagnoses including generalized muscle weakness. R96's annual Care Area Assessment (CAA) dated 1/11/18, indicated R96 had impaired cognition and "very poor eyesight." R96's CAA further indicated that he required assistance with activities of daily living. R96's care plan, revised on 10/2/18, identified R96 was "blind but does have some vision." The care plan further indicated R96 was at risk for falls, required assistance with toileting and mobility and to "keep call light within reach when resident in room." During an interview on 10/31/18, at 2:56 p.m. registered nurse (RN)-C, also senior clinical manager, stated it was her expectation for all resident's to have their call light within reach when they are in their room. A facility call light policy was requested on 10/31/18, but not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could	21810		

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21810	Continued From page 25 develop and implement policies and procedures related to the call lights. The DON or designee, could provide training for all nursing staff related to call lights. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21810		
21880	MN St. Statute 144.651 Subd. 20 Patients & Residents of HC Fac.Bill of Rights Subd. 20. Grievances. Patients and residents shall be encouraged and assisted, throughout their stay in a facility or their course of treatment, to understand and exercise their rights as patients, residents, and citizens. Patients and residents may voice grievances and recommend changes in policies and services to facility staff and others of their choice, free from restraint, interference, coercion, discrimination, or reprisal, including threat of discharge. Notice of the grievance procedure of the facility or program, as well as addresses and telephone numbers for the Office of Health Facility Complaints and the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12) shall be posted in a conspicuous place. Every acute care inpatient facility, every residential program as defined in section 253C.01, every nonacute care facility, and every facility employing more than two people that provides outpatient mental health services shall have a written internal grievance procedure that, at a minimum, sets forth the process to be followed; specifies time limits, including time limits for facility response; provides for the patient	21880		12/11/18

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21880	Continued From page 26 or resident to have the assistance of an advocate; requires a written response to written grievances; and provides for a timely decision by an impartial decision maker if the grievance is not otherwise resolved. Compliance by hospitals, residential programs as defined in section 253C.01 which are hospital-based primary treatment programs, and outpatient surgery centers with section 144.691 and compliance by health maintenance organizations with section 62D.11 is deemed to be compliance with the requirement for a written internal grievance procedure. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to respond and resolve reports of missing personal clothing for 1 of 2 resident (R30) who reported missing property in the facility. Findings include: During resident council meeting on 10/30/18, at 3:28 p.m. R30 stated she was missing several items of personal clothing including two new shirts and underwear. R30 stated it "drives me nuts" because nobody had taken any responsibility about the missing items. R30 stated staff just told her they didn't know what happened to her belongings. On 10/30/18, at 4:16 p.m. the facility's grievance log was reviewed. There were no grievances documented regarding R30's missing clothing.	21880	Corrected	

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21880	Continued From page 27 On 11/1/18, at 9:27 a.m. R30 stated during the summer a shirt of hers went missing from the laundry. R30 described it as a "sailor shirt" with gold buttons on the shoulders and had blue and white strips. R30 stated it was labeled with her name. R30 stated she went to the laundry room to look for it with the laundry aide (LA) but did not find it. R30 stated nobody followed up with her about her missing shirt. R30 also stated two weeks ago the facility lost a brand new sweater of hers. R30 stated she put it in a bag and gave it to staff at the nurse station to be sent down to laundry to be labeled. R30 stated she asked staff at the nurse station about what happened to it and they told her they did not know. R30 stated nobody helped her try to find it. R30 was admitted to the facility on 6/13/18. R30's Significant Change Minimum Data Set dated 8/7/18, indicated that R30 was cognitively intact. On 11/1/18, at 10:43 a.m. the director of social services (DSS) stated staff expectation for missing items was to let the unit social worker or nursing supervisor know when they became aware of missing resident belongings. DSS stated that either the social worker or nursing supervisor would fill out a grievance form regarding the missing items. DSS stated the she was the point of contact with staff in the laundry if they became aware of any missing items. DSS explained the facility had a better chance of locating missing items when they found out about them right away when they were discovered missing. DSS was not aware of any grievances or reports of missing laundry for R30. DSS stated she did not see any grievance for R30 on the facility's grievance log.	21880		

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21880	Continued From page 28 On 11/1/18, at 12:06 p.m. LA stated that she usually looked for missing clothes per request of nursing staff or social workers. LA also stated that the formal grievance would be completed by social workers. The facility's Grievance Procedure dated January 2017, indicated staff would notify social worker, nurse case manager, nursing supervisor as soon as possible regarding any grievance brought to their attention. SUGGESTED METHOD OF CORRECTION: The Director of Nursing could re-educate staff on grievance process including who to notify if a resident has missing items. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21880		

Electronically delivered
November 27, 2018

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

Re: State Nursing Home Licensing Orders - Project Number S5343031

Dear Administrator:

The above facility was surveyed on October 29, 2018 through November 1, 2018 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

the Suggested Method of Correction and the Time Period For Correction.

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

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

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

Eva Loch, Unit Supervisor
Metro D Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: eva.loch@state.mn.us
Phone: (651) 201-3792
Fax: (651) 215-9697

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.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division