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	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Minnesota Masonic Home Care Center	11501 Masonic Home Drive Bloomington, MN 55437

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, interview and document review, the facility failed to ensure the D1 unit shower room was maintained in a clean, sanitary manner when 25% of the shower walls were observed to be covered with unidentified pink matter. This had the potential to affect 27 of the 29 residents who resided on D1 and utilized the shower room on a routine basis.Findings include:During observation on 2/11/26 at 9 a.m., pink matter deposits were observed on the shower walls. The shower walls were covered with white tiles, and the pink matter was observed over the caulking lines and the baseboard tiles. The water knob/handle was covered with white calcium-like deposits, and there was a chrome fixture with rust-colored spots and a rust-colored stain on one of the walls right below the chrome fixture. Two plastic brushes with long handles were on the shower floor. Both brushes had pink matter on the base of the bristles. A clear plastic bag was knotted to the handheld shower head, the bag had pink matter on both ends.During observation and interview on 9/11/26 at 9:22 a.m., nursing assistant (NA)- G stated she gave a shower to a resident at 8:00 a.m. NA-G stated, after the shower, she picked up the garbage and linen and took it to the respective areas and went back to the shower room to clean the shower chair. NA-G stated, she used one of the white brushes that were on the shower floor. NA-G verified there was pink matter on the shower walls and white brushes. NA-G stated the housekeeper cleans the walls and floors.During observation and interview on 2/11/26 at 9:29 a.m., housekeeper (H)-A stated she cleaned the shower rooms every day. H-A verified the walls and brushes had pink matter as previously noted and said sometimes she uses bleach to clean those areas. H-A stated she didn't clean the shower the day before. She said she used white brushes and washcloths when she washed the shower walls. H-A stated she would ask her supervisor to supply new brushes.During observation on 2/12/26 at 9:06 a.m., the shower walls had been cleaned but there was still some pink matter on the tiles closer to the floor. The two brushes containing pink matter were leaning against the wall.During observation and interview on 2/12/26 at 9:30 a.m., infection preventionist nurse (IP) stated she was not sure what the pink matter was, but the shower needed to be cleaned, and she removed the brushes from the shower room and said they needed to be replaced.During an interview on 9/12/26 at 9:50 a.m., the administrator stated the shower should be cleaned to provide a clean environment for the residents. Administrator added, the brushes are being replaced right now.Facility's policy titled Cleaning of Resident's Spaces dated 10/2025, indicated the procedure was in place to ensure that all resident spaces were cleaned and maintained to the highest standards of hygiene and comfort.

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.

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to accommodate resident needs by ensuring the call light was accessible for 2 of 2 residents (R144, and R45) reviewed for call lights. Findings include: R144 R144's annual comprehensive Minimum Data Set (MDS) dated [DATE], indicated R144 had severe cognitive impairment, had no behaviors and didn't refuse cares. MDS indicated she had bilaterally impaired range of motion, needed substantial assistance with showers, upper body dressing, transfers and bed mobility. MDS also indicated R144 was dependent on toileting hygiene, bathing, lower body dressing and oral hygiene. R144's diagnosis list dated 2/12/26, indicated diagnoses of Parkinson's disease, dementia, left shoulder pain, dysphagia, atherosclerosis, muscle weakness, and tremors. R144's falls care plan dated 2/12/26 identified R144 at risk of falls. The care plan directed staff to be sure R144's call light was within reach, and to encourage her to use it for assistance. R144 needed prompt response to all requests for assistance, During observation on 2/9/26 at 6:30 p.m., R144 was sitting in her wheelchair (WC) in front of the TV. R144's call light was on top of a recliner chair behind the resident's WC and out of reach. During observation on 2/9/26 at 6:40 p.m., R144 was sitting in her WC in front of the TV, and her call light was on the recliner chair, out of reach. During observation and interview on 2/9/26 at 6:47 p.m. R144's call light was still out of her reach. Nursing assistant (NA)-F stated R144 could sometimes put the call light on. NA-F verified the call light was on the recliner chair and out of R144's reach. NA-F stated she [R144] will not be able to reach the call light. During interview on 2/11/26 at 11:24 a.m., nurse manager/licensed practical nurse (LPN)-C stated the call light should be placed within residents' reach. R45 R45's admissions Minimum Data Set (MDS) dated [DATE] identified R45 with moderate cognitive impairment, required assistance of two for transfers from bed to wheelchair using a mechanical lift. During continuous observation on 2/9/26 starting at 3:58 p.m., R45 was transferred from her bed to wheelchair by two nursing assistants (NA's) using a mechanical lift. Both aides left the room with R45 in wheelchair and call light wrapped around the bedrail of R45's bed out of reach and sight of R45. At 4:04 p.m. R45 stated, I am able to use the call light to ask for help, but I do not know where it is now. At 4:18 p.m., NA-A entered R45's room to transfer her to an activity and stated he had forgotten to place her call light in reach. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview with family member (FM)-A on 2/10/26 at 1:52 p.m., FM-A stated her mother (R45) relies on the call light. It has to be right there in her sight and reach, otherwise she will worry that no one is around to help her. During interview with nurse manager, (LPN)-C on 2/12/26 at 8:50 a.m., LPN-C stated expectation of call lights to be in reach of residents at all times. During interview with director of nursing (DON) on 2/12/26 at 8:57 a.m., DON stated expectation of, call lights should be in reach for residents to call for help if needed. Facility policy on reasonable accommodation of needs was requested and not received.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to revise the care plan to include the methods staff utilized and found effective for behavioral de-escalation for 1 of 1 residents (R101) reviewed for behavioral symptoms of dementia. Findings include:R101's quarterly Minimum Data Set (MDS) dated [DATE], indicated R101 had severely impaired cognition and a diagnosis of dementia. The MDS indicated R101 was dependent on staff for most activities of daily living. R101's care plan dated 3/27/25, indicated that R101 was resistant to care and taking medications, as well as having delusional thoughts at times. The care plan had the following interventions:-Dated 5/9/24, keep the resident's routine consistent and try to provide consistent caregivers as much as possible to decrease confusion.-Dated 5/13/24, allow the resident to make decisions about the treatment regimen to provide a sense of control/choice and encourage the resident when she accepts staff assistance.-Dated 10/3/24, cue, reorient, and supervise as needed.-Dated 3/27/25, allow the resident to sit at her own table outside the dining room at mealtimes to decrease overstimulation and anxiety. -Dated 3/28/25, use a plastic lipped plate with a non-slip mat underneath at mealtimes to prevent the plate from falling off the table.-The care plan was reviewed and lacked personalized behavioral de-escalation interventions such as watching the news/videos of puppies, receiving preferred snacks, and having quiet time in her room, which, per staff interview (as seen below), were effective for R101.R101's progress note dated 1/29/26 at 1:09 p.m., indicated R191 was screaming in her room, was offered chocolate, ate the item, and calmed down. R101's progress note dated 2/7/26 at 9:16 p.m., indicated R101 was screaming after dinner and was offered snacks and was calmer after. R101's progress note dated 2/9/26 at 5:46 p.m., indicated that R101 was screaming at the beginning of the shift and kept insisting that she had an appointment with her daughter, and was offered a piece of chocolate, which she did take. R101's progress note on 2/10/26 at 1:27 p.m., the progress note indicated R101 was heard screaming and saying help me, help me. The resident was offered a chocolate treat, and the resident was calmer after. R101's Kardex dated 2/11/26 was reviewed and lacked personalized behavioral de-escalation interventions such as watching the news/videos of puppies, receiving preferred snacks, and having quiet time in her room, which, per staff interview (as seen below), were effective for R101.During an observation on 2/9/26 at 2:56 p.m., R101 was observed in her room from the hallway yelling, I'm still alive, I'm still alive, they are telling a bunch of lies! as well as inaudible statements. After a few minutes, two unknown staff members were observed to enter R101's room and were heard to offer the resident a piece of chocolate and appeared to continue to talk with the resident, although further conversation was inaudible from the hallway. R101 was not heard yelling during her interaction with staff. During an interview on 2/11/26 at 8:29 a.m., nursing assistant (NA)-B stated R101 did have some behaviors, such as yelling even when no one was interacting with her and being resistant to care. NA-B stated that when she worked with R101 in the past, what worked when R101 was having these behaviors was to assist the resident back to her room to let her calm down. If R101 was being resistant to care or having behaviors, she would not force R101 to do anything, but would give R101 a cup of coffee, a banana, or chocolate, which she enjoys, and then reapproach. NA-B stated that when she had worked with R101 in the past, these interventions generally worked for her, and R101 would calm down, and she would be able to complete cares. During an interview on 2/11/26 at 8:32 a.m., licensed practical nurse (LPN)-D, the nurse manager of the unit, stated R101 had behaviors such as screaming, yelling, and paranoia, and would look very uncomfortable while doing so. LPN-D stated R101 would scream about things such as worries that her daughter was in a car accident or she needed to go to a doctor's appointment, even when no one was in the room. LPN-D stated that when R101 was elevated, she would assist the resident to her room away from others and have her watch the news and videos of puppies, which (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	helped calm her down. The nurse manager stated the resident was also responsive to receiving food items that she liked, such