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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: CYBR

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 **02/29/2020** (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 :
Sarah Grebenc, Unit Supervisor 03/12/2020 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Douglas Larson, Enforcement Specialist 03/12/2020 (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
03/11/2020
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 12, 2020

CMS Certification Number (CCN): 245343

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 February 21, 2020 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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 12, 2020

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

RE: CCN: 245343
Cycle Start Date: January 10, 2020

Dear Administrator:

On February 29, 2020, the Minnesota Department(s) of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

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

ID: CYBR

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Facility ID: 00232

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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 **01/10/2020** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
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03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
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FISCAL YEAR ENDING DATE: (L35)
12/31

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To (b) :

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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)

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17. SURVEYOR SIGNATURE Date :
Sarah Grebenc, Unit Supervisor 02/07/2020 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Douglas Larson, Enforcement Specialist 03/10/2020 (L20)

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

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
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3. Both of the Above :
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09/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)
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
January 30, 2020

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

RE: CCN: 245343
Cycle Start Date: January 10, 2020

Dear Administrator:

On January 10, 2020, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be 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.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Sarah Grebenc, 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: sarah.grebenc@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 April 10, 2020 (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 July 10, 2020 (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: https://mdhprovidercontent.web.health.state.mn.us/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: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

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 _____	C 01/10/2020

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 1/6-1/10/2020, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On 1/6/2020 through 1/10/2020, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was not in compliance with 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. The following complaints were also investigated: H5343054C- Not Substantiated H5343055C- Substantiated with citation F760 H5343056C- Not substantiated, H5343057C- Substantiated, no citations H5343058C- Unsubstantiated	F 000		
F 760	Residents are Free of Significant Med Errors	F 760		2/21/20

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

Electronically Signed | 02/06/2020

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 _____	C 01/10/2020

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 760 SS=D	Continued From page 1 CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure accurate transcription of physician orders, resulting in omission of a significant medication for 1 of 5 residents (R477) reviewed for medication errors. Findings include: R477's admission record, undated, indicated diagnoses of fluid overload, localized edema (swelling caused due to excess fluid accumulation in the body tissues) and aftercare following surgery for neoplasm (tumor). R477's admission Minimum Data Set (MDS) assessment dated 8/27/19, indicated intact cognition based on a Brief Inventory of Mental Status score (BIMS) of 15 [15 indicates intact cognition]. The MDS also indicated R477 required assistance with Activities of Daily Living (ADLs), and diagnoses included: hypertension (high blood pressure), dilated cardiomyopathy (condition where the heart cannot pump blood effectively) and disorder of the kidney and ureter. R477's corresponding Care Area Assessment (CAA) dated 9/2/19, indicated R477 was at risk for pressure ulcers due to risk factors which included edema to bilateral lower extremities (BLE). R477 had a planned discharge with anticipated	F 760	483.45(f)(2) Residents are free of any significant medication errors. 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 (MMHCC) to ensure safe administration of all medications/treatments and safe care transitions, which includes but is not limited to correct transcription of admission orders. It is the policy of MMHCC to provide verification of admission orders via a nurse review on admitting shift and night shift. In order to minimize adverse events that impact current and future residents, MMHCC has a Quality Assurance Performance Improvement system to identify, report, track, and analyze errors.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245343	A. BUILDING _____ B. WING _____	C 01/10/2020

