*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered
April 11, 2025

Administrator
Presbyterian Homes Of Bloomington
9889 Penn Avenue South
Bloomington, MN  55431

RE: CCN: 245556
Cycle Start Date: April 3, 2025

Dear Administrator:

On April 3, 2025, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of

the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by July 3, 2025 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by October 3, 2025 (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

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Electronically delivered
April 11, 2025

Administrator
Presbyterian Homes Of Bloomington
9889 Penn Avenue South
Bloomington, MN  55431

Re: State Nursing Home Licensing Orders
Event ID: 33HZ11

Dear Administrator:

The above facility was surveyed on March 31, 2025 through April 3, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

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

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any 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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245556 | A. BUILDING _____ B. WING _____ | C 04/03/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PRESBYTERIAN HOMES OF BLOOMINGTON | 9889 PENN AVENUE SOUTH BLOOMINGTON, MN 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 |
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| E 000 | Initial Comments<br><br>On 3/31/25 to 4/3/25, a survey for compliance with §483.73, Appendix Z, Emergency Preparedness Requirements for Long Term Care Facilities was conducted during a standard recertification survey. The facility was in compliance.<br><br>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. | E 000 | | |
| F 000 | INITIAL COMMENTS<br><br>On 3/31/25 to 4/3/25, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.<br><br>In addition to the recertification survey, the following complaints were reviewed<br><br>The following complaints were reviewed with no deficiency issued.<br>H55562221C(MN00110870)<br>H55562222C(MN00110416)<br><br>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. | F 000 | | |

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

Electronically Signed | 04/21/2025

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

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| F 000 | Continued From page 1<br>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 644 SS=D | Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2)<br><br>§483.20(e) Coordination.<br>A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes:<br><br>§483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care.<br><br>§483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to notify the county (designated State Mental Health Authority - SMHA) for 1 of 1 resident (R11) with new onset of mental illness.<br><br>Findings include:<br><br>R11's 6/23/23, Initial Pre-Admission Screening (PAS), did not identify a diagnosis of mental illness and did not indicate the need for a Level II | F 644 | 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 | 5/6/25 |

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| F 644 | Continued From page 2<br>(PASARR) to be completed.<br><br>R11's 8/31/23, Provider Order identified R11 was to receive olanzapine (treats schizophrenia and bipolar disorder) 1.25 milligrams (mg) at night and 1.25 mg as needed for anxiety/paranoia and lack of redirection.<br><br>R11's 2/3/25, Significant change Minimum Data Set (MDS) assessment identified R11 was dependent on staff for cares and activities of daily living (ADLs). R11 had a diagnoses of dementia, anxiety, depression, and a psychotic disorder other than schizophrenia, and took antipsychotics on a routine and as needed (PRN) basis. R11 was severely cognitively impaired and had disorganized thinking that would come and go with change in severity, and had little interest or pleasure in doing things and felt down, depressed and hopeless two to six days during the 14-day assessment period.<br><br>R11's undated, current diagnosis list identified R11 received a new diagnosis of unspecified psychosis not due to a substance or known physiological condition on 2/16/24.<br><br>R11's medical record lacked any indication that the county (SMHA) had been notified since the new onset of R11's mental illness.<br><br>Interview on 4/2/25 at 11:35 a.m., with social service designee identified she was aware R11 had a newly evident diagnosis of psychosis to support R11's dementia. She identified she was not directed to contact the designated-state mental health authority and never thought to do that. | F 644 | any appropriate forum, including in an independent dispute resolution, or, if appealable remedies are subsequently imposed, by timely appeal to the Departmental Appeals Board.<br><br>R11 had a change in mental health diagnosis at the facility. The facility did not obtain PASRR Level 2 at the time. R11 PASRR was updated with Hennepin County and is current and up to date.<br><br>A facility audit will be completed on all residents to ensure appropriate level one and level two services are initiated for all residents with developmental delays or mental illness. To ensure the PASRR was in place per policy for all residents. Those identified that we did not follow will be sent to the county.<br><br>Household Coordinators/ Admissions coordinators were reeducated on the Pre-Admission Screening and Resident Review (PASRR) Policy and procedures. The PHS PASRR Screening Policy was reviewed and is current and up to date<br><br>All new admissions and residents with changes in mental health will be audited to ensure the PASSR Level 2 is completed in 4 weeks. The results will be reported to the QAPI team, to determine the frequency of ongoing audits for compliance. Administrator/designee will be responsible for monitoring compliance. Date Certain is Tuesday, May 6, 2025. | |

