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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 202Z

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00169

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245324**
2.STATE VENDOR OR MEDICAID NO.
(L2) **505497400**

3. NAME AND ADDRESS OF FACILITY
(L3) **THE ESTATES AT BLOOMINGTON LLC**
(L4) **9200 NICOLLET AVENUE SOUTH**
(L5) **BLOOMINGTON, MN** (L6) **55420**

4. TYPE OF ACTION: **2** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **03/01/2017**

6. DATE OF SURVEY **08/27/2021** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **68** (L18)
13.Total Certified Beds **68** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: B (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	68			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE — Date :
Sara Freking, HFE NE II — 10/14/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kamala Fiske-Downing, Enforcement Specialist — 10/15/2021 (L20)

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

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
07/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
01111
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically Submitted
September 20, 2021

Administrator
The Estates At Bloomington LLC
9200 Nicollet Avenue South
Bloomington, MN 55420

RE: CCN: 245324
Cycle Start Date: August 27, 2021

Dear Administrator:

On August 27, 2021, survey was completed at your facility by the Minnesota Department 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.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted immediate jeopardy to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On August 27, 2021, the situation of immediate jeopardy to potential health and safety cited at F880 was removed. However, continued non-compliance remains at the lower scope and severity of F.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition: The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective October 5, 2021.

- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

This Department is also recommending that CMS impose a civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective October 5, 2021, (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective October 5, 2021,(42 CFR 488.417 (b)).

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

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,160; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective August 27, 2021. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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

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

DEPARTMENT CONTACT

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

Jennifer Kolsrud Brown, RN, Unit Supervisor
Rochester District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: jennifer.kolsrud@state.mn.us
Office: (507) 206-2727 Mobile: (507) 461-9125

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 their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction

occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 27, 2022 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

APPEAL RIGHTS DENIAL OF PAYMENT

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

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

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

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions

are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

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

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

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

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245324	A. BUILDING _____ B. WING _____	C 08/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT BLOOMINGTON LLC	9200 NICOLLET AVENUE SOUTH BLOOMINGTON, MN 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
E 000	Initial Comments On 8/25/21, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The 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. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained.	E 000		
E 032 SS=C	Primary/Alternate Means for Communication CFR(s): 483.73(c)(3) §403.748(c)(3), §416.54(c)(3), §418.113(c)(3), §441.184(c)(3), §460.84(c)(3), §482.15(c)(3), §483.73(c)(3), §483.475(c)(3), §484.102(c)(3), §485.68(c)(3), §485.625(c)(3), §485.727(c)(3), §485.920(c)(3), §486.360(c)(3), §491.12(c)(3), §494.62(c)(3). [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following: (3) Primary and alternate means for communicating with the following:	E 032		10/4/21

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

Electronically Signed | 09/28/2021

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 032	Continued From page 1 (i) [Facility] staff. (ii) Federal, State, tribal, regional, and local emergency management agencies. *[For ICF/IIDs at §483.475(c):] (3) Primary and alternate means for communicating with the ICF/IID's staff, Federal, State, tribal, regional, and local emergency management agencies. This REQUIREMENT is not met as evidenced by: Based on interview and policy review, the facility failed to ensure the communication plan included primary and alternate means for communicating with staff and Federal, State, tribal, regional, and local emergency management agencies. This had the potential to affect all residents in the facility. Findings include: When interviewed on 08/25/21, at 10:04 a.m., the administrator verified there had been no planning for alternate communication with staff, residents, Federal, State, tribal, regional, and local emergency management agencies and had only phone numbers for each party. Review of the policy titled Disaster Planning and Emergency Preparedness/Operation Plan, revised 04/19/21, did not include a communication plan as directed in the regulation.	E 032	Facility communication plan was updated to include an alternate means of communication (emails) with staff and federal, state, tribal, regional, and local emergency management agencies. Education initiated to staff on the facility communication plan specific to alternate means of communication. Audits to ensure appropriate means of communication are available to staff will be completed weekly x4 and then monthly x2. Audit results will be reviewed by the QAPI committee for further recommendations.	
F 000	INITIAL COMMENTS On 8/23/21 - 8/27/21, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. The facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B,	F 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 000	Continued From page 2 Requirements for Long Term Care Facilities. The survey resulted in an Immediate Jeopardy (IJ) at F880 when the facility failed to keep R23 who had a diagnosis of a potentially infectious disease on transmission based precautions until symptoms resolved. The IJ began on 8/23/21, at 2:30 p.m. and the immediacy was removed on 8/27/21, at 2:47 p.m. ,but noncompliance remained at the lower scope and severity level of F - widespread scope and severity level, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. The following complaints were found to be UNSUBSTANTIATED: H5324116C (MN46671) H5324117C (MN47882/MN48911) H5324118C (MN48466) H5324119C (MN48982) H5324120C (MN50075) H5324121C (MN51434) H5324122C (MN52703). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments 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.	F 000		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment	F 584		10/4/21

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F 584	Continued From page 3 CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and	F 584		

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F 584	Continued From page 4 §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure the 300A tub and shower room was kept clean, sanitary and in good repair, which had the potential to affect all 42 residents identified by the facility who utilized 300A tub and shower room. Findings include: During interview on 8/23/21, at 1:20 p.m. R15 stated the common showers were always "grungy", and had not appeared to be cleaned nor sanitized between resident uses. R15 stated "I've been brought in there with poop on the floor." During an observation of the 300A tub and shower room on 8/24/21, at 10:22 a.m., there was a clump of dried black hair approximately two inches in diameter on the shower floor. There was a chipped and broken off tile on the corner of the shower entrance by the floor approximately four inches in length. The broken tile had a jagged edge. Along the back corner of the shower floor where tile and grout met, there was a flat, black, speckled dry stain in a thin line along the grout measuring approximately one foot in length. The white shower curtain was torn, brittle and approximately one-third of it was broken off. The white shower curtain also had black, speckled, and dried stain in the folds. There was a shower chair with drainage holes and the middle hole had a dried brown substance packed in it.	F 584	300 A tub room and shower room was immediately cleaned, hair was removed off the ground the chipped and broken tile was replaced, the shower curtain was replaced, and shower chair was removed and cleaned before being put back into use, along the back corner of the wall the shower floor tile where the grout and tile met was cleaned, towels were removed from bathtub, incontinence briefs, clothing hanger, shaving razor, package of continence care wipes and hairbrush were removed from area. Other shower rooms have been audited to ensure a safe, clean and homelike environment. Education initiated to all appropriate staff on disinfecting the shower/tub after each resident use and proper disinfectants to be used. DON or designee will complete audits weekly x4 and then monthly x2. Audit results will be reviewed by the QAPI committee for further recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245324	A. BUILDING _____ B. WING _____	C 08/27/2021

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THE ESTATES AT BLOOMINGTON LLC	9200 NICOLLET AVENUE SOUTH BLOOMINGTON, MN 55420

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F 584	Continued From page 5	F 584		

The bathtub contained several wrinkled towels that appeared to have been once wet and air dried while crumpled up laying on the tub floor. There was a box of gloves in the bathtub, several folded incontinence briefs, a clothing hanger, shaving razor, package of continence care wipes and a hairbrush with black hair on it.

During interview and observation on 8/24/21, at 10:49 a.m. nursing assistant (NA)-A stated R16 was going to have a shower. NA-A stated after a shower they would clean the tub room with regular soap. NA-A stated was not aware of any disinfectant that should have been used. NA-A brought R16 into the 300A tub and shower room and closed the door.

During interview 8/24/21, at 10:49 a.m. registered nurse (RN)-A stated the expectation was for housekeeping to deep clean the tub and shower room in the evening and the nursing assistants would clean and disinfect between residents. NA-A was asked to bring R16 out of the shower room. RN-A entered the shower room and was shown the matted hair, broken tile, and black stains on the tile, grout, floor and curtain and was shown the torn curtain. RN-A was also shown the tub which contained dried towels, box of gloves, several folded incontinence briefs, a clothing hanger, shaving razor, package of continence care wipes and a hairbrush with black hair on it. RN-A was shown the shower chair with the brown substance packed in the middle drainage hole. At this time that shower chair had R16's clean clothing and face mask placed on top of it. RN-A agreed verbally this was not homelike, clean, sanitary, safe or in good repair. RN-A stated none of these issues had been reported and she would have expected staff to report it. RN-A stated she

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F 584	Continued From page 6 would "call off" R16's shower and have staff clean and repair the shower and tub room. Policy on cleaning requested and not provided.	F 584		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure a comprehensive nursing assessment was completed for a surgical wound to monitor for infection and healing for 1 of 3 residents (R167) reviewed for wound care. Findings include: R167's hospital discharge instructions dated 8/19/21, indicated to keep R167's surgical wound dressing clean, dry and intact (CDI). R167's face sheet indicated facility admission on 8/19/21, with diagnoses of left femur fracture and diabetes. R167's 48 hour baseline care plan dated 8/19/21, indicated R167 would be followed by the wound care team.	F 684	R167 has been discharged from the facility. Current residents have been identified for surgical wounds and monitoring for infection and healing. Education initiated to appropriate staff on completing a comprehensive nursing assessment upon admission/re-admission to address wounds/sutures and adding orders to monitor for signs of infection. DON or designee will conduct audits weekly x4 and then monthly x2. Audit results will be reviewed by the QAPI committee.	10/4/21

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F 684	Continued From page 7	F 684		

R167's care plan dated 8/23/21 indicated R167 was admitted with a hip fracture repair with sutures and indicated R167 was blind. Interventions to monitor skin integrity and the wound site were implemented 8/23/21.

R167's treatment administration record (TAR) indicated to assess the wound for signs and symptoms of infection starting 8/24/21. In addition, the TAR indicated to keep the dressing CDI on 8/24/21. Further, the TAR indicated on 8/25/21, to assess each shift if the wound sutures were intact, dressing was clean and intact, and to report signs and symptoms of infection every shift and as indicated.

When interviewed on 8/24/21, at 10:01 a.m. R167 stated he had a bandage on his left hip, he had surgery on 8/15/21, and no one had looked at it since he had been admitted. R167 indicated he was blind and could not see it, and did not know what the wound looked like under the bandage.

When interviewed 8/24/21, at 2:25 p.m. nurse practitioner (NP)-A from [name] Healthcare orthopedic department indicated the hospital discharge instructions for R167 indicated she would have expected a nurse to assess the dressing as the order was to keep it CDI and the only way to know if it was CDI was to look at it or assess it. NP-A also indicated if facility staff was unsure what to do, she would have expected them to call.

When interviewed on 8/24/21, at 3:41 p.m. registered nurse (RN)-C indicated medical doctor (MD)-C saw R167 and would write an order to change the dressing when it is soiled and PRN.

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F 684	Continued From page 8 RN-C indicated there should have been an order sooner and the wound should have been assessed daily. RN-C indicated he checked the treatment plan and the physician orders, and there were none to assess the wound. When interviewed on 8/24/21, at 4:17 p.m. MD-C indicated the wound was assessed that day, the wound had minimal serosanguinous (contains both blood and clear yellow liquid known as blood serum) drainage, and some old drainage on the dressing. MD-C indicated she would expect staff to follow instructions from discharge regarding wound care. MD-C indicated if the wound and dressing are not not assessed, R167 could develop an infection. The director of nurses was not available for interview. When interviewed on 8/25/21, at 11:26 a.m. RN-A stated the order to leave the dressing CDI was is in resident's banner (at the top of the page) in the electronic medical record, but not in the orders, and if it were not in the orders, it would not populate to the TAR and nurses would not know to perform the assessment. RN-A indicated is was an oversight and the order would be added. The Monarch Healthcare Management Policy Statement Sheet, implementing Medication and Treatment Orders, dated 2/17, directed staff to implement treatment orders within 24 hours of when the orders were received.	F 684		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3)	F 690		10/4/21

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F 690	Continued From page 9 §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to perform proper catheter care for 1 of 2 residents (R11) observed	F 690	R11 bedsheets were changed and proper catheter was provided. R11 has been discharged from the facility.	

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F 690	Continued From page 10 for catheter cares. Findings include: R11's admission minimum data set (MDS) dated 5/11/21, indicated R11 was cognitively intact and required extensive assistance of two staff for toilet use and personal hygiene. R11's MDS further indicated R11 had impairment of both sides upper and lower extremities. R11's care area assessment (CAA) indicated R11 triggered for activities of daily living (ADL) function related to the need for assistance with all ADL's. R11's CAA further indicated R11 had a self-care deficit related to Parkinson's disease and rention of urine. R11's CAA indicated R11 required assistance related to indwelling catheter care with the assist of one to follow facility's protocol for catheter care. R11's Care Plan dated 8/24/21, indicated R11 had a neuromusclar dysfunction of the bladder and had a alteration in elimination which required a indwelling foley catheter (catheter which is placed in the bladder by a water-filled balloon). R11's care plan indicated R11 requested per his preference to use a leg bag while awake and asleep. R11 care plan directed staff to monitor R11 leg bag and to empty as needed, monitor foley catheter output, foley catheter care per policy, and assistance with toileting and peri-cares. R11's admission record dated 8/25/21, indicated R11 had the diagnoses of Parkinson's disease (progressive nervous system disorder that affects movement), neuromusclar dysfunction(flaccid or spastic) of the bladder, history of urinary tract	F 690	Current residents have been identified for proper catheter care use. Education initiated to all appropriate staff on proper catheter care including drainage, not allowing tip of catheter to be in contact with urine, cleansing tip of the tubing on leg bag. DON or designee will audit weekly x4 and then monthly x2. Audit results will be reviewed by the QAPI committee.	

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F 690	Continued From page 11	F 690		

infection, and type two diabetes mellitus (high levels of sugar in the blood).

R11's physician order dated 11/5/20, indicated R11 was taking Finasteride (used to shrink an enlarged prostate) tablet 5 mg daily for neuromuscular dysfunction of the bladder.

R11's physician order dated 11/15/20, directed staff to empy leg bag every four hours and as needed.

R11's nursing progress note (PN) dated 7/18/21, indicated R11 had complained of pain and burning sensation in the penis. R11's physician ordered a urine anlysis and culture.

R11's nursing PN dated 8/2/21, indicated nursing assistant reported R11's bed and clothes were wet from urine.

R11's nursing (PN) dated 8/11/21, indicated that R11 had his foley catheter changed related to pain and encrustations. Writer administered bed-bath, changed resident clothing, administered pericares.

During an observation on 8/23/21, at 1:23 p.m. R11 leg bag was full of dark yellow concentrated urine. R11's room and cookie crumbs on the floor and on R11 bed. Multiple flies were flying all over R11 room landing on R11 and a two flies were observed crawling up inside R11 tubing of the leg bag.

During an observation on 8/23/21, at 2:22 p.m. R11 lying in his bed with leg bag straped to his right leg which is positioned out straight. R11's leg bag was found to be bulging and contained

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F 690	Continued From page 12	F 690		

dark yellow concentrated urine with sediment. Nursing assistant (NA)-G walken into R11 room and emptied 500 millilitres (ml) from R11's leg bag into a graduated cylinder and allowed the tubing to become covered with the urine as it emptied into the cylinder. NA-G did not cleanse the tip of the leg bag with an alcohol wipe once it was emptied. R11 leg bag filled back up three quarters full after being emptied. R11's sheets toward the foot of the left side of bed to have dry yellow stain measuring 18 inches in diameter. On the floor next to the left side end of bed dried yellow stain was seen.

During observation on 8/24/21, at 8:09 a.m. R11 was observed lying in bed with legs lying straight in bed with leg bag attached to R11 right leg. R11 sheets were stained with a dark yellow color at the end of the bed on the right side for R11 leg bag.

During an interview on 8/23/21, at 2:24 p.m. licensed pratical nurse (LPN)-A stated she was not aware of flies crawling up the catheter tubing and it is possible if this is happening R11 could get an infection. LPN-A stated she would get a NA into R11's room to empty the catheter bag and change the sheets on R11's bed. LPN- A further stated R11 likes to eat food in his room and it gets all over the floor and bed which makes the room a host for flies or other bugs.

During an interview on 8/23/21, at 2:25 p.m. R11 stated he had been getting pain at the catheter insetion site and it felt like it is pulling. R11 further stated he had staff come in and leave the clamp open were urine is leaking all over his bed and floor.

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F 690	Continued From page 13	F 690		

During an interview on 8/23/21, at 2:30 p.m. NA-G stated she was not aware she needed to cleanse the tip of the tubing. NA-G further stated she is not sure why she let the end of the catheter tubing sit in urine as the graduated cylinder filled as she emptied R11's leg bag.

During an interview on 8/23/21, at 2:35 p.m. LPN-A stated NA-G should not have let the end of the leg bag tubing sit inside the urine on the graduated cylinder. LPN-A stated NA-G should have cleansed the end of the tubing and ensure the bag was emptied completely.

During an interview with family member (FM)- B on 8/25/21, at 9:20 a.m. FM stated she had concerns about the care the resident catheter care. FM-B stated R11 is at risk for urinary tract infection because of his Parkinson's Disease and had a history of urinary tract infections. FM-B requested staff to use lidocaine jelly (numbing medication) prior to insertion of the catheter and at times the facility denied R11's request so R11 goes to the VA clinic to have the catheter replaced. FM-11 further states the night nursing assistance have emptied the leg bag and left the clamp open so urine would spill onto the bed and floor. FM-F further stated she observed staff pull up the bed side table right through the puddle of urine on the floor and would leave the wet sheets on the bed. FM-F stated when she came to visit R11 had flies in is room and they would crawl on the leg bag and on the tubing and up the bottom tube to the clamp. FM-F further stated "How is that not a concern for infection?"

During an interview on 8/23/21 at 3:30 p.m. registered nurse (RN)-A stated her expecations is catheter care is completed by all nursing

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F 690	Continued From page 14 assistants and nursing staff. RN-A stated the tubing from the leg bag should not be directly sitting in the urine as the urine is being emptied. RN-A stated it is an infection risk if the urine is not completely emptied and the urine may back flow into the bladder. RN-A further stated her expectations for the staff to change bedding as necessary and keep the room free of bugs including from crawling into the leg bag tubing. The facility's policy Catheter Care dated 11/19, indicated to provide clinents a safe, hygienic, and thorough catheter care. The facility's policy to notify nurse of unusal observation. The facility's policy lacked direction on care related to emptying catheter bag. The facility's policy Infection Prevention and Control dated 8/17, indicated to provide a safe, sanitary, and comfortable environment to help prevent the develpoment of infection.	F 690		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.	F 755		10/4/21

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F 755	Continued From page 15 §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to administer medications as ordered for 2 of 9 residents (R31, R59) reviewed for medication administration. Findings include: R31's quarterly Minimum Data Set (MDS) dated 6/25/21, indicated severely impaired cognition. R31 required extensive assist with dressing and hygiene. R31 had a diagnosis of diabetes mellitus. R31's care plan lacked a diabetic focus care area. R31's order summary from 12/2/20 - 8/24/21, indicated -starting 12/2/20, monitor for hypoglycemia (low blood glucose) symptoms every shift. The orders	F 755	R31 care plan had been updated to include a diabetic focus care area. R31 orders were updated to reflect increased insulin order. R59 has been discharged from the facility. Current residents have been identified to include a diabetic focus care area and orders reviewed for accuracy. Education initiated to appropriate staff on transcription of orders and process for obtaining medication when pharmacy is not able to provide it. DON or designee will audit weekly x4 and monthly x2. Audit results will be reviewed by the QAPI committee.	

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F 755	Continued From page 16	F 755		

lacked direction to monitor for hyperglycemia symptoms (elevated blood glucose).
-starting 4/7/21, check blood glucose three times a day with meals and call nurse practitioner (NP) if blood glucose less than 75 or greater than 400.
-starting 7/13/21, administer insulin glargine 30 units subcutaneously at bedtime related to type 1 diabetes mellitus.

R31's physician progress note dated 8/6/21, indicated R31 was seen by request due to two falls in the past week. New orders were given to increase bedtime glargine (insulin) to 32 units given sustained hyperglycemia (elevated blood glucose) and draw A1C lab (blood test result which reflects average blood sugar level for the past several months) the next lab day. previous A1C results on 2/9/21, was was 7.7% (normal A1C level is below 5.7%).

R31's blood glucose results indicated the following ranges:
-8/6/21: 252 - 462 milligrams/deciliter (mg/dL)
-8/7/21: 75 - 307 mg/dL
-8/8/21: 131 - 510 mg/dL
-8/9/21: 117 - 297 mg/dL
-8/10/21: 93 - 281 mg/dL
-8/11/21: 178 - 310 mg/dL
-8/12/21: 224 - 322 mg/dL
-8/13/21: 180 - 387 mg/dL
-8/14/21: 274 - 324 mg/dL
-8/15/21: 287 - 332 mg/dL
-8/16/21: 185 - 364 mg/dL
-8/17/21: 208 - 357 mg/dL
-8/18/21: 165 - 327 mg/dL
-8/19/21: 179 - 364 mg/dL
-8/20/21: 135 - 367 mg/dL
-8/21/21: 227 - 368 mg/dL
-8/22/21: 183 - 398 mg/dL

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F 755	Continued From page 17 -8/23/21: 124 - 246 mg/dL -8/24/21: 198 - 364 mg/dL -8/25/21: 175 - 230 mg/dL R31's medication administration record (MAR) from 8/6/21 - 8/24/21, indicated the new increased insulin order was not implemented and R31 continued to receive insulin glargine 30 units subcutaneously at bedtime. During interview 8/25/21, at 11:07 a.m. licensed practical nurse (LPN)-A stated the nurses would have transcribed any new orders from a provider visit. LPN-A reviewed R31's current physician orders and stated R31 was prescribed insulin glargine 30 units subcutaneously at bedtime. During interview 8/25/21, at 11:13 a.m. registered nurse (RN)-A stated R31's orders directed the nursing staff to administer insulin glargine 30 units subcutaneously at bedtime. R31 then reviewed the latest physician orders from 8/6/21, and saw the new order to increase to 32 units. RN-A stated this insulin order along with the A1C blood draw had not been transcribed. During interview 8/25/21, at 11:18 a.m. RN-B stated the new order for glargine and blood draw had not been transcribed and should have. During interview 8/25/21, at 3:32 p.m. nurse practitioner (NP)-B stated she wrote the orders for increased insulin and the blood draw on 8/6/21, during her visit and would have expected the new orders to have started that same day. NP-B stated she reviewed R31's blood sugars since her visit and they remained elevated. R59	F 755		

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F 755	Continued From page 18	F 755		

R59's face sheet indicated R59 was admitted 7/29/21, with diagnoses of prostate cancer.