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

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F 760	Continued From page 2 return MDS completed on 10/2/19. R477 had a re-entry from acute care hospital MDS completed on 10/8/19. R477's hospital discharge orders dated 10/8/19, included an order for triamterene-HCTZ 37.5-25 milligram (mg) tablet, take one tablet by mouth daily for bilateral lower extremity (BLE) edema and hypertension. [This medication is commonly known as Dyazide or Maxide-25 and is classified as a diuretic]. A facility medication error report dated 10/10/19, at 5:16 p.m. indicated R477 had order for triamterene-HCTZ 37.5-25 mg, take one tablet by mouth daily for hypertension and BLE edema. The report indicated a chart audit had been performed and triamterene-HCTZ had never been entered into the computer as an order resulting in R477 missing two doses of the medication before it was discovered. A progress note dated 10/14/19, by nurse practitioner (NP)-C indicated R477 had not received her prescribed diuretic following hospitalization due to a medication error. Further-C had documented R477 reported increased weight, shortness of breath, and documented the resident's right leg "split open" due to fluid. As a result, R477 was started on torsemide (also a diuretic medication, used to reduce extra fluid in the body (edema) to lessen symptoms such as shortness of breath and swelling in arms, legs, and abdomen), and R477's edema and weight had improved as reported by R477 when she reported her swelling decreased and denied shortness of breath, cough or congestion. The NP wrote orders to continue lasix (diuretic) 20 mg daily, with potassium 10 meq (milliequivalents) daily, and repeat blood work in the morning.	F 760	Medication/treatment error review is completed by the Medical Director/designee, DON/designee, Pharmacist, Nurse Management, Education Manager and Clinical Data Manager. R477 discharged on 10/19/19, prior to this survey. Upon discovery of the 10/10/19 transcription error, a thorough investigation and team review took place according to facility policy. An additional Admission Orders procedure was implemented on 10/21/19. A review was conducted of current resident□s, who admitted during the date span 10/01/19-2/6/20, to ensure a medication review took place. No medication omissions were discovered. The Midnight Census sheet was modified to include auditing of admission orders. To enhance current compliant operations and under the direction of the DON, nursing education was conducted beginning 1/10/20. The training emphasized: 1) verification of each page of the original admission orders by the admission nurse and night nurse; and 2) review of the Admission Orders policy. Nurse Managers/Supervisors received	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245343	A. BUILDING _____ B. WING _____	C 01/10/2020

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 760	Continued From page 3 Review of R477's daily weights documented on the October 2019 MAR included: -191.3 pounds (lbs) on 10/9/19 -190 lbs on 10/11/29 -191.2 lbs on 10/12/19 -179.6 lbs on 10/13/19 -176.6 lbs on 10/14/19 -175.8 lbs on 10/15/19 -177.4 lbs on 10/16/19 -178.8 lbs on 10/18/19 -178.8 lbs on 10/19/19 Review of R477's edema (observable swelling from fluid accumulation in body tissues) as documented in the nursing progress notes included: -10/8/19 at 11:59 p.m. admission progress note stated +2 - +3 pitting edema to BLE. Pedal pulses palpated bilaterally but difficult due to edema. -10/9/19 at 12:45 p.m. Edema to left upper extremity (LUE) +1. Edema to lower extremities +2. -10/9/19 at 10:22 p.m. Lung sounds clear in all fields, Denies shortness of breath. -10/10/19 at 12:32 p.m. Lung sounds clear but left basal areas faint crackles present. Edema to LUE +1. Edema to lower extremities +2. -10/10/19, at 5:04 p.m. the documentation indicated R477 had not received Triamterene-HCTZ on 10/9/19 or 10/10/19. NP was notified and was informed R477 did not want any diuretics. R477 was noted to have 2+ edema to lower extremities at that time. At that time, the NP discontinued the Triamterene-HCTZ. -10/11/19 at 10:22 PM Lung sounds are clear, diminished in basal areas. +2 pitting edema to left lower extremity, +1 pitting edema to right lower extremity. Pedal pulses palpated bilaterally.	F 760	additional education from 1/10/20 to 1/16/20. The training emphasized: 1) Daily auditing of original admission orders stamped and signed by two nurses; and 2) Tracking of audits via the updated Midnight Census sheet. Random audits will be done weekly for three (3) months then randomly thereafter. Audits to include verification of transcribed admission orders and 2) original orders initialed by two nurses. Audits will be reviewed in the Quality Assurance meetings. Person responsible; DON or designee Compliance date is 2/21/20	

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	245343	A. BUILDING _____ B. WING _____	C 01/10/2020

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F 760	Continued From page 4	F 760		