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| F 644 | Continued From page 3<br>Interview on 4/3/25 at 10:09 a.m., with the administrator indicated it was expected the facility would file a Level I to the county for all admissions and if a Level II was needed the facility would follow the recommendations. If a resident was identified to have a newly evident diagnosis of a mental illness the facility would resubmit a Level I PASARR for recommendations.<br><br>Review of July 2024 Pre-Admission Screening and Resident Review (PASRR) Policy identified the facility would evaluate mental disorders and/or intellectual disability upon admission to the facility. A Level II would be referred to the state-designated authority when a resident had a newly evident or serious mental disorder, exhibit behavioral, psychiatric, mood related, or had a significant change in status. | F 644 | | |
| F 758 SS=D | Free from Unnec Psychotropic Meds/PRN Use<br>CFR(s): 483.45(c)(3)(e)(1)-(5)<br><br>§483.45(e) Psychotropic Drugs.<br>§483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:<br>(i) Anti-psychotic;<br>(ii) Anti-depressant;<br>(iii) Anti-anxiety; and<br>(iv) Hypnotic<br><br>Based on a comprehensive assessment of a resident, the facility must ensure that---<br><br>§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs | F 758 | | 5/6/25 |

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| F 758 | Continued From page 4<br>unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;<br><br>§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;<br><br>§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and<br><br>§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.<br><br>§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to ensure as-needed (PRN) antipsychotic medications (group of medications used to treat psychosis) were limited to 14 days of use or re-evaluated by the medical provider to ensure necessity and reduce the risk of complication for 1 of 5 residents (R26) reviewed | F 758 | R26 had an order for Quetiapine 50mg PRN. The pharmacist did communicate a 14 day stop date was needed; The facility failed to initiate 14 days stop date. The facility completed the stop date on the day this was brought to the attention of the facility from the surveyor and new orders | |

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| F 758 | Continued From page 5<br>for unnecessary medication use.<br><br>Findings include:<br><br>R26's admission Minimum Data Set (MDS) assessment, dated 3/9/25, indicated R26 had moderately impaired cognition with no hallucinations or delusions, no behaviors and no rejection of care. R26 required supervision from staff for activities of daily living (ADLs). The MDS indicated R26 diagnoses included: anxiety, depression, generalized weakness, and mild cognitive impairment of uncertain or unknown etiology,<br><br>R26's Order Summary Report, printed 4/2/25, indicated R26 had an order for 50 milligrams (mg) quetiapine fumarate (antipsychotic medication) by mouth as needed for agitation started on 3/3/25. The report included a section titled "End Date" that did not include a date for this order.<br><br>R26's Medication Administration Record (MAR) for the months of March and April, printed 4/1/25, indicated R26 received the PRN quetiapine with the order date 3/3/25, three times during this period.<br><br>During an interview on 4/2/25 at 10:07 a.m., consulting pharmacist (CP)-A stated he reviewed resident's orders monthly, which included reviewing for 14 day end dates on PRN antipsychotic medications. CP-A stated he sent over a pharmacy recommendation on 3/11/25, for an end date on the PRN quetiapine order. Director of nursing (DON) verified the order for PRN quetiapine was active and did not have the required 14 day stop date. Both CP-A and DON acknowledged PRN antipsychotic medications | F 758 | were received.<br><br>A facility audit for all residents on Psych medications will be initiated. Facility to ensure all PRN medications have stop dates per PHS policy for Psych medications. The Psychotropic Medication policy was reviewed and is current and up to date.<br><br>Education to all Licensed nursing staff, HUC, and Household Coordinators to ensure appropriate follow-through on psychotropic medication management is completed.<br><br>All new admissions and residents who have changes in psych medications will be audited for 4 weeks. The results will be reported to the QAPI team, to determine the frequency of ongoing audits for compliance. Clinical Administrator/designee will be responsible for monitoring compliance. Date Certain is Tuesday, May 6, 2025. | |