as chocolate. LPN-D stated she was not sure if these things had made it to the care plan but didn't routinely put things like this in the care plan, but could start doing so. LPN-D stated the care plan and the Kardex was where facility staff put interventions related to behaviors the resident was having, and where the nurses and aides could see updates. During an interview on 2/11/26 at 8:43 a.m., LPN-E stated she was the nurse for R101 today and worked with her frequently. LPN-E stated something that had worked previously and today for R101 when she was having behaviors or resistant to care, was talking about puppies and her daughter. LPN-E stated she would also assist R101 to a quiet spot, such as her room, when she was having behaviors, because that seems to calm her down.During an interview on 2/12/26 at 8:39 a.m., the director of nursing (DON) stated that the nurse managers oversaw updating the care plan with personalized interventions. The DON stated that she would expect personalization of the care plan, including the basic things that the resident likes, such as food items, and interventions specific to the resident, but acknowledged this can be hard to determine for residents with dementia, as this can change day to day. The facility's Care Plans policy dated 10/2025, indicated the facility would provide resident-centered care in accordance with the resident's preferences and stated goals as outlined in the care plan. The policy indicated the care plan must include the interventions that were to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The care plan indicated the nurse was to update the care plan to reflect the changing needs of the resident. The policy indicated that the nursing assistants were to participate in weekly interdisciplinary team meetings regarding all residents to ensure the residents' care plan was accurately developed. The policy indicated that every two weeks, the nursing assistants would review the Kardex and provide attestation that any changes were reported to the nurse.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review the facility failed to ensure residents using a continuous positive airway pressure (CPAP) machine had appropriate orders for use to include equipment setting and humidification as appropriate for 3 of 3 residents (R1, R91, and R150) reviewed for respiratory equipment. Findings include: R1 R1's significant change in status (SCSA) Minimum Data Set (MDS) dated [DATE] identified R1 with intact cognition, required substantial assistance for toileting, dressing, and hygiene. In addition, diagnoses include heart failure, kidney disease, obstructive sleep apnea (OSA) and dependence on oxygen. Also, R1 receiving hospice services (end of life care). R1's physician orders dated 11/26/25 identified: Continuous Positive Air Pressure (CPAP) at home settings, on at hour of sleep (HS), off in morning (AM), for dx: OSA. R1's care plan dated 12/10/25 identified CPAP on at pre-programmed settings when sleeping. No settings were identified. R1's medical record failed to identify settings for CPAP. During observation and interview with R1 on 2/11/26 at 12:09 p.m., R1 stated he had been prescribed CPAP since 2013 and the machine that was being used by the facility It is from my home. R1 stated he was not aware of facility asking or programming his CPAP. During interview with licensed practical nurse (LPN)-B on 2/11/26 at 12:20 p.m., LPN-B stated we don't look at settings. We only unplug it and wash it and put fresh water in the reservoir. LPN-B stated, we would not know if there is a problem with it unless it alarms somehow or doesn't turn on. R91 R91's quarterly MDS dated [DATE] identified R91 with impaired cognition, required assistance with all assistance with daily living (ADL's) and had diagnoses of diabetes, kidney disease, OSA ,and morbid obesity. R91's orders dated 7/1/24 identified: CPAP at home settings, on at HS, off in AM, for dx: sleep apnea. R91's care plan dated 5/13/24 identified R91 with CPAP on at pre-programmed settings when sleeping. During interview with unit nurse manager/licensed practical nurse (LPN)-C on 2/12/26 at 8:39 a.m., LPN-C stated, we do not have specific orders for settings and troubleshooting the CPAPs and it is important to have those so we all know how to set them up if needed and provide maintenance. During interview with director of nursing (DON) on 2/12/26 at 8:57 a.m. DON stated facility did not (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	obtain specific CPAP settings and orders from medical providers when admitting residents. DON stated she agreed that specific settings and orders are needed to ensure residents receive ordered treatments, which include CPAP. DON agreed that CPAP settings should be put in the resident physician orders and care plans. R150 R150 quarterly Minimum Data Set (MDS), dated [DATE], indicated R150 was admitted to the care facility on 2/11/25 and had moderate cognitive impairment. The MDS Further indicated R150 required substantial to maximum assistance with bathing and dressing and partial to moderate assistance with personal hygiene. R150's Diagnosis List indicated R150 had several medical diagnoses including obstructive sleep apnea, dated 2/11/25. R150's Orders, indicated an order, dated 12/17/25, for CPAP at home setting on a bedtime and off in the morning for a diagnosis of obstructive sleep apnea. R150's care plan, dated 2/11/25, also indicated CPAP on preprogrammed setting when sleeping. During