



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

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

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

Dear Administrator:

On December 1, 2020, we notified you a remedy was imposed. On January 29, 2021 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of January 27, 2021.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective January 15, 2021 did not go into effect. (42 CFR 488.417 (b))

In our letter of December 1, 2020, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from January 31, 2021 due to denial of payment for new admissions. Since your facility attained substantial compliance on January 27, 2021, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink that reads 'Kamala Fiske-Downing'.

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program

Minnesota Masonic Home Care Center

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Program Assurance Unit

Health Regulation Division

Telephone: (651) 201-4112 Fax: (651) 215-9697

Email: Kamala.Fiske-Downing@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Delivered Electronically

March 1, 2021

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

Subject: Minnesota Masonic Home Care Center – Administrative review 2567 modification
CMS Certification Number (CCN): # 245343
Event ID: 9XMB11

Dear Administrator:

This is notice of an administrative review of a citation cited at tag F600 issued pursuant to the survey Event ID 9XMB11, completed on January 5, 2021 as a part of MDH's Quality Assurance review. As a result of this review, it was determined the deficiency cited did not represent an immediate jeopardy situation, and confirmed you had already implemented corrective action to remove the deficient practice prior to our onsite survey.

Since we have determined this is not a valid example of a current deficient practice under this regulation, it will be removed from the Statement of Deficiencies.

A revised Statement of Deficiencies is attached.

Sincerely,

A handwritten signature in black ink that reads 'Susan B. Frericks'.

Susan Frericks, Unit Supervisor
Licensing and Certification Program
Health Regulation Division
Telephone: 218-368-4467

cc: Office of Ombudsman for Long-Term Care
Brenda Fischer, Assistant Program Manager
Licensing and Certification File

An equal opportunity employer.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245343	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/23/2020
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NAME OF PROVIDER OR SUPPLIER MINNESOTA MASONIC HOME CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 11501 MASONIC HOME DRIVE BLOOMINGTON, MN 55437
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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) COMPLETION DATE
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E 000	Initial Comments A COVID-19 Focused Infection Control survey was conducted 12/23/20, at your facility by the Minnesota Department of Health to determine compliance with Emergency Preparedness regulations §483.73(b)(6). The facility was IN full compliance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS Revised 2567 as a result of MDH's Informal Dispute Resolution A COVID-19 Focused Infection Control survey was conducted on 12/23/2020, to determine compliance with §483.80 Infection Control. The facility was determined NOT to be in compliance. As a result, a deficiency was cited at F883. 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. Upon receipt of an acceptable electronic POC, a revisit of your facility will be conducted to validate substantial compliance with the regulations has	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 01/15/2021
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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 AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/01/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245343	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/23/2020
NAME OF PROVIDER OR SUPPLIER MINNESOTA MASONIC HOME CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 11501 MASONIC HOME DRIVE BLOOMINGTON, MN 55437		
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F 000	Continued From page 1 been attained in accordance with your verification.	F 000			

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

PRINTED: 03/01/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245343	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 01/29/2021
NAME OF PROVIDER OR SUPPLIER MINNESOTA MASONIC HOME CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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}	<p>INITIAL COMMENTS</p> <p>Revised 2567B for the revisit as a result of MDH's Administrative Review.</p> <p>A revisit was conducted on 1/29/21, to follow up on deficiencies issued related to the (EX: abbreviated) survey exited on DATE. Your facility was IN compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities.</p> <p>The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.</p>	{F 000}			

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

TITLE

(X6) DATE

Electronically Signed

01/29/2021

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.



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 20, 2021

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

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

Dear Administrator:

On December 1, 2020 and January 8, 2021, we informed you of imposed enforcement remedies.

On January 5, 2021, the Minnesota Department of Health completed a survey and it has been determined that your facility continues to not to be in substantial compliance. The most serious deficiencies in your facility were found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

As a result of the survey findings:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective January 31, 2021, will remain in effect.
- Directed plan of correction, Federal regulations at 42 CFR § 488.424 Please see electronically attached documents for the DPOC.