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| F 758 | Continued From page 6<br>were to be limited to 14 days.<br><br>On 4/2/25 at 11:32 a.m., DON provided a copy of the pharmacy review. DON stated the doctor addressed it today and discontinued the medication. DON verified it had not been addressed prior to surveyor bringing to their attention.<br><br>During a follow up interview on 4/3/25 at 10:03 a.m., DON stated the expectation was when the orders were put in for a PRN antipsychotic, a 14-day end date would be entered also as this was part of processing the order.<br><br>A facility policy titled Psychotropic Medication Use Policy, dated 3/2025, indicated "Anti-psychotics: may only be used for 14 days. If the prescribing practitioner wishes to write a new order for the PRN anti-psychotic the resident must first be evaluated." | F 758 | | |
| F 812 SS=F | Food Procurement,Store/Prepare/Serve-Sanitary<br>CFR(s): 483.60(i)(1)(2)<br><br>§483.60(i) Food safety requirements.<br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br>(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.<br>(iii) This provision does not preclude residents | F 812 | | 5/6/25 |

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| F 812 | Continued From page 7<br>from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and document review, the facility failed to ensure monitoring and timely removal of facility food stored in refrigerators and freezers was completed to reduce the risk of foodborne illness. This had the potential to affect approximately 20 residents who consumed meals from the third-floor kitchen, and all residents in the facility who received meals from the main facility kitchen.<br><br>Findings include:<br><br>During the initial tour with the assistant dietary director (DA)-A on 3/31/25 at 12:30 p.m., the following foods were found in the walk-in refrigerator and freezer of the main facility kitchen.<br><br>-One opened container sealed with plastic wrap; ranch dressing labeled use by 3/27/25.<br>-One opened container of Chow Mein noodles with an expiration date of 3/4/25.<br>-One opened container of Pace salsa with a use by date 3/8/25.<br>-One single container of chocolate ice cream dated 8/12/24.<br><br>During the walk through DA-A removed the expired food. DA-A stated the cooks were supposed to go through the refrigerator and freezers daily. After the initial walk-through, evening cook (C)-A confirmed the cooks are | F 812 | During initial walk throughs the following items were found in the refrigerator/freezer:<br><br>Main kitchen findings:<br><br>One opened container sealed with plastic wrap; ranch dressing labeled use by 3/27/25 □ immediately removed and discarded.<br><br>One opened container of Chow Mein noodles with an expiration date of 3/4/25 □ immediately removed and discarded.<br><br>One opened container of Pace salsa with a use by date 3/8/25 □ immediately removed and discarded.<br><br>One single container of chocolate ice cream dated 8/12/25 □ immediately removed and discarded.<br><br>Crossway kitchen findings:<br><br>One multi-use grape juice container for the unit dispenser which expired 6/24 □ immediately removed and discarded.<br><br>Plastic container with dozens of single use | |