R59's provider orders indicated Xtandi (a medication used to treat men with prostate cancer) was ordered for R59 on 7/30/21.

A provider note from nurse practitioner (NP)-B dated 7/30/21, indicated the pharmacy was unable to provide Xtandi and the medication order would be on hold until family could provide the medication.

R59's nursing progress notes dated 8/7/21, 8/8/21, 8/9/21, 8/10/21, and 8/11/21 indicated Xtandi was not administered as the medication was on hold, with no mention of contacting the family to bring it.

Nursing progress noted dated 8/12/2021, at 7:58 a.m. indicated Xtandi was on hold, the medication had not been provided by the family, and the DON had been notified. R59's progress notes do not indicate any contact was made to family to request the medication.

R59's nursing progress note dated 8/24/21, at 10:49 a.m. indicated Xtandi was on hold until family can provide the medication.

When interviewed on 8/24/21, at 11:01 a.m. family member (FM)-A indicated she had the medication at home but was instructed she could not bring medications from home. FM-A indicated she had not been contacted or asked to bring the medication.

When interviewed on 8/24/21, at 10:20 a.m. RN-Z

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F 755	Continued From page 19	F 755		

at [name] Oncology stated she had told the facility this resident needed Xtandi. RN-Z indicated the oncology office provided the facility social worker (SW)-A a medication list and a note from the provider indicating the need for this medication. RN-Z stated the oncology office stressed the need for this medication. RN-Z stated no one had called to request an order for this medication if they could not get it at the facility. RN-Z indicated R59 has prostate cancer that needs to be monitored, and the cancer was being controlled by Xtandi. RN-Z indicated it would be important for R59 to restart the medication.

When interviewed on 8/25/21, at 01:26 p.m. RN-D stated Xtandi was on hold for R59. RN-D indicated he was told by the DON when R59 was admitted the family was to provide it. RN-D stated he could not find a note about the family being notified. RN-D had not contacted the family to bring the medication.

When interviewed on 8/25/21, at 1:41 p.m. RN-B stated she did not know what happened with the medication Xtandi nor why R59 had not received it. RN-B had not contacted the family to bring the medication.

When interviewed on 8/26/21, at 9:05 a.m. RN-A stated Xtandi was not listed on the hospital discharge paperwork, but family said it was needed. RN-A stated the pharmacy could not get Xtandi for the facility as it was a specialty oncology medication, and that family needed to provide it. RN-A stated she had not documented that she told family to bring it.

When interviewed on 8/26/21, at 9:31 a.m. SW-A stated she had talked to FM-A about bringing the

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F 755	Continued From page 20 medication, but had not documented it. When interviewed on 8/26/21, at 9:42 a.m. RN-A stated the resident was scheduled for discharge, and R59 would get the medication when he gets home. When interviewed on 8/26/21, at 11:09 a.m. 9:47 a.m. pharmacist (PH)-A stated Xtandi could only be provided by the family or the specialty pharmacy. PH-A stated the medication modulates hormones to prevent the progression of cancer. During email communication on 8/25/21, at 12:51 p.m. the regional director of operations (RDO) stated the facility lacked a policy or procedure for medication administration.	F 755		
F 803 SS=D	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically;	F 803		10/4/21

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F 803	Continued From page 21 §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to accommodate dietary preferences for 1 of 1 residents (R58) reviewed for food. Findings include: R58's admission Minimum Data Set (MDS) dated 8/5/21 indicated R58 had moderately impaired cognition and had diagnosis of alcoholic liver disease and portal hypertension. R58's MDS further indicated R58 was independent with eating. R58's careplan dated 8/3/21, 8/3/21 Care Plan indicated Alteration in communication R58's meal tray card dated 8/25/21, identified R58 had no direction or indication R58 required a mechanical soft diet for oral intake. R58's meal ticket further indicated R58 had dislikes to bacon and preferred sausage. R58 received sausage crumbles to R58 as a replacement for bacon for breakfast. The meal ticket directed staff to offer preferred foods when possible. R58's dietary order dated 8/2/21, indicated R58 had a consistent carbohydrate diet with regular texture.	F 803	R58 meal tray ticket has been updated to reflect resident preferences. Current residents have been interviewed and resident preferences updated on tray tickets and care plan as needed. Education initiated to staff on resident preferences and tray accuracy. Culinary Director or designee will audit weekly x4, monthly x2. Audit results will be reviewed by the QAPI committee.	

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F 803	Continued From page 22 R58's dietitian progress noted dated 8/20/21, indicated R58 should continue with current diet. On 8/24/21, at 2:00 p.m. when approached and asked how the meal service had been R58 stated "I was served ground up sausage this morning, and I do not like it." R58 stated he had food dislikes and notified the dietitian of my dislikes to some foods such as bacon, pancakes, and french toast. R58 stated he did not like ground sausage and does not need to have his meat cut up. R58 stated my preference is the a full sausage patty or links. On 8/24/21, at 2:26 p.m. dietary manager (DM) stated R58 was on a regular carbohydrate controlled diet with regular texture. The DM further stated R58 was served ground sausage by mistake and ground sausage is for a mechanical diet. DM stated she would notify dietary staff to provide residents the meal choices R58 prefers. DM stated her expectation is for staff to follow meal trays as directed and as ordered. A facility policy was requested and was not provided.	F 803		
F 880 SS=J	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F 880		10/4/21

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F 880	Continued From page 23 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable	F 880		

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F 880	Continued From page 24 disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement appropriate precautions against clostridium difficile colitis (CDI) (a inflammation of the colon caused by the bacteria clostridium difficile) including use of appropriate personal protective equipment (PPE) and isolation precautions to prevent the spread of COVID-19 for 1 of 1 resident (R23) who required quarantine. This practice resulted in an immediate jeopardy (IJ) situation for residents and staff as a result of the facility not implementing proper transmission based precautions (TBP). This non-compliance has the potential to spread infections to other residents in the facility. The IJ began on 8/23/21, at 2:30 p.m. when the facility failed to continue with transmission based precautions (TBP) when R23 was to be on	F 880	The facility currently has no residents on precautions besides R23. Due to R23 roommate being at a higher risk for signs and symptoms of C-Diff, monitoring orders were put in place for the next 7 days. The facility will review all like residents who are on antibiotics to ensure they do not have signs and symptoms of C-diff specific to diarrhea/loose stools. All like resident based off of record review and resident interview do not present with signs and symptoms of C-Diff. Facility is now following the CDC guidelines for enteric precautions. Transmission-based precautions grid/procedure was reviewed and remains current.	

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F 880	Continued From page 25 quarantine for COVID-19 and failed to initiate contact precautions for active C-diff while R23 continued to display symptoms of CDI, including loose stools. In addition, the staff present on the 300 wing were not wearing appropriate PPE prior to entering R23's room. The administrator and director of nursing (DON) were notified of the IJ on 8/26/21, at 12:15 p.m. The IJ was removed on 8/27/21, at 2:47 p.m.,but noncompliance remained at the lower scope and severity level of F - widespread scope and severity level, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: CDC guidance Create a Plan for Managing New Admissions and Readmissions indicates Residents with confirmed SARS-CoV-2 infection who have not met criteria to discontinue Transmission-Based Precautions should be placed in the designated COVID-19 care unit, regardless of vaccination status. In general, all unvaccinated residents who are new admissions and readmissions should be placed in a 14-day quarantine, even if they have a negative test upon admission. The Centers for Disease Control and Prevention (CDC) guidance on confirmed clostridioides difficile infection (CDI) isolating and initiating contact precautions for confirmed dated 7/12/21, recommended placement of patients on enteric contact precautions in a single patient room with a dedicated toilet. Enteric precautions indicated staff to wear a gown and gloves and wash hands with soap and water. For patients with confirmed CDI should remain on contact	F 880	Staff education has been initiated and will remain ongoing regarding transmission based precautions, and CDC guidelines for enteric precautions to include appropriate signage, PPE usage and hand hygiene. Staff education has been initiated and will remain ongoing regarding C-Diff specific to signs and symptoms. Staff education has been initiated specific to when to place a resident on and off precautions based on infection. Staff education has been initiated regarding communication between departments specific to notification of when a resident is on and taken off precautions, this will be completed through the PCC dashboard, morning meeting, and appropriate signage on resident door, NAR staff education initiated regarding verbally communicating with the licensed nurse of any loose stools prior to documenting in point of care. Staff will be educated prior to the start of their next scheduled shift. Staff who are on an extended leave will receive a mailed packet and will be required to send back an acknowledgement form of understanding. The Director of Nursing or designee will complete daily audits x 2 weeks, weekly for 4 weeks and then monthly for 3 months and then the QAPI committee will review for ongoing audits. Audits will consist of DON/Designee reviewing all admissions, re-admissions and resident with current and new infections to determine if precautions are required.	

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F 880	Continued From page 26 precautions for at least 48 hours after diarrhea has resolved or longer. Adhere to recommended hand hygiene practices, use dedicated patient care equipment (blood pressure cuffs and stethoscopes), and implement daily patient bathing or showering with soap and water. The Centers for Disease Control and Prevention (CDC) guidance on perform environmental cleaning to prevent CDI dated 7/12/21, recommended to create a daily terminal cleaning protocols and checklist for patient care areas and equipment, perform daily cleaning of CDI patient rooms using a C-Diff sporicidal agent (EPA List K), clean and disinfect the patient care environment including the immediate vicinity around CDI patient and high touch surfaces at least once a day, and all shared equipment prior to use with another patient. The CDC further provided guidance for cleaning additional areas which are contaminated during transient visits by patient with confirmed CDI such as physical therapy (PT) room. The CDC Progression of a CDI infection dated 7/12/21, identified risk factors for getting CDI infection occur if a person had a previous infection with CDI, being over the age of 65, recent stay at a hospital or nursing home. CDC further indicated a person with a weakened immune system. The Safety Data Sheet (SDS) for Sani-Cloth Bleach Germicidal Disposable Wipe dated 8/12/16, indicated efficacy use for the CDI. The SDS indicated the active ingredients of sodium hypochlorite which is commonly referred to as bleach.	F 880	DON/Designee will audit each identified resident who is required to be on precautions has the appropriate signage and PPE accessible. DON/Designee will complete 5 staff infection control questions/quizzes based on the above frequency to ensure their knowledge and understanding of the policies and procedures listed above. DPOC Summary ¿The facility has contracted with an infection preventionist consultant to provide consultation and oversight for infection prevention and control within the facility. The contract establishes that the consultant will work with the facility for a minimum of two (2) months. ¿The infection preventionist consultant has worked with the facility to conduct a Root Cause Analysis (RCA) to identify and address the reasons for noncompliance identified in the CMS 2567. ¿QAPI committee, and Governing Body have participated in the completion of the RCA. ¿The facility took immediate action to implement an infection prevention plan consistent with the requirements at 42 CFR ¿ 483.80 for the affected residents impacted by the noncompliance identified in the CMS 2567 to include identification of other residents that may have been impacted by the noncompliant practice. This plan validated that -Intiated training on transmission based precautions (TBP) and initiation of contact precautions; -Staff will use PPE appropriately based on	

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F 880	Continued From page 27 The facility list of quarantine residents indicated only R165 was on quarantine and ended on 8/26/21. The facility provided list of residents on antibiotics in the last 14 days indicated R17, R24, R42, R214 were identified at risk. The facility's list lacked R61 who was R23's roommate who was taking an antibiotic for her chronic obstructive pulmonary disease. R23's admission minimum data set (MDS) assessment dated 6/16/21, indicated R23 was cognitively intact and had diagnoses of obstructive and reflux uropathy, rheumatoid arthritis, and chronic kidney disease. R23's MDS further indicated R23 was frequently incontinent of stool and had a indwelling catheter. R23's care area assessment (CAA) dated 6/17/21, indicated R23 required a total assist of two for all activities of daily living (ADL), and required a Hoyer lift for transfers. R23's CAA further indicated R23 needed assistance for toileting every two to three hours and Foley catheter care. R23's Care Plan initiated 8/23/21 indicated R23 had a history of CDI and directed staff to monitor for signs and symptoms of CDI. R23 care plan lacked direction to place R23 on enteric precautions (general contact precautions, gloves and gown. Handwashing with soap and water must be performed; an alcohol-based hand rub is not sufficient. Equipment, such as stethoscopes, should be wiped down when leaving patient rooms in all contact precautions). R23's care plan for Covid 19 date initiated 6/15/21 included an intervention to screen for signs and symptoms	F 880	appropriate transmission-based requirements; -Staff are provided with and use Personal Protective Equipment (PPE) in accordance with the Centers for Disease Control (CDC) guidelines; -Staff have the tools and abilities to ensure residents that meet criteria for isolation upon admission remain in quarantine; except for medical necessity; -R23 and roommate were assessed daily for changes in health status and have not experienced a change in condition. -The infection preventionist consultant□s will assist the facility in completing the CMS infection Control self-assessment found in the CMS publication QSO-20-20-ALL, Prioritization o Survey Activity and reviewing relevant facility infection control policies and procedures. -The infection preventionist consultant will support the facility□s Quality Assurance and Performance Improvement Committee with assistance from Governing Body to conduct root cause analysis (RCA) to identify the problem(s) that resulted in deficiency and develop intervention or corrective action plan to prevent recurrence and review policies for the following: -Cohorting Residents/Transmission Based Precaution Isolation -Equipment/Environment-proper disinfection -Hand Hygiene -Personal Protective Equipment (PPE) ¿The infection preventionist consultant□s action plan will include education for staff that provides direct resident care, as well	

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F 880	Continued From page 28 upon return for 14 days. R23's Admission Record printed 8/25/21, indicated R23 had diagnoses of urinary tract infection (UTI), bacterial infection, rheumatoid arthritis, chronic kidney disease, and severe sepsis with septic shock. R23's immunization record printed 8/25/21, indicated R23 had first COVID-19 vaccine on 7/21/21. R23 had not received the second dose for Covid. R23's order summary for 8/21, indicated R23 was on Vancomycin (antibiotic) 125 mg by mouth every 6 hours for CDI. R23's order summary further indicated on 8/24/21, R23 was placed on 14-day quarantine droplet precautions related to unvaccinated to Covid-19 until 9/4/21. The order summary further indicated on 8/24/21, R23 was placed on enteric precautions for CDI and may be discontinue if R23's stools are formed and only having one stool a day. R23's Hospital History and Physical (HP) dated 8/18/21, indicated R23 had diarrhea present for several weeks of five or more watery stools a day. R23's HP further indicated R23 had a recent history of CDI and was recently treated with antibiotics for infected kidney stone. R23's Hospital progress note (PN) dated 8/18/21, at 10:47 p.m. indicated R23 was positive of CDI and was started on Vancomycin (medication to treat infection) 125 milligrams (mg) four times a day for the treatment of CDI and was placed on enteric precautions. R23's Hospital nurse progress note dated	F 880	as staff that enter into resident rooms including the following topics: Standard Infection Control Practices Cohorting Residents/Transmission Based Precaution isolation Disinfecting Shared Medical Equipment/Environment Hand Hygiene Personal Protective Equipment (PPE) ¿The infection preventionist consultant and director of nursing will carefully establish in advance a dedicated area as the care location for residents with disease, including with or without current symptoms of illness. ¿Programs will use resources from well-established centers of geriatric health services education ¿After completion of the training, staff competency will be validated by a post-test or observation of compliance. If the facility employs staff or contract staff with limited English proficiency (LEP), the facility will ensure education is provided in a language understandable to the LEP staff member(s). ¿The facility and infection preventionist consultant will design a scheduled, objective format for the facility to implement for the follow-up employee supervision and work performance appraisal. Facility supervisors will conduct onsite observations and appraise employee implementation of the knowledge, skills and procedures. At the successful completion of the DPOC, the facility will provide required documents as described in the DPOC,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245324	A. BUILDING _____ B. WING _____	C 08/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT BLOOMINGTON LLC	9200 NICOLLET AVENUE SOUTH BLOOMINGTON, MN 55420

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F 880	Continued From page 29 8/19/21, at 6:11 p.m. indicated R23 had multiple loose stools. R23's Hospital nurse progress note dated 8/20/21, at 6:03 a.m. indicated R23 had been on enteric precautions for CDI and was incontinent of stool at times. R23's Hospital Transfer Form dated 8/21/21, indicated R23 was treated while in the hospital for diarrhea from CDI colitis. R23's Hospital Transfer form directed the facility to start R23 on Vancomycin 125 mg by mouth four times a day. R23's PN dated 8/21/21, indicated R23 was readmitted to the facility after hospitalization for a new diagnosis of CDI. R23 PN further indicated R23 was placed on contact precautions. R23's nursing assistant (NA) note dated 8/21/21, indicated R23 had a large loose diarrhea stool. R23's NA note dated 8/23/21, indicated R23 had a large loose diarrhea stool. R23's PN dated 8/23/21, indicated R23 continued on antibiotics for CDI. R23 requested a BRAT (Bananas, Rice, Applesauce, Toast) diet (restrictive diet recommended for people with gastrointestinal distress like vomiting, diarrhea, or gastroenteritis). R23's special instruction dated 8/23/21, had no indication R23 was on contact precautions or quarantine. R23's NA care sheet dated 8/25/21, indicated R23 was an assist of two for all ADL's and was Hoyer lift transfer. R23's NA care sheet lacked	F 880	Checklist: Documents Required for Successful Completion of the Directed Plan	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245324	A. BUILDING _____ B. WING _____	C 08/27/2021

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F 880	Continued From page 30	F 880		

indication R23 was on precautions for CDI or quarantine for COVID-19.

During an observation on 8/23/21, 11:30 a.m. R23's room lacked PPE supplies outside the room. There was no signage indicating transmission-based precautions were in place.

During an interview with R23 on 8/23/21, at 11:45 p.m. R23 stated she was recently hospitalized with a urinary tract infection and was diagnosed with CDI. R23 stated she was not aware she was on precautions. R23 further stated staff wear only goggles and a mask. R23 stated staff used the vital machine equipment on her and than on her roommate. R23 further stated this is her second time of having CDI. R23 stated she had loose diarrhea stool since she returned to the facility on 8/21/21, and they do not bag her clothes, garbage, or meal tray separate. R23 stated she had stomach pain, diarrhea, nausea, some tenderness, and R23 further stated she requested a BRAT diet until she felt better.

During an interview on 8/23/21, at 12:00 p.m. housekeeping (HSKP)-B stated he was not aware R23 was on precautions. HSKP-B further stated he had just finished cleaning R23's room like he normally did.

During an observation on 8/23/21, at 12:30 p.m. an aide was observed entering R23 room wearing only surgical mask and face shield. NA-F brought in R23's lunch meal tray and placed it on the over the bed table. NA-F repositioned the table over R23 who was lying in bed and assisted with repositioning the water pitcher. NA-F left room and gathered R23's roommate's tray. NA-F did not wash her hands after repositioning R23's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245324	A. BUILDING _____ B. WING _____	C 08/27/2021

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F 880	Continued From page 31	F 880		

table or when she left the room.

During an observation on 8/23/21, at 12:55 p.m. NA-F walked into R23's room wearing a mask and goggles. NA-F, removed R23 lunch tray, repositioned R23's water cup on the over bed table prior to leaving R23's room. NA-F was observed using hand sanitizer.

During an interview on 8/23/21, at 1:00 p.m. registered nurse (RN)-D stated he was not aware R23 was on precautions. RN-D further stated if R23 was placed on precautions than R23 should have her supplies outside the room and signs on the door. RN-D stated when he started working today there were no precautions signs or personal protective equipment (PPE) outside R23's door. RN-D stated when he reviewed 23's chart there was no indications R23 was on precautions for C-Diff or quarantine for COVID-19. RN-D stated it is important for the staff who provide direct care to know if a resident is on precautions so we do not spread infections to other residents.

During an observation on 8/23/21, at 1:30 p.m. R23 was observed in the therapy department standing with hands on the parallel bars. PT-A who did not have a gown on or N95 mask was observed to have direct contact with R23. Four other unidentified residents attended rehab in the same room following R23. PT-A was observed to have worked with the other residents after R23.

During an interview on 8/23/21, at 2:00 p.m. NA-F stated she was notified by the previous shift, R23 had a large loose diarrhea stool recorded in her nursing assistant documentation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245324	A. BUILDING _____ B. WING _____	C 08/27/2021

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F 880	Continued From page 32	F 880		

During observation on 8/23/21, at 2:30 p.m. NA-F was observed providing peri-care to R23. NA-F had on a mask and goggles. NA-F was observed leaning on the edge of the bed during the provision of cares. NA-F exited the room and used alcohol-based hand sanitizer and did not wash her hands with soap and water. NA was observed to go into R212's room to provide cares.

