DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
June 1, 2026

Administrator
The Estates at Bloomington LLC
9200 NICOLLET AVENUE SOUTH
BLOOMINGTON, MN 55420

RE: CCN: 245324
Cycle Start Date: April 23, 2026

Dear Administrator:

On June 1, 2026, the Minnesota Departments 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.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

May 5, 2026

Administrator
The Estates at Bloomington LLC
9200 NICOLLET AVENUE SOUTH
BLOOMINGTON, MN 55420

RE: CCN:245324

Cycle Start Date: April 23, 2026

Dear Administrator:

On April 23, 2026, 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" and/or an "E" tag), i.e., the plan of correction should be directed to:

Stefanie Salberg, Regional Operations Supervisor
Metro C District Office
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: stefanie.salberg@state.mn.us
Office: 651-201-4393 Mobile: 651-279-5602

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 July 23, 2026 (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 October 23, 2026 (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)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution
This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.
A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245324	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Estates at Bloomington LLC	**9200 NICOLLET AVENUE SOUTH , BLOOMINGTON, Minnesota, 55420**

(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
E0000	Initial Comments On 4/20/26 - 4/23/26, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. 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.	E0000		05/21/2026
F0000	INITIAL COMMENTS On 4/20/26 - 4/23/26, a standard recertification survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. Your facility was NOT in compliance. 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 onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F0000		05/21/2026
F0550 SS = D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.	F0550	Immediate corrective action-Staff have been knocking on R9 door since this incident occurred per observation. Corrective action as it applies to others: All residents could be affected. Resident rights policy has been reviewed with no changes noted.	05/21/2026

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 reverse for further 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245324	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/23/2026

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F0550 SS = D	Continued from page 1 §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observation and interview, the facility failed to ensure dignity was maintained for 2 of 2 residents (R9, R13) reviewed for dignity when staff failed to knock, introduced themselves, and wait for permission to enter resident rooms prior to entry. Findings include: R9 R9's quarterly Minimum Data Set (MDS) dated 1/6/26 identified R9 with dementia, psychosis and dependent on staff for all cares. In addition, R9 was enrolled in hospice.	F0550	Continued from page 1 Education: DNS or Designee to initiate ongoing education with all staff regarding resident rights, privacy, and dignity, including knocking, announcing themselves, and waiting for acknowledgment before entering their room. Date of Compliance: May21, 2026. Recurrence will be prevented by: Audits will be conducted for 5 residents 3 times a week for 4 weeks to ensure staff are knocking on residents' room door, waiting and announcing themselves before entering. The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease or discontinue the audits. Corrections will be monitored by: DON/ or Designee	05/21/2026

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F0550 SS = D	Continued from page 2 R13 R13's quarterly MDS dated 1/8/26 identified R13 was cognitively intact and had diagnoses of fibromyalgia, anxiety, depression and chronic pain. During observation and interview on 4/20/26 at 2:30 p.m., the State Agency (SA) surveyor was in process of screening R13 in their room which was shared with R9. The bedroom door to hallway was closed and a privacy curtain was pulled around R13 who was lying on bed. Nursing assistant (NA)-A entered the room with R9 who was seated in Broda wheelchair. During this time NA-A failed to knock, introduce herself, and wait for permission to enter the room. NA-A wheeled R9 into the middle of the room and then turned around and left the room without speaking. At 2:35 p.m., NA-A and NA-B entered room again without knocking. Both looked at SA and then exited room with R9. During interview both NA-A and NA-B verified they did not knock, introduce themselves, and wait for permission to enter the shared room. Both NA-A and NA-B stated it was important to "knock before entering" and NA-B stated, "Did not think of it". During interview with R13 on 4/20/26 at 2:47 p.m., R13 stated most staff failed to knock and wait for permission to enter her room which she did not like. R13 stated an instance where a staff member "popped her head into my room and the curtain [facing the hallway] while I was naked and she did not even knock or introduce herself." R13 was upset and verbalized "this is my home. Why would anyone do that?" During interview with director of nursing (DON) on 4/23/26 at 6:45 a.m., DON stated expectation of all staff to knock and wait for permission to enter any resident room. Facility policy was requested and not received.	F0550		05/21/2026
F0558 SS = D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is NOT MET as evidenced by: During observation, interview, and record review, the	F0558	Immediate corrective action: Call light was placed within R9 reach. Corrective action as it applies to others: Full house audits was completed to Ensure all residents have a clip attached to call light and call light is within resident's reach. Process change/policy: Call light policy reviewed with no changes noted. Education: DNS or Designee to initiate ongoing education with all staff on the importance of call	05/21/2026