This Department continues to recommend that CMS impose a civil money penalty. (42 CFR 488.430 through 488.444).

You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective January 31, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective January 31, 2021.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new

Minnesota Masonic Home Care Center

January 20, 2021

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admissions.

As we notified you in our letter of December 1, 2020, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from January 31, 2021

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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

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

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

DEPARTMENT CONTACT

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

Susan Frericks, Unit Supervisor
Metro D District Office
Licensing and Certification Program

Minnesota Masonic Home Care Center

January 20, 2021

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Health Regulation Division

Minnesota Department of Health

PO Box 64990

St. Paul MN 55164-0900

Email: susan.frericks@state.mn.us

Mobile: (218) 368-4467

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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their 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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by May 10, 2021 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services,

Minnesota Masonic Home Care Center

January 20, 2021

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Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at <https://dab.efile.hhs.gov> no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

**Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462**

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION/ 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/lrc_idr.cfm

Minnesota Masonic Home Care Center

January 20, 2021

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You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at:

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,



Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

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

PRINTED: 01/29/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245343	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/05/2021
NAME OF PROVIDER OR SUPPLIER MINNESOTA MASONIC HOME CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 1/5/21, an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found NOT to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaint was found to be SUBSTANTIATED: H#5343064C, with a deficiency cited at F600 free from abuse and neglect. 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 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to	F 600		1/27/21	

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

TITLE

(X6) DATE
01/26/2021

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

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F 600	<p>Continued From page 1</p> <p>treat the resident's medical symptoms.</p> <p>§483.12(a) The facility must-</p> <p>§483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to keep a resident free from physical abuse by another resident for 1 of 2 residents (R1) reviewed for resident to resident abuse.</p> <p>Findings include:</p> <p>R1's Face Sheet dated 1/5/21, identified diagnoses of Alzheimer's disease, dementia, and adjustment disorder with anxiety.</p> <p>R1's admission Minimum Data Set (MDS) dated 11/2/20, identified R1 had severe cognitive impairment.</p> <p>R1's care plan dated 1/5/21, identified R1 was vulnerable related to her cognitive impairment. R1 expressed frustration in regards to other residents, and had yelled at other residents when she perceived they were not doing things correctly or were in her house. Staff were directed to monitor R1 for inappropriate verbal communication, and violence or aggression towards others.</p> <p>R1's Order Listing Report dated 1/5/21, ordered staff to identify any physical injuries that may be present near mouth or new pain. Staff were ordered to monitor for any changes from baseline regarding behavior or mood and to monitor if R1</p>	F 600	<p>F600 483.12 (a)(1)</p> <p>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.</p> <p>It is the policy of Minnesota Masonic Home Care Center to provide residents with a safe, clean, comfortable and homelike environment which is free from abuse, neglect and corporal punishment of any type by anyone.</p> <p>On 1/2/21, upon the nurse witnessing R2 strike R1 the following occurred: R2 was immediately removed from the area, R1 was assessed and provided first aid to a left lower lip injury. The nursing supervisor, Director of Nursing, Administrator, Nurse Practitioner and</p>		

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F 600	<p>Continued From page 2</p> <p>seemed agitated or verbally aggressive toward R2.</p> <p>R2's Face Sheet dated 1/5/21, identified a diagnosis of other frontotemporal dementia, dementia with behavioral disturbance, paranoid personality disorder, generalized anxiety disorder, and delusional disorders.</p> <p>R2's quarterly MDS dated 10/7/20, identified R2 to have moderate impaired cognition.</p> <p>R2's care plan dated 1/5/21, identified R2 triggers for physical aggression when other residents talk load or speak aggressively. R2 had a mood problem related to his diagnoses of anxiety and paranoia. R2 had the potential to become physically aggressive to hit related to anger. Staff were directed to monitor R2 for aggressive behavior towards others manifested by attempting to strike, push or punch others. Staff were directed to not talk to R2 in a rapid, excited rate as this may lead to increased behaviors for R2. Staff were directed to remove R2 from load speaking residents.</p> <p>Facility Interdisciplinary Team (IDT) Review notes dated 1/4/21, identified R2 struck R1 in the lip on 1/2/21.</p> <p>On 1/2/21, at 11:00 a.m. a progress note indicated R2 returned to the dayroom approximately 20 minutes after the incident. R2 waved to an unidentified resident and tried to talk to R1. R2 asked R1 if she was okay, and that it had not been his fault. RN-A explained to R2 that it would be best to not be near R1, and escorted R2 back to his room.</p>	F 600	<p>resident representatives were notified. Non-pharmacologic and pharmacologic orders and care plan modifications were made for R2 and R1. Staff interviews were conducted and an investigation was initiated. The altercation was self-reported to the Office of Health Facility Complaints.</p> <p>Progress notes for R1 from 1/2/21-1/4/21, indicated R1 did not remember what happened. Additional notes observe a small black scab at lower lip, no swelling or new injury. R1 denied pain or discomfort and no chewing difficulty was noted. Lip injury resolved on 1/5/21.</p> <p>R1 saw the Nurse Practitioner on 1/8/21, and the house psychologist on 1/15/21.</p> <p>R2 saw the Nurse Practitioner on 1/4/21, and the house psychologist on 1/15/21 and 1/26/21. Additional non-pharmacologic and pharmacologic orders and care plan modifications/review occurred on 1/5/21, 1/6/21, 1/7/21, 1/8/21, 1/13/21, 1/20/21, and 1/22/21.</p> <p>All residents are vulnerable adults and have the potential to be affected.</p> <p>The policy and procedures were reviewed on 1/5/21 for Resident Protection Plan, Resident Rights- Safe Environment, and Responding to Allegations of Abuse.</p> <p>Under the direction of the Director of Nursing, memory care staff received immediate education on 1/2/21.</p>		

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NAME OF PROVIDER OR SUPPLIER MINNESOTA MASONIC HOME CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 600	<p>Continued From page 3</p> <p>On 1/2/21, at 12:09 p.m. a progress note indicated R1 was seated in a recliner in the dayroom, and had been talking constantly. R1 had been jumping from one topic to another when R2 entered the dayroom. R1 told R2 to turn around and get out of her house. R2 rushed toward R1, and hit R1 in her face. Registered nurse (RN)-A intervened and pulled R2 away from R1. R1 was noted to have blood on the left side of her mouth, and sustained a small cut on left lower lip. R2 had been directed back to his room. R1's cut had been cleansed, and a cold pack given for the injured site. R1 did not remember what had happened.</p> <p>On 1/2/21, at 8:01 p.m. a progress note indicated R1 had been very talkative during the shift. R1 asked other residents questions, told them to be quiet, and what to do. There had been no bleeding noted from R1's mouth.</p> <p>On 1/3/21, at 2:09 p.m. a progress note indicated R1 had a small black scab on her lower lip, with no swelling. R1 denied pain or discomfort. R1 talked non-stop all shift, and made paranoid statements.</p> <p>During interview on 1/5/21, at 11:05 a.m. nursing assistant (NA)-A reported R1 was outgoing, and her dementia caused her to yell out at times. NA-A stated R1 spoke a lot, which agitated other residents and caused conflicts between residents. NA-A stated registered nurse (RN)-A had been in the room at the time of the incident, and he heard R1 yell R2's name. NA-A stated R2 had increased behaviors when his schedule changed, and the incident likely resulted from a change in R2's routine.</p>	F 600	<p>Education included/emphasized R2's behavior, potential triggers and interventions to keep residents safe. Additional memory care staff education was conducted from 1/8/21-1/26/21. Education included/emphasized R2's specific type of dementia, behavioral expressions and maintaining his schedule.</p> <p>Facility-wide re-education was conducted on 1/26/21. Education included/emphasized resident protection, abuse, and reporting requirements.</p> <p>Audits of R1 and R2's general mood and behavioral expressions will be conducted 4 times a week for 1 month and randomly thereafter. Audits will be reviewed in the Quality Assurance meetings.</p> <p>Person responsible; Director of Nursing or designee</p> <p>Compliance date is 1/27/21</p>		

