DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 27, 2019

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

RE: CCN 245343
Cycle Start Date: September 6, 2019

Dear Administrator:

On September 6, 2019, survey was completed at your facility by the Minnesota Department(s) 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 isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department is recommending that CMS impose a civil money penalty. You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

- Civil money penalty. (42 CFR 488.430 through 488.444)

DEPARTMENT CONTACT

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

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

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.

Feel free to contact me if you have questions.

Sincerely,

Alison Helm

Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206

Email: alison.helm@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245343	A. BUILDING _____ B. WING _____	C 09/06/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 9/4/19, through 9/6/19, an abbreviated 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. Complaint H5343052C was found to be substantiated with no deficiency cited. Complaint H5343053C was found to be substantiated at F689, at past non-compliance. Although no plan of correction is required for a finding of past non-compliance, it is required the facility acknowledge receipt of the electronic documents.	F 000		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to implement fall interventions and provide supervision to reduce the risk of accident hazards for 1 of 3 residents (R1) reviewed for accidents. R1 sustained harm when care planned interventions were not followed and R1 fell sustaining a hip fracture. It was determined the	F 689	Past noncompliance: no plan of correction required.	10/4/19

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

Electronically Signed | 10/04/2019

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F 689	Continued From page 1	F 689		

facility had already implemented corrective action therefore, this is being cited as past noncompliance.

Findings include:

Fall incidents for the past quarter were requested, and only one was provided for review, the fall incident report from 8/23/19. The fall incident report dated 8/23/19, indicated R1 fell at 5:25 p.m. when nursing assistant (NA)-A left R1 unattended on the toilet to retrieve an incontinent product from outside of the bathroom. When NA-A returned R1 was on the floor and was complaining of hip pain. The medical doctor (MD) was notified and an X-ray obtained. The report indicated R1 had sustained a mildly displaced left femoral neck fracture. The report R1 had been left alone unattended in the bathroom, as a result, NA-A was immediately educated about the importance of following the care plan.

R1's significant change Minimum Data Set (MDS) assessment dated 5/2/19, indicated R1 had no falls since prior assessment. The care area assessment (CAA) worksheet for falls was completed corresponding with the significant change MDS. The CAA worksheet, also dated 5/2/19, indicated falls were of concern related to having balance issues, needing assistance with mobility and transfers, and use of psychotropic medications. R1's subsequent quarterly MDS dated 7/25/19, indicated R1 had no falls since previous assessment. An MDS completed on 8/29/19, indicated R1 passed away in the facility 6 days after the fall.

R1's care plan dated 8/7/19, indicated R1 was at risk for falls due to weakness, a neurological

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F 689	Continued From page 2	F 689		

disorder and pain. Additionally, R1 was cognitively impaired and used poor judgement and would self-transfer. The care plan indicated R1 had multiple falls prior to admission to the facility and a fall with injury prior to admission. The care plan goal was to be free from falls and injury. The interventions included: anticipate needs, be alert to periods of increased anxiety or escalating behaviors, and not to leave the resident alone in the bathroom while toileting due to possibility of self-transfers.

A progress note dated 8/24/19, indicated R1's family discussed the risks and benefits of surgical intervention, and what would happen if there was no intervention, with R1's medical doctor (MD). The family had subsequently decided against surgery. The risks and benefits of either decision had been discussed including: pneumonia, blood clot, and risk of death.

NA-B was interviewed on 9/4/19, at 2:22 p.m. NA-B stated she had recently received training as a follow up to R1's fall incident. NA-B stated the training included how to access resident care plan information, the importance of following the care plan, and how to proactively stock incontinent products.

On 9/6/19, at 12:27 p.m. NA-C was interviewed and confirmed having received training to have all rooms stocked with incontinent products at beginning of shift, and also to read Kardex to make sure to get updates on residents' care information.

On 9/6/19, at 12:34 p.m. NA-D also verified receiving training and said, "We are each responsible for our own shift and there is a par

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F 689	Continued From page 3	F 689		

level of at least five incontinent products to make sure they are stocked at beginning of shift".

The mandatory training documentation with staff signatures dated, 8/26/19 and 8/28/29, was reviewed. The training included information for staff on accessing the Kardex to obtain current care plan interventions for providing correct resident care and to ensure supplies of incontinent products. The documentation indicated the training was mandatory for all nursing staff.

The administrator was interviewed on 9/6/19, at approximately 1:30 p.m.. The administrator verified the care plan had not been followed when NA-A left R1 alone in the bathroom, and R1 fell sustaining the fracture. The administrator added, "[NA-A] had been an employee for several years without problems and was very remorseful of the event." The administrator verified NA-A received immediate coaching and disciplinary action and had to demonstrate competency before resuming provision of cares. The administrator further stated, "Training was provided to all NA staff on the unit immediately after the fall occurred, and was also provided for all staff."

The Director of Nursing (DON) was interviewed on 9/6/19, at 1:00 p.m. The DON explained she had received immediate notification the evening of the fall. She had instructed the nursing staff to provide immediate training for the staff on the unit regarding following the care plan and ensuring all incontinent products were available. When it was discovered the resident had a hip fracture, the event was reported to the State Agency. The DON verified the care plan had not been followed for R1 as he should not have been left alone in

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F 689	Continued From page 4	F 689		

the bathroom. The DON stated NA-A was given a disciplinary action and was not allowed to continue cares until he could demonstrate how to obtain current care plan interventions, and expressed understanding of the importance of following the care plan interventions.

The facility's March 2018 policy, Fall management Protocol, indicated falls were to be immediately reported to the nurse manager. Additionally, immediate interventions were to be put in place to address the believed cause for the fall. Further, the protocol indicated a fall scene investigation must also be completed at the time of the fall, and indicated all falls would be reviewed by the interdisciplinary team and the care plan revised as needed.

The facility's May 2017 policy, Care Plan Procedure, indicated the facility must develop and follow the comprehensive care plan. NAs were to participate in weekly team meetings regarding residents to ensure accurate development of the care plan.

Although R1 fell on 8/23/19, as a result of the staff leaving R1 unattended, it was verified the deficient practice had been corrected prior to the survey. Through record review and staff interviews, it was determined re-education of all staff had been completed to correct the deficient practice to ensure resident care plan interventions for falls were implemented, and resident rooms were adequately stocked with care supplies. The provider had re-educated all non-licensed nursing staff as of 8/28/19.

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

RE: CCN 245343
Cycle Start Date: September 6, 2019

Dear Administrator:

The above facility survey was completed on September 6, 2019 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

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,

Alison Helm

Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

Minnesota Department of Health

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	00232	A. BUILDING: _____ B. WING _____	C 09/06/2019

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 9/4/19 through 9/6/19, surveyors of this Department's staff visited the above provider and the the facility was found in compliance. Complaints H5343053C and H343052C were investigated and were found to be substantiated with no correction orders issued. You have agreed to participate in the electronic	2 000		

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

Electronically Signed | 10/04/19

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2 000	Continued From page 1 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		