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| F 812 | Continued From page 8<br>suppose to check both the refrigerator and the freezer for expired dates daily.<br><br>During a tour of the Crossway kitchen on 4/1/25 at 12:16 p.m., the following foods were found in the refrigerator.<br><br>-One multi-use grape juice container for the unit dispenser which expired 6/24.<br>-Plastic container with dozens of single use cream cheese, undated.<br>-Plastic container with dozens of single use creamers, undated.<br>-Four packs of pancakes and two packs of waffles, unlabeled.<br>-Cocktail sauce expired 9/24.<br><br>During an interview on 4/1/25 at 12:16 p.m., Crossway server (DA)-B stated the process was to check for expired foods daily, however was unsure about the process of pancakes, waffles, cream cheese, or creamer. The pancakes and waffles were brought up from the main freezer every day and kept for about two days on the unit. DA-B confirmed the pancakes and waffles in the refrigerator were unlabeled, and indicated servers were responsible for checking the snack cart. DA-B confirmed there was no process for documenting how or when the snack cart was checked for expiration dates.<br><br>During an interview on 4/1/25 at 12:41, DA-A stated kitchen supervisors conducted audits on each floor. DA-A confirmed that DA-B did come down to ask what she should do with the unlabeled items. DA-A stated that DA-B should throw the unlabeled items away.<br><br>During an interview on 4/1/25 at 12:49, DA-B | F 812 | cream cheese, undated □ immediately removed and discarded.<br><br>Plastic container with dozens of single use creamers, undated □ immediately removed and discarded.<br><br>Four packs of pancakes and two packs of waffles, unlabeled□ immediately removed and discarded.<br><br>Cocktail sauce expired 9/24 □ immediately removed and discarded.<br><br>All issues cited in the survey were immediately addressed and corrected.<br><br>All culinary staff will be educated on labeling and dating in line with our current and up-to-date policy, Label and Dating Policy. Additionally, cooks will receive additional education on the process for ensuring audits are completed on a regular basis to ensure no expired goods are in the refrigerator or freezer.<br><br>All refrigerators and freezers on the units and in the main kitchen will be audited for four weeks. The results will be reported to the QAPI team, to determine the frequency of ongoing audits for compliance. The Nutrition and Culinary Director/designee will be responsible for monitoring compliance. Date Certain is: Tuesday, May 6, 2025. | |

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| F 812 | Continued From page 9 | F 812 | | |

stated no one told them what they should do with unlabeled food.

During an interview on 4/1/25 at 12:54 p.m., kitchen supervisor (DA)-D confirmed the unit refrigerator had pancakes and waffles that were not labeled. The food was removed and placed on a cart to take back to the main kitchen. The expired juice was taken out of the garbage and the expired date was confirmed with the supervisor as 6/24 and placed on the cart. DA-D confirmed there was no process for single use cream cheese and creamers that are undated and placed on the cart.

During an interview on 4/2/25 at 8:21 a.m., per-diem Crossway server (DA)-C stated the process was to take food from the main kitchen freezer, place a label with a use by date, and then bring food to the unit. The food should be used within three days. DA-C confirmed pancakes and waffles came from the main kitchen freezer. DA-C opened the refrigerator and confirmed 1.5 packages of pancakes were in the refrigerator. One package was opened, and both were unlabeled. DA-C brought up one package of pancakes that was on the counter opened without a date, but confirmed the package was taken from the freezer that morning and had a label completed and ready to be placed on the package. DA-C stated the packages in the refrigerator must have been there from the server on 4/1/25.

The facility's undated Labeling and Dating Policy indicated foods that are not marked will be discarded.

The facility's Safe Food Storage Policy, dated

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| F 812 | Continued From page 10<br>4/2019 directed staff to label, date, and properly cover all foods items upon opening of package. | F 812 | | |

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| 2 000 | Initial Comments<br><br>*****ATTENTION******<br><br>NH LICENSING CORRECTION ORDER<br><br>In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.<br><br>Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.<br><br>You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.<br><br>INITIAL COMMENTS:<br>On 3/31/25 to 4/3/25, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and | 2 000 | | |

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| 2 000 | Continued From page 1<br>identify the date when they will be completed.<br><br>The following complaints were reviewed:<br>H55562221C(MN00110870)<br>H55562222C(MN00110416)<br>NO citations were issued.<br><br>Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction.<br><br>You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. | 2 000 | | |