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

PRINTED: 01/29/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245343	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/05/2021
NAME OF PROVIDER OR SUPPLIER MINNESOTA MASONIC HOME CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 11501 MASONIC HOME DRIVE BLOOMINGTON, MN 55437		
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F 600	<p>Continued From page 4</p> <p>During interview on 1/5/21, at 11:35 a.m. housekeeper (H)-A stated she noticed R2 had increased abusive behaviors over the past 6 months. H-A stated R2 liked to be in control, and when not in control, R2 seemed to have more behavioral issues.</p> <p>During interview on 1/5/21, at 11:44 a.m. licensed practical nurse (LPN)-A stated R2 liked to have a structured routine, and would get agitated if his routine got disrupted, or when other residents disturbed him. LPN-A stated he heard about the incident when R2 entered the dayroom, got upset, and hit R1 in the face after R1 yelled at R2. LPN-A felt the change in R2's routine and being yelled at by R1 caused R2 act out.</p> <p>During interview on 1/5/21, at 12:04 p.m. NA-B reported R1 talked a lot, and had been the reason R2 hit R1. R2 did not like to be disturbed by others and when disturbed, it set him off. MA-B stated R1 could be mean, and call staff and residents names. NA-B thought R2 got frustrated with R1, which caused him to become abusive.</p> <p>During interview on 1/5/21, at 1:20 p.m. R2's family member (FM)-A, stated R2's agitation, anxiety and behaviors had gotten worse within the past month. FM-S stated when someone bothered R2, he would get agitated and became impulsive.</p> <p>During interview on 1/5/21, at 1:41 p.m. R1's family member (FM)-B stated the facility told him a resident punched his wife in the face. FM-B stated he did not approve of the incident, and did not want it to ever happen again. FM-B stated he could no longer care for wife, and he trusted to facility to keep her safe.</p>	F 600			

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F 600	Continued From page 5 During interview on 1/5/21, at 2:42 p.m. RN-A stated R2 came into the dayroom, and R1 told him to get out of her house. R2 ran up to R1 and hit her in the face, which cased R1 to bleed. RN-A stated R1 had blood coming out of her mouth, and a cut on her lower left lip area. RN-A stated the following day, R1 had a small scab on her lip, but did not complain when asked if it hurt. RN-A stated R2 got agitated and did not like it when someone told him what to do. RN-A stated R2 often put his hand up and tried to threaten others when he got angry. RN-A stated if she had not been at the scene of the incident, she believed R2 would have hit R1 more than once. During interview on 1/5/21, at 2:20 p.m. the director of nursing (DON) stated at the time of the incident, RN-A had been in the day room. R2 came out of his room for a meal, but the dining room door had been closed. Since the door was closed, R2 went to the dayroom where R1 had been agitated. R2 did not like loud noises, and told R1 to shut up. R1 told R2 to go to hell, and that this had been her place. The DON stated in response, R2 proceed to slap R1 across the face, and RN-A intervened right away. The DON believed the root cause to the situation had been the closed door to the dining room, which interfered with R2's schedule. The facility policy Resident Protection Plan dated 5/19, identified each individual within the facility had the right to be free from physical abuse and the facility is to protected individuals cared for from all forms of abuse.	F 600			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 20, 2021

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

Re: Event ID: 9XMB11

Dear Administrator:

The above facility survey was completed on January 5, 2021 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 feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink that reads 'Kamala Fiske-Downing'.

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us