During observation on 8/24/21, at 8:45 a.m. R23's door to the room was open. No sign on door indicating precautions. R23 was lying in her bed.

During an interview on 8/24/21, at 8:45 a.m. HSKP-A stated R23 was not on precautions on 8/23. HSKP-A further stated she would see the precautions sign on the door and would talk with nursing staff before entering the room to see what is required. HSKP-A stated if R23 did not have a precautions sign on the door the non-direct care staff would not be aware of the precautions and use the same supplies to clean the rooms as all the other rooms which means we could spread germs.

During observation at 8/24/21, at 8:49 a.m. R23's roommate was observed to have left the room without wearing a mask and left the door open.

During an interview on 8/24/21, at 8:50 a.m. R23's roommate stated she was not aware of any concerns regarding needing to quarantine or concerns about special precautions. R23's roommate further stated no one explained precautions to her and stated she felt it was not fair she needed to keep the door shut when she was not ill. R23's roommate stated she gets claustrophobic with the door is shut.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 880	Continued From page 33	F 880		

During an interview on 8/24/21, at 9:00 a.m. NA-C stated R23 had a large loose diarrhea stool 8/23/21, and had multiple loose stools since R23 returned to facility. NA-C stated she had been wearing only a mask and goggles when providing cares to R23.

During observation on 08/24/21, at 9:03 a.m. two unidentified maintenance staff, wearing only a surgical mask and goggles, opened R23's door touching the handle, and entered R23's room. The maintenance staff moved R23's overhead bedside table to the side of the room, cleaned off the sprinkler head, before the staff moved the table back. The maintenance staff than closed the door touching the handle as they left R23's room. The maintenance staff was observed not sanitizing or washing hands before entering R212 room, when they opened R212 door using the handle and walked in. The maintenance staff cleaned the sprinkler head in R212 before they opened the door and left the room.

R23's special instructions dated 8/24/21, indicated R23 was on 14 day quarantine droplet precautions related to R23 being unvaccinated with an end date of 9/4/21.

During an interview on 8/24/21, at 9:14 a.m. RN-C stated R23 was now on contact and droplet precautions, and that is why the cart was outside the door.

During an interview on 8/24/21, at 9:20 a.m. RN-C stated R23 had loose stools at least twice since returning to the facility according to the nursing assistant documentation. RN-C stated the nursing progress notes from 8/23/21, does

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245324	A. BUILDING _____ B. WING _____	C 08/27/2021

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F 880	Continued From page 34	F 880		

not indicate loose stools. RN-C stated if R23 had CDI she should be on precautions and RN-A would direct us. RN-C stated staff should be wearing gowns and booties with the other PPE when entering R23's room. RN-C further stated R23's roommate should be educated on what precautions to protect herself which includes leaving the door shut.

During an interview on 8/24/21, at 9:21 a.m. HSKP- B stated he would follow and wear whatever the precautions directed on the sign placed on the door.

During observation on 8/24/21 at 9:53 a.m. signs were affixed to R23's door which alerted staff to stop and see the nurse prior to entering R23's room and advised droplet precautions were required.

During an interview on 8/24/21, at 10:00 a.m. RN-A stated R23 was placed on precautions for CDI when she was readmitted after her hospitalization and was placed on vancomycin. RN-A stated R23 did not need to be on precautions because R23 was not having loose diarrhea stools. RN-A stated she only reviewed the nursing notes and not the nursing assistance documentation. RN-A stated she was not aware of R23 having loose stools. RN-A stated after she reviewed the nursing assistant documentation and found the aide documented large loose diarrhea stool. RN-A further stated if R23 had one stool a day she does not need precautions anymore per the doctor's order. RN-A stated since R23 was not fully vaccinated for COVID-19 and was recently hospitalized R23 should be on quarantine. RN-A stated no precautions were being used on 8/23/21, for the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245324	A. BUILDING _____ B. WING _____	C 08/27/2021

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F 880	Continued From page 35	F 880		

quarantine status for the COVID-19. RN-A further stated she is not sure why there was no precautions cart outside the room or precautions sign on the door and said maybe the morning nurse removed it.

During an interview on 8/24/21, at 11:00 a.m. the assistant director of nursing (ADON) stated R23 was not on any precautions on 8/23/21, and was unsure of who removed the precautions but should have left the precautions in place.

During an interview on 8/24/21, at 2:15 p.m. the medical doctor (MD)-C stated if R23 still had loose diarrhea stool, she should remain on precautions until stools are formed. MD-C further stated giving directions to stop precautions because R23's stools were formed and had no diarrhea. MD-C stated R23 could still spread CDI if she still had even one diarrhea stool.

During an observation on 8/25/21, at 8:15 a.m. NA-E entered R23's room wearing a mask and goggles. NA-E emptied R23's overnight catheter bag into a container and removed roughly 700 milliliters and emptied into the toilet. NA-E was observed removing gloves and left R23's room performing hand hygiene with hand sanitizer. NA-E was not wearing a gown when cares were performed.

During an interview on 8/25/21, at 10:00 a.m. PT-A stated she provided physical therapy for R23 in the therapy department and used the parallel bars on 8/23/21. PT-A stated R23 had physical therapy on 8/23/21 and 8/24/21. PT-A stated she was not aware R23 was on precautions for CDI or quarantine for COVID-19 at the time therapy was preformed and could not

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F 880	Continued From page 36	F 880		

find documentation in R23's chart. PT-A stated the therapy department was cleaned with a bleach based solution by housekeeping on 8/24/21, because of the C DIFF diagnosis of R23. PT-A stated she got R23 up using the the EZ stand and did not use a bleach based cleaner or wipe after transferring R23. PT-A stated she only wore a mask and goggles during R23's therapy sessions on 8/23/21 and 8/24/21.

During a follow up observation on 08/26/21 on 8:03 a.m. of outside R23's room , there was purple top Sani wipes, gloves, mask, garbage bags, red bags, and a bucket with blood pressure kit, oximeter. PPE cart lacked N-95 mask, gown, or bleach disinfecting wipes.

During an interview on 8/26/21, at 8:27 a.m. RN-A stated any staff who go into R23's room to assist her are required to wear a gown, mask, goggles, and gloves. RN-A stated her expectation is R23 be on droplet precautions. RN-A stated she was not aware R23 did not have her own vital sign equipment and staff were using the electronic vital equipment wheeled in from the hallway which is used for all the other residents. RN-A stated staff are required to wear the proper PPE if going into R23 room to deliver a meal tray, fill water, assist to the commode , and staff are expected to remove the PPE as directed.

During observation on 8/26/21, at 8:58 a.m. NA-B held a clip board as TMA-A put on a N95 mask with the assistance of RN-A, and gown prior to entering R23's room. NA-B handed TMA-A the clipboard as TMA-A entered R23's room. RN-A hands TMA-A a box of vital equipment from the bottom of the PPE cart located outside of R23's room. TMA-A comes out of the room, PPE was

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	245324	A. BUILDING _____ B. WING _____	C 08/27/2021

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F 880	Continued From page 37	F 880		

removed prior to leaving the room and used hand sanitizer to cleanse hands.

During an interview on 8/26/21, at 10:01 a.m. Occupational therapist (OT)-I stated, the normal procedures for cleaning the equipment in the therapy department, is prior to residents coming into the therapy equipment we clean the equipment using the purple top sani wipes, we let it dry for three minutes, and after the resident finishes we use the purple top sani wipes and let it dry for three minutes.

The Safety Data Sheet (SDS) for Super Sani Cloth Germicidal Disposable Wipe dated 1/30/18, did not indicate efficacy use for the CDI. The SDS indicated active ingredients containing a quaternary and alcohol-based solution.

During an interview on 8/26/21, at 10:30 a.m. NA-B stated during shift report this morning she was told R23 was having an average of two stools a day which are soft to loose in consistency and definitely not a formed stool. NA-C stated she documents every time R23 would have a stool and not just once a day. NA-B further stated nursing assistance should be reporting to the nurse when R23 had loose stools.

During an interview on 8/26/21, at 11:59 a.m. Nurse Practitioner (NP)-B stated R23 must have one formed stool a day for three days prior to removing precautions.

The facility's policy Clostridium Difficile dated 10/18, indicated measures are taken to prevent the occurrence of Clostridium difficile infections (CDI) among residents. The facility's policy further indicated precautions are taken while

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245324	A. BUILDING _____ B. WING _____	C 08/27/2021

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THE ESTATES AT BLOOMINGTON LLC	9200 NICOLLET AVENUE SOUTH BLOOMINGTON, MN 55420

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F 880	Continued From page 38	F 880		

caring for residents with CDI to prevent transmission to others. The facility's policy identified residents considered high risk of developing symptoms associated with C Diff included those with advancing age, gastrointestinal manipulation (nasogastric tube insertion), and antibiotic or anti-neoplastic therapy. The facility's policy further identified the primary reservoirs for C Diff are infected people and surfaces where spores can persist on resident care items and surfaces for several months. The facility's policy directed staff to prevention and intervention included ongoing surveillance of CDI, increased awareness of symptoms and risk factors, frequent hand washing with soap and water by staff and residents, wearing gloves when soiled articles are handled. The facility's policy further directed staff to place residents on contact precautions, place resident in private room if available, staff to be vigilant on hand hygiene using soap and water. The facility's policy indicated for environmental cleaning of resident's room with CDI is done with household bleach and water solution or EPA registered germicidal agent effective against C Diff spores.

The facility's policy Infection Prevention and Control Program dated 8/17, indicated the major elements of the program is the prevention of infection. The facility's policy further indicated all personnel will be trained on infection control policies and procedures upon hire and periodically thereafter. The facility's policy indicated the prevention of infection included implementing appropriate isolation precautions and following disease specific guidelines as those of Center of Disease Control (CDC).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 880	Continued From page 39	F 880		

The facility's policy Contact Enteric Precautions dated 7/14, indicated contact enteric precautions will be used in the care of all residents know or suspected to be infected with organisms that are transmitted by contact with the patient or contaminated surfaces and are particular to infections pertaining to gastrointestinal organisms that re difficult to kill or are easily transmissible. The facility's policy specified residents who have acute diarrhea of unknown etiology, with Clostridium difficile (CDI), and with Norovirus or rotavirus. The facility's policy directed staff to clean hands with soap and water after direct and indirect contact with the resident or with resident's items which included tables, rails, bathroom fixtures, and knobs, and after removing gloves. The facility's policy further directed staff to wear gloves as necessary for all standard precautions, also wear a gown, mask, eye protection or face shield during cares. The facility's policy further directed staff a gown should be worn when contact with environmental surfaces and items in the resident's room which are like to be contaminated (items close to or used by resident). Staff are directed to remove the gown and discard before leaving the resident's environment. The facility policy's directed staff to dedicate resident equipment to a single resident which included commodes, thermometers, blood pressure cuffs, and stethoscopes. Staff were directed to limit movement of symptomatic resident from the room to essential purposes only.

The IJ which began on 8/23/21, was removed on 8/27/21 at 2:47 p.m. when it could be verified through observation, interview and document review the facility: conducted a general higher risk assessment for those who are on antibiotics to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245324	A. BUILDING _____ B. WING _____	C 08/27/2021

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F 880	Continued From page 40 ensure they do not have signs or symptoms of C-Diff. The facility reviewed the CDC's guidelines and grid for enteric precautions, transmission-based precautions to include appropriate signage, PPE usage, and hand hygiene. The facility provided facility wide education on transmission-based precautions and CDC guideline for enteric precautions. Additionally, the facility-initiated education on communication on notification of change of condition, specific precautions based on infection, and documentation. The facility identified monitoring and testing plans for all facility residents, reviewing all admissions and resident with current and new infections to determine if precautions are required.	F 880		

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	245324	A. BUILDING _____ B. WING _____	C 08/27/2021

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E 000	Initial Comments On 8/25/21, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The 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. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained.	E 000		
E 032	Primary/Alternate Means for Communication CFR(s): 483.73(c)(3) §403.748(c)(3), §416.54(c)(3), §418.113(c)(3), §441.184(c)(3), §460.84(c)(3), §482.15(c)(3), §483.73(c)(3), §483.475(c)(3), §484.102(c)(3), §485.68(c)(3), §485.625(c)(3), §485.727(c)(3), §485.920(c)(3), §486.360(c)(3), §491.12(c)(3), §494.62(c)(3). [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following: (3) Primary and alternate means for communicating with the following:	E 032		10/4/21

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

Electronically Signed | 09/28/2021

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E 032	Continued From page 1 (i) [Facility] staff. (ii) Federal, State, tribal, regional, and local emergency management agencies. *[For ICF/IIDs at §483.475(c):] (3) Primary and alternate means for communicating with the ICF/IID's staff, Federal, State, tribal, regional, and local emergency management agencies. This REQUIREMENT is not met as evidenced by: Based on interview and policy review, the facility failed to ensure the communication plan included primary and alternate means for communicating with staff and Federal, State, tribal, regional, and local emergency management agencies. This had the potential to affect all residents in the facility. Findings include: When interviewed on 08/25/21, at 10:04 a.m., the administrator verified there had been no planning for alternate communication with staff, residents, Federal, State, tribal, regional, and local emergency management agencies and had only phone numbers for each party. Review of the policy titled Disaster Planning and Emergency Preparedness/Operation Plan, revised 04/19/21, did not include a communication plan as directed in the regulation.	E 032	Facility communication plan was updated to include an alternate means of communication (emails) with staff and federal, state, tribal, regional, and local emergency management agencies. Education initiated to staff on the facility communication plan specific to alternate means of communication. Audits to ensure appropriate means of communication are available to staff will be completed weekly x4 and then monthly x2. Audit results will be reviewed by the QAPI committee for further recommendations.	
F 000	INITIAL COMMENTS On 8/23/21 - 8/27/21, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. The facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B,	F 000		

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F 000	Continued From page 2 Requirements for Long Term Care Facilities. The survey resulted in an Immediate Jeopardy (IJ) at F880 when the facility failed to keep R23 who had a diagnosis of a potentially infectious disease on transmission based precautions until symptoms resolved. The IJ began on 8/23/21, at 2:30 p.m. and the immediacy was removed on 8/27/21, at 2:47 p.m. ,but noncompliance remained at the lower scope and severity level of F - widespread scope and severity level, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. The following complaints were found to be UNSUBSTANTIATED: H5324116C (MN46671) H5324117C (MN47882/MN48911) H5324118C (MN48466) H5324119C (MN48982) H5324120C (MN50075) H5324121C (MN51434) H5324122C (MN52703). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments 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.	F 000		
F 584	Safe/Clean/Comfortable/Homelike Environment	F 584		10/4/21

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F 584 SS=E	Continued From page 3 CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and	F 584		

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F 584	Continued From page 4 §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure the 300A tub and shower room was kept clean, sanitary and in good repair, which had the potential to affect all 42 residents identified by the facility who utilized 300A tub and shower room. Findings include: During interview on 8/23/21, at 1:20 p.m. R15 stated the common showers were always "grungy", and had not appeared to be cleaned nor sanitized between resident uses. R15 stated "I've been brought in there with poop on the floor." During an observation of the 300A tub and shower room on 8/24/21, at 10:22 a.m., there was a clump of dried black hair approximately two inches in diameter on the shower floor. There was a chipped and broken off tile on the corner of the shower entrance by the floor approximately four inches in length. The broken tile had a jagged edge. Along the back corner of the shower floor where tile and grout met, there was a flat, black, speckled dry stain in a thin line along the grout measuring approximately one foot in length. The white shower curtain was torn, brittle and approximately one-third of it was broken off. The white shower curtain also had black, speckled, and dried stain in the folds. There was a shower chair with drainage holes and the middle hole had a dried brown substance	F 584	300 A tub room and shower room was immediately cleaned, hair was removed off the ground the chipped and broken tile was replaced, the shower curtain was replaced, and shower chair was removed and cleaned before being put back into use, along the back corner of the wall the shower floor tile where the grout and tile met was cleaned, towels were removed from bathtub, incontinence briefs, clothing hanger, shaving razor, package of continence care wipes and hairbrush were removed from area. Other shower rooms have been audited to ensure a safe, clean and homelike environment. Education initiated to all appropriate staff on disinfecting the shower/tub after each resident use and proper disinfectants to be used. DON or designee will complete audits weekly x4 and then monthly x2. Audit results will be reviewed by the QAPI committee for further recommendations.	

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F 584	Continued From page 5	F 584		

packed in it.

The bathtub contained several wrinkled towels that appeared to have been once wet and air dried while crumpled up laying on the tub floor. There was a box of gloves in the bathtub, several folded incontinence briefs, a clothing hanger, shaving razor, package of continence care wipes and a hairbrush with black hair on it.

During interview and observation on 8/24/21, at 10:49 a.m. nursing assistant (NA)-A stated R16 was going to have a shower. NA-A stated after a shower they would clean the tub room with regular soap. NA-A stated was not aware of any disinfectant that should have been used. NA-A brought R16 into the 300A tub and shower room and closed the door.

During interview 8/24/21, at 10:49 a.m. registered nurse (RN)-A stated the expectation was for housekeeping to deep clean the tub and shower room in the evening and the nursing assistants would clean and disinfect between residents. NA-A was asked to bring R16 out of the shower room. RN-A entered the shower room and was shown the matted hair, broken tile, and black stains on the tile, grout, floor and curtain and was shown the torn curtain. RN-A was also shown the tub which contained dried towels, box of gloves, several folded incontinence briefs, a clothing hanger, shaving razor, package of continence care wipes and a hairbrush with black hair on it. RN-A was shown the shower chair with the brown substance packed in the middle drainage hole. At this time that shower chair had R16's clean clothing and face mask placed on top of it. RN-A agreed verbally this was not

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F 584	Continued From page 6 homelike, clean, sanitary, safe or in good repair. RN-A stated none of these issues had been reported and she would have expected staff to report it. RN-A stated she would "call off" R16's shower and have staff clean and repair the shower and tub room. Policy on cleaning requested and not provided.	F 584		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure a comprehensive nursing assessment was completed for a surgical wound to monitor for infection and healing for 1 of 3 residents (R167) reviewed for wound care. Findings include: R167's hospital discharge instructions dated 8/19/21, indicated to keep R167's surgical wound dressing clean, dry and intact (CDI). R167's face sheet indicated facility admission on 8/19/21, with diagnoses of left femur fracture and diabetes.	F 684	R167 has been discharged from the facility. Current residents have been identified for surgical wounds and monitoring for infection and healing. Education initiated to appropriate staff on completing a comprehensive nursing assessment upon admission/re-admission to address wounds/sutures and adding orders to monitor for signs of infection. DON or designee will conduct audits weekly x4 and then monthly x2. Audit	10/4/21

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F 684	Continued From page 7 R167's 48 hour baseline care plan dated 8/19/21, indicated R167 would be followed by the wound care team. R167's care plan dated 8/23/21 indicated R167 was admitted with a hip fracture repair with sutures and indicated R167 was blind. Interventions to monitor skin integrity and the wound site were implemented 8/23/21. R167's treatment administration record (TAR) indicated to assess the wound for signs and symptoms of infection starting 8/24/21. In addition, the TAR indicated to keep the dressing CDI on 8/24/21. Further, the TAR indicated on 8/25/21, to assess each shift if the wound sutures were intact, dressing was clean and intact, and to report signs and symptoms of infection every shift and as indicated. When interviewed on 8/24/21, at 10:01 a.m. R167 stated he had a bandage on his left hip, he had surgery on 8/15/21, and no one had looked at it since he had been admitted. R167 indicated he was blind and could not see it, and did not know what the wound looked like under the bandage. When interviewed 8/24/21, at 2:25 p.m. nurse practitioner (NP)-A from [name] Healthcare orthopedic department indicated the hospital discharge instructions for R167 indicated she would have expected a nurse to assess the dressing as the order was to keep it CDI and the only way to know if it was CDI was to look at it or assess it. NP-A also indicated if facility staff was unsure what to do, she would have expected	F 684	results will be reviewed by the QAPI committee.	

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F 684	Continued From page 8	F 684		

them to call.

When interviewed on 8/24/21, at 3:41 p.m. registered nurse (RN)-C indicated medical doctor (MD)-C saw R167 and would write an order to change the dressing when it is soiled and PRN. RN-C indicated there should have been an order sooner and the wound should have been assessed daily. RN-C indicated he checked the treatment plan and the physician orders, and there were none to assess the wound.

When interviewed on 8/24/21, at 4:17 p.m. MD-C indicated the wound was assessed that day, the wound had minimal serosanguinous (contains both blood and clear yellow liquid known as blood serum) drainage, and some old drainage on the dressing. MD-C indicated she would expect staff to follow instructions from discharge regarding wound care. MD-C indicated if the wound and dressing are not not assessed, R167 could develop an infection.

The director of nurses was not available for interview.

When interviewed on 8/25/21, at 11:26 a.m. RN-A stated the order to leave the dressing CDI was is in resident's banner (at the top of the page) in the electronic medical record, but not in the orders, and if it were not in the orders, it would not populate to the TAR and nurses would not know to perform the assessment. RN-A indicated is was an oversight and the order would be added.