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| 2 000 | Continued From page 2<br>PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES. | 2 000 | | |
| 2 550 | MN Rule 4658.0400 Subp. 4 Comprehensive Resident Assessment; Review<br><br>Subp. 4. Review of assessments. A nursing home must examine each resident at least quarterly and must revise the resident's comprehensive assessment to ensure the continued accuracy of the assessment.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and document review, the facility failed to ensure the Minimum Data Set (MDS) was accurately coded with the potential for inaccurate federal reimbursement and resident care planning for 2 of 3 residents (R51, R94) reviewed for MDS accuracy.<br><br>Findings include:<br><br>R51's quarterly MDS dated 2/17/25, indicated under "Section N - Medications", that R51 had received an antibiotic during the look-back period (LBP). The MDS indicated under "Section M- Skin Conditions", that R51 had a stage III pressure ulcer.<br><br>R51's progress note dated 2/14/25 at 1:38 p.m., indicated R51 had a stage II pressure injury. | 2 550 | Corrected | 5/6/25 |

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| 2 550 | Continued From page 3<br><br>R51's medical record was reviewed and did not indicate her right big toe pressure injury had reached stage III or that she had received an antibiotic during the LBP.<br><br>During an interview on 4/2/25 at 2:14 p.m., the director of nursing (DON) confirmed he had reviewed R51's record and did not find evidence that R51's pressure injury to her right big toe had ever been a stage III. The DON stated he had also assessed R51's pressure injury in the past and had not ever assessed it at stage III. The DON stated he thought floor staff had some confusion on what constituted a stage III pressure injury and might have incorrectly informed the MDS nurse of the stage so it had been coded incorrectly.<br><br>During an interview on 4/3/25 at 8:34 a.m., the regional MDS nurse (RN)-B confirmed she had reviewed R51's medical record and R51 had not received an antibiotic during the LBP. RN-B stated she had talked with the care coordinator at the time of the assessment who had thought the pressure injury to R51's right big toe was a stage III so she had documented it that way.<br>R94's completed discharge return not anticipated (DRNA) MDS, dated 3/3/25, identified R94 discharged on 2/28/25, with a recorded discharge status reading, "04. Short-Term General Hospital (acute hospital, IPPS)."<br><br>R94's census had an admitted date of 1/13/25, and discharged date of 2/28/25.<br><br>R94's recapitulation of stay, dated 2/19/25 and signed by R94's daughter, identified R94 was hospitalized from 12/30/24 to 1/13/25, for left upper extremity cellulitis and admitted to Presbyterian Bloomington Landing TCU | 2 550 | | |

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| 2 550 | Continued From page 4<br><br>(transitional care unit) from Fairview Southdale Hospital on 1/13/25.<br><br>R94's progress note, dated 2/28/25, identified R94 discharged to an alternate assisted living/memory care facility. R94 was picked up by his family and transported by car.<br><br>During an interview on 4/3/25 at 9:35 a.m., the regional MDS nurse (RN)-D reviewed R94's MDS dated 3/3/25, and confirmed the discharge was coded for hospitalization and should have been coded as assisted living. RN-D provided contact information for the MDS nurse (RN)-E that completed the MDS on 3/3/2025.<br><br>During an interview on 4/3/25 at 9:41 a.m., the MDS nurse RN-E reviewed R94's MDS dated 3/3/25 and stated, "I made a mistake". RN-E confirmed that the MDS section A, A2105 was marked as Discharge Status Short-Term General Hospital Acute Hospital IPPS.<br><br>A facility's Resident Assessment Instrument (RAI) Process: MDS 3.0, Care Area Assessments, Care Planning, and Submission policy, dated 3/2025, identified the interdisciplinary team (IDT) would complete the MDS in accordance with guidelines set in the current RAI user's manual.<br><br>SUGGESTED METHOD OF CORRECTION:<br>The director of nursing (DON) or designee could review and revise policies and procedures related to ensuring that each individual resident's comprehensive assessment is accurately completed. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure staff accurately complete assessments. | 2 550 | | |

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| 2 550 | Continued From page 5<br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 2 550 | | |
| 21100 | MN Rule 4658.0650 Subp. 5 Food Supplies; Storage of Perishable food<br><br>Subp. 5. Storage of perishable food. All perishable food must be stored off the floor on washable, corrosion-resistant shelving under sanitary conditions, and at temperatures which will protect against spoilage.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and document review, the facility failed to ensure monitoring and timely removal of facility food stored in refrigerators and freezers was completed to reduce the risk of foodborne illness. This had the potential to affect approximately 20 residents who consumed meals from the third-floor kitchen, and all residents in the facility who received meals from the main facility kitchen.<br><br>Findings include:<br><br>During the initial tour with the assistant dietary director (DA)-A on 3/31/25 at 12:30 p.m., the following foods were found in the walk-in refrigerator and freezer of the main facility kitchen.<br><br>-One opened container sealed with plastic wrap; ranch dressing labeled use by 3/27/25.<br>-One opened container of Chow Mein noodles with an expiration date of 3/4/25.<br>-One opened container of Pace salsa with a use by date 3/8/25.<br>-One single container of chocolate ice cream | 21100 | Corrected | 5/6/25 |

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| 21100 | Continued From page 6<br>dated 8/12/24.<br><br>During the walk through DA-A removed the expired food. DA-A stated the cooks were supposed to go through the refrigerator and freezers daily. After the initial walk-through, evening cook (C)-A confirmed the cooks are suppose to check both the refrigerator and the freezer for expired dates daily.<br><br>During a tour of the Crossway kitchen on 4/1/25 at 12:16 p.m., the following foods were found in the refrigerator.<br><br>-One multi-use grape juice container for the unit dispenser which expired 6/24.<br>-Plastic container with dozens of single use cream cheese, undated.<br>-Plastic container with dozens of single use creamers, undated.<br>-Four packs of pancakes and two packs of waffles, unlabeled.<br>-Cocktail sauce expired 9/24.<br><br>During an interview on 4/1/25 at 12:16 p.m., Crossway server (DA)-B stated the process was to check for expired foods daily, however was unsure about the process of pancakes, waffles, cream cheese, or creamer. The pancakes and waffles were brought up from the main freezer every day and kept for about two days on the unit. DA-B confirmed the pancakes and waffles in the refrigerator were unlabeled, and indicated servers were responsible for checking the snack cart. DA-B confirmed there was no process for documenting how or when the snack cart was checked for expiration dates.<br><br>During an interview on 4/1/25 at 12:41, DA-A stated kitchen supervisors conducted audits on | 21100 | | |

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| 21100 | Continued From page 7<br><br>each floor. DA-A confirmed that DA-B did come down to ask what she should do with the unlabeled items. DA-A stated that DA-B should throw the unlabeled items away.<br><br>During an interview on 4/1/25 at 12:49, DA-B stated no one told them what they should do with unlabeled food.<br><br>During an interview on 4/1/25 at 12:54 p.m., kitchen supervisor (DA)-D confirmed the unit refrigerator had pancakes and waffles that were not labeled. The food was removed and placed on a cart to take back to the main kitchen. The expired juice was taken out of the garbage and the expired date was confirmed with the supervisor as 6/24 and placed on the cart. DA-D confirmed there was no process for single use cream cheese and creamers that are undated and placed on the cart.<br><br>During an interview on 4/2/25 at 8:21 a.m., per-diem Crossway server (DA)-C stated the process was to take food from the main kitchen freezer, place a label with a use by date, and then bring food to the unit. The food should be used within three days. DA-C confirmed pancakes and waffles came from the main kitchen freezer. DA-C opened the refrigerator and confirmed 1.5 packages of pancakes were in the refrigerator. One package was opened, and both were unlabeled. DA-C brought up one package of pancakes that was on the counter opened without a date, but confirmed the package was taken from the freezer that morning and had a label completed and ready to be placed on the package. DA-C stated the packages in the refrigerator must have been there from the server on 4/1/25. | 21100 | | |