an interview on 2/11/26 at 7:41 a.m., nursing assistant (NA)-C stated the NAs would place R150's CPAP machine at bedtime and remove it in the morning, stating the nurses were responsible cleaning the machine. During an interview on 2/11/26 at 8:41 a.m., registered nurse (RN)-A stated the CPAPs she had worked with at the care facility came with the resident's preprogrammed from home. RN-A stated staff would simply fill the chamber with water and turn it on and did not monitor to ensure the machine was set at the correct settings. RN-A confirmed CPAP settings, including R150's, directed to use home settings and were not resident specific. During an interview on 2/11/26 at 9:15 a.m., nurse manager and licensed practical nurse (LPN)-F confirmed that resident CPAPs came to the facility preprogrammed and most resident families managed the resident CPAPs. LPN-F stated if something looked not right with a resident's CPAP, staff would be expected to notify her, and she would try to get in touch with family or possibly the resident's pulmonologist if one was involved in the resident's care, to inquire about proper settings. Facility policy on CPAP management and orders was requested and not received.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, and interview, the facility failed to ensure food was served at palatable temperatures for 1 of 1 residents (R31) who were observed to be served and expressed concerns about inappropriate food temperature.Findings include:R31R31's admissions Minimum Data Set (MDS) dated [DATE] identified R31 with intact cognition.During interview with R31 on 2/10/26 at 2:06 p.m., R31 stated, I have a problem with 90% of the time [when food] gets here it is lukewarm.During breakfast meal service to R31 room on 2/11/26 at 8:10 a.m., dietary aide (DA)-B was asked to obtain temperature of R31 food prior to bringing meal tray into her room. Both DA-B and licensed practical nurse (LPN)-A verified the glass of milk was 51 degrees Fahrenheit (F), and oatmeal was 136 degrees F. DA-B stated, milk should be at 40 [degrees F] or below and oatmeal should be over 140 [degrees F]. DA-B stated importance of serving food at proper temp ,to make sure [residents] don't get sick. LPN-A unable to state acceptable temperature parameters.During interview with dietary supervisor (DS) on 2/10/26 at 8:25 a.m., DS stated expectation of serving food to residents as, Milk should be in the 40's [degree Fahrenheit] and Oatmeal should be at least 140 [degrees Fahrenheit]. DS stated the milk should have ben colder to be served and not [safe or] appetizing to have food that is not a desired temp.Facility policy on serving food to residents at desirable temperatures was requested and not received.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure enhanced barrier precautions (EBP) were followed for 1 of 1 resident (R8), reviewed for EBP. Findings include:R8's significant change Minimum Data Set (MDS) dated [DATE], indicated R8 had moderate cognitive impairment, did not refuse cares, needed substantial assistance with dressing, bed mobility and was dependent with toileting hygiene and bathing.R8's medical diagnosis report dated 2/11/26, indicated diagnoses of urinary tract infection, type 2 diabetes, retention of urine, chronic kidney disease stage 2, lumbar vertebra compression fracture and hypertension.R8's physician orders record dated 2/11/26, included and order for an indwelling catheter.R8's care plan dated 2/11/26, indicated R8 was on EBP due to having a foley catheter and a chronic wound. R8's care plan indicated the EBP protected R8 from drug-resistant infection and instructed staff to use a gown and gloves during identified high-risk cares. During observation on 2/9/26 at 3:08 p.m., an EBP sign was posted on the wall next to R8's door. The sign indicated the staff needed to clean their hands before entering the room. It also indicated staff needed to wear a gown and gloves for high contact resident care activities including providing hygiene, changing briefs and catheter care. During observation on 2/10/26 at 2:05 p.m., nursing assistant (NA)-E and NA-D provided bowel incontinent care to R8. NA-D and NA-E were wearing gloves but not gowns. During interview on 2/10/26 at 2:14 p.m., NA-D stated she had worked at the facility for a month. NA-D stated she forgot to wear a gown and said she should wear one for potential infections.During interview on 2/10/26 at 2:19 p.m., NA-E stated the sign next to R8's room meant he had to wear a gown and gloves when he provided catheter care, but not when R8 had a bowel movement. NA-E smiled and said I knew I needed to use a gown. I didn't use it because I was rushing. NA-E stated it was important to use a gown because the catheter can transfer germs, and the employees can get in contact with germs. During an interview on 2/11/26 at 12:56 p.m., the infection preventionist (IP), stated she would expect staff to utilize required PPE such as gowns and gloves to follow EBP. When asked if she would expect staff to wear a gown and gloves when completing perineal care after a bowel movement for a resident with a catheter, she stated she would if the staff were in prolonged close contact. Facility's policy titled Standard and Transmission Based Precautions dated 3/2025, indicated EBP was designed to reduce transmission of multidrug-resistant organisms (MDROs). The policy indicated Nursing home residents with chronic wounds or indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs.