Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 1, 2026

Administrator
Presbyterian Homes Of Bloomington
9889 PENN AVENUE SOUTH
BLOOMINGTON, MN 55431

RE: CCN:245556

Cycle Start Date: June 24, 2026

Dear Administrator:

On June 24, 2026, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

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

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

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Jen Bahr, RN, Regional Operations Supervisor
Bemidji District Office
Health Regulation Division
Minnesota Department of Health
705 5th Street NW, Suite A Bemidji, Minnesota 56601-2933
Email: Jennifer.bahr@state.mn.us
Office: (218) 308-2104

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

If substantial compliance with the regulations is not verified by September 24, 2026 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by

the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by December 24, 2026 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution
This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.
A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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

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

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

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division

445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245556	A. BUILDING B. WING	06/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESBYTERIAN HOMES OF BLOOMINGTON	9889 PENN AVENUE SOUTH , BLOOMINGTON, Minnesota, 55431

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments On 6/23/26 through 6/24/26, a survey for compliance with CFR §483.73, Appendix Z, Emergency Preparedness Requirements was conducted during a standard recertification survey. The facility was in compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E0000		07/31/2026
F0000	INITIAL COMMENTS On 6/23/26 through 6/24/26, a federal recertification survey (S5556041-0) was conducted using the Risk-Based Survey (RBS) process at your facility. Your facility was not in compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with no deficiencies were cited: H55563000C (245337053) and H55562999C (249698195) The following complaints were reviewed: H55562998C (259845001) with a deficiency cited at F755. 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.	F0000		07/31/2026

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245556	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESBYTERIAN HOMES OF BLOOMINGTON	9889 PENN AVENUE SOUTH , BLOOMINGTON, Minnesota, 55431

(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
F0755 SS = D	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(f). 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 ensure medication orders received following a hospital visit were obtained, transcribed, and implemented timely for 1 of 3 residents (R110) reviewed for hospital return. The facility's failure resulted in a five-day delay in implementing an emergency department order increasing R110's torsemide dosage following treatment for worsening heart failure symptoms and placed the resident at risk for worsening fluid overload and respiratory compromise. Findings include: R110's admission Minimum Data Set dated 2/23/26,	F0755	This Plan of Correction and the responses to each F-Tag are submitted to maintain certification in the Medicare and Medicaid programs and constitute a credible allegation of compliance. The written responses do not constitute an admission of noncompliance or agreement with any findings stated under the F-Tags. The facility reserves the right to dispute all findings and deficiencies in any appropriate forum, including in an independent dispute resolution, or, if appealable remedies are subsequently imposed, by timely appeal to the Department Appeals Board. F0755 Pharmacy Services/Procedures/Pharmacist/Records This Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure medication orders received following a hospital visit were obtained, transcribed, and implemented timely for 1 of 3 residents (R110) reviewed for hospital return. The facility's failure resulted in a five-day delay in implementing an emergency department order increasing R110's torsemide dosage following treatment for worsening heart failure symptoms and placed the resident at risk for worsening fluid overload and respiratory compromise. The facility reviewed its Medication Administration Policy, Physician Orders Policy, and the Referral Processing Policy. The policies remain current and in effect. The facility completed a retrospective review of R110's medical record, emergency department documentation, physician orders, medication administration records, and progress notes. The review confirmed that an emergency department order dated 03/06/2026 increasing Torsemide from 5 mg daily to 10 mg daily was not obtained, transcribed, or implemented until 03/11/2026. The resident's Torsemide dosage was subsequently adjusted by the provider based upon ongoing clinical assessment. A comprehensive clinical review was conducted, and no adverse outcomes directly attributable to the delayed transcription and implementation of the emergency department's order were identified. All licensed nursing staff involved in the resident's return from the emergency department received re-education regarding the process for obtaining, reviewing, transcribing, verifying, and implementing	07/31/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245556	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESBYTERIAN HOMES OF BLOOMINGTON	9889 PENN AVENUE SOUTH , BLOOMINGTON, Minnesota, 55431

(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
F0755 SS = D	Continued from page 2 identified R110 had moderate cognition and diagnoses included acute respiratory failure and hypoxia, heart failure, orthostatic hypotension, nonrheumatic tricuspid (valve) insufficiency, and atrial septal defect. R110 had shortness of breath or trouble breathing with exertion and received oxygen therapy and diuretics daily. R110's care plan dated 2/23/26 identified R110 required assistance of one staff for activities of daily living including bed mobility, transfers, toileting and ambulation. The plan identified R110 had an alteration in respiratory status and required oxygen via nasal cannula due to acute respiratory failure with hypoxia. R110's geriatric services provider visit dated 3/5/26, identified R110 was taking Torsemide (a medication used to treat fluid retention [edema] in people with medical conditions including heart failure) 5 mg daily. R110's emergency department note dated 3/6/26, identified R110's Torsemide was increased from 5 mg daily to 10 mg daily. R110's after visit summary from the 3/6/26 emergency room visit was requested although not received. R110's geriatric services provider visit dated 3/16/26, identified R110 was taking Torsemide 20 mg daily. R110's progress notes identified the following: n 3/3/26 at 7:45 a.m., R110 received torsemide 5 mg, one tablet by mouth in the morning. On 3/6/26 at 8:57 a.m., change of condition note: R110 was admitted to the facility with post right sided heart failure exacerbation. During the stay, R110's weight steadily increased, resident noted to have increased edema to bilateral lower extremities and upper extremities in the hands. Lungs were clear, resident denied shortness of breath, was noted to be using accessory muscles for respiration. Resident required oxygen via nasal cannula at 4 LPM (liters per minute), which was a change from baseline at 2 LPM. Updated doctor. R110 and wife agreed to transfer resident to ER for further assessment. R110 placed on non-rebreather face mask (a mask used to deliver high concentrations of oxygen quickly). On 3/6/26 at 21:39 p.m., R110 returned from the	F0755	Continued from page 2 hospital and emergency department orders upon a resident's return to the facility. The facility conducted a house-wide review of all residents who returned from a hospital or emergency department visit within the last 30 days. The review included emergency department and hospital discharge paperwork, after-visit summaries, provider orders, medication administration records, treatment records, and progress notes to verify that all new and changed orders were obtained, reviewed, transcribed, communicated, and implemented timely. Any discrepancies identified during the review were immediately addressed through physician notification, order clarification, transcription correction, documentation updates, and resident assessment as indicated. Residents identified with potential concerns were evaluated to ensure their current care and treatment needs were appropriately met. The facility also reviewed current practices for resident returns from hospitals and emergency departments to ensure orders are accurately communicated and implemented. Licensed nursing staff, health unit coordinators, and clinical leadership were re-educated regarding expectations for obtaining discharge documentation, completing nurse-to-nurse communication when documentation is unavailable or not provided, verifying medication and treatment orders, and documenting actions taken upon resident return. To prevent recurrence, the facility implemented a standardized Hospital Return and Readmission Process requiring nursing staff to obtain and review discharge documentation, after-visit summaries, and provider orders upon resident return. If discharge paperwork is unavailable at the time of return, nursing staff are required to immediately contact the sending hospital or emergency department to obtain nurse-to-nurse report and request documentation prior to completion of the admission/readmission process. All new or changed physician orders will be reconciled, transcribed, and verified by a licensed nurse and second checked. Licensed nursing staff and health unit coordinators received education on the revised process and expectations for timely order implementation and documentation.	07/31/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245556	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESBYTERIAN HOMES OF BLOOMINGTON	9889 PENN AVENUE SOUTH , BLOOMINGTON, Minnesota, 55431

(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
F0755 SS = D	Continued from page 3 hospital in stable condition except R110's oxygen saturation (O2 sats) was 83% on 2 LPM oxygen. The note failed to identify if the doctor ordered any changes in medications. On 3/12/26 at 10:06 a.m., a progress note identified R110 started an increased dose of torsemide. The note did not identify the dosage administered. R110's progress notes dated 3/7/26 through 3/11/26 contained no evidence the emergency department order increasing torsemide had been obtained, reviewed, transcribed, or implemented.R110's Medication Administration Record dated 3/1/26 through 3/31/26, identified R110 received the following medications: 3/1/26 through 3/11/26, R110 received Torsemide 5 mg tablet once daily in the morning. The order was discontinued on 3/11/26. 3/12/26 through 3/13/26, R110 received Torsemide 5 mg two tablets (10 mg) by mouth in the morning. The order was started on 3/11/26 and discontinued 3/14/26. 3/14/26, R110 received Torsemide 20 mg tablet once daily in the morning. The order was started on 3/13/26 and discontinued 3/14/26. 3/15/26 through 3/16/26, R110 received Torsemide 20 mg tablet once daily in the morning. The order started on 3/14/26 and discontinued 5/11/26. The facility continued administering torsemide 5 mg daily from 3/7/26 through 3/11/26 despite the emergency department order dated 3/6/26 increasing the medication to 10 mg daily. R110's quality concern form dated 6/15/26, identified the administrator received a voicemail from family member (FM)-A regarding concerns after R110's emergency room (ER) visit on 3/6/26. The report identified R110's Torsemide was increased, although the medication change was not completed until five days later. During interview on 6/23/26 at 11:02 a.m., FM-A stated on 3/6/26, R110 was sent to the ER and returned later the same day with medication changes. The ER doctor increased R110's Torsemide from 5 mg daily to 10 mg daily, although the facility didn't make the change until five days later. Then the day after the facility changed the resident's medication, the provider increased the residents Torsemide again to 20 mg daily. FM-A stated the facility failed to increase R110's Torsemide according to the doctor's orders.	F0755	Continued from page 3 To ensure ongoing compliance, the Director of Nursing or designee will audit all hospital, and emergency department returns for evidence that discharge documentation was obtained, physician orders were reconciled and implemented, and required documentation was completed. Audits will be conducted weekly for four weeks. Any identified concerns will be addressed immediately through corrective action and staff re-education as appropriate. Audit results will be reviewed through the facility's Quality Assurance and Performance Improvement (QAPI) process to ensure sustained compliance and prevent recurrence. Date certain is July 31, 2026	07/31/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245556	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESBYTERIAN HOMES OF BLOOMINGTON	9889 PENN AVENUE SOUTH , BLOOMINGTON, Minnesota, 55431

(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
F0755 SS = D	Continued from page 4 During interview on 6/23/26 at 5:54 p.m., registered nurse (RN)-A stated when a resident returned from the ER, the facility would receive the ER orders via fax or verbal order from the ER nurse. If the resident returned without paperwork, the receiving nurse would contact the hospital for orders. Either the health unit coordinator (HUC) or receiving nurse would enter the orders. During interview on 6/24/26 at 8:19 a.m., the director of nursing (DON) stated that when R110 returned from the ER on 3/6/26, the nurse did not receive the ER paperwork from the family. If the nurses don't receive paperwork from the hospital, they would assume there were no new orders. When asked the DON if it was the nurses' responsibility to contact the ER if they didn't receive paperwork, the DON stated, "I will have to get back to you on that." At the time of survey exit, the DON failed to provide an answer. When interviewed on 6/24/26 8:51 a.m., RN-B stated generally, when a resident was readmitted by the ER, the ER would provide paperwork including an after-visit summary (AVS) identifying if there were any new orders. If a resident returned without paperwork, the receiving nurse should contact the ER and verify if there were new orders. When R110 returned from the ER on 3/6/26, the nurses should have contacted the ER for nurse-to-nurse report and/or request an AVS, and there should have been a chart note completed identifying what the new orders included. RN-B stated the risks of not knowing what happened during an ER visit, included potential changes in medications that could be missed which may cause changes in the resident's medical condition. On 6/24/26 at 10:35 a.m., the administrator stated the facility did not have a specific policy for readmissions. The administrator stated the facility did not have a policy to define the process for when residents returned without paperwork and were readmitted from the hospital; and they were still working on the investigation on what happened. A facility readmission policy was requested although not received.	F0755		07/31/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245556	(X2) MULTIPLE CONSTRUCTION A. BUILDING **1N - NEW BUILDI...** B. WING	(X3) DATE SURVEY COMPLETED **06/24/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Presbyterian Homes Of Bloomington	**9889 PENN AVENUE SOUTH , BLOOMINGTON, Minnesota, 55431**

(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
K0000 Bldg. 1N	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted on 06/24/2026, by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Presbyterian Homes of Bloomington was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145	K0000		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245556	(X2) MULTIPLE CONSTRUCTION A. BUILDING **1N - NEW BUILDI...** B. WING	(X3) DATE SURVEY COMPLETED **06/24/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Presbyterian Homes Of Bloomington	**9889 PENN AVENUE SOUTH , BLOOMINGTON, Minnesota, 55431**

(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
K0000 Bldg. 1N	Continued from page 1 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Presbyterian Homes of Bloomington Care Center is a 3-story building with a full basement that was built in 2005 determined to be of Type II(222) construction. The facility is separated from an assisted living occupancy by 2-hour fire rated construction. The facility is fully protected throughout by an automatic fire sprinkler system and has a fire alarm system with smoke detection in resident rooms, corridors and spaces open to the corridor that is monitored for automatic fire department notification. The facility has a capacity of 98 beds and had a census of 93 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K0000		
K0372 SS = E Bldg. 1N	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101	K0372	Wall penetrations above the Archway household entry doors were sealed using red-colored fire barrier caulk on 6/24/2026. This penetration was likely recently caused by contractor work installing	06/25/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245556	(X2) MULTIPLE CONSTRUCTION A. BUILDING **1N - NEW BUILDI...** B. WING	(X3) DATE SURVEY COMPLETED **06/24/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Presbyterian Homes Of Bloomington	**9889 PENN AVENUE SOUTH , BLOOMINGTON, Minnesota, 55431**

(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
K0372 SS = E Bldg. 1N	Continued from page 2 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-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. This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke barriers per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.1, 19.3.7.3, 8.5.2.2, and 8.5.6.2. This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 06/24/2026 at 11:06 AM, it was revealed by observation that there was a penetration in the smoke barrier above the smoke barrier doors in Archway on the 3rd floor caused by low voltage wires. An interview with the Environmental Services Director and the Administrative Intern verified this deficient finding at the time of discovery.	K0372	Continued from page 2 our new nurse call system. All hallway smoke barriers were inspected by maintenance and deputy fire marshal, with all other penetrations noted to be sealed appropriately. Maintenance staff will proactively communicate with contractors prior to installing or pulling wires to regarding expectation to fill penetrations that may occur during work. Maintenance will also audit and inspect all future contractor work to ensure all penetrations are sealed properly by contractors when the job is completed. The Environmental Services Director and/or designee is responsible for compliance.	06/25/2026

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

August 12, 2026

Administrator
PRESBYTERIAN HOMES OF BLOOMINGTON
9889 PENN AVENUE SOUTH
BLOOMINGTON, MN 55431

RE: CCN: 245556
Cycle Start Date: June 24, 2026

Dear Administrator:

On August 6, 2026, the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

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