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F0558 SS = D	Continued from page 3 facility failed to accommodate resident needs by ensuring the call light was accessible for 1 of 1 residents (R9) reviewed for call lights. Findings include: R9 R9's quarterly Minimum Data Set (MDS) dated 1/6/26 identified R9 with impaired cognition, no limitation in upper extremity range of motion and dependent on staff for turning, repositioning, transfers, and all personal cares. R9's diagnoses include dementia. In addition, R9 was enrolled in hospice. During observation on 4/20/26 at 2:30 p.m., nursing assistant (NA)-A wheeled R9 into the middle of their room without placing a call light in reach and then turned around and left the room without speaking. R13's call light was on R13's bed which was approximately 15 feet away. During interview upon leaving R13's room, NA-A confirmed R13 was not able to use her legs and would not have been able to reach the call light while seated in the middle of the room. During observation on 4/21/26 at 9:00 a.m., R9 was lying in bed positioned partially on her right side. The head of the bed was elevated to 45 degrees, and two pillows were under her head. One pillow was positioned along the left side of her body, and one pillow was positioned to her right side. The call light was attached to bed sheet under right sided pillow hanging down to the bed frame and out of sight of R9. During interview with nursing assistant (NA)-A on 4/22/26 at 8:24 a.m., NA-A verbalized familiarity with taking care of R9 and, "[R9] is able to use the call light". NA-A stated expectation of call light to be in reach of residents if they need assistance. During interview with director of nursing (DON) on 4/23/26 at 6:47 a.m., DON stated expectation of every resident "should have a call light in reach" and "It is their lifeline" to ask for help if needed. Facility policy titled Call Light, updated 5/16/23 identified, "Call cords, buttons, or other communication devices must be placed where they are within reach of each resident".	F0558	Continued from page 3 lights within reach and to be placed within reach before leaving a resident unattended. Date of Compliance: May21, 2026. Recurrence will be prevented by: Audits will be conducted for 4 residents 3 times a week for 4 weeks to ensure residents' call lights are within their reach and that they have a clip. The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease or discontinue the audits. Corrections will monitored by: DON/ or Designee	05/21/2026

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F0628 SS = D	Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2) §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section.	F0628	Immediate corrective action: R4 has returned to facility. Corrective action as it applies to others : All residents could be affected Process changes/Policy: Bed Holds and Returns were reviewed and no changes identified Education: DNS or Designee to initiate ongoing education for all nurses to the bed hold process including documenting all attempts made if a bed hold was unable to be obtained. Date of Compliance: May 21, 2026. Recurrence will be prevented by: Audit all residents that has been transferred to ensure bed holds are obtained and documentation is in place for 4 weeks. The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease or discontinue the audits. Corrections will monitored by: DON/ or Designee	05/21/2026

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F0628 SS = D	Continued from page 5 §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the	F0628		05/21/2026

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F0628 SS = D	Continued from page 6 mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with	F0628		05/21/2026

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F0628 SS = D	Continued from page 7 paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to provide a written transfer notice and notice of bed hold for 1 of 1 residents (R4) reviewed for hospitalization. Findings include: R4’s admissions Minimum Data Set dated 2/23/26 identified R4 with impaired cognition, required assistance with all personal cares, and diagnoses of hemiplegia (form of paralysis affecting one side of the body), diabetes and anxiety. R4’s electronic medical record (EMR) progress notes lacked indication of a hospitalization or emergency room visit since admission to facility on 2/18/26. R4’s hospital after visit summary dated 4/14/26,	F0628		05/21/2026

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F0628 SS = D	Continued from page 8 identified R4 was transferred to the emergency room for diarrhea. During interview with R4 on 4/20/26 at 1:27 p.m., R4 stated she had had a hospitalization for diarrhea recently but did not know what the date was. In addition, R4 could not recall whether she was offered or provided a transfer form or bed hold notice at the time of the emergency room visit. R4's emergency contact was called on 4/22/26 at 11:25 a.m., with no answer. During interview with registered nurse (RN)-C on 4/22/26 at 11:50 a.m., RN-C stated expectations of staff to offer and provide a signed transfer form and bed hold to resident or guardian to accompany the resident to the hospital upon transfer for higher level of treatment. Also, the nurse is expected to document in the electronic medical record (EMR) that they offered and provided the transfer form and bed hold to the resident or guardian in a progress note. If the nurse left a message, then the nurse was to document that a message was left, and the facility was expected to follow up with the resident or guardian until they received an answer. RN-C stated the original transfer form and bed hold should be downloaded into the EMR under the Forms tab by the facility. RN-C verified that he was the nurse that sent R4 to the hospital on 4/14/26. RN-C stated he believed he had called and left a message with R4's guardian but did not document it. During interview with licensed practical nurse (LPN)-A on 4/22/26 at 12:01 p.m., LPN-A stated expectations of nursing staff to offer and provide a signed transfer form and bed hold to accompany the resident to the hospital upon transfer for higher level of treatment. Also, the nurse is expected to document in the electronic medical record (EMR) that they offered and provided the forms to the resident or guardian in a progress note. If the nurse left a message, then the nurse was to document that a message was left, and the facility was expected to follow up with the resident or guardian until they received an answer. During interview with director of nursing (DON) on 4/22/26 at 1:22 p.m., the DON stated expectation of staff to offer and provide a signed transfer form and bed hold to accompany the resident to the hospital upon transfer for higher level of treatment and the nurse was expected to document it in a progress note. If the nurse left a message, then the nurse was to document that a message was left, and the facility was expected to follow up with the resident or	F0628		05/21/2026