-10/12/19 at 3:13 p.m. therapy notified nursing the right lower extremity tubigrips was wet with pink fluid. R477 has a scratch that is weeping clear fluid. Applied an abdominal pad and kerlix. R477 denied knowing how scratch occurred but thought it might be from sock puller she used previous. R477 asked if she is getting a "water pill". Nurse explained that NP discontinued diuretic earlier in the week due to request of R477. R477 said she does want a diuretic now for chronic edema. On call doctor called, and an order for torsemide was obtained.
-10/12/19 at 6:23 p.m. new weeping scratch to RLE dressed with ABD and kerlix. No signs of infection. Edema +3 to BLE. Oxygen saturations remained stable on room air. Lung sounds clear.
-10/13/19 at 2:53 p.m. On-Call NP notified of R477's concerns about weight loss due to diuretic. NP ordered medication adjustments and labs to be drawn. R477 declined to go to hospital for evaluation.
-10/13/19 at 11:14 p.m. Edema noted +3 to BLE. Denied shortness of breath and cough. Oxygen saturation remained stable on room air. Lung sound clear.
-10/14/19 Lung sounds clear.
-10/14/19 Nursing educated R477 on diuretics and correlation with kidney function. R477 upset that diuretics were not started sooner.
-10/15/19 Lung sounds are clear, +2 bilateral lower extremity edema. Abdominal pad and kerlix wrapped around the RLE which was saturated. Denies shortness of breath.
-10/16/19 at 11:43 p.m. NP notified of increase in weight from yesterday up 2.9 lbs. No shortness of breath. Clear to auscultation. No orders.
-10/16/19 at 11:45 a.m. Edema increase to feet and ankles with left greater than right. Dressing change to LLE is intact and weeping slowly. No

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F 760	Continued From page 5	F 760		

signs of infection
-10/17/19 10:50 p.m. Bilateral feet have +1 edema. Color, moisture, sensitivity intact in upper and lower extremities.
-10/18/19 at 11:16 a.m. Lung sounds are clear. Denies cough or shortness of breath. +2 pitting edema to bilateral lower extremities. Resident had a planned discharge to home this day.

R477 was interviewed via telephone on 1/8/20, at 12:21 p.m., and stated after kidney surgery and while she resided in the hospital she was put on a diuretic. R477 stated the hospital discharge papers listed a diuretic to start at the nursing home. R477 felt as if those orders were ignored until she insisted on starting a diuretic the weekend of 10/12/19.

Family member (FM)-C was interviewed via telephone on 1/09/20, at 3:21 p.m. FM-C reported being aware of R477's concerns. FM-C reported some care was good at the facility but there were concerns about communication with the NP and medications.

When interviewed on 1/8/20 at 1:11 p.m. registered nurse manager (RN)-A confirmed the Maxide order was not entered. "I think it was not entered and missed for two days, but she (R477) didn't want to take them (diuretics) after it was discovered. However, later she (R477) did want to start on a diuretic." RN-A stated the process for admission orders is the health unit coordinators (HUC) put in faxed admission orders and the HUC is considered the first double check. The admitting nurse double checks and compares to the original orders which come with the resident. The night nurse triple checks.

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When interviewed 1/08/20, at 2:51 p.m. RN-B reported having many conversations with R477 about the Maxide and diuretics in general. RN-B stated yes R477 missed the two doses (of Maxide) then declined to start a diuretic until the weekend. RN-B explained to R477 that diuretic use can effect kidney function.

When interviewed on 1/09/20 at 9:18 a.m., nurse practitioner (NP)-C stated after the hospitalization, R477 was seen on rounds on 10/9/19 and 10/14/19. Overall, R477's edema was at baseline and weights were stable. NP-C reported being aware of the medication error. NP-C added R477 had a history of refusing medications.

When interviewed by telephone on 1/9/20, at 4:38 p.m. consultant pharmacist (CP)-A stated medication errors are reviewed and signed during facility pharmacy visits every one to two months. CP-A stated side effects of a missed diuretic could be major or minor and might include swelling or blood pressure issues. Further, CP-A stated side effects depended on what the diuretic was being used for.

On 1/10/20, at 9:18 a.m. the director of nursing (DON) stated the expectation was the admitting nurses should have verified the orders the HUC entered and compared the faxed orders to the original orders to ensure accuracy. The DON stated after the incident [medication error] a new procedure was developed in which the HUC enters the orders and two nurses (admitting nurse and night nurse) are to check for accuracy. Additionally, all original orders are stamped, signed and dated by HUC, admit nurse and night nurse.

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F 760	Continued From page 7 The facility's 10/21/19 policy Admission Orders, included: "To ensure that admission orders are transcribed correctly, sent to pharmacy timely and verified by two nurses for accuracy."	F 760		
F 838 SS=F	Facility Assessment CFR(s): 483.70(e)(1)-(3) §483.70(e) Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include: §483.70(e)(1) The facility's resident population, including, but not limited to, (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population; (iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population; (iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that	F 838		2/21/20

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F 838	Continued From page 8 may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.70(e)(2) The facility's resources, including but not limited to, (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies; (iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to develop a facility assessment that included an identification of resident population, evaluation of diseases, conditions, physical, functional or cognitive limitations of the resident population's, acuity of residents, staff competencies requirement, staffing requirements and plan, and identification of resources needed to care for resident population. It also failed to	F 838	483.70(e) Facility assessment 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 838	Continued From page 9 identify and include ethnic, cultural, or religious factors that may need to be considered to meet resident needs. This had the potential to affect all 196 residents who resided at the facility. Findings Include: Review of the facility assessment dated 9/30/19, did not provide the details of its resident population which would determine the staffing plan and competency requirements for staff. The assessment indicated a listing of the number of equipment and other supplies that were available however, it lacked the indication of the resident population and condition that required the use of the equipment and supplies. In addition the assessment did not include ethnic, cultural, or religious factors that may need to be considered to meet resident needs Review of the Daily Census dated 1/9/20, indicated the Memory Care unit was a twenty bed unit with eighteen current residents who resided in the unit with diagnoses which included behavioral and personality disorders, and Alzheimer's and/or dementia. The facility assessment did not identify this resident population and did not indicate the competency requirements and staffing plan needed to care for the residents in the Memory Care unit and further lacked details of resident population and staffing assessments and plan for other units. During interview on 1/09/20, at 4:19 p.m. the Quality Assessment Coordinator (QAC) indicated the facility assessments were done on an ongoing basis with collaboration between admission and staffing personnel. QAC touched base with admission staff on an ongoing basis	F 838	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 (MMHCC) to complete an annual assessment of facility-wide resources to guide senior leaders regarding resident admission types and the staffing and equipment/supply acquisition required to address the needs of those residents. It is the policy of MMHCC to maintain sufficient nursing staff with the appropriate competencies and skills sets to provide care and services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident; as determined by resident assessments and individual plans of care and considering the number, acuity, and diagnoses of the facility□'s resident population. All referrals for admission are screened by admissions staff and/or the Director of Nursing or the Senior Clinical Care Manager to assure that care needs are able to be met by staff on a specific unit. A review was conducted of current residents and it was found that MMHCC could appropriately provide care for their needs. MMHCC's Facility Assessment has been modified using the CMS QIO Facility	

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F 838	Continued From page 10 and they were updated on the assessments which were reviewed weekly. Admission personnel were aware of the acuity of the resident population the facility accepted. Review of 10/2017, policy titled: QAPI: Facility Wide Resource Assessment, indicated the purpose of the assessment was to establish a system for annual assessment of facility-wide resources. This annual assessment will guide decision making of senior leaders regarding type of patient admissions, staffing, equipment and supply acquisition to address the needs of those patients. The senior leaders of the MN Masonic Home will conduct a facility wide resource assessment annually, coordinated by the Quality Assurance Coordinator.	F 838	Assessment Tool format to meet the required elements of the Facility Assessment. The Facility Assessment policy was updated on 2/3/20. To enhance current compliant operations and under the direction of the Quality Assurance coordinator, education was conducted with QAPI team members on 2/6/20 regarding the required elements of the Facility Assessment. A review of the facility assessment (which includes potential changes in staffing and resident population) will occur quarterly x 4 then annually thereafter. Audits will be reviewed in the Quality Assurance meetings. Person responsible; Quality Assurance Coordinator or designee Compliance date is 2/21/20	

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 01/13/2020. At the time of this survey, Minnesota Masonic Home Care Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, the Health Care Facilities Code. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/06/2020

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

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Healthcare Fire Inspections
State Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101-5145, OR

By email to:
FM.HC.Inspections@state.mn.us

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A description of what has been, or will be, done to correct the deficiency.