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|---|---|---|---|
| | 00189 | A. BUILDING: _____ B. WING _____ | C 04/03/2025 |

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

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| 21100 | Continued From page 8<br><br>The facility's undated Labeling and Dating Policy indicated foods that are not marked will be discarded.<br><br>The facility's Safe Food Storage Policy, dated 4/2019 directed staff to label, date, and properly cover all foods items upon opening of package.<br><br>SUGGESTED METHOD OF CORRECTION: The administrator, registered dietician, or designee could ensure foods are stored and labeled properly to prevent potential degraded food served to residents of the facility. The facility could update or create policies and procedures, and educate staff on specific requirements or interventions related to food storage and labeling. The administrator, registered dietician, or designee could perform audits for a designated amount of time as determined by the Quality Assurance Performance Improvement (QAPI) committee to ensure food items are stored and labeled appropriately. The facility could report those findings to QAPI for further recommendations and determine the need for further monitoring or compliance.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 21100 | | |
| 21426 | MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control<br><br>(a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of | 21426 | | 5/1/25 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| 21426 | Continued From page 9<br><br>Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines.<br><br>(b) Written compliance with this subdivision must be maintained by the nursing home.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and document review, the facility failed to ensure that required tuberculosis (TB) testing was completed for 1 of 6 staff members and 2 of 6 residents (R16, R72) with the potential to affect all 89 residents residing in the facility.<br><br>Findings include:<br><br>The Centers for Disease Control (CDC) Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis in Health Care Setting, 2005, directed that all residents and employees were to receive a two-step tuberculin skin test (TST) or a laboratory screening for TB. If an employee or resident tested positive for any of the aforementioned tests, a chest x-ray, and/or medical examination by a medical practitioner was to be completed to rule out active disease. The guideline indicated if a healthcare worker had documentation of previous treatment for TB | 21426 | R16 and R72 had incomplete documentation regarding fulfilling the steps of TB Mantoux 2 step test upon admission to facility. Facility did not document correctly the results of the 2 step Mantoux TB Test. R16 immunization tab was updated to reflect the negative test result for step 1 of the TB Mantoux Test and R72 immunization tab was updated to reflect the negative test result for step 1 of the TB Mantoux Test.<br>RN-C had incomplete documentation regarding a chest x-ray with a known history of a positive TB skin test. As well, as confirmed treat for tuberculosis from Hennepin County Medical Center. RN-C has been removed from the schedule and will be returned once a chest x-ray is received and shows no active<br>All residents in the facility were reviewed for TB Mantoux testing, those who were | |

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| 21426 | Continued From page 10<br><br>disease, they should receive one chest radiograph result to exclude TB disease.<br><br>R16's significant change Minimum Data Set (MDS) dated 12/30/24, indicated R16 was admitted to the facility on 7/24/24 and was diagnosed with a thyroid disorder and Alzheimer's disease.<br><br>R16's immunization record dated 10/30/24, indicated the first step of the TST was administered on 7/24/24 and the results were "undetermined". The record indicated step two of the TST was given on 8/9/24 and the results were negative. R16's medical record was reviewed and the results to the first step of the TST were not found.<br><br>R72's admission MDS dated 1/21/25, indicated R72 was admitted to the facility on 1/15/25 and was diagnosed with a stroke, heart failure, and dementia.<br><br>R72's immunization record dated 1/29/25, indicated the first step of the TST was administered on 1/15/25 and the results were still pending. The record indicated step two of the TST was given on 1/29/25 and the results were negative. R72's medical record was reviewed and the results of the first step of the TST were not found.<br><br>Registered nurse (RN)-C's Nurse Health Screen, indicated RN-C had a previous positive reaction to a TB skin test and had received treatment for latent TB in 9/2000 through 7/2001. Chest radiograph results for RN-C were requested and not received.<br><br>During an interview on 4/3/25 at 9:15 a.m., the | 21426 | not in compliance, will be brought into compliance.<br>All new hires and current employees with a history of a positive test result were reviewed for completion of chest x-ray resulting in no active TB infection. Those who were not in compliance, will be brought into compliance.<br>Education to all licensed nursing staff to ensure appropriate follow through on fully completing the 2 Step TB Mantoux skin test is completed and documented correctly in the immunization tab of Point Click Care or a chest x-ray showing chest radiographic results confirm negative for tuberculosis. Education to all employee health staff members and human resources for process as it pertains to TB testing for new hires. Policy as it pertains to employees that are new with a history of a positive test result is in the process of being reviewed and will be updated to meet state and federal requirements.<br>Audits will be completed of all new admissions to ensure the residents are receiving the 2 step TB test or having a negative chest x-ray to rule out TB to those who qualify for testing and will be completed for 4 weeks. Additionally, all new hires will be audited for compliance for the next 4 weeks. The results will be reported to the QAPI team, to determine the frequency of ongoing audits for compliance. Administrator/designee will be responsible for monitoring compliance.<br>Date Certain is Tuesday, May 1, 2025. | |