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F0628 SS = D	Continued from page 9 guardian until they received an answer. DON verified R4's EMR did not have a transfer form or bed hold notice and that facility failed to follow up on obtaining it. DON stated, "should be done". Facility policy titled Bed-Holds and Returns, updated 2/26/26 identified, "Prior to a transfer, written information will be given to the residents and the resident representatives that explains in detail: a. The rights and limitations of the resident regarding bed-holds; b. The reserve bed payment policy as indicated by the state plan (Medicaid residents); c. The facility per diem rate required to hold a bed (non-Medicaid residents), or to hold a bed beyond the state bed-hold period (Medicaid residents); and d. The details of the transfer (per the Notice of Transfer)."	F0628		05/21/2026
F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.	F0656	Immediate corrective action: R67 care plan has been reviewed to include more information regarding her behavior and added more interventions. This information was also updated on the NAR guide. Corrective action as it applies to others: Full house audits was done to identify all residents with fluid restrictions. Those residents were reviewed to determine compliance and ensured interventions are in place for noncompliant residents. Education: DNS or Designee to initiate ongoing education to Nurse Leaders regarding fluid restrictions, noncompliance and developing/implementing and revising a comprehensive person center careplan with individualized interventions. Process change/policy: Care Planning policy reviewed with no changes identified. Date of Compliance: May21, 2026. Recurrence will be prevented by: DNS or Designee will audit all residents with fluid restrictions to monitor compliance and need for interventions for 4 weeks. The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease or discontinue the audits. Corrections will monitored by: DON/ or Designee	05/21/2026

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F0656 SS = D	Continued from page 10 (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and record review, the facility failed to develop and implement, or revise as needed, a comprehensive, person-centered care plan with individualized interventions for 1 of 1 resident (R67) reviewed for fluid management, related to the resident's diagnosis of polydipsia (excessive, persistent thirst or compulsive, excessive water consumption) and ongoing fluid-seeking behaviors Findings include: R67's quarterly Minimum Data Set (MDS), dated 3/17/26, indicated R67 was admitted to the care facility on 10/25 and had severe cognitive impairment. R67's Diagnoses, dated 10/25/24, indicated R67 had a diagnosis of polydipsia. R67's care plan, dated 10/29/24, indicated a risk versus benefit form was completed and on file for R67 for not following the recommended diet related to the diagnosis of polydipsia. The care plan also indicated R67 was observed trying to get drinks from other residents and drinking water out of the bathroom sink. The care plan contained interventions, dated 3/24/25 of an 1800 milliliter fluid restriction and to offer fluids and snacks between meals. The care plan however lacked any updated or resident specific interventions to reduce fluid seeking behaviors and to increase R67's comfort related to polydipsia despite R67's continued repeated attempts to obtain more	F0656		05/21/2026