2. The actual, or proposed, completion date.

3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.

Minnesota Masonic Home Care Center 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 are monitored for automatic fire department notification.

The facility has a capacity of 214 beds and had a census of 203 at the time of the survey.

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K 000	Continued From page 2 The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 291 SS=C	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to test and maintain emergency lighting within accordance with NFPA 101 (2012), Life Safety Code, Section 7.9.3 and NFPA 110 (2010), Standard for Emergency and Standby Power Systems, Section 7.3.1. This deficient practice could affect all 203 residents. Findings include: On a facility tour between the hours of 10:00 AM and 3:00 PM on 01/13/2020, it was revealed that the facility could not provide evidence of having completed a 90-minute annual test of the battery-operated emergency light, for the indoor generator. This deficient practice was verified by the Director of Facilities Maintenance at the time of discovery.	K 291	Emergency Lighting 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. Upon notification that the annual 90 minute test, for the indoor generator battery-operated emergency light, was not appropriately documented, another test was conducted on 1/15/20. The battery-operated emergency light, for the indoor generator, functioned without failure. To enhance current compliant operations and under the direction of the	2/14/20

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K 291	Continued From page 3	K 291	Maintenance Supervisor: 1) The Generator Testing and Inspection policy was revised on 2/3/20 to include testing of the battery-operated emergency light; 2) A Unit Class was conducted on 2/4/20 that emphasized the monthly 30 second test and annual 90 minute test for the battery-operated emergency light, for the indoor generator plus documentation requirements; and 3) The MN Department of Health posted form titled Battery-operated Emergency Lights □ Test Log was initiated by 2/4/20. Monthly audits (which includes review of inspection logs) will be done for three (3) months and randomly thereafter. Audits will be reviewed in the Quality Assurance meetings. Person responsible; Maintenance Supervisor Compliance date is 2/14/20	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and	K 918		2/14/20

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K 918	Continued From page 4 transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility did not test and maintain essential electrical system in accordance with NFPA 99 (2012) Health Care Facilities Code, Sections 6.4.4, 6.4.4.1.1.3, 6.5.4 and NFPA 110 (2010) Standard for Emergency and Standby Power Systems, Section 8.4.1. This deficient practice could affect all 90 residents. Findings include: On a facility tour between the hours of 10:00 AM	K 918	Electrical Systems - Essential Electric System CFR(s): NFPA 101 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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245343	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/13/2020**

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K 918	Continued From page 5 and 3:00 PM on 01/13/2020, it was revealed that the facility could not provide evidence for having conducted weekly inspections on the emergency generator located in Building "D". This deficient practice was verified by the Director of Facilities Maintenance at the time of discovery.	K 918	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. Upon notification that the weekly inspection of the emergency D building generator was not appropriately documented, a weekly inspection of the generator was conducted. The D building generator weekly inspection was performed without failure on 1/15/20. To enhance current compliant operations and under the direction of the Maintenance Supervisor: 1) The Generator Testing and Inspection policy was revised on 2/3/20; 2) A Unit Class was conducted on 2/4/20 that emphasized weekly generator inspection, monthly generator testing, documentation requirements and response to any failure; and 3) The MN Department of Health posted form titled Emergency Generator - Weekly Generator Checklist was initiated by 2/4/20. Weekly audits (which includes review of inspection logs) will be done for three (3) months and randomly thereafter. Audits will be reviewed in the Quality Assurance meetings. Person responsible; Maintenance Supervisor Compliance date is 2/14/20	

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