The Monarch Healthcare Management Policy Statement Sheet, implementing Medication and

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F 684	Continued From page 9 Treatment Orders, dated 2/17, directed staff to implement treatment orders within 24 hours of when the orders were received.	F 684		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to	F 690		10/4/21

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F 690	Continued From page 10 restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to perform proper catheter care for 1 of 2 residents (R11) observed for catheter cares. Findings include: R11's admission minimum data set (MDS) dated 5/11/21, indicated R11 was cognitively intact and required extensive assistance of two staff for toilet use and personal hygiene. R11's MDS further indicated R11 had impairment of both sides upper and lower extremities. R11's care area assessment (CAA) indicated R11 triggered for activities of daily living (ADL) function related to the need for assistance with all ADL's. R11's CAA further indicated R11 had a self-care deficit related to Parkinson's disease and rention of urine. R11's CAA indicated R11 required assistance related to indwelling catheter care with the assist of one to follow facility's protocol for catheter care. R11's Care Plan dated 8/24/21, indicated R11 had a neuromusclar dysfunction of the bladder and had a alteration in elimination which required a indwelling foley catheter (catheter which is placed in the bladder by a water-filled balloon). R11's care plan indicated R11 requested per his preference to use a leg bag while awake and asleep. R11 care plan directed staff to monitor R11 leg bag and to empty as needed, monitor foley catheter output, foley catheter care per	F 690	R11 bedsheets were changed and proper catheter was provided. R11 has been discharged from the facility. Current residents have been identified for proper catheter care use. Education initiated to all appropriate staff on proper catheter care including drainage, not allowing tip of catheter to be in contact with urine, cleansing tip of the tubing on leg bag. DON or designee will audit weekly x4 and then monthly x2. Audit results will be reviewed by the QAPI committee.	

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F 690	Continued From page 11	F 690		

policy, and assistance with toileting and peri-cares.

R11's admission record dated 8/25/21, indicated R11 had the diagnoses of Parkinson's disease (progressive nervous system disorder that affects movement), neuromusclar dysfunction(flaccid or spastic) of the bladder, history of urinary tract infection, and type two diabetes mellitus (high levels of sugar in the blood).

R11's physician order dated 11/5/20, indicated R11 was taking Finasteride (used to shrink an enlarged prostate) tablet 5 mg daily for neuromuscular dysfunction of the bladder.

R11's physician order dated 11/15/20, directed staff to empy leg bag every four hours and as needed.

R11's nursing progress note (PN) dated 7/18/21, indicated R11 had complained of pain and burning sensation in the penis. R11's physician ordered a urine anlysis and culture.

R11's nursing PN dated 8/2/21, indicated nursing assistant reported R11's bed and clothes were wet from urine.

R11's nursing (PN) dated 8/11/21, indicated that R11 had his foley catheter changed related to pain and encrustations. Writer administered bed-bath, changed resident clothing, administered pericares.

During an observation on 8/23/21, at 1:23 p.m. R11 leg bag was full of dark yellow concentrated urine. R11's room and cookie crumbs on the floor

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F 690	Continued From page 12	F 690		

and on R11 bed. Multiple flies were flying all over R11 room landing on R11 and a two flies were observed crawling up inside R11 tubing of the leg bag.

During an observation on 8/23/21, at 2:22 p.m. R11 lying in his bed with leg bag straped to his right leg which is positioned out straight. R11's leg bag was found to be bulging and contained dark yellow concentrated urine with sediment. Nursing assistant (NA)-G walken into R11 room and emptied 500 millilitres (ml) from R11's leg bag into a graduated cylinder and allowed the tubing to become covered with the urine as it emptied into the cylinder. NA-G did not cleanse the tip of the leg bag with an alcohol wipe once it was emptied. R11 leg bag filled back up three quarters full after being emptied. R11's sheets toward the foot of the left side of bed to have dry yellow stain measuring 18 inches in diameter. On the floor next to the left side end of bed dried yellow stain was seen.

During observation on 8/24/21, at 8:09 a.m. R11 was observed lying in bed with legs lying straight in bed with leg bag attached to R11 right leg. R11 sheets were stained with a dark yellow color at the end of the bed on the right side for R11 leg bag.

During an interview on 8/23/21, at 2:24 p.m. licensed pratical nurse (LPN)-A stated she was not aware of flies crawling up the catheter tubing and it is possible if this is happening R11 could get an infection. LPN-A stated she would get a NA into R11's room to empty the catheter bag and change the sheets on R11's bed. LPN- A further stated R11 likes to eat food in his room

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	245324	A. BUILDING _____ B. WING _____	C 08/27/2021

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F 690	Continued From page 13	F 690		

and it gets all over the floor and bed which makes the room a host for flies or other bugs.

During an interview on 8/23/21, at 2:25 p.m. R11 stated he had been getting pain at the catheter insetion site and it felt like it is pulling. R11 further stated he had staff come in and leave the clamp open were urine is leaking all over his bed and floor.

During an interview on 8/23/21, at 2:30 p.m. NA-G stated she was not aware she needed to cleanse the tip of the tubing. NA-G further stated she is not sure why she let the end of the catheter tubing sit in urine as the graduated cylinder filled as she emptied R11's leg bag.

During an interview on 8/23/21, at 2:35 p.m. LPN-A stated NA-G should not have let the end of the leg bag tubing sit inside the urine on the graduated cylinder. LPN-A stated NA-G should have cleansed the end of the tubing and ensure the bag was emptied completely.

During an interview with family member (FM)- B on 8/25/21, at 9:20 a.m. FM stated she had concerns about the care the resident catheter care. FM-B stated R11 is at risk for urinary tract infection because of his Parkinson's Disease and had a history of urinary tract infections. FM-B requested staff to use lidocaine jelly (numbing medication) prior to insertion of the catheter and at times the facility denied R11's request so R11 goes to the VA clinic to have the catheter replaced. FM-11 further states the night nursing assistance have emptied the leg bag and left the clamp open so urine would spill onto the bed and floor. FM-F further stated she observed staff pull

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F 690	Continued From page 14 up the bed side table right through the puddle of urine on the floor and would leave the wet sheets on the bed. FM-F stated when she came to visit R11 had flies in is room and they would crawl on the leg bag and on the tubing and up the bottom tube to the clamp. FM-F further stated "How is that not a concern for infection?" During an interview on 8/23/21 at 3:30 p.m. registered nurse (RN)-A stated her expecations is catheter care is completed by all nursing assistants and nursing staff. RN-A stated the tubing from the leg bag should not be directly sitting in the urine as the urine is being emptied. RN-A stated it is an infection risk if the urine is not completely emptied and the urine may back flow into the bladder. RN-A further stated her expectations for the staff to change bedding as necessary and keep the room free of bugs including from crawling into the leg bag tubing. The facility's policy Catheter Care dated 11/19, indicated to provide clinents a safe, hygienic, and thorough catheter care. The facility's policy to notify nurse of unusal observation. The facility's policy lacked direction on care related to emptying catheter bag. The facility's policy Infection Prevention and Control dated 8/17, indicated to provide a safe, sanitary, and comfortable environment to help prevent the develpoment of infection.	F 690		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency	F 755		10/4/21

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F 755	Continued From page 15 drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to administer medications as ordered for 2 of 9 residents (R31, R59) reviewed for medication administration. Findings include:	F 755	R31 care plan had been updated to include a diabetic focus care area. R31 orders were updated to reflect increased insulin order. R59 has been discharged from the facility. Current residents have been identified to	

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F 755	Continued From page 16 R31's quarterly Minimum Data Set (MDS) dated 6/25/21, indicated severely impaired cognition. R31 required extensive assist with dressing and hygiene. R31 had a diagnosis of diabetes mellitus. R31's care plan lacked a diabetic focus care area. R31's order summary from 12/2/20 - 8/24/21, indicated -starting 12/2/20, monitor for hypoglycemia (low blood glucose) symptoms every shift. The orders lacked direction to monitor for hyperglycemia symptoms (elevated blood glucose). -starting 4/7/21, check blood glucose three times a day with meals and call nurse practitioner (NP) if blood glucose less than 75 or greater than 400. -starting 7/13/21, administer insulin glargine 30 units subcutaneously at bedtime related to type 1 diabetes mellitus. R31's physician progress note dated 8/6/21, indicated R31 was seen by request due to two falls in the past week. New orders were given to increase bedtime glargine (insulin) to 32 units given sustained hyperglycemia (elevated blood glucose) and draw A1C lab (blood test result which reflects average blood sugar level for the past several months) the next lab day. previous A1C results on 2/9/21, was was 7.7% (normal A1C level is below 5.7%). R31's blood glucose results indicated the following ranges: -8/6/21: 252 - 462 milligrams/deciliter (mg/dL) -8/7/21: 75 - 307 mg/dL -8/8/21: 131 - 510 mg/dL	F 755	include a diabetic focus care area and orders reviewed for accuracy. Education initiated to appropriate staff on transcription of orders and process for obtaining medication when pharmacy is not able to provide it. DON or designee will audit weekly x4 and monthly x2. Audit results will be reviewed by the QAPI committee.	

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F 755	Continued From page 17 -8/9/21: 117 - 297 mg/dL -8/10/21: 93 - 281 mg/dL -8/11/21: 178 - 310 mg/dL -8/12/21: 224 - 322 mg/dL -8/13/21: 180 - 387 mg/dL -8/14/21: 274 - 324 mg/dL -8/15/21: 287 - 332 mg/dL -8/16/21: 185 - 364 mg/dL -8/17/21: 208 - 357 mg/dL -8/18/21: 165 - 327 mg/dL -8/19/21: 179 - 364 mg/dL -8/20/21: 135 - 367 mg/dL -8/21/21: 227 - 368 mg/dL -8/22/21: 183 - 398 mg/dL -8/23/21: 124 - 246 mg/dL -8/24/21: 198 - 364 mg/dL -8/25/21: 175 - 230 mg/dL R31's medication administration record (MAR) from 8/6/21 - 8/24/21, indicated the new increased insulin order was not implemented and R31 continued to receive insulin glargine 30 units subcutaneously at bedtime. During interview 8/25/21, at 11:07 a.m. licensed practical nurse (LPN)-A stated the nurses would have transcribed any new orders from a provider visit. LPN-A reviewed R31's current physician orders and stated R31 was prescribed insulin glargine 30 units subcutaneously at bedtime. During interview 8/25/21, at 11:13 a.m. registered nurse (RN)-A stated R31's orders directed the nursing staff to administer insulin glargine 30 units subcutaneously at bedtime. R31 then reviewed the latest physician orders from 8/6/21, and saw the new order to increase to 32 units. RN-A stated this insulin order along with the A1C	F 755		

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F 755	Continued From page 18	F 755		

blood draw had not been transcribed.

During interview 8/25/21, at 11:18 a.m. RN-B stated the new order for glargine and blood draw had not been transcribed and should have.

During interview 8/25/21, at 3:32 p.m. nurse practitioner (NP)-B stated she wrote the orders for increased insulin and the blood draw on 8/6/21, during her visit and would have expected the new orders to have started that same day. NP-B stated she reviewed R31's blood sugars since her visit and they remained elevated.

R59

R59's face sheet indicated R59 was admitted 7/29/21, with diagnoses of prostate cancer.

R59's provider orders indicated Xtandi (a medication used to treat men with prostate cancer) was ordered for R59 on 7/30/21.

A provider note from nurse practitioner (NP)-B dated 7/30/21, indicated the pharmacy was unable to provide Xtandi and the medication order would be on hold until family could provide the medication.

R59's nursing progress notes dated 8/7/21, 8/8/21, 8/9/21, 8/10/21, and 8/11/21 indicated Xtandi was not administered as the medication was on hold, with no mention of contacting the family to bring it.

Nursing progress noted dated 8/12/2021, at 7:58 a.m. indicated Xtandi was on hold, the medication had not been provided by the family,

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F 755	Continued From page 19	F 755		

and the DON had been notified. R59's progress notes do not indicate any contact was made to family to request the medication.

R59's nursing progress note dated 8/24/21, at 10:49 a.m. indicated Xtandi was on hold until family can provide the medication.

When interviewed on 8/24/21, at 11:01 a.m. family member (FM)-A indicated she had the medication at home but was instructed she could not bring medications from home. FM-A indicated she had not been contacted or asked to bring the medication.

When interviewed on 8/24/21, at 10:20 a.m. RN-Z at [name] Oncology stated she had told the facility this resident needed Xtandi. RN-Z indicated the oncology office provided the facility social worker (SW)-A a medication list and a note from the provider indicating the need for this medication. RN-Z stated the oncology office stressed the need for this medication. RN-Z stated no one had called to request an order for this medication if they could not get it at the facility. RN-Z indicated R59 has prostate cancer that needs to be monitored, and the cancer was being controlled by Xtandi. RN-Z indicated it would be important for R59 to restart the medication.

When interviewed on 8/25/21, at 01:26 p.m. RN-D stated Xtandi was on hold for R59. RN-D indicated he was told by the DON when R59 was admitted the family was to provide it. RN-D stated he could not find a note about the family being notified. RN-D had not contacted the family to bring the medication.

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F 755	Continued From page 20 When interviewed on 8/25/21, at 1:41 p.m. RN-B stated she did not know what happened with the medication Xtandi nor why R59 had not received it. RN-B had not contacted the family to bring the medication. When interviewed on 8/26/21, at 9:05 a.m. RN-A stated Xtandi was not listed on the hospital discharge paperwork, but family said it was needed. RN-A stated the pharmacy could not get Xtandi for the facility as it was a specialty oncology medication, and that family needed to provide it. RN-A stated she had not documented that she told family to bring it. When interviewed on 8/26/21, at 9:31 a.m. SW-A stated she had talked to FM-A about bringing the medication, but had not documented it. When interviewed on 8/26/21, at 9:42 a.m. RN-A stated the resident was scheduled for discharge, and R59 would get the medication when he gets home. When interviewed on 8/26/21, at 11:09 a.m. 9:47 a.m. pharmacist (PH)-A stated Xtandi could only be provided by the family or the specialty pharmacy. PH-A stated the medication modulates hormones to prevent the progression of cancer. During email communication on 8/25/21, at 12:51 p.m. the regional director of operations (RDO) stated the facility lacked a policy or procedure for medication administration.	F 755		
F 803 SS=D	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7)	F 803		10/4/21

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F 803	Continued From page 21 §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to accommodate dietary preferences for 1 of 1 residents (R58) reviewed for food. Findings include: R58's admission Minimum Data Set (MDS) dated 8/5/21 indicated R58 had moderately impaired	F 803	R58 meal tray ticket has been updated to reflect resident preferences. Current residents have been interviewed and resident preferences updated on tray tickets and care plan as needed. Education initiated to staff on resident preferences and tray accuracy.	

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F 803	Continued From page 22 cognition and had diagnosis of alcoholic liver disease and portal hypertension. R58's MDS further indicated R58 was independent with eating. R58's careplan dated 8/3/21, 8/3/21 Care Plan indicated Alteration in communication R58's meal tray card dated 8/25/21, identified R58 had no direction or indication R58 required a mechanical soft diet for oral intake. R58's meal ticket further indicated R58 had dislikes to bacon and preferred sausage. R58 received sausage crumbles to R58 as a replacement for bacon for breakfast. The meal ticket directed staff to offer preferred foods when possible. R58's dietary order dated 8/2/21, indicated R58 had a consistent carbohydrate diet with regular texture. R58's dietitian progress noted dated 8/20/21, indicated R58 should continue with current diet. On 8/24/21, at 2:00 p.m. when approached and asked how the meal service had been R58 stated "I was served ground up sausage this morning, and I do not like it." R58 stated he had food dislikes and notified the dietitian of my dislikes to some foods such as bacon, pancakes, and french toast. R58 stated he did not like ground sausage and does not need to have his meat cut up. R58 stated my preference is the a full sausage patty or links. On 8/24/21, at 2:26 p.m. dietary manager (DM) stated R58 was on a regular carbohydrate controlled diet with regular texture. The DM	F 803	Culinary Director or designee will audit weekly x4, monthly x2. Audit results will be reviewed by the QAPI committee.	

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F 803	Continued From page 23 further stated R58 was served ground sausage by mistake and ground sausage is for a mechanical diet. DM stated she would notify dietary staff to provide residents the meal choices R58 prefers. DM stated her expectation is for staff to follow meal trays as directed and as ordered. A facility policy was requested and was not provided.	F 803		
F 880 SS=J	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;	F 880		10/4/21

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F 880	Continued From page 24 §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F 880		

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F 880	Continued From page 25 §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement appropriate precautions against clostridium difficile colitis (CDI) (a inflammation of the colon caused by the bacteria clostridium difficile) including use of appropriate personal protective equipment (PPE) and isolation precautions to prevent the spread of COVID-19 for 1 of 1 resident (R23) who required quarantine. This practice resulted in an immediate jeopardy (IJ) situation for residents and staff as a result of the facility not implementing proper transmission based precautions (TBP). This non-compliance has the potential to spread infections to other residents in the facility. The IJ began on 8/23/21, at 2:30 p.m. when the facility failed to continue with transmission based precautions (TBP) when R23 was to be on quarantine for COVID-19 and failed to initiate contact precautions for active C-diff while R23 continued to display symptoms of CDI, including loose stools. In addition, the staff present on the 300 wing were not wearing appropriate PPE prior to entering R23's room. The administrator and director of nursing (DON) were notified of the IJ on 8/26/21, at 12:15 p.m. The IJ was removed on 8/27/21, at 2:47 p.m.,but noncompliance remained at the lower scope and severity level of F - widespread scope and severity level, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy.	F 880	The facility currently has no residents on precautions besides R23. Due to R23 roommate being at a higher risk for signs and symptoms of C-Diff, monitoring orders were put in place for the next 7 days. The facility will review all like residents who are on antibiotics to ensure they do not have signs and symptoms of C-diff specific to diarrhea/loose stools. All like resident based off of record review and resident interview do not present with signs and symptoms of C-Diff. Facility is now following the CDC guidelines for enteric precautions. Transmission-based precautions grid/procedure was reviewed and remains current. Staff education has been initiated and will remain ongoing regarding transmission based precautions, and CDC guidelines for enteric precautions to include appropriate signage, PPE usage and hand hygiene. Staff education has been initiated and will remain ongoing regarding C-Diff specific to signs and symptoms. Staff education has been initiated specific to when to place a resident on and off precautions based on infection. Staff education has been initiated regarding communication	

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	245324	A. BUILDING _____ B. WING _____	C 08/27/2021

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F 880	Continued From page 26 Findings include: CDC guidance Create a Plan for Managing New Admissions and Readmissions indicates Residents with confirmed SARS-CoV-2 infection who have not met criteria to discontinue Transmission-Based Precautions should be placed in the designated COVID-19 care unit, regardless of vaccination status. In general, all unvaccinated residents who are new admissions and readmissions should be placed in a 14-day quarantine, even if they have a negative test upon admission. The Centers for Disease Control and Prevention (CDC) guidance on confirmed clostridioides difficile infection (CDI) isolating and initiating contact precautions for confirmed dated 7/12/21, recommended placement of patients on enteric contact precautions in a single patient room with a dedicated toilet. Enteric precautions indicated staff to wear a gown and gloves and wash hands with soap and water. For patients with confirmed CDI should remain on contact precautions for at least 48 hours after diarrhea has resolved or longer. Adhere to recommended hand hygiene practices, use dedicated patient care equipment (blood pressure cuffs and stethoscopes), and implement daily patient bathing or showering with soap and water. The Centers for Disease Control and Prevention (CDC) guidance on perform environmental cleaning to prevent CDI dated 7/12/21, recommended to create a daily terminal cleaning protocols and checklist for patient care areas and equipment, perform daily cleaning of CDI patient	F 880	between departments specific to notification of when a resident is on and taken off precautions, this will be completed through the PCC dashboard, morning meeting, and appropriate signage on resident door, NAR staff education initiated regarding verbally communicating with the licensed nurse of any loose stools prior to documenting in point of care. Staff will be educated prior to the start of their next scheduled shift. Staff who are on an extended leave will receive a mailed packet and will be required to send back an acknowledgement form of understanding. The Director of Nursing or designee will complete daily audits x 2 weeks, weekly for 4 weeks and then monthly for 3 months and then the QAPI committee will review for ongoing audits. Audits will consist of DON/Designee reviewing all admissions, re-admissions and resident with current and new infections to determine if precautions are required. DON/Designee will audit each identified resident who is required to be on precautions has the appropriate signage and PPE accessible. DON/Designee will complete 5 staff infection control questions/quizzes based on the above frequency to ensure their knowledge and understanding of the policies and procedures listed above. DPOC Summary ¿The facility has contracted with an infection preventionist consultant to	

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F 880	Continued From page 27 rooms using a C-Diff sporicidal agent (EPA List K), clean and disinfect the patient care environment including the immediate vicinity around CDI patient and high touch surfaces at least once a day, and all shared equipment prior to use with another patient. The CDC further provided guidance for cleaning additional areas which are contaminated during transient visits by patient with confirmed CDI such as physical therapy (PT) room. The CDC Progression of a CDI infection dated 7/12/21, identified risk factors for getting CDI infection occur if a person had a previous infection with CDI, being over the age of 65, recent stay at a hospital or nursing home. CDC further indicated a person with a weakened immune system. The Safety Data Sheet (SDS) for Sani-Cloth Bleach Germicidal Disposable Wipe dated 8/12/16, indicated efficacy use for the CDI. The SDS indicated the active ingredients of sodium hypochlorite which is commonly referred to as bleach. The facility list of quarantine residents indicated only R165 was on quarantine and ended on 8/26/21. The facility provided list of residents on antibiotics in the last 14 days indicated R17, R24, R42, R214 were identified at risk. The facility's list lacked R61 who was R23's roommate who was taking an antibiotic for her chronic obstructive pulmonary disease. R23's admission minimum data set (MDS)	F 880	provide consultation and oversight for infection prevention and control within the facility. The contract establishes that the consultant will work with the facility for a minimum of two (2) months. ¿The infection preventionist consultant has worked with the facility to conduct a Root Cause Analysis (RCA) to identify and address the reasons for noncompliance identified in the CMS 2567. ¿QAPI committee, and Governing Body have participated in the completion of the RCA. ¿The facility took immediate action to implement an infection prevention plan consistent with the requirements at 42 CFR ¿ 483.80 for the affected residents impacted by the noncompliance identified in the CMS 2567 to include identification of other residents that may have been impacted by the noncompliant practice. This plan validated that -Intiated training on transmission based precautions (TBP) and initiation of contact precautions; -Staff will use PPE appropriately based on appropriate transmission-based requirements; -Staff are provided with and use Personal Protective Equipment (PPE) in accordance with the Centers for Disease Control (CDC) guidelines; -Staff have the tools and abilities to ensure residents that meet criteria for isolation upon admission remain in quarantine; except for medical necessity; -R23 and roommate were assessed daily	

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F 880	Continued From page 28 assessment dated 6/16/21, indicated R23 was cognitively intact and had diagnoses of obstructive and reflux uropathy, rheumatoid arthritis, and chronic kidney disease. R23's MDS further indicated R23 was frequently incontinent of stool and had a indwelling catheter. R23's care area assessment (CAA) dated 6/17/21, indicated R23 required a total assist of two for all activities of daily living (ADL), and required a Hoyer lift for transfers. R23's CAA further indicated R23 needed assistance for toileting every two to three hours and Foley catheter care. R23's Care Plan initiated 8/23/21 indicated R23 had a history of CDI and directed staff to monitor for signs and symptoms of CDI. R23 care plan lacked direction to place R23 on enteric precautions (general contact precautions, gloves and gown. Handwashing with soap and water must be performed; an alcohol-based hand rub is not sufficient. Equipment, such as stethoscopes, should be wiped down when leaving patient rooms in all contact precautions). R23's care plan for Covid 19 date initiated 6/15/21 included an intervention to screen for signs and symptoms upon return for 14 days. R23's Admission Record printed 8/25/21, indicated R23 had diagnoses of urinary tract infection (UTI), bacterial infection, rheumatoid arthritis, chronic kidney disease, and severe sepsis with septic shock. R23's immunization record printed 8/25/21, indicated R23 had first COVID-19 vaccine on 7/21/21. R23 had not received the second dose	F 880	for changes in health status and have not experienced a change in condition. -The infection preventionist consultant□s will assist the facility in completing the CMS infection Control self-assessment found in the CMS publication QSO-20-20-ALL, Prioritization o Survey Activity and reviewing relevant facility infection control policies and procedures. -The infection preventionist consultant will support the facility□s Quality Assurance and Performance Improvement Committee with assistance from Governing Body to conduct root cause analysis (RCA) to identify the problem(s) that resulted in deficiency and develop intervention or corrective action plan to prevent recurrence and review policies for the following: -Cohorting Residents/Transmission Based Precaution Isolation -Equipment/Environment-proper disinfection -Hand Hygiene -Personal Protective Equipment (PPE) ¿The infection preventionist consultant□s action plan will include education for staff that provides direct resident care, as well as staff that enter into resident rooms including the following topics: Standard Infection Control Practices Cohorting Residents/Transmission Based Precaution isolation Disinfecting Shared Medical Equipment/Environment Hand Hygiene Personal Protective Equipment (PPE) ¿The infection preventionist consultant	

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F 880	Continued From page 29 for Covid. R23's order summary for 8/21, indicated R23 was on Vancomycin (antibiotic) 125 mg by mouth every 6 hours for CDI. R23's order summary further indicated on 8/24/21, R23 was placed on 14-day quarantine droplet precautions related to unvaccinated to Covid-19 until 9/4/21. The order summary further indicated on 8/24/21, R23 was placed on enteric precautions for CDI and may be discontinue if R23's stools are formed and only having one stool a day. R23's Hospital History and Physical (HP) dated 8/18/21, indicated R23 had diarrhea present for several weeks of five or more watery stools a day. R23's HP further indicated R23 had a recent history of CDI and was recently treated with antibiotics for infected kidney stone. R23's Hospital progress note (PN) dated 8/18/21, at 10:47 p.m. indicated R23 was positive of CDI and was started on Vancomycin (medication to treat infection) 125 milligrams (mg) four times a day for the treatment of CDI and was placed on enteric precautions. R23's Hospital nurse progress note dated 8/19/21, at 6:11 p.m. indicated R23 had multiple loose stools. R23's Hospital nurse progress note dated 8/20/21, at 6:03 a.m. indicated R23 had been on enteric precautions for CDI and was incontinent of stool at times. R23's Hospital Transfer Form dated 8/21/21, indicated R23 was treated while in the hospital	F 880	and director of nursing will carefully establish in advance a dedicated area as the care location for residents with disease, including with or without current symptoms of illness. ¿Programs will use resources from well-established centers of geriatric health services education ¿After completion of the training, staff competency will be validated by a post-test or observation of compliance. If the facility employs staff or contract staff with limited English proficiency (LEP), the facility will ensure education is provided in a language understandable to the LEP staff member(s). ¿The facility and infection preventionist consultant will design a scheduled, objective format for the facility to implement for the follow-up employee supervision and work performance appraisal. Facility supervisors will conduct onsite observations and appraise employee implementation of the knowledge, skills and procedures. At the successful completion of the DPOC, the facility will provide required documents as described in the DPOC, Checklist: Documents Required for Successful Completion of the Directed Plan	

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F 880	Continued From page 30	F 880		

for diarrhea from CDI colitis. R23's Hospital Transfer form directed the facility to start R23 on Vancomycin 125 mg by mouth four times a day.

R23's PN dated 8/21/21, indicated R23 was readmitted to the facility after hospitalization for a new diagnosis of CDI. R23 PN further indicated R23 was placed on contact precautions.

R23's nursing assistant (NA) note dated 8/21/21, indicated R23 had a large loose diarrhea stool.

R23's NA note dated 8/23/21, indicated R23 had a large loose diarrhea stool.

R23's PN dated 8/23/21, indicated R23 continued on antibiotics for CDI. R23 requested a BRAT (Bananas, Rice, Applesauce, Toast) diet (restrictive diet recommended for people with gastrointestinal distress like vomiting, diarrhea, or gastroenteritis).

R23's special instruction dated 8/23/21, had no indication R23 was on contact precautions or quarantine.

R23's NA care sheet dated 8/25/21, indicated R23 was an assist of two for all ADL's and was Hoyer lift transfer. R23's NA care sheet lacked indication R23 was on precautions for CDI or quarantine for COVID-19.

During an observation on 8/23/21, 11:30 a.m. R23's room lacked PPE supplies outside the room. There was no signage indicating transmission-based precautions were in place.

During an interview with R23 on 8/23/21, at 11:45

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F 880	Continued From page 31	F 880		

p.m. R23 stated she was recently hospitalized with a urinary tract infection and was diagnosed with CDI. R23 stated she was not aware she was on precautions. R23 further stated staff wear only goggles and a mask. R23 stated staff used the vital machine equipment on her and than on her roommate. R23 further stated this is her second time of having CDI. R23 stated she had loose diarrhea stool since she returned to the facility on 8/21/21, and they do not bag her clothes, garbage, or meal tray separate. R23 stated she had stomach pain, diarrhea, nausea, some tenderness, and R23 further stated she requested a BRAT diet until she felt better.

During an interview on 8/23/21, at 12:00 p.m. housekeeping (HSKP)-B stated he was not aware R23 was on precautions. HSKP-B further stated he had just finished cleaning R23's room like he normally did.

During an observation on 8/23/21, at 12:30 p.m. an aide was observed entering R23 room wearing only surgical mask and face shield. NA-F brought in R23's lunch meal tray and placed it on the over the bed table. NA-F repositioned the table over R23 who was lying in bed and assisted with repositioning the water pitcher. NA-F left room and gathered R23's roommate's tray. NA-F did not wash her hands after repositioning R23's table or when she left the room.

During an observation on 8/23/21, at 12:55 p.m. NA-F walked into R23's room wearing a mask and goggles. NA-F, removed R23 lunch tray, repositioned R23's water cup on the over bed table prior to leaving R23's room. NA-F was

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	245324	A. BUILDING _____ B. WING _____	C 08/27/2021

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F 880	Continued From page 32	F 880		

observed using hand sanitizer.

During an interview on 8/23/21, at 1:00 p.m. registered nurse (RN)-D stated he was not aware R23 was on precautions. RN-D further stated if R23 was placed on precautions than R23 should have her supplies outside the room and signs on the door. RN-D stated when he started working today there were no precautions signs or personal protective equipment (PPE) outside R23's door. RN-D stated when he reviewed 23's chart there was no indications R23 was on precautions for C-Diff or quarantine for COVID-19. RN-D stated it is important for the staff who provide direct care to know if a resident is on precautions so we do not spread infections to other residents.

During an observation on 8/23/21, at 1:30 p.m. R23 was observed in the therapy department standing with hands on the parallel bars. PT-A who did not have a gown on or N95 mask was observed to have direct contact with R23. Four other unidentified residents attended rehab in the same room following R23. PT-A was observed to have worked with the other residents after R23.

During an interview on 8/23/21, at 2:00 p.m. NA-F stated she was notified by the previous shift, R23 had a large loose diarrhea stool recorded in her nursing assistant documentation.

During observation on 8/23/21, at 2:30 p.m. NA-F was observed providing peri-care to R23. NA-F had on a mask and goggles. NA-F was observed leaning on the edge of the bed during the provision of cares. NA-F exited the room and used alcohol-based hand sanitizer and did not

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	245324	A. BUILDING _____ B. WING _____	C 08/27/2021

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F 880	Continued From page 33	F 880		

wash her hands with soap and water. NA was observed to go into R212's room to provide cares.

During observation on 8/24/21, at 8:45 a.m. R23's door to the room was open. No sign on door indicating precautions. R23 was lying in her bed.

During an interview on 8/24/21, at 8:45 a.m. HSKP-A stated R23 was not on precautions on 8/23. HSKP-A further stated she would see the precautions sign on the door and would talk with nursing staff before entering the room to see what is required. HSKP-A stated if R23 did not have a precautions sign on the door the non-direct care staff would not be aware of the precautions and use the same supplies to clean the rooms as all the other rooms which means we could spread germs.

During observation at 8/24/21, at 8:49 a.m. R23's roommate was observed to have left the room without wearing a mask and left the door open.

During an interview on 8/24/21, at 8:50 a.m. R23's roommate stated she was not aware of any concerns regarding needing to quarantine or concerns about special precautions. R23's roommate further stated no one explained precautions to her and stated she felt it was not fair she needed to keep the door shut when she was not ill. R23's roommate stated she gets claustrophobic with the door is shut.

During an interview on 8/24/21, at 9:00 a.m. NA-C stated R23 had a large loose diarrhea stool 8/23/21, and had multiple loose stools since R23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 880	Continued From page 34	F 880		

returned to facility. NA-C stated she had been wearing only a mask and goggles when providing cares to R23.

During observation on 08/24/21, at 9:03 a.m. two unidentified maintenance staff, wearing only a surgical mask and goggles, opened R23's door touching the handle, and entered R23's room. The maintenance staff moved R23's overhead bedside table to the side of the room, cleaned off the sprinkler head, before the staff moved the table back. The maintenance staff than closed the door touching the handle as they left R23's room. The maintenance staff was observed not sanitizing or washing hands before entering R212 room, when they opened R212 door using the handle and walked in. The maintenance staff cleaned the sprinkler head in R212 before they opened the door and left the room.

R23's special instructions dated 8/24/21, indicated R23 was on 14 day quarantine droplet precautions related to R23 being unvaccinated with an end date of 9/4/21.

During an interview on 8/24/21, at 9:14 a.m. RN-C stated R23 was now on contact and droplet precautions, and that is why the cart was outside the door.

During an interview on 8/24/21, at 9:20 a.m. RN-C stated R23 had loose stools at least twice since returning to the facility according to the nursing assistant documentation. RN-C stated the nursing progress notes from 8/23/21, does not indicate loose stools. RN-C stated if R23 had CDI she should be on precautions and RN-A would direct us. RN-C stated staff should be

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F 880	Continued From page 35	F 880		

wearing gowns and booties with the other PPE when entering R23's room. RN-C further stated R23's roommate should be educated on what precautions to protect herself which includes leaving the door shut.

During an interview on 8/24/21, at 9:21 a.m. HSKP- B stated he would follow and wear whatever the precautions directed on the sign placed on the door.

During observation on 8/24/21 at 9:53 a.m. signs were affixed to R23's door which alerted staff to stop and see the nurse prior to entering R23's room and advised droplet precautions were required.

During an interview on 8/24/21, at 10:00 a.m. RN-A stated R23 was placed on precautions for CDI when she was readmitted after her hospitalization and was placed on vancomycin. RN-A stated R23 did not need to be on precautions because R23 was not having loose diarrhea stools. RN-A stated she only reviewed the nursing notes and not the nursing assistance documentation. RN-A stated she was not aware of R23 having loose stools. RN-A stated after she reviewed the nursing assistant documentation and found the aide documented large loose diarrhea stool. RN-A further stated if R23 had one stool a day she does not need precautions anymore per the doctor's order. RN-A stated since R23 was not fully vaccinated for COVID-19 and was recently hospitalized R23 should be on quarantine. RN-A stated no precautions were being used on 8/23/21, for the quarantine status for the COVID-19. RN-A further stated she is not sure why there was no

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	245324	A. BUILDING _____ B. WING _____	C 08/27/2021

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F 880	Continued From page 36	F 880		

precautions cart outside the room or precautions sign on the door and said maybe the morning nurse removed it.

During an interview on 8/24/21, at 11:00 a.m. the assistant director of nursing (ADON) stated R23 was not on any precautions on 8/23/21, and was unsure of who removed the precautions but should have left the precautions in place.

During an interview on 8/24/21, at 2:15 p.m. the medical doctor (MD)-C stated if R23 still had loose diarrhea stool, she should remain on precautions until stools are formed. MD-C further stated giving directions to stop precautions because R23's stools were formed and had no diarrhea. MD-C stated R23 could still spread CDI if she still had even one diarrhea stool.

During an observation on 8/25/21, at 8:15 a.m. NA-E entered R23's room wearing a mask and goggles. NA-E emptied R23's overnight catheter bag into a container and removed roughly 700 milliliters and emptied into the toilet. NA-E was observed removing gloves and left R23's room performing hand hygiene with hand sanitizer. NA-E was not wearing a gown when cares were performed.

During an interview on 8/25/21, at 10:00 a.m. PT-A stated she provided physical therapy for R23 in the therapy department and used the parallel bars on 8/23/21. PT-A stated R23 had physical therapy on 8/23/21 and 8/24/21. PT-A stated she was not aware R23 was on precautions for CDI or quarantine for COVID-19 at the time therapy was preformed and could not find documentation in R23's chart. PT-A stated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245324	A. BUILDING _____ B. WING _____	C 08/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT BLOOMINGTON LLC	9200 NICOLLET AVENUE SOUTH BLOOMINGTON, MN 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
F 880	Continued From page 37	F 880		

the therapy department was cleaned with a bleach based solution by housekeeping on 8/24/21, because of the C DIFF diagnosis of R23. PT-A stated she got R23 up using the the EZ stand and did not use a bleach based cleaner or wipe after transferring R23. PT-A stated she only wore a mask and goggles during R23's therapy sessions on 8/23/21 and 8/24/21.

During a follow up observation on 08/26/21 on 8:03 a.m. of outside R23's room , there was purple top Sani wipes, gloves, mask, garbage bags, red bags, and a bucket with blood pressure kit, oximeter. PPE cart lacked N-95 mask, gown, or bleach disinfecting wipes.

During an interview on 8/26/21, at 8:27 a.m. RN-A stated any staff who go into R23's room to assist her are required to wear a gown, mask, goggles, and gloves. RN-A stated her expectation is R23 be on droplet precautions. RN-A stated she was not aware R23 did not have her own vital sign equipment and staff were using the electronic vital equipment wheeled in from the hallway which is used for all the other residents. RN-A stated staff are required to wear the proper PPE if going into R23 room to deliver a meal tray, fill water, assist to the commode , and staff are expected to remove the PPE as directed.

During observation on 8/26/21, at 8:58 a.m. NA-B held a clip board as TMA-A put on a N95 mask with the assistance of RN-A, and gown prior to entering R23's room. NA-B handed TMA-A the clipboard as TMA-A entered R23's room. RN-A hands TMA-A a box of vital equipment from the bottom of the PPE cart located outside of R23's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245324	A. BUILDING _____ B. WING _____	C 08/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT BLOOMINGTON LLC	9200 NICOLLET AVENUE SOUTH BLOOMINGTON, MN 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
F 880	Continued From page 38	F 880		

room. TMA-A comes out of the room, PPE was removed prior to leaving the room and used hand sanitizer to cleanse hands.

During an interview on 8/26/21, at 10:01 a.m. Occupational therapist (OT)-I stated, the normal procedures for cleaning the equipment in the therapy department, is prior to residents coming into the therapy equipment we clean the equipment using the purple top sani wipes, we let it dry for three minutes, and after the resident finishes we use the purple top sani wipes and let it dry for three minutes.

The Safety Data Sheet (SDS) for Super Sani Cloth Germicidal Disposable Wipe dated 1/30/18, did not indicate efficacy use for the CDI. The SDS indicated active ingredients containing a quaternary and alcohol-based solution.

During an interview on 8/26/21, at 10:30 a.m. NA-B stated during shift report this morning she was told R23 was having an average of two stools a day which are soft to loose in consistency and definitely not a formed stool. NA-C stated she documents every time R23 would have a stool and not just once a day. NA-B further stated nursing assistance should be reporting to the nurse when R23 had loose stools.

During an interview on 8/26/21, at 11:59 a.m. Nurse Practitioner (NP)-B stated R23 must have one formed stool a day for three days prior to removing precautions.

The facility's policy Clostridium Difficile dated 10/18, indicated measures are taken to prevent

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245324	A. BUILDING _____ B. WING _____	C 08/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT BLOOMINGTON LLC	9200 NICOLLET AVENUE SOUTH BLOOMINGTON, MN 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
F 880	Continued From page 39	F 880		

the occurrence of Clostridium difficile infections (CDI) among residents. The facility's policy further indicated precautions are taken while caring for residents with CDI to prevent transmission to others. The facility's policy identified residents considered high risk of developing symptoms associated with C Diff included those with advancing age, gastrointestinal manipulation (nasogastric tube insertion), and antibiotic or anti-neoplastic therapy. The facility's policy further identified the primary reservoirs for C Diff are infected people and surfaces where spores can persist on resident care items and surfaces for several months. The facility's policy directed staff to prevention and intervention included ongoing surveillance of CDI, increased awareness of symptoms and risk factors, frequent hand washing with soap and water by staff and residents, wearing gloves when soiled articles are handled. The facility's policy further directed staff to place residents on contact precautions, place resident in private room if available, staff to be vigilant on hand hygiene using soap and water. The facility's policy indicated for environmental cleaning of resident's room with CDI is done with household bleach and water solution or EPA registered germicidal agent effective against C Diff spores.

The facility's policy Infection Prevention and Control Program dated 8/17, indicated the major elements of the program is the prevention of infection. The facility's policy further indicated all personnel will be trained on infection control policies and procedures upon hire and periodically thereafter. The facility's policy indicated the prevention of infection included

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245324	A. BUILDING _____ B. WING _____	C 08/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT BLOOMINGTON LLC	9200 NICOLLET AVENUE SOUTH BLOOMINGTON, MN 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
F 880	Continued From page 40 implementing appropriate isolation precautions and following disease specific guidelines as those of Center of Disease Control (CDC). The facility's policy Contact Enteric Precautions dated 7/14, indicated contact enteric precautions will be used in the care of all residents know or suspected to be infected with organisms that are transmitted by contact with the patient or contaminated surfaces and are particular to infections pertaining to gastrointestinal organisms that re difficult to kill or are easily transmissible. The facility's policy specified residents who have acute diarrhea of unknown etiology, with Clostridium difficile (CDI), and with Norovirus or rotavirus. The facility's policy directed staff to clean hands with soap and water after direct and indirect contact with the resident or with resident's items which included tables, rails, bathroom fixtures, and knobs, and after removing gloves. The facility's policy further directed staff to wear gloves as necessary for all standard precautions, also wear a gown, mask, eye protection or face shield during cares. The facility's policy further directed staff a gown should be worn when contact with environmental surfaces and items in the resident's room which are like to be contaminated (items close to or used by resident). Staff are directed to remove the gown and discard before leaving the resident's environment. The facility policy's directed staff to dedicate resident equipment to a single resident which included commodes, thermometers, blood pressure cuffs, and stethoscopes. Staff were directed to limit movement of symptomatic resident from the room to essential purposes only.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245324	A. BUILDING _____ B. WING _____	C 08/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT BLOOMINGTON LLC	9200 NICOLLET AVENUE SOUTH BLOOMINGTON, MN 55420

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F 880	Continued From page 41 The IJ which began on 8/23/21, was removed on 8/27/21 at 2:47 p.m. when it could be verified through observation, interview and document review the facility: conducted a general higher risk assessment for those who are on antibiotics to ensure they do not have signs or symptoms of C-Diff. The facility reviewed the CDC's guidelines and grid for enteric precautions, transmission-based precautions to include appropriate signage, PPE usage, and hand hygiene. The facility provided facility wide education on transmission-based precautions and CDC guideline for enteric precautions. Additionally, the facility-initiated education on communication on notification of change of condition, specific precautions based on infection, and documentation. The facility identified monitoring and testing plans for all facility residents, reviewing all admissions and resident with current and new infections to determine if precautions are required.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245324	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/24/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT BLOOMINGTON LLC	**9200 NICOLLET AVENUE SOUTH BLOOMINGTON, MN 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
K 000	INITIAL COMMENTS FIRE SAFETY An annual L/fe Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 08/24/2021. At the time of this survey, The Estates at Bloomington was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, the Health Care Facilities Code. 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 64 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

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

FIRE SAFETY SURVEY REPORT
CRUCIAL DATA EXTRACT
(TO BE USED WITH CMS-2786 FORMS)

PROVIDER NUMBER	FACILITY NAME	SURVEY DATE
K1 245324	**THE ESTATES AT BLOOMINGTON LLC**	*K4 **08/24/2021**

K6 DATE OF PLAN APPROVAL

K3 : MULTIPLE CONSTRUCTION

TOTAL NUMBER OF BUILDINGS 1

NUMBER OF THIS BUILDING 01

[A]

A BUILDING
B WING
C FLOOR
D APARTMENT UNIT

LSC FORM INDICATOR

Health Care Form		
12	2786 R	2012 EXISTING
13	2786 R	2012 NEW

ASC Form		
14	2786 U	2012 EXISTING
15	2786 U	2012 NEW

ICF/MR Form		
16	2786 V, W, X	2012 EXISTING
17	2786 V, W, X	2012 NEW

*K7 [12] SELECT NUMBER OF FORM USED FROM ABOVE

(Check if K321 or K351 are marked as not applicable in the 2786 M, R, T, U, V, W, X, Y and Z.)

K321: [3] K351: [3]

COMPLETE IF ICF/MR IS SURVEYED UNDER CHAPTER 21

SMALL (16 BEDS OR LESS)

K8: [ ]

1 PROMPT
2 SLOW
3 IMPRACTICAL

LARGE

K8: [ ]

4 PROMPT
5 SLOW
6 IMPRACTICAL

APARTMENT HOUSE

K8: [ ]

7 PROMPT
8 SLOW
9 IMPRACTICAL

ENTER E-SCORE HERE

K5: [ ] e.g 2.5

*K9 : FACILITY MEETS LSC BASED ON: (*Check all that apply*)

A1 [X]	A2 [ ]	A3 [ ]	A4 [ ]	A5 [ ]
(COMP. WITH ALL PROVISIONS)	(ACCEPTABLE POC)	(WAIVERS)	(FSES)	(PERFORMANCE BASED DESIGN)

FACILITY DOES NOT MEET LSC:

B. [ ]

K180:

A. [X]	B. [ ]	C. [ ]
FULLY SPRINKLERED (All required areas are sprinklered)	PARTIALLY SPRINKLERED (Not all required areas are sprinklered)	NONE (No sprinkler system)

*MANDATORY

FIRE SAFETY SURVEY REPORT - 2012 LIFE SAFETY CODE HEALTHCARE

1. (A) PROVIDER NUMBER	1. (B) MEDICAID I.D. NO.
K1 245324	K2

PART I — Life Safety Code, New and Existing
PART II — Health Care Facilities Code, New and Existing
PART III — Recommendation for Waiver
PART IV – Crucial Data Extract
OPTIONAL — Chapter 4 – NFPA 101A - Fire Safety Evaluation System for Health Care Occupancies – CMS-2786T

Identifying information as shown in applicable records. Enter changes, if any, alongside each item, giving date of change.

2. NAME OF FACILITY	2. (A) MULTIPLE CONSTRUCTION (BLDGS)	2. (B) ADDRESS OF FACILITY (STREET, CITY, STATE, ZIP CODE)	
The Estates at Bloomington	A. BUILDING 01 B. WING C. FLOOR K3	9200 Nicollet Avenue South Bloomington, MN 55420	A. (●) Fully Sprinklered (All required areas are sprinklered) B. ( ) Partially Sprinklered (Not all required areas are sprinklered) C. ( ) None (No sprinkler system) K0180

3. SURVEY FOR	4. DATE OF SURVEY	DATE OF PLAN APPROVAL	SURVEY UNDER
[✔] MEDICARE [✔] MEDICAID	8/24/2021 K4	K6	5. (●) 2012 EXISTING 6. ( ) 2012 NEW K7

5. SURVEY FOR CERTIFICATION OF

1. ( ) HOSPITAL 2. (●) SKILLED/NURSING FACILITY 4. ( ) ICF/IID UNDER HEALTH CARE 5. ( ) HOSPICE

IF "2" OR "5" ABOVE IS MARKED, CHECK APPROPRIATE ITEM(S) BELOW

1. [✔] ENTIRE FACILITY 2. [ ] DISTINCT PART OF (SPECIFY) _____

3. [ ] IF DISTINCT PART OF HOSPITAL, IS HOSPITAL ACCREDITED?
a. [ ] YES b. [ ] NO

6. BED COMPOSITION a. TOTAL NO. OF BEDS IN THE FACILITY	b. NUMBER OF HOSPITAL BEDS CERTIFIED FOR MEDICARE	c. NUMBER OF SKILLED BEDS CERTIFIED FOR MEDICARE	d. NUMBER OF SKILLED BEDS CERTIFIED FOR MEDICAID	e. NUMBER OF NF or ICF/IID BEDS CERTIFIED FOR MEDICAID
68	____	68	68	____

7. A. (●) THE FACILITY MEETS THE STANDARD, BASED UPON (CHECK ALL APPROPRIATE BOXES)

1. (●) COMPLIANCE WITH ALL PROVISIONS 2. ( ) ACCEPTANCE OF A PLAN OF CORRECTION 3. [ ] RECOMMENDED WAIVERS 4. [ ] FSES 5. [ ] PERFORMANCE BASED DESIGN

B. ( ) THE FACILITY DOES NOT MEET THE STANDARD
K9

SURVEYOR *(Signature)*	TITLE	OFFICE	DATE
Roy M Kingsley	Deputy State Fire Marshal	Minnesota State Fire Marshal Division	8/24/2021
SURVEYOR ID 37008 K10			
FIRE AUTHORITY OFFICIAL William Abderhalden 37009	TITLE Fire Safety Supervisor	OFFICE Minnesota State Fire Marshal Division	DATE 09/17/2021

CMS FORMS SHALL BE COMPLETED AND RETAINED AS PART OF THE SURVEY RECORD.

ID PREFIX		MET	NOT MET	N/A	REMARKS
	PART I – NFPA 101 LSC REQUIREMENTS (Items in italics relate to the FSES)				
	SECTION 1 – GENERAL REQUIREMENTS				
K100	**General Requirements – Other** List in the REMARKS section any LSC Section 18.1 and 19.1 General 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.	◉	○	○	
K111	**Building Rehabilitation** ***Repair, Renovation, Modification, or Reconstruction*** Any building undergoing repair, renovation, modification, or reconstruction complies with both of the following: • Requirements of Chapter 18 and 19. • Requirements of the applicable Sections 43.3, 43.4, 43.5, and 43.6. 18.1.1.4.3, 19.1.1.4.3, 43.1.2.1 ***Change of Use or Change of Occupancy*** Any building undergoing change of use or change of occupancy classification complies with the requirements of Section 43.7, unless permitted by 18.1.1.4.2 or 19.1.1.4.2. 18.1.1.4.2 (4.6.7 and 4.6.11), 19.1.1.4.2 (4.6.7 and 4.6.11), 43.1.2.2 (43.7) ***Additions*** Any building undergoing an addition shall comply with the requirements of Section 43.8. If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors with at least a 1-1/2 hour fire resistance rating. Additions comply with the requirements of Section 43.8. 18.1.1.4.1 (4.6.7 and 4.6.11), 18.1.1.4.1.1 (8.3), 18.1.1.4.1.2, 18.1.1.4.1.3, 19.1.1.4.1 (4.6.7 and 4.6.11), 19.1.1.4.1.1 (8.3), 19.1.1.4.1.2, 19.1.1.4.1.3, 43.1.2.3(43.8)	○	○	◉	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K112	**Sprinkler Requirements for Major Rehabilitation** If a nonsprinklered smoke compartment has undergone major rehabilitation the automatic sprinkler requirements of 18.3.5 have been applied to the smoke compartment. In cases where the building is not protected throughout by a sprinkler system, the requirements of 18.4.3.2, 18.4.3.3, and 18.4.3.8 are also met. Note: Major rehabilitation involves the modification of more than 50 percent, or more than 4500 ft² of the area of the smoke compartment. 18.1.1.4.3.3, 19.1.1.4.3.3	○	○	◉	
K131	**Multiple Occupancies – Sections of Health Care Facilities** Sections of health care facilities classified as other occupancies meet all of the following: • They are not intended to serve four or more inpatients for purposes of housing, treatment, or customary access. • They are separated from areas of health care occupancies by construction having a minimum two hour fire resistance rating in accordance with Chapter 8. • The entire building is protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. Hospital outpatient surgical departments are required to be classified as an Ambulatory Health Care Occupancy regardless of the number of patients served. 18.1.3.3, 19.1.3.3, 42 CFR 482.41, 42 CFR 485.623	○	○	◉	
K132	**Multiple Occupancies – Contiguous Non-Health Care Occupancies** Non-health care occupancies that are located immediately next to a Health Care Occupancy, but are primarily intended to provide outpatient services are permitted to be classified as Business or Ambulatory Health Care Occupancies, provided the facilities are separated by construction having not less than two hour fire resistance-rated construction, and are not intended to provide services simultaneously for four or more inpatients. Outpatient surgical departments must be classified as Ambulatory Health Care Occupancy regardless of the number of patients served. 18.1.3.4.1, 19.1.3.4.1	○	○	◉	

<table>
<tr><th>ID PREFIX</th><th></th><th>MET</th><th>NOT MET</th><th>N/A</th><th>REMARKS</th></tr>
<tr><td>K133</td><td>Multiple Occupancies – Construction Type
Where separated occupancies are in accordance with 18/19.1.3.2 or 18/19.1.3.4, the most stringent construction type is provided throughout the building, unless a two hour separation is provided in accordance with 8.2.1.3, in which case the construction type is determined as follows:
• The construction type and supporting construction of the health care occupancy is based on the story in which it is located in the building in accordance with 18/19.1.6 and Tables 18/19.1.6.1.
• The construction type of the areas of the building enclosing the other occupancies shall be based on the applicable occupancy chapters.
18.1.3.5, 19.1.3.5, 8.2.1.3</td><td>◉</td><td>○</td><td>○</td><td></td></tr>
<tr><td>K161</td><td>Building Construction Type and Height
2012 EXISTING
Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7
19.1.6.4, 19.1.6.5
<table>
<tr><th></th><th></th><th>Construction Type</th><th></th></tr>
<tr><td>1</td><td>○</td><td>I (442), I (332), II (222)</td><td>Any number of stories non-sprinklered or sprinklered</td></tr>
<tr><td>2</td><td>◉</td><td>II (111)</td><td>One story non-sprinklered
Maximum 3 stories sprinklered</td></tr>
<tr><td>3</td><td>○</td><td>II (000)</td><td rowspan="4">Not allowed non-sprinklered
Maximum 2 stories sprinklered</td></tr>
<tr><td>4</td><td>○</td><td>III (211)</td></tr>
<tr><td>5</td><td>○</td><td>IV (2HH)</td></tr>
<tr><td>6</td><td>○</td><td>V (111)</td></tr>
<tr><td>7</td><td>○</td><td>III (200)</td><td rowspan="2">Not allowed non-sprinklered
Maximum 1 story sprinklered</td></tr>
<tr><td>8</td><td>○</td><td>V (000)</td></tr>
</table>
Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5)
Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate.</td><td>◉</td><td>○</td><td>○</td><td>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.</td></tr>
</table>

ID PREFIX		MET	NOT MET	N/A	REMARKS
K161	2012 NEW Building construction type and stories meets Table 18.1.6.1, unless otherwise permitted by 18.1.6.2 through 18.1.6.7 18.1.6.4, 18.1.6.5	○	○	◉	

		Construction Type	
1	○	I (442), I (332), II (222)	Not allowed non-sprinklered Any number of stories sprinklered
2	○	II (111)	Not allowed non-sprinklered Maximum 3 stories sprinklered
3	○	II (000)	Not allowed non-sprinklered Maximum 1 story sprinklered
4	○	III (211)	
5	○	IV (2HH)	
6	○	V (111)	
7	○	III (200)	Not allowed non-sprinklered
8	○	V (000)	

Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 18.3.5)

Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate.

K162	**Roofing Systems Involving Combustibles** 2012 EXISTING Buildings of Type I (442), Type I (332), Type II (222), or Type II (111) having roof systems employing combustible roofing supports, decking or roofing meet the following: 1. roof covering meets Class C requirements. 2. roof is separated from occupied building portions with a noncombustible floor assembly using not less than 2½ inches concrete or gypsum fill. 3. attic or other space is either unoccupied or protected throughout by an approved automatic sprinkler system. 19.1.6.2*, ASTM E108, ANSI/UL 790	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K162	2012 NEW Buildings of Type I (442), Type I (332), Type II (222), Type II (111) having roof systems employing combustible roofing supports, decking or roofing meet the following: 1. roof covering meets Class A requirements. 2. roof is separated from occupied building portions with 2 hour fire resistive noncombustible floor assembly using not less than 2½ inches concrete or gypsum fill. 3. the structural elements supporting the rated floor assembly meet the required fire resistance rating of the building. 18.1.6.2, ASTM E108, ANSI/UL 790	○	○	◉	
K163	**Interior Nonbearing Wall Construction** Interior nonbearing walls in Type I or II construction are constructed of noncombustible or limited-combustible materials. Interior nonbearing walls required to have a minimum 2 hour fire resistance rating are permitted to be fire-retardant-treated wood enclosed within noncombustible or limited-combustible materials, provided they are not used as shaft enclosures. 18.1.6.4, 18.1.6.5, 19.1.6.4, 19.1.6.5	◉	○	○	
	SECTION 2 – MEANS OF EGRESS REQUIREMENTS				
K200	**Means of Egress Requirements – Other** List in the REMARKS section any LSC Section 18.2 and 19.2 Means of Egress 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. 18.2, 19.2	◉	○	○	
K211	**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	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K221	**Patient Sleeping Room Doors** Locks on patient sleeping room doors are not permitted unless the key-locking device that restricts access from the corridor does not restrict egress from the patient room, or the locking arrangement is permitted for patient clinical, security or safety needs in accordance with 18.2.2.2.5 or 19.2.2.2.5. 18.2.2.2, 19.2.2.2, TIA 12-4	◉	○	○	
K222	**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 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	◉	○	○	Exit doors

ID PREFIX		MET	NOT MET	N/A	REMARKS
K222	☐ 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	◉	○	○	Exit doors
K223	**Doors with Self-Closing Devices** Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: • Required manual fire alarm system; and • Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and • Automatic sprinkler system, if installed; and • Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K224	**Horizontal-Sliding Doors** Horizontal-sliding doors permitted by 7.2.1.14 that are not automatic-closing are limited to a single leaf and shall have a latch or other mechanism to ensure the door will not rebound. Horizontal-sliding doors serving an occupant load fewer than 10 shall be permitted, providing all of the following criteria are met: • Area served by the door has no high hazard contents. • Door is operable from either side without special knowledge or effort. • Force required to operate the door in the direction of travel is ≤ 30 lbf to set the door in motion and ≤ 15 lbf to close or open to the required width. • Assembly is appropriately fire rated, and where rated, is self-or automatic-closing by smoke detection per 7.2.1.8, and installed per NFPA 80. • Where required to latch, the door has a latch or other mechanism to ensure the door will not rebound. 18.2.2.2.10, 19.2.2.2.10	○	○	◉	
K225	**Stairways and Smokeproof Enclosures** Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2	◉	○	○	
K226	**Horizontal Exits** Horizontal exits, if used, are in accordance with 7.2.4 and the provisions of 18.2.2.5.1 through 18.2.2.5.7, or 19.2.2.5.1 through 19.2.2.5.4. 18.2.2.5, 19.2.2.5	◉	○	○	
K227	**Ramps and Other Exits** Ramps, exit passageways, fire and slide escapes, alternating tread devices, and areas of refuge are in accordance with the provisions 7.2.5 through 7.2.12. 18.2.2.6 to 18.2.2.10 or 19.2.2.6 to 19.2.2.10	◉	○	○	
K231	**Means of Egress Capacity** The capacity of required means of egress is in accordance with 7.3. 18.2.3.1, 19.2.3.1	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K232	**Aisle, Corridor or Ramp Width** 2012 EXISTING The width of aisles or corridors (clear or unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of nonambulatory patients on stretchers, except as modified by 19.2.3.4, exceptions 1-5. 19.2.3.4, 19.2.3.5	◉	○	○	
	2012 NEW The width of aisles or corridors (clear and unobstructed) serving as exit access in hospitals and nursing homes shall be at least 8 feet. In limited care facility and psychiatric hospitals, width of aisles or corridors shall be at least 6 feet, except as modified by the 18.2.3.4 or 18.2.3.5 exceptions. 18.2.3.4, 18.2.3.5	○	○	◉	
K233	**Clear Width of Exit and Exit Access Doors** 2012 EXISTING Exit access doors and exit doors are of the swinging type and are at least 32 inches in clear width. Exceptions are provided for existing 34-inch doors and for existing 28-inch doors where the fire plan does not require evacuation by bed, gurney, or wheelchair. 19.2.3.6, 19.2.3.7	◉	○	○	
	2012 NEW Exit access doors and exit doors are of the swinging type and are at least 41.5 inches in clear width. In psychiatric hospitals or limited care facilities, doors are at least 32 inches wide. Doors not subject to patient use, in exit stairway enclosures, or serving newborn nurseries shall be no less than 32 inches in clear width. If using a pair of doors, the doors shall be provided with a rabbet, bevel, or astragal at the meeting edge, at least one of the doors shall provide 32 inches in clear width, and the inactive leaf of the pair shall be secured with automatic flush bolts. 18.2.3.6, 18.2.3.7	○	○	◉	
K241	**Number of Exits – Story and Compartment** Not less than two exits, remote from each other, and accessible from every part of every story are provided for each story. Each smoke compartment shall likewise be provided with two distinct egress paths to exits that do not require the entry into the same adjacent smoke compartment. 18.2.4.1-18.2.4.4, 19.2.4.1-19.2.4.4	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K251	**Dead-End Corridors and Common Path of Travel** 2012 EXISTING Dead-end corridors shall not exceed 30 feet. Existing dead-end corridors greater than 30 feet shall be permitted to be continued to be used if it is impractical and unfeasible to alter them. 19.2.5.2	◉	○	○	
K251	2012 NEW Dead-end corridors shall not exceed 30 feet. Common path of travel shall not exceed 100 feet. 18.2.5.2, 18.2.5.3	○	○	◉	
K252	**Number of Exits – Corridors** Every corridor shall provide access to not less than two approved exits in accordance with Sections 7.4 and 7.5 without passing through any intervening rooms or spaces other than corridors or lobbies. 18.2.5.4, 19.2.5.4	◉	○	○	
K253	**Number of Exits – Patient Sleeping and Non-Sleeping Rooms** Patient sleeping rooms of more than 1,000 square feet or nonsleeping rooms of more than 2,500 square feet have at least two exit access doors remotely located from each other. 18.2.5.5.1, 18.2.5.5.2, 19.2.5.5.1, 19.2.5.5.2	◉	○	○	
K254	**Corridor Access** All habitable rooms not within suites have a door leading directly outside to grade or have a door leading to an exit access corridor. Patient sleeping rooms with less than eight patient beds may have one room intervening to reach an exit access corridor provided the intervening room is equipped with an approved automatic smoke detection system. 18.2.5.6.1 through 18.2.5.6.4, 19.2.5.6.1 through 19.2.5.6.4	◉	○	○	
K255	**Suite Separation, Hazardous Content, and Subdivision** All suites are separated from the remainder of the building (including from other suites) by construction meeting the separation provisions for corridor construction (18.3.6.2-18.3.6.5 or 19.3.6.2-19.3.6.5). Existing approved barriers shall be allowed to continue to be used provided they limit the transfer of smoke. Intervening rooms have no hazardous areas and hazardous areas within suites comply with 18/19.2.5.7.1.3. Subdivision of suites shall be by noncombustible or limited-combustible construction. 18.2.5.7.1.2 through 18.2.5.7.1.4, 19.2.5.7.1.2, 19.2.5.7.1.3, 19.2.5.7.1.4	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K256	**Sleeping Suites** Occupants shall have exit access to a corridor or direct access to a horizontal exit. Where ≥ 2 exits are required, one exit access door may be to a stairway, passageway or to the exterior. Suites shall be provided with constant staff supervision. Staff shall have direct visual supervision of patient sleeping rooms, from a constantly attended location or the room shall be provided with an automatic smoke detection system. Suites more than 1,000 ft² shall have 2 or more remote exits. One means of egress from the suite shall be to a corridor and one may be into an adjacent suite separated in accordance with corridor requirements. Suites shall not exceed the following size limitations: • 5,000 square feet if the suite is not fully smoke detected or fully sprinklered. • 7,500 square feet if the suite is either fully smoke detected or fully sprinklered. • 10,000 square feet if the suite is both fully smoke detected and fully sprinklered and the sleeping rooms have direct supervision from a constantly attended location. Travel distance between any point in a suite to exit access shall not exceed 100 feet and distance to an exit shall not exceed 150 feet (200 feet if building is fully sprinklered). 18.2.5.7.2, 19.2.5.7.2	○	○	◉	
K257	**Non-Sleeping Suites** Occupants shall have exit access to a corridor or direct access to a horizontal exit. Where ≥ 2 exits are required, one exit access door may be to a stairway, passageway or to the exterior. Suites more than 2,500 ft² shall have 2 or more remote exits. One means of egress from the suite shall be to a corridor and one may be into an adjacent suite separated in accordance with corridor requirements. Suites shall not exceed 10,000 ft². Travel distance between any point in a suite to exit access shall not exceed 100 feet and distance to an exit shall not exceed 150 feet (200 feet if building is fully sprinklered). 18.2.5.7.3, 19.2.5.7.3	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K261	**Travel Distance to Exits** Travel distance (excluding suites) to exits are measured in accordance with 7.6. • From any point in the room or suite to exit less than or equal to 150 feet (less than or equal to 200 feet if the building is fully sprinklered). • Point in a room to room door less than or equal to 50 feet. 18.2.6, 19.2.6	◉	○	○	
K271	**Discharge from Exits** Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7	◉	○	○	
K281	**Illumination of Means of Egress** Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8	◉	○	○	
K291	**Emergency Lighting** Emergency lighting of at least 1-1/2 hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1	◉	○	○	
K292	**Life Support Means of Egress** 2012 NEW (INDICATE N/A FOR EXISTING) Buildings equipped with or requiring the use of life support systems (electro-mechanical or inhalation anesthetics) have illumination of means of egress, emergency lighting equipment, exit, and directional signs supplied by the life safety branch of the electrical system described in NFPA 99. (Indicate N/A if life support equipment is for emergency purposes only.) 18.2.9.2, 18.2.10.5	○	○	◉	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K293	**Exit Signage** 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.)	◉	○	○	
	2012 NEW Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 18.2.10.1	○	○	◉	
	SECTION 3 – PROTECTION				
K300	**Protection – Other** List in the REMARKS section any LSC Section 18.3 and 19.3 Protection 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.	◉	○	○	
K311	**Vertical Openings – Enclosure** 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1-hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 *If all vertical openings are properly enclosed with construction providing at least a 2 hour fire resistance rating, also check this box.* ☐	○	○	◉	
	2012 NEW Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 2 hours connecting four or more stories. (1-hour for single story building and buildings up to three stories in height.) An atrium may be used in accordance with 8.6.7. 18.3.1 through 18.3.1.5	○	○	◉	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K321	**Hazardous Areas – Enclosure** 2012 EXISTING Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with ¾ 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 sq. ft.)	☑	☑	☐
c. Repair, Maintenance, and Paint Shops	☑	☑	☐
d. Soiled Linen Rooms (exceeding 64 gal.)	☑	☑	☐
e. Trash Collection Rooms (exceeding 64 gal.)	☑	☑	☐
f. Combustible Storage Rooms/Spaces (over 50 sq. ft.)	☑	☑	☐
g. Laboratories (if classified as Severe Hazard - see K322)	☐	☐	☑

ID PREFIX		MET	NOT MET	N/A	REMARKS
K321	2012 NEW Hazardous areas are protected in accordance with 18.3.2.1. The areas shall be enclosed with a 1-hour fire-rated barrier, with a ¾ hour fire-rated door without windows (in accordance with 8.7.1.1). Doors shall be self-closing or automatic-closing in accordance with 7.2.1.8. Hazardous areas are protected by a sprinkler system in accordance with 9.7, 18.3.2.1, and 8.4. *Describe the floor and zone locations of hazardous areas that are deficient in REMARKS.* 18.3.2.1, 7.2.1.8, 8.4, 8.7, 9.7		○	○	◉	

Area	Automatic Sprinkler	Separation	N/A
a. Boiler and Fuel-Fired Heater Rooms	☐	☐	☐
b. Laundries (larger than 100 sq. ft.)	☐	☐	☐
c. Repair, Maintenance, and Paint Shops	☐	☐	☐
d. Soiled Linen Rooms (exceeding 64 gal.)	☐	☐	☐
e. Trash Collection Rooms (exceeding 64 gal.)	☐	☐	☐
f. Combustible Storage Rooms/Spaces (over 50 and less than 100 sq. ft.)	☐	☐	☐
g. Combustible Storage Rooms/Spaces (over 100 sq. ft.)	☐	☐	☐
h. Laboratories (if classified as Severe Hazard - see K322)	☐	☐	☐

ID PREFIX		MET	NOT MET	N/A	REMARKS
K322	**Laboratories** Laboratories employing quantities of flammable, combustible, or hazardous materials that are considered a severe hazard are protected by 1-hour fire resistance-rated separation, automatic sprinkler system, and are in accordance with 8.7 and with NFPA 99. Laboratories not considered a severe hazard are protected as hazardous areas (see K321). Laboratories using chemicals are in accordance with NFPA 45, *Standard on Fire Protection for Laboratories Using Chemicals*. Gas appliances are of appropriate design and installed in accordance with NFPA 54. Shutoff valves are marked to identify material they control. Devices requiring medical grade oxygen from the piped distribution system meet the requirements under 11.4.2.2 (NFPA 99). 18.3.2.2, 19.3.2.2, 8.7, 8.7.4.1 (LSC) 9.3.1.2, 11.4.3.2, 15.4 (NFPA 99)	○	○	◉	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K323	**Anesthetizing Locations** Areas designated for administration of general anesthesia (i.e., inhalation anesthetics) are in accordance with 8.7 and NFPA 99. Zone valves are: located immediately outside each life-support, critical care, and anesthetizing location of moderate sedation, deep sedation, or general anesthesia for medical gas or vacuum; readily accessible in an emergency; and arranged so shutting off any one anesthetizing location will not affect others. Area alarm panels are provided to monitor all medical gas, medical-surgical vacuum, and piped WAGD systems. Panels are at locations that provide for surveillance, indicate medical gas pressure decreases of 20 percent and vacuum decreases of 12 inch gauge HgV, and provide visual and audible indication. Alarm sensors are installed either on the source side of individual room zone valve box assemblies or on the patient/use side of each of the individual zone box valve assemblies. The EES critical branch supplies power for task illumination, fixed equipment, select receptacles, and select power circuits, and EES equipment system supplies power to ventilation system. Heating, cooling, and ventilation are in accordance with ASHRAE 170. Medical supply and equipment manufacturer's instructions for use are considered before reducing humidity levels to those allowed by ASHRAE, per S&C 13-58. 18.3.2.3, 19.3.2.3 (LSC) 5.1.4.8.7, 5.1.4.8.7.2, 5.1.9.3, 5.1.9.3.4, 6.4.2.2.4.2 (NFPA 99)	○	○	◉	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K324	**Cooking Facilities** Cooking equipment is protected in accordance with NFPA 96, *Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations*, unless: • residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2. • cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or • cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2	◉	○	○	
K325	**Alcohol Based Hand Rub Dispenser (ABHR)** ABHRs are protected in accordance with 8.7.3.1, unless all conditions are met: • Corridor is at least 6 feet wide. • Maximum individual dispenser capacity is 0.32 gallons (0.53 gallons in suites) of fluid and 18 ounces of Level 1 aerosols. • Dispensers shall have a minimum of four foot horizontal spacing. • Not more than an aggregate of 10 gallons of fluid or 1135 ounces of aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room. • Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30. • Dispensers are not installed within 1 inch of an ignition source. • Dispensers over carpeted floors are in sprinklered smoke compartments. • ABHR does not exceed 95 percent alcohol. • Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11). • ABHR is protected against inappropriate access. 18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K331	**Interior Wall and Ceiling Finish** 2012 EXISTING Interior wall and ceiling finishes, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and have a flame spread rating of Class A or Class B. The reduction in class of interior finish for a sprinkler system as prescribed in 10.2.8.1 is permitted. 10.2, 19.3.3.1, 19.3.3.2 *Indicate flame spread rating(s).* B	◉	○	○	
	2012 NEW Interior wall and ceiling finishes, including exposed interior surfaces of buildings such as fixed or movable walls, partitions and columns have a flame spread rating of Class A. The reduction in class of interior finish for a sprinkler system as prescribed in 10.2.8.1 is permitted. Individual rooms not exceeding four persons may have a Class A or B finish. Lower half of corridor walls, not exceeding 4 feet in height, may have a Class A or B flame spread rating. 10.2, 18.3.3.1, 18.3.3.2 *Indicate flame spread rating(s).* _____	○	○	◉	
K332	**Interior Floor Finish** 2012 NEW (Indicate N/A for 2012 EXISTING) Interior finishes shall comply with 10.2. Floor finishes in exit enclosures and exit access corridors and spaces not separated by walls that resist the passage of smoke shall be Class I or II. 18.3.3.3.1, 18.3.3.3.2, 18.3.3.3.3, 10.2, 10.2.7.1, 10.2.7.2	◉	○	○	
K341	**Fire Alarm System – Installation** A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, *National Electric Code,* and NFPA 72, *National Fire Alarm Code* to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K342	**Fire Alarm System – Initiation** Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of egress near each required exit. Manual alarm boxes in patient sleeping areas shall not be required at exits if manual alarm boxes are located at all nurse's stations or other continuously attended staff location, provided alarm boxes are visible, continuously accessible, and 200' travel distance is not exceeded. 18.3.4.2.1, 18.3.4.2.2, 19.3.4.2.1, 19.3.4.2.2, 9.6.2.5	◉	○	○	
K343	**Fire Alarm – Notification** 2012 EXISTING Positive alarm sequence in accordance with 9.6.3.4 are permitted in buildings protected throughout by a sprinkler system. Occupant notification is provided automatically in accordance with 9.6.3 by audible and visual signals. In critical care areas, visual alarms are sufficient. The fire alarm system transmits the alarm automatically to notify emergency forces in the event of a fire. 19.3.4.3, 19.3.4.3.1, 19.3.4.3.2, 9.6.4, 9.7.1.1(1)	◉	○	○	
	2012 NEW Positive alarm sequence in accordance with 9.6.3.4 are permitted. Occupant notification is provided automatically in accordance with 9.6.3 by audible and visual signals. In critical care areas, visual alarms are sufficient. The fire alarm system transmits the alarm automatically to notify emergency forces in the event of a fire. Annunciation and annunciation zoning for fire alarm and sprinklers shall be provided by audible and visual indicators and zones shall not be larger than 22,500 square feet per zone. 18.3.4.3 through 18.3.4.3.3, 9.6.4	○	○	◉	
K344	**Fire Alarm – Control Functions** The fire alarm automatically activates required control functions and is provided with an alternative power supply in accordance with NFPA 72. 18.3.4.4, 19.3.4.4, 9.6.1, 9.6.5, NFPA 72	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K345	**Fire Alarm System – Testing and Maintenance** A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, *National Electric Code,* and NFPA 72, *National Fire Alarm and Signaling Code.* Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72	◉	○	○	
K346	**Fire Alarm – Out of Service** Where required fire alarm system is out of services for more than 4 hours in a 24 hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6	◉	○	○	
K347	**Smoke Detection** 2012 EXISTING Smoke detection systems are provided in spaces open to corridors as required by 19.3.6.1. 19.3.4.5.2	◉	○	○	
	2012 NEW Smoke detection systems are provided in spaces open to corridors as required by 18.3.6.1 In nursing homes, an automatic smoke detection system is installed in the corridors of all smoke compartments containing resident sleeping rooms, unless the resident sleeping rooms have: • smoke detection, or • automatic door closing devices with integral smoke detectors on the room side that provide occupant notification. Such detectors are electrically interconnected to the fire alarm system. 18.3.4.5.2, 18.3.4.5.3	○	○	◉	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K351	**Sprinkler System – Installation** 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, *Standard for the Installation of Sprinkler Systems.* In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 ft² and sprinkler coverage covers the closet footprint as required by NFPA 13, *Standard for Installation of Sprinkler Systems.* 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1)	◉	○	○	
	2012 NEW Buildings are to be protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, *Standard for the Installation of Sprinkler Systems.* In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where State and local regulations prohibit sprinklers. Listed quick-response or listed residential sprinklers are used throughout smoke compartments with patient sleeping rooms. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 ft² and sprinkler coverage covers the closet footprint as required by NFPA 13, *Standard for Installation of Sprinkler Systems.* 18.3.5.1, 18.3.5.4, 18.3.5.5, 18.3.5.6, 9.7, 9.7.1.1(1), 18.3.5.10	○	○	◉	
K352	**Sprinkler System – Supervisory Signals** Automatic sprinkler system supervisory attachments are installed and monitored for integrity in accordance with NFPA 72, *National Fire Alarm and Signaling Code,* and provide a signal that sounds and is displayed at a continuously attended location or approved remote facility when sprinkler operation is impaired. 9.7.2.1, NFPA 72	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K353	**Sprinkler System – Maintenance and Testing** Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, *Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems.* Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked. 7/2/2021 b) Who provided system test. Fire Construction c) Water system supply source. City of Bloomington *Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.* 9.7.5, 9.7.7, 9.7.8, and NFPA 25	◉	○	○	
K354	**Sprinkler System – Out of Service** Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24 hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25)	◉	○	○	
K355	**Portable Fire Extinguishers** Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, *Standard for Portable Fire Extinguishers.* 18.3.5.12, 19.3.5.12, NFPA 10	◉	○	○	
K361	**Corridors – Areas Open to Corridor** Spaces (other than patient sleeping rooms, treatment rooms and hazardous areas), waiting areas, nurse's stations, gift shops, and cooking facilities, open to the corridor are in accordance with the criteria under 18.3.6.1 and 19.3.6.1. 18.3.6.1, 19.3.6.1	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K362	**Corridors – Construction of Walls** 2012 EXISTING Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the transfer of smoke. In nonsprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Fixed fire window assemblies in corridor walls are in accordance with Section 8.3, but in sprinklered compartments there are no restrictions in area or fire resistance of glass or frames. *If the walls have a fire resistance rating, give the rating* Smoke *if the walls terminate at the underside of the ceiling, give brief description in REMARKS, describing the ceiling throughout the floor area.* 19.3.6.2, 19.3.6.2.7	◉	○	○	
	2012 NEW Corridor walls shall form a barrier to limit the transfer of smoke. Such walls shall be permitted to terminate at the ceiling where the ceiling is constructed to limit the transfer of smoke. No fire resistance rating is required for the corridor walls. 18.3.6.2	○	○	◉	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K363	**Corridor – Doors** 2012 EXISTING Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1¾ inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5lbf is applied, whether or not power is applied. Clearance between bottom of door and floor covering is not exceeding 1 inch. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.	◉	○	○	
	2012 NEW Doors protecting corridor openings shall be constructed to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have self-latching and positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5lbf is applied, whether or not power is applied. Clearance between bottom of door and floor covering is not exceeding 1 inch. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 18.3.6.3.6 are permitted. 18.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatic closing devices, etc.	○	○	◉	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K364	**Corridor – Openings** Transfer grilles are not used in corridor walls or doors. Auxiliary spaces that do not contain flammable or combustible materials are permitted to have louvers or be undercut. In other than smoke compartments containing patient sleeping rooms, miscellaneous openings are permitted in vision panels or doors, provided the openings per room do not exceed 20 in² and are at or below half the distance from floor to ceiling. In sprinklered rooms, the openings per room do not exceed 80 in². Vision panels in corridor walls or doors shall be fixed window assemblies in approved frames. (In fully sprinklered smoke compartments, there are no restrictions in the area and fire resistance of glass and frames.) 18.3.6.5.1, 19.3.6.5.2, 8.3	◉	○	○	
K371	**Subdivision of Building Spaces – Smoke Compartments** 2012 EXISTING Smoke barriers shall be provided to form at least two smoke compartments on every sleeping floor with a 30 or more patient bed capacity. Size of compartments cannot exceed 22,500 square feet or a 200-foot travel distance from any point in the compartment to a door in the smoke barrier. 19.3.7.1, 19.3.7.2 *Detail in REMARKS zone dimensions including length of zones and dead-end corridors.*	◉	○	○	
	2012 NEW Smoke barriers shall be provided to form at least two smoke compartments on every floor used by inpatients for sleeping or treatment, and on every floor with an occupant load of 50 or more persons, regardless of use. Size of compartments cannot exceed 22,500 square feet or a 200-foot travel distance from any point in the compartment to a door in the smoke barrier. Smoke subdivision requirements do not apply to any of the stories or areas described in 18.3.7.2. 18.3.7.1, 18.3.7.2 *Detail in REMARKS zone dimensions including length of zones and dead-end corridors.*	○	○	◉	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K372	**Subdivision of Building Spaces – Smoke Barrier Construction** 2012 EXISTING Smoke barriers shall be constructed to a ½ hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) *Describe any mechanical smoke control system in REMARKS.*	◉	○	○	
	2012 NEW Smoke barriers shall be constructed to provide at least a 1-hour fire resistance rating and constructed in accordance with 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations of fully ducted HVAC systems. 18.3.7.3, 18.3.7.4, 18.3.7.5, 8.3 *Describe any mechanical smoke control system in REMARKS.*	○	○	◉	
K373	**Subdivision of Building Spaces – Accumulation Space** Space shall be provided on each side of smoke barriers to adequately accommodate the total number of occupants in adjoining compartments. 18.3.7.5.1, 18.3.7.5.2, 19.3.7.5.1, 19.3.7.5.2	◉	○	○	
K374	**Subdivision of Building Spaces – Smoke Barrier Doors** 2012 EXISTING Doors in smoke barriers are 1¾-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 in for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K374	2012 NEW Doors in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded core wood. Required clear widths are provided per 18.3.7.6(4) and (5). Nonrated protective plates of unlimited height are permitted. Horizontal-sliding doors comply with 7.2.1.14. Swinging doors shall be arranged so that each door swings in an opposite direction. Doors shall be self-closing and rabbets, bevels, or astragals are required at the meeting edges. Positive latching is not required. 18.3.7.6, 18.3.7.7, 18.3.7.8	○	○	◉	
K379	**Smoke Barrier Door Glazing** 2012 EXISTING Openings in smoke barrier doors shall be fire-rated glazing or wired glass panels in steel frames. 19.3.7.6, 19.3.7.6.2, 8.5	◉	○	○	
	2012 NEW Windows in smoke barrier doors shall be installed in each cross corridor swinging or horizontal-sliding door protected by fire-rated glazing or by wired glass panels in approved frames. 18.3.7.9	○	○	◉	
K381	**Sleeping Room Outside Windows and Doors** Every patient sleeping room has an outside window or outside door. In new occupancies, sill height does not exceed 36 inches above the floor. Windows in atrium walls are considered outside windows. Newborn nurseries and rooms intended for occupancy less than 24 hours have no outside window or door requirements. Window sills in special nursing care areas (e.g., ICU, CCU, hemodialysis, neonatal) do not exceed 60 inches above the floor. 42 CFR 403, 418, 460, 482, 483, and 485	◉	○	○	
	SECTION 4 – SPECIAL PROVISIONS				
K400	**Special Provisions – Other** List in the REMARKS section any LSC Section 18.4 and 19.4 Special Provisions 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.	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K421	**High-Rise Buildings** 2012 EXISTING High-rise buildings are protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7 within 12 years of LSC final rule effective date. 19.4.2	○	○	◉	
	2012 NEW High-rise buildings comply with section 11.8. 18.4.2	○	○	◉	
	SECTION 5 – BUILDING SERVICES				
K500	**Building Services – Other** List in the REMARKS section any LSC Section 18.5 and 19.5 Building Services 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.	◉	○	○	
K511	**Utilities – Gas and Electric** Equipment using gas or related gas piping complies with NFPA 54, *National Fuel Gas Code*, electrical wiring and equipment complies with NFPA 70, *National Electric Code*. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2	◉	○	○	
K521	**HVAC** Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2	◉	○	○	
K522	**HVAC – Any Heating Device** Any heating device, other than a central heating plant, is designed and installed so combustible materials cannot be ignited by device, and has a safety feature to stop fuel and shut down equipment if there is excessive temperature or ignition failure. If fuel fired, the device also: • is chimney or vent connected. • takes air for combustion from outside. • provides for a combustion system separate from occupied area atmosphere. 18.5.2.2, 19.5.2.2	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K523	**HVAC – Suspended Unit Heaters** Suspended unit heaters are permitted provided the following are met: • Not located in means of egress or in patient rooms. • Located high enough to be out of reach of people in the area. • Has a safety feature to stop fuel and shut down equipment if there is excessive temperature or ignition failure. 18.5.2.3(1), 19.5.2.3(1)	○	○	◉	
K524	**HVAC – Direct-Vent Gas Fireplaces** Direct-vent gas fireplaces, as defined in NFPA 54, inside of all smoke compartments containing patient sleeping areas comply with the requirements of 18.5.2.3(2), 19.5.2.3(2). 18.5.2.3(2), 19.5.2.3(2), NFPA 54	○	○	◉	
K525	**HVAC – Solid Fuel-Burning Fireplaces** Solid fuel-burning fireplaces are permitted in other than patient sleeping areas provided: • Areas are separated by 1-hour fire resistance construction. • Fireplace complies with 9.2.2. • Fireplace enclosure resists breakage up to 650°F and has heat-tempered glass. • Room has supervised CO detection per 9.8. 18.5.2.3(3) and 19.5.2.3(3)	○	○	◉	
K531	**Elevators** 2012 EXISTING Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, *Safety Code for Elevators and Escalators.* Firefighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, *Safety Code for Existing Elevators and Escalators.* All existing elevators, having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 19.5.3, 9.4.2, 9.4.3	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K531	2012 NEW Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, *Safety Code for Elevators and Escalators.* Firefighter's Service is operated monthly with a written record. New elevators conform to ASME/ANSI A17.1, *Safety Code for Elevators and Escalators,* including Firefighter's Service Requirements. (Includes firefighter's Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 18.5.3, 9.4.2, 9.4.3	○	○	◉	
K532	**Escalators, Dumbwaiters, and Moving Walks** 2012 EXISTING Escalators, dumbwaiters, and moving walks comply with the provisions of 9.4. All existing escalators, dumbwaiters, and moving walks conform to the requirements of ASME/ANSI A17.3, *Safety Code for Existing Elevators and Escalators.* (Includes escalator emergency stop buttons and automatic skirt obstruction stop. For power dumbwaiters, includes hoistway door locking to keep doors closed except for floor where car is being loaded or unloaded.) 19.5.3, 9.4.2.2	○	○	◉	
	2012 NEW Escalators, dumbwaiters, and moving walks comply with the provisions of 9.4. 18.5.3, 9.4.2.2	○	○	◉	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K541	**Rubbish Chutes, Incinerators, and Laundry Chutes** 2012 EXISTING (1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor shall be sealed by fire resistive construction to prevent further use or shall be provided with a fire door assembly having a fire protection rating of 1-hour. All new chutes shall comply with 9.5. (2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, shall be provided with automatic extinguishing protection in accordance with 9.7. (3) Any trash chute shall discharge into a trash collection room used for no other purpose and protected in accordance with 8.4. (Existing laundry chutes permitted to discharge into same room are protected by automatic sprinklers in accordance with 19.3.5.9 or 19.3.5.7.) (4) Existing fuel-fed incinerators shall be sealed by fire resistive construction to prevent further use. 19.5.4, 9.5, 8.4, NFPA 82	◉	○	○	Facility has a Laundry chute
	2012 NEW Rubbish chutes, incinerators, and laundry chutes shall comply with the provisions of Section 9.5, unless otherwise specified in 18.5.4.2. • The fire resistance rating of chute charging room shall not be required to exceed 1-hour. • Any rubbish chute or linen chute shall be provided with automatic extinguishing protection in accordance with Section 9.7. • Chutes shall discharge into a trash collection room used for no other purpose and shall be protected in accordance with 8.7. 18.5.4.2, 8.7, 9.5, 9.7, NFPA 82	○	○	◉	
	SECTION 6 – RESERVED				
	SECTION 7 – OPERATING FEATURES				
K700	**Operating Features – Other** List in the REMARKS section any LSC Section 18.7 and 19.7 Operating Features 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 in Form CMS-2567.	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K711	**Evacuation and Relocation Plan** There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.7.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3	◉	○	○	
K712	**Fire Drills** Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 18.7.1.4 through 18.7.1.7, 19.7.1.4 through 19.7.1.7	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K741	**Smoking Regulations** Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4	◉	○	○	
K751	**Draperies, Curtains, and Loosely Hanging Fabrics** Draperies, curtains including cubicle curtains and loosely hanging fabric or films shall be in accordance with 10.3.1. Excluding curtains and draperies: at showers and baths; on windows in patient sleeping room located in sprinklered compartments; and in non-patient sleeping rooms in sprinklered compartments where individual drapery or curtain panels do not exceed 48 square feet or total area does not exceed 20 percent of the wall. 18.7.5.1, 18.3.5.11, 19.7.5.1, 19.3.5.11, 10.3.1	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K752	**Upholstered Furniture and Mattresses** Newly introduced upholstered furniture meets Class I or char length, and heat release criteria in accordance with 10.3.2.1 and 10.3.3, unless the building is fully sprinklered. Newly introduced mattresses shall meet char length and heat release criteria in accordance with 10.3.2.2 and 10.3.4, unless the building is fully sprinklered. Upholstered furniture and mattresses belonging to nursing home residents do not have to meet these requirements as all nursing homes are required to be fully sprinklered. Newly introduced upholstered furniture and mattresses means purchased on or after the LSC final rule effective date. 18.7.5.2, 18.7.5.4, 19.7.5.2, 19.7.5.4	◉	○	○	
K753	**Combustible Decorations** Combustible decorations shall be prohibited unless one of the following is met: • Flame retardant or treated with approved fire-retardant coating that is listed and labeled for product. • Decorations meet NFPA 701. • Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289. • Decorations, such as photographs, paintings and other art are attached to the walls, ceilings and non-fire-rated doors in accordance with 18.7.5.6(4) or 19.7.5.6(4). • The decorations in existing occupancies are in such limited quantities that a hazard of fire development or spread is not present. 18.7.5.6, 19.7.5.6	◉	○	○	
K761	**Maintenance, Inspection & Testing - Doors** Fire doors assemblies are inspected and tested annually in accordance with NFPA 80 *Standard for Fire Doors and Other Opening Protectives*. Fire doors that are not located in required fire barriers, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspection and testing have an understanding of the operating components of the doors. Written records of inspection and testing are maintained and are available for review. 18.7.6, 19.7.6, 8.3.3.1 (LSC), 5.2, 5.2.3 (NFPA 80)	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K754	**Soiled Linen and Trash Containers** Soiled linen or trash collection receptacles shall not exceed 32 gallons in capacity. The average density of container capacity in a room or space shall not exceed 0.5 gallons/square feet. A total container capacity of 32 gallons shall not be exceeded within any 64 square feet area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gallons shall be located in a room protected as a hazardous area when not attended. Containers used solely for recycling are permitted to be excluded from the above requirements where each container is ≤ 96 gal. unless attended, and containers for combustibles are labeled and listed as meeting FM Approval Standard 6921 or equivalent. 18.7.5.7, 19.7.5.7	◉	○	○	
K771	**Engineer Smoke Control Systems** 2012 EXISTING When installed, engineered smoke control systems are tested in accordance with established engineering principles. Test documentation is maintained on the premises. 19.7.7	○	○	◉	
	2012 NEW When installed, engineered smoke control systems are tested in accordance with NFPA 92, *Standard for Smoke Control Systems*. Test documentation is maintained on the premises. 18.7.7	○	○	◉	
K781	**Portable Space Heaters** Portable space heating devices shall be prohibited in all health care occupancies. Unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8	○	○	◉	
K791	**Construction, Repair, and Improvement Operations** Construction, repair, and improvement operations shall comply with 4.6.10. Any means of egress in any area undergoing construction, repair, or improvements shall be inspected daily to ensure its ability to be used instantly in case of emergency and compliance with NFPA 241. 18.7.9, 19.7.9, 4.6.10, 7.1.10.1	○	○	◉	