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F0656 SS = D	Continued from page 11 fluids. R67's April 2026 Treatment Administration Record (TAR), indicated R67's fluid intake and fluid seeking behaviors were being monitored but lacked resident specific interventions to assist with R67's fluid seeking behavior. During observation and interview on 4/21/26 at approximately 1:30 p.m., R67 was pacing between her room and hallway, asking to get into the bathroom. A sign hung on R67's door indicating to keep door closed and not allow R67 access to the bathroom. Two unnamed staff members were talking and stated R67's bathroom door remained lock to prevent R67 from drinking water from the bathroom sink, the other stating "I think she needs more reminders". During an interview on 4/22/26 at 9:30 a.m., nursing assistant (NA)-C stated staff monitored R67's food and fluid intake during meals and tracked intake as part of care. The NA-C reported that fluids provided in R67's room were thickened and offered in small cups, and when R67 requested fluids, staff provided thickened liquids in small amounts using the small medication cups. The NA-C further stated the resident frequently requested fluids. During an interview on 4/22/26 at 10:43 a.m., registered nurse (RN)-B stated R67's fluid intake was monitored due to a history of hospitalization for aspiration concerns and returned to the facility with aspiration pneumonia and fluid retention while on furosemide. The RN reported the resident was currently on daily weights and a fluid restriction. The RN further stated staff manage R67's excessive thirst through frequent redirection when she requested additional fluids; however, the resident continued to request fluids frequently and became upset and call staff names when additional fluids were not provided. The RN indicated R67 was provided fluids in the form of pudding, ice cream, supplements, and one water jug per shift. The RN also stated the resident's bathroom door was kept closed and a commode was used as part of management. During an interview on 4/23/26 at 9:00 a.m., nurse manager and registered nurse (RN)-D and the director of nursing (DON) stated R67's fluid intake was monitored and when the resident reported feeling thirsty, staff provided recommended fluids. The nurse manager reported staff were aware of the resident's excessive thirst and a risk-versus-benefit approach was utilized, including direction for float staff to check with the nurse; however, they acknowledged the resident's polydipsia was not specifically care planned. The Nurse Manager further stated interventions such as lemon oral swabs were available but had not been trialed to address the resident's thirst. It was also stated that while the behavior was documented in	F0656		05/21/2026

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F0656 SS = D	Continued from page 12 the nutrition section of the record, it lacked individualized interventions to guide staff in managing the resident's excessive fluid-seeking behavior and should be care planned so new staff know how to address R67's polydipsia. A facility policy titled Care Planning, revised 11/2024, indicated, "The interdisciplinary team (IDT), in conjunction with the resident and the resident representative, will develop and implement a comprehensive individualized care plan no later than the 21st day of admission of the resident. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment."	F0656		05/21/2026
F0695 SS = D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to ensure accurate and complete respiratory care documentation and resident-specifc ordered settings for the use and management of a BIPAP device (bilevel positive airway pressure device - a non-invasive ventilation machine to helps in breathing) for 1 of 1 resident (R17) reviewed for respiratory care. Findings include: R17's quarterly Minimum Data Set (MDS), dated 3/18/26, indicated R17 was admitted to the facility on 7/10/24, had a Brief Interview for Mental Status (BIMS) score of 14 (indicating intact cognition), and utilized a non-invasive mechanical ventilator. R17's physician orders, printed 4/23/26, indicated an order for a BIPAP machine to be applied at bedtime (HS), to remain on during nocturnal hours, and to be removed in the morning. Additional orders directed staff to change the BIPAP water daily, including emptying, drying, and refilling the chamber with distilled water to the fill line without overfilling	F0695	Immediate corrective action: R17 BiPAP ordered settings for the use and management of a BIPAP device was entered in the order. Corrective action as it applies to others: Full house audits was completed to ensure all residents that have BiPAP/CPAP have order settings are in the BiPAP/CPAP orders. Education: DNS/or Designee to initiate education with all nurses on the importance of obtaining BiPAP/CPAP settings and enter it in resident's chart. Date of Compliance: May21, 2026. Recurrence will be prevented by: Will audit all residents with BiPAP/CPAP to ensure settings are in the BiPAP/CPAP orders for 4 weeks. The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease or discontinue the audits. Corrections will monitored by: DON/or Designee	05/21/2026

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F0695 SS = D	Continued from page 13 each evening shift. Weekly orders included cleaning the BIPAP water chamber with gentle soap and allowing it to air dry, as well as cleaning the BIPAP mask and tubing with gentle soap and warm water and allowing them to air dry every Sunday on the evening shift. The orders, however, lacked specific BIPAP settings and did not include clear direction for staff to verify or maintain prescribed settings. During an interview on 4/22/26 at 10:43 a.m., registered nurse (RN)-B stated that for residents with a CPAP or BIPAP, the machines typically arrived pre-set and staff were instructed not to adjust the settings unless there was a malfunction. RN-B stated nurses checked the machine to ensure the settings remained as originally set, particularly for residents who may attempt to alter the device; however, no documented settings were identified for R17 to verify accuracy. During an interview on 4/23/26 at 9:00 a.m., nurse manager and registered nurse (RN)-D stated when a BIPAP was ordered, the facility typically faxed the order to a respiratory company (such as Northwest Respiratory), who then came to the facility to set up the machine. RN-D stated staff were expected to have specific settings documented in the orders and that nurses assisted residents with donning and doffing the BIPAP and ensuring the setting are correct. RN-D further stated she had recently reviewed R17's record and was unable to locate documentation identifying the respiratory company responsible for setup or the specific BIPAP settings, noting R17 was the only resident for whom this information could not be found and that follow-up was in progress. A facility policy on respiratory care/BIPAP care was requested and not received.	F0695		05/21/2026
F0757 SS = D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or	F0757	Immediate corrective action: R5 & R28 pain assessment was completed to identify nonpharmacological nursing intervention and those were added into their orders and care plan Corrective action as it applies to others: full house audit was completed to identify residents that received prn pain medications and ensure that they have a non-pharmacological pain intervention in their orders and care plan. Process change/Policy: Pain Management Protocol was reviewed and no changes needed.	05/21/2026

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F0757 SS = D	Continued from page 14 §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure non-pharmacological interventions were attempted and recorded prior to the administration of as-needed (PRN) narcotic/opioid and non-narcotic medication to help facilitate person-centered care planning and reduce the risk of complication (i.e., constipation, sedation) for 2 of 6 residents (R5, R28) reviewed for unnecessary medication use. Findings include: R5 R5's admission Minimum Data Set (MDS) assessment, dated 3/19/26, identified R5 had intact cognition with no hallucinations, delusions, verbal or physical behaviors. R5 did reject cares 1-3 times during observation period. In addition, the MDS outlined R5 received both scheduled and PRN pain medications during the review; however, did not receive any non-medication intervention for pain. Further, R5 indicated they had occasional pain which they rated at four (4) out of 10 (10 being the worst possible). R5's care plan, initiated on 3/17/26, identified R5 had an alteration in pain due to low back pain with a list goal of "adequate relief from pain as evidenced by verbalization and freedom from signs/signs of non-verbal indicators of pain." The care plan listed intervention to help R5 meet this goal which included, "provide non-medicinal forms of pain relief such as positioning, rest, massage, etc.," and "pain medication as ordered my MD," and "document on effectiveness of pain medication."	F0757	Continued from page 14 Education: Nursing staff were educated on pain management protocols, including offering nonpharmacological pain interventions. License nurses were educated on requirement to attempt and document non-pharmacological interventions prior to administering prn pain medications. Clinical leaders were educated regarding assessing for resident specific nonpharmacological interventions and to add them to the orders and the care plan Date of Compliance: May21, 2026. Recurrence will be prevented by: Audits will be completed for all new admissions and readmissions weekly for 4 weeks to ensure resident specific non-pharmacological interventions are in the orders and the care plan. Audit 5 residents to ensure non-pharm pain intervention is documented before offering prn pain medications weekly for 4 weeks. The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease or discontinue the audits. Corrections will monitored by: DON/Designee	05/21/2026

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F0757 SS = D	Continued from page 15 R5's April Medication and Treatment Administration Report (MAR/TAR) for 4/1/26 to 4/22/26 was reviewed and identified the following relevant information: -hydrocodone-acetaminophen 5-325 mg tablet – give one tablet by mouth as needed for severe pain twice a day for 10 days, separate doses by at least 6 hours with a start date of 3/23/26 and end date of 4/6/26 which had been administered 5 times. One administration was marked with an "I" which indicated ineffective and one with an "U" which indicated unknown per follow-up code guide. The remaining 3 administrations were documented with an "e" indicated effective. All administrations were documented with pain scale. There was no documentation with administration of a nonpharmacological intervention being offered prior to administration. - hydrocodone-acetaminophen 5-325 mg tablet – give one tablet by mouth as needed for severe pain for 7 days with a start date of 4/6/26 and end date of 4/13/26 which had been administered 5 times. Administrations documented with an "e" indicating effective along with a pain scale prior to administration. There was no documentation on the MAR of nonpharmacological interventions prior to administration. -hydrocodone-acetaminophen (opioid pain medication)5-325 milligram (mg) tablet – give one tablet by mouth as needed for pain for 10 days with a start date of 4/13/26 and end date of 4/24/26 which had been administered 6 times. Administrations documented with an "e" indicating effective along with a pain scale prior to administration. There was no documentation on the MAR of nonpharmacological interventions prior to administration. -methocarbamol (medication used to relieve pain) 600 mg tablet – give 600 mg by mouth as needed for pain / spasms with a start date of 3/19/26 which had been administered 22 times. The MAR/TAR lacked any orders or documentation for nonpharmacological interventions offered or attempted prior to administration of PRN medication administrated for pain. R5's progress notes, dated 4/1/26 to 4/22/26, were reviewed. Progress notes lacked evidence of nonpharmacological interventions being offered or attempted prior to administration of PRN pain medication.	F0757		05/21/2026

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F0757 SS = D	Continued from page 16 R5's medical record was reviewed and lacked evidence of what, if any, non-pharmacological interventions were offered or attempted prior to the administration of the PRN narcotic medication all the administered doses from 4/1/26 to 4/22/26. During an observation and interview on 4/20/26 at 3:22 p.m., R5 was observed lying in bed. R5 stated he had chronic pain and took muscle relaxants and narcotics to manage the pain. During the interview, R5 was administered pain medication (hydrocodone-acetaminophen and methocarbamol). During the observation, R5 was asked about a pain scale but was not offered any nonpharmacological interventions prior to the administration. R5 stated sometimes they will sometimes offer him alternatives prior to pain medications which are helpful such as putting a pillow underneath him to help reposition him. During an interview on 4/22/26 at 2:05 p.m., registered nurse (RN)-C stated when a resident reported pain, an assessment would be completed which included location of pain and vital signs. RN-C stated they would offer PRN pain medication and contact the provider if needed. RN-C stated if the resident was offered any non-pharmacological interventions, it would be documented on the MAR/TAR or in a progress note. During an interview on 4/23/26 at 9:14 a.m., licensed practical nurse care coordinator (LPN)-B stated the expectation would be a nurse completed a full evaluation on a resident when pain was reported. LPN-B stated the expectation would be a nonpharmacological intervention would be offered and documented prior to administration of PRN pain medications. During a follow up interview on 4/23/26 at 9:51 a.m., LPN-B verified there were no documented non-pharmacological interventions for R5 prior to administration of PRN pain medications. R28 R28's Minimum Data Set (MDS), dated 2/23/26, indicated R28 was admitted to the facility on 2/18/26, had a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition, and received PRN pain medication. The MDS further indicated R28 did not receive non-medication pain interventions. R28's care plan, initiated 2/20/26, indicated the resident was to receive non-pharmacological pain interventions, including positioning, rest, massage,	F0757		05/21/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245324	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Estates at Bloomington LLC	**9200 NICOLLET AVENUE SOUTH , BLOOMINGTON, Minnesota, 55420**

(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
F0757 SS = D	Continued from page 17 and other comfort measures. However, the electronic medical record lacked documentation identifying resident-specific non-pharmacological interventions that had been attempted, what interventions were effective, or what interventions were ineffective for R28's pain management. Record review of physician orders indicated Cymbalta (Duloxetine) 60 mg daily for fibromyalgia and Methocarbamol (a muscle relaxant) 500 mg every 6 hours as needed for pain/spasm. The record lacked any individualized, resident-specific non-pharmacological interventions associated with the PRN (as needed) pain regimen. R28's Medication Administration Record (MAR) and Treatment Administration Record (TAR) indicated R28 received 7 doses of Methocarbamol in April, with no corresponding documentation of non-pharmacological pain interventions provided prior to administration. During an interview on 4/22/26 at 10:43 a.m., registered nurse (RN)-B stated that when residents requested pain medication, they may receive PRN medication as needed. RN-B stated non-pharmacological interventions should be offered prior to PRN administration and documented in the MAR/TAR. RN-B stated residents with pain should have an associated order to offer specific non-pharmacological interventions and document via number association in the MAR/TAR. During an interview on 4/23/26 at 9:00 a.m., the nurse manager and (RN-D) and the Director of Nursing (DON) stated the expectation was that non-pharmacological pain interventions, such as repositioning, distraction, and other comfort measures, were to be implemented and documented prior to or in conjunction with PRN pain medication use. RN-D further stated that individualized non-pharmacological interventions should be identified in the care plan and documented to reflect what is effective or ineffective. At 9:52 a.m. on 4/23/26, follow-up with the DON indicated that non-pharmacological interventions for R28's muscle relaxer use could not be located, and the DON acknowledged that interventions must be documented to determine effectiveness and guide ongoing care. A facility policy titled Pain Management Protocol, dated 3/23/23, identified "nursing will evaluate for appropriate non-pharmacological interventions to address the individual's pain."	F0757		05/21/2026

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F0921 SS = D	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is NOT MET as evidenced by: During observation and interview, the facility failed to maintain a safe, comfortable, and homelike environment for 2 of 2 residents (R9, R13) reviewed whose main bedroom ceiling light did not function properly. Findings include: R9 R9's quarterly Minimum Data Set (MDS) dated 1/6/26 identified R9 with impaired cognition, no limitation in upper extremity range of motion and dependent on staff for turning, repositioning, transfers, and all personal cares. R9's diagnoses include dementia. In addition, R9 was enrolled in hospice. R13 R13's quarterly MDS dated 1/8/26 identified R13 with intact cognition and diagnoses of fibromyalgia, anxiety, depression and chronic pain. During observation and interview with R13 on 4/20/26 at 2:31 p.m., R13 pointed to flickering ceiling light and stated it had not worked for a long time. R13 stated she was frustrated, "to have that strobe light flicker on and off" which caused her headaches. R13 stated she had to currently use the pull string light over the head of her bed instead, otherwise the room was dark. During interview with nursing assistant (NA)-D on 4/22/26 at 1:39 p.m., NA-D stated expectation of staff to use the electronic messaging system, called TELS, to request maintenance repairs. NA-D stated all staff were trained and aware of putting in requests for maintenance to address. NA-D stated she was aware of R9 and R13's ceiling light not working for at least a month. "No one likes [their light] flickering."	F0921	Immediate corrective action: R9 & R13 overhead light was replaced and is in working condition. Corrective action as it applies to others: Full house audit was completed to check all lights to ensure they are in working condition. Education: Will educate all staff to ensure that non-working lights orders are placed in TELS (so that maintenance is aware that they need to fix it) to get it fixed. Date of Compliance: May21, 2026. Recurrence will be prevented by: Audit all lights in the building once a week for 4 weeks to ensure they are in working condition. If lights are not working, ensure there is an order in TELS to get them fixed. The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease or discontinue the audits. Corrections will monitored by: Administrator/Designee	05/21/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245324	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/23/2026

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F0921 SS = D	Continued from page 19 During interview with director of nursing (DON) on 4/23/26 at 6:50 a.m., DON stated expectations of all staff to use the electronic messaging system, called TELS, to request maintenance repairs. DON stated the maintenance director (MT-D) would then receive the requests and prioritize them and address them. During interview with MT-D on 4/23/26 at 10:31 a.m., MT-D stated expectations of all staff to use the electronic messaging system, called TELS, to request maintenance repairs. He would then prioritize the requests and address them. MT-D verified no TELS requests were ever submitted for R9 and R13's ceiling light. "I cannot fix something if it is not in the TELS system." Facility policy on reporting maintenance concerns was requested and not received.	F0921		05/21/2026

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	245324	A. BUILDING **01 - MAIN BUILD...** B. WING	**04/21/2026**

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K0000 Bldg. 01	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 04/21/2026. At the time of this survey, The Estates at Bloomington 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, Health Care Facilities Code. 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. 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. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145	K0000		05/21/2026

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 reverse for further 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245324	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **04/21/2026**

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K0000 Bldg. 01	Continued from page 1 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 detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. The Estates at Bloomington is a 1-story building with a partial basement. The building was constructed at 3 different times with original building being constructed in 1957 and was determined to be of Type II (111) construction. In 1963, an addition was constructed and was determined to be of Type II (111) construction. Then in 1999, an addition was constructed and was determined to be Type II (111) 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 spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 68 beds and had a census of 66 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K0000		05/21/2026

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K0911 SS = F Bldg. 01	Electrical Systems - Other CFR(s): NFPA 101 Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to install emergency lighting in Emergency Power systems (EPS) equipment locations per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, sections 7.3.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 04/21/2026 at 10:58 AM, it was revealed by observation that an emergency light was not installed near the emergency generator transfer switch. An interview with the Administrator, Maintenance Director, and the Regional Maintenance Director verified this deficient finding at the time of discovery.	K0911	Immediate Corrective Action: Emergency lighting was installed near the emergency generator transfer switch per Life Safety Code requirements. All other emergency power system equipment locations were audited and have appropriate emergency lighting installed. Maintenance Director was educated on routine inspection requirements for emergency lighting in emergency power system locations. Date of Compliance: 5/21/2026 Re-occurrence will be prevented by: Audit of emergency lighting in emergency power system areas will be completed weekly x4 weeks to ensure emergency lighting remains operational and compliant with Life Safety Code requirements. The results of these audits will be reviewed at the facility QAPI meeting for input on the need to increase, decrease, or discontinue the audits. Corrections will be monitored by: Maintenance Director/Designee	05/21/2026
K0211 SS = E Bldg. 01	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This STANDARD is NOT MET as evidenced by:	K0211	Immediate Corrective Action: The patient scale stored in the egress corridor near physical therapy was immediately removed. All egress corridors throughout the facility were audited and are free from obstruction per Life Safety Code requirements. Staff were educated on maintaining clear egress corridors at all times. Date of Compliance: 5/21/2026	05/21/2026