ID PREFIX		MET	NOT MET	N/A	REMARKS
	PART II – HEALTH CARE FACILITIES CODE REQUIREMENTS				
K900	**Health Care Facilities Code - Other** List in the REMARKS section any NFPA 99 requirements (excluding Chapter 7, 8, 12, and 13) that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Health Care Facilities Code or NFPA standard citation, should be included on Form CMS-2567.	◉	○	○	
K901	**Fundamentals – Building System Categories** Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99)	◉	○	○	
K902	**Gas and Vacuum Piped Systems – Other** List in the REMARKS section any NFPA 99 Chapter 5 Gas and Vacuum 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 5 (NFPA 99)	○	○	◉	
K903	**Gas and Vacuum Piped Systems – Categories** Medical gas, medical air, surgical vacuum, WAGD, and air supply systems are designated: ☐ Category 1. Systems in which failure is likely to cause major injury or death. ☐ Category 2. Systems in which failure is likely to cause minor injury. ☐ Category 3. Systems in which failure is not likely to cause injury, but can cause discomfort. Deep sedation and general anesthesia are not to be administered using a Category 3 medical gas system. 5.1.1.1, 5.2.1, 5.3.1.1, 5.3.1.5 (NFPA 99)	○	○	◉	
K904	**Gas and Vacuum Piped Systems – Warning Systems** All master, area, and local alarm systems used for medical gas and vacuum systems comply with appropriate Category warning system requirements, as applicable. 5.1.9, 5.2.9, 5.3.6.2.2 (NFPA 99)	○	○	◉	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K905	**Gas and Vacuum Piped Systems – Central Supply System Identification and Labeling** Containers, cylinders and tanks are designed, fabricated, tested, and marked in accordance with 5.1.3.1.1 through 5.1.3.1.7. Locations containing only oxygen or medical air have doors labeled with "Medical Gases, NO Smoking or Open Flame". Locations containing other gases have doors labeled "Positive Pressure Gases, NO Smoking or Open Flame, Room May Have Insufficient Oxygen, Open Door and Allow Room to Ventilate Before Opening." 5.1.3.1, 5.2.3.1, 5.3.10 (NFPA 99)	○	○	◉	
K906	**Gas and Vacuum Piped Systems – Central Supply System Operations** Adaptors or conversion fittings are prohibited. Cylinders are handled in accordance with 11.6.2. Only cylinders, reusable shipping containers, and their accessories are stored in rooms containing central supply systems or cylinders. No flammable materials are stored with cylinders. Cryogenic liquid storage units intended to supply the facility are not used to transfill. Cylinders are kept away from sources of heat. Valve protection caps are secured in place, if supplied, unless cylinder is in use. Cylinders are not stored in tightly closed spaces. Cylinders in use and storage are prevented from exceeding 130°F, and nitrous oxide and carbon dioxide cylinders are prevented from reaching temperatures lower than manufacture recommendations or 20°F. Full or empty cylinders, when not connected, are stored in locations complying with 5.1.3.3.2 through 5.1.3.3.3, and are not stored in enclosures containing motor-driven machinery, unless for instrument air reserve headers. 5.1.3.2, 5.1.3.3.17, 5.1.3.3.1.8, 5.1.3.3.4, 5.2.3.2, 5.2.3.3, 5.3.6.20.4, 5.6.20.5, 5.3.6.20.7, 5.3.6.20.8, 5.3.6.20.9 (NFPA 99)	○	○	◉	
K907	**Gas and Vacuum Piped Systems – Maintenance Program** Medical gas, vacuum, WAGD, or support gas systems have documented maintenance programs. The program includes an inventory of all source systems, control valves, alarms, manufactured assemblies, and outlets. Inspection and maintenance schedules are established through risk assessment considering manufacturer recommendations. Inspection procedures and testing methods are established through risk assessment. Persons maintaining systems are qualified as demonstrated by training and certification or credentialing to the requirements of AASE 6030 or 6040. 5.1.14.2.1, 5.1.14.2.2, 5.1.15, 5.2.14, 5.3.13.4.2 (NFPA 99)	○	○	◉	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K908	**Gas and Vacuum Piped Systems – Inspection and Testing Operations** The gas and vacuum systems are inspected and tested as part of a maintenance program and include the required elements. Records of the inspections and testing are maintained as required. 5.1.14.2.3, B.5.2, 5.2.13, 5.3.13, 5.3.13.4 (NFPA 99)	○	○	◉	
K909	**Gas and Vacuum Piped Systems – Information and Warning Signs** Piping is labeled by stencil or adhesive markers identifying the gas or vacuum system, including the name of system or chemical symbol, color code (Table 5.1.11), and operating pressure if other than standard. Labels are at intervals not more than 20 feet, are in every room, at both sides of wall penetrations, and on every story traversed by riser. Piping is not painted. Shutoff valves are identified with the name or chemical symbol of the gas or vacuum system, room or area served, and caution to not use the valve except in emergency. 5.1.14.3, 5.1.11.1, 5.1.11.2, 5.2.11, 5.3.13.3, 5.3.11 (NFPA 99)	○	○	◉	
K910	**Gas and Vacuum Piped Systems – Modifications** Whenever modifications are made that breach the pipeline, any necessary installer and verification test specified in 5.1.2 is conducted on the downstream portion of the medical gas piping system. Permanent records of all tests required by system verification tests are maintained. 5.1.14.4.1, 5.1.14.4.6, 5.2.13, 5.3.13.4.3 (NFPA 99)	○	○	◉	
K911	**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)	◉	○	○	
K912	**Electrical Systems – Receptacles** Power receptacles have at least one, separate, highly dependable grounding pole capable of maintaining low-contact resistance with its mating plug. In pediatric locations, receptacles in patient rooms, bathrooms, play rooms, and activity rooms, other than nurseries, are listed tamper-resistant or employ a listed cover. If used in patient care room, ground-fault circuit interrupters (GFCI) are listed. 6.3.2.2.6.2 (F), 6.3.2.2.4.2 (NFPA 99)	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K913	**Electrical Systems – Wet Procedure Locations** Operating rooms are considered wet procedure locations, unless otherwise determined by a risk assessment conducted by the facility governing body. Operating rooms defined as wet locations are protected by either isolated power or ground-fault circuit interrupters. A written record of the risk assessment is maintained and available for inspection. 6.3.2.2.8.4, 6.3.2.2.8.7, 6.4.4.2	○	○	◉	
K914	**Electrical Systems – Maintenance and Testing** Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of ≤ 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals ≤ 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99)	◉	○	○	
K915	**Electrical Systems – Essential Electric System Categories** ○ Critical care rooms (Category 1) in which electrical system failure is likely to cause major injury or death of patients, including all rooms where electric life support equipment is required, are served by a Type 1 EES. ◉ General care rooms (Category 2) in which electrical system failure is likely to cause minor injury to patients (Category 2) are served by a Type 1 or Type 2 EES. ○ Basic care rooms (Category 3) in which electrical system failure is not likely to cause injury to patients and rooms other than patient care rooms are not required to be served by an EES. Type 3 EES life safety branch has an alternate source of power that will be effective for 1 1/2 hours. 3.3.138, 6.3.2.2.10, 6.6.2.2.2, 6.6.3.1.1 (NFPA 99), TIA 12-3	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K916	**Electrical Systems – Essential Electric System Alarm Annunciator** A remote annunciator that is storage battery powered is provided to operate outside of the generating room in a location readily observed by operating personnel. The annunciator is hard-wired to indicate alarm conditions of the emergency power source. A centralized computer system (e.g., building information system) is not to be substituted for the alarm annunciator. 6.4.1.1.17, 6.4.1.1.17.5 (NFPA 99)	◉	○	○	
K917	**Electrical Systems – Essential Electric System Receptacles** Electrical receptacles or cover plates supplied from the life safety and critical branches have a distinctive color or marking. 6.4.2.2.6, 6.5.2.2.4.2, 6.6.2.2.3.2 (NFPA 99)	◉	○	○	
K918	**Electrical Systems – Essential Electric System Maintenance and Testing** The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K919	**Electrical Equipment – Other** List in the REMARKS section any NFPA 99 Chapter 10, *Electrical Equipment*, 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 10 (NFPA 99)	◉	○	○	
K920	**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	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K921	**Electrical Equipment – Testing and Maintenance Requirements** The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuing training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8	◉	○	○	
K922	**Gas Equipment – Other** List in the REMARKS section any NFPA 99 Chapter 11 Gas Equipment 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 11 (NFPA 99)	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K923	**Gas Equipment – Cylinder and Container Storage** **≥ 3,000 cubic feet** Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. **> 300 but <3,000 cubic feet** Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. **≤ 300 cubic feet** In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of ≤ 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING". Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)	◉	○	○	
K924	**Gas Equipment – Testing and Maintenance Requirements** Anesthesia apparatus are tested at the final path to patient after any adjustment, modification or repair. Before the apparatus is returned to service, each connection is checked to verify proper gas and an oxygen analyzer is used to verify oxygen concentration. Defective equipment is immediately removed from service. Areas designated for servicing of oxygen equipment are clean and free of oil, grease, or other flammables. Manufacturer service manuals are used to maintain equipment and a scheduled maintenance program is followed. 11.4.1.3, 11.5.1.3, 11.6.2.5, 11.6.2.6 (NFPA 99)	○	○	◉	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K925	**Gas Equipment – Respiratory Therapy Sources of Ignition** Smoking materials are removed from patients receiving respiratory therapy. When a nasal cannula is delivering oxygen outside of a patient's room, no sources of ignition are within in the site of intentional expulsion (1-foot). When other oxygen deliver equipment is used or oxygen is delivered inside a patient's room, no sources of ignition are within the area are of administration (15-feet). Solid fuel-burning appliances is not in the area of administration. Nonmedical appliances with hot surfaces or sparking mechanisms are not within oxygen-delivery equipment or site of intentional expulsion. 11.5.1.1, TIA 12-6 (NFPA 99)	◉	○	○	
K926	**Gas Equipment – Qualifications and Training of Personnel** Personnel concerned with the application, maintenance and handling of medical gases and cylinders are trained on the risk. Facilities provide continuing education, including safety guidelines and usage requirements. Equipment is serviced only by personnel trained in the maintenance and operation of equipment. 11.5.2.1 (NFPA 99)	◉	○	○	
K927	**Gas Equipment – Transfilling Cylinders** Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, *Transfilling of High Pressure Gaseous Oxygen Used for Respiration*. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99). 11.5.2.2 (NFPA 99)	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K928	**Gas Equipment – Labeling Equipment and Cylinders** Equipment listed for use in oxygen-enriched atmospheres are so labeled. Oxygen metering equipment and pressure reducing regulators are labeled "OXYGEN-USE NO OIL". Flowmeters, pressure reducing regulators, and oxygen-dispensing apparatus are clearly and permanently labeled designating the gases for which they are intended. Oxygen-metering equipment, pressure reducing regulators, humidifiers, and nebulizers are labeled with name of manufacturer or supplier. Cylinders and containers are labeled in accordance with CGA C-7. Color coding is not utilized as the primary method of determining cylinder or container contents. All labeling is durable and withstands cleaning or disinfecting. 11.5.3.1 (NFPA 99)	◉	○	○	
K929	**Gas Equipment – Precautions for Handling Oxygen Cylinders and Manifolds** Handling of oxygen cylinders and manifolds is based on CGA G-4, Oxygen. Oxygen cylinders, containers, and associated equipment are protected from contact with oil and grease, from contamination, protected from damage, and handled with care in accordance with precautions provided under 11.6.2.1 through 11.6.2.4 (NFPA 99). 11.6.2 (NFPA 99)	◉	○	○	
K930	**Gas Equipment – Liquid Oxygen Equipment** The storage and use of liquid oxygen in base reservoir containers and portable containers comply with sections 11.7.2 through 11.7.4 (NFPA 99). 11.7 (NFPA 99)	◉	○	○	
K931	**Hyperbaric Facilities** All occupancies containing hyperbaric facilities comply with construction, equipment, administration, and maintenance requirements of NFPA 99. Chapter 14 (NFPA 99)	○	○	◉	
K932	**Features of Fire Protection – Other** List in the REMARKS section any NFPA 99 Chapter 15 Features of Fire Protection 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 15 (NFPA 99)	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K933	**Features of Fire Protection – Fire Loss Prevention in Operating Rooms** Periodic evaluations are made of hazards that could be encountered during surgical procedures, and fire prevention procedures are established. When flammable germicides or antiseptics are employed during surgeries utilizing electrosurgery, cautery or lasers: • packaging is non-flammable. • applicators are in unit doses. • Preoperative "time-out" is conducted prior the initiation of any surgical procedure to verify: o application site is dry prior to draping and use of surgical equipment. o pooling of solution has not occurred or has been corrected. o solution-soaked materials have been removed from the OR prior to draping and use of surgical devices. o policies and procedures are established outlining safety precautions related to the use of flammable germicide or antiseptic use. Procedures are established for operating room emergencies including alarm activation, evacuation, equipment shutdown, and control operations. Emergency procedures include the control of chemical spills, and extinguishment of drapery, clothing and equipment fires. Training is provided to new OR personnel (including surgeons), continuing education is provided, incidents are reviewed monthly, and procedures are reviewed annually. 15.13 (NFPA 99)	○	○	◉	

PART III – RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

For each item of the Life Safety Code recommended for waiver, list the survey report form item number and state the reason for the conclusion that: (a) the specific provisions of the code, if rigidly applied, would result in unreasonable hardship on the facility, and (b) the waiver of such unmet provisions will not adversely affect the health and safety of the patients. If additional space is required, attach additional sheet(s).

PROVISION NUMBER(S)	JUSTIFICATION
K400	

Surveyor *(Signature)*	Title	Office	Date
Fire Authority Official *(Signature)*	Title	Office	Date

PART IV - FIRE SAFETY SURVEY REPORT
CRUCIAL DATA EXTRACT
(TO BE USED WITH CMS 2786 FORMS)

Provider Number	Facility Name	Survey Date
K1		*K4

K6 DATE OF PLAN APPROVAL

K3 MULTIPLE CONSTRUCTION ☐

TOTAL NUMBER OF BUILDINGS _____

NUMBER OF THIS BUILDING _____

A. BUILDING
B. WING
C. FLOOR
D. APARTMENT UNIT

LSC FORM INDICATOR

HEALTH CARE FORM		
12	2786R	2012 EXISTING
13	2786R	2012 NEW

AHCO FORM		
14	2786U	2012 EXISTING
15	2786U	2012 NEW

ICF/IID FORM		
16	2786V, W, X	2012 EXISTING
17	2786V, W, X	2012 NEW

*K7 ☐ SELECT NUMBER OF FORM USED FROM ABOVE

COMPLETE IF ICF/IID IS SURVEYED UNDER CHAPTER 33, EXISTING

SMALL (16 BEDS OR LESS)

K8 ☐
1. PROMPT
2. SLOW
3. IMPRACTICAL

LARGE

K8 ☐
4. PROMPT
5. SLOW
6. IMPRACTICAL

APARTMENT HOUSE

K8 ☐
7. PROMPT
8. SLOW
9. IMPRACTICAL

(Check if K321 or K351 are marked as not applicable in the 2786 M, R, T, U, V, W, X, and Y.)

K321: ☐ K351: ☐

COMPLETE IF ICF/IID IS SURVEYED UNDER CHAPTER 33, EXISTING

ENTER E – SCORE

K5: ☐ e.g. 2.5

*K9 FACILITY MEETS LSC BASED ON *(Check all that Apply)*

A1. ☐	A2. ☐	A3. ☐	A4. ☐	A5. ☐
(COMP. WITH ALL PROVISIONS)	(ACCEPTABLE POC)	(WAIVERS)	(FSES)	(PERFORMANCE BASED DESIGN)

FACILITY DOES NOT MEET LSC

B. ☐

K0180

A. ☐	B. ☐	C. ☐
FULLY SPRINKLERED (All required areas are sprinklered)	PARTIALLY SPRINKLERED (Not all required areas are sprinklered)	NONE (No sprinkler system)

*MANDATORY