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K0211 SS = E Bldg. 01	Continued from page 3 Based on observation and staff interview, the facility failed to maintain egress corridors per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.1, 19.2.3.4, and 7.1.10.1. This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 04/21/2026 at 11:36 AM, it was revealed by observation that a patient scale was being stored in the egress corridor near physical therapy. An interview with the Administrator, Maintenance Director, and the Regional Maintenance Director verified this deficient finding at the time of discovery.	K0211	Continued from page 3 Re-occurrence will be prevented by: Audit of egress corridors to ensure hallways remain free from obstructions will be completed daily x5 days, then weekly x4 weeks. The results of these audits will be reviewed at the facility QAPI meeting for input on the need to increase, decrease, or discontinue the audits. Corrections will be monitored by: Maintenance Director/Designee	05/21/2026
K0222 SS = E Bldg. 01	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and	K0222	Immediate Corrective Action: The courtyard gate latch was repaired/replaced to ensure it can be readily operated under all lighting conditions per Life Safety Code. All other egress doors and latches throughout the facility were audited and operate appropriately. Maintenance staff were educated on routine inspection of egress door hardware. Date of Compliance: 5/21/2026 Re-occurrence will be prevented by: Audit of egress doors and latches to ensure proper operation will be completed weekly x4 weeks. The results of these audits will be reviewed at the facility QAPI meeting for input on the need to increase, decrease, or discontinue the audits. Corrections will be monitored by: Maintenance Director/Designee	05/21/2026

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K0222 SS = E Bldg. 01	Continued from page 4 detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain egress doors per NFPA 101 (2012 edition), Life Safety Code, sections 7.2.1.5.3 and 7.2.1.5.10. This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 04/21/2026 at 11:30 AM, it was revealed by observation that the latch on the gate to exit the courtyard was not a style that could be readily operated under all lighting conditions. An interview with the Administrator, Maintenance Director, and the Regional Maintenance Director verified this deficient finding at the time of	K0222		05/21/2026

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K0222 SS = E Bldg. 01	Continued from page 5 discovery.	K0222		05/21/2026
K0321 SS = E Bldg. 01	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain hazardous rooms per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.1.3, 19.3.2.1.5, and 7.2.1.8.1. This deficient finding could	K0321	Immediate Corrective Action: The boiler room door was repaired and now fully closes and positively latches per Life Safety Code requirements. All other hazardous area doors were audited and positively latch appropriately. Maintenance Director was educated on routine maintenance and inspection of hazardous area doors. Date of Compliance: 5/21/2026 Re-occurrence will be prevented by: Audit of hazardous area doors to ensure doors fully close and positively latch will be completed weekly x4 weeks. The results of these audits will be reviewed at the facility QAPI meeting for input on the need to increase, decrease, or discontinue the audits. Corrections will be monitored by: Maintenance Director/Designee	05/21/2026

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K0321 SS = E Bldg. 01	Continued from page 6 have a patterned impact on the residents within the facility. Findings include: On 04/21/2026 at 10:59 AM, it was revealed by observation that the door to the boiler room would get hung up on the floor and not fully close and latch when testing the self-closing device. An interview with the Administrator, Maintenance Director, and the Regional Maintenance Director verified this deficient finding at the time of discovery.	K0321		05/21/2026
K0920 SS = E Bldg. 01	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain the usage of electrical adaptive devices NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.5.2.3.1 and 10.2.4.2.1, NFPA 101 (2012 edition), Life Safety Code, section 9.1.2, NFPA 70, (2011 edition), National Electrical Code, sections 400.8, and UL 1363. These deficient findings could have a patterned impact on the residents within the facility.	K0920	Immediate Corrective Action: The daisy-chained power strips in the Nurse Manager’s office were removed and the refrigerator was plugged directly into an approved wall outlet. The refrigerator in the Culinary Director’s office was removed from the power strip and plugged directly into an approved wall outlet. All other offices and resident care areas were audited to ensure proper use of power strips and electrical equipment per Life Safety Code requirements. Staff were educated on appropriate use of power strips and extension cords. Date of Compliance: 5/21/2026 Re-occurrence will be prevented by: Audit of electrical equipment, power strips, and extension cords will be completed weekly x4 weeks to ensure compliance with Life Safety Code requirements. The results of these audits will be reviewed at the facility QAPI meeting for input on the need to increase, decrease, or discontinue the audits. Corrections will be monitored by: Maintenance Director/Designee	05/21/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245324	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **04/21/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Estates at Bloomington LLC	**9200 NICOLLET AVENUE SOUTH , BLOOMINGTON, Minnesota, 55420**

(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
K0920 SS = E Bldg. 01	Continued from page 7 Findings include: On 04/21/2026 at 11:14 AM, it was revealed by observation that there were two power strips daisy-chained together with a refrigerator plugged into them in the Nurse Manager's office. 2. On 04/21/2026 at 11:16 AM, it was revealed by observation that there was a refrigerator plugged into a power strip in the Culinary Director's office. An interview with the Administrator, Maintenance Director, and the Regional Maintenance Director verified these deficient findings at the time of discovery.	K0920		05/21/2026