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

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| 21426 | Continued From page 11<br><br>DON confirmed he had reviewed R16's and R72's medical records and was unable to find the results for the first step of the TST for both residents. The DON stated he expected nursing staff to determine the TST results and then document these results under the immunization record tab. The DON confirmed they did not have a chest x-ray on file for RN-C but stated he did not feel they needed to as she had gotten treatment for TB.<br><br>The facility's undated Tuberculosis Control Plan, indicated all skilled facility residents would be administered a TST within 72 hours of admission and a two-step procedure would be followed. If the initial TST was negative staff would wait until 14 days after the initial reading to administer the second step, but if the result was positive, the resident would have a chest x-ray completed. The policy indicated that an employee who had a previously positive reaction to a TST will have a chest x-ray completed unless they can provide documentation of a negative chest x-ray dated after the date of the positive test. The policy indicated that if an employee had a history of TB infection, they did not need to perform a TST test but must submit documentation of a previously positive test or documented completion of treatment for TB disease.<br><br>SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) could review and revise policies and procedures for TB surveillance. The DON could educate all appropriate staff on the policies and procedures. The DON could monitor resident and employee TB screening to ensure ongoing compliance.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 21426 | | |

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| 21535 | MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General<br><br>Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used:<br>A. in excessive dose, including duplicate drug therapy;<br>B. for excessive duration;<br>C. without adequate indications for its use; or<br>D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued.<br>In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and document review, the facility failed to ensure as-needed (PRN) antipsychotic medications (group of medications used to treat psychosis) were limited to 14 days of use or re-evaluated by the medical provider to ensure necessity and reduce the risk of complication for 1 of 5 residents (R26) reviewed for unnecessary medication use.<br><br>Findings include: | 21535 | Corrected | 5/6/25 |

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| 21535 | Continued From page 13<br><br>R26's admission Minimum Data Set (MDS) assessment, dated 3/9/25, indicated R26 had moderately impaired cognition with no hallucinations or delusions, no behaviors and no rejection of care. R26 required supervision from staff for activities of daily living (ADLs). The MDS indicated R26 diagnoses included: anxiety, depression, generalized weakness, and mild cognitive impairment of uncertain or unknown etiology,<br><br>R26's Order Summary Report, printed 4/2/25, indicated R26 had an order for 50 milligrams (mg) quetiapine fumarate (antipsychotic medication) by mouth as needed for agitation started on 3/3/25. The report included a section titled "End Date" that did not include a date for this order.<br><br>R26's Medication Administration Record (MAR) for the months of March and April, printed 4/1/25, indicated R26 received the PRN quetiapine with the order date 3/3/25, three times during this period.<br><br>During an interview on 4/2/25 at 10:07 a.m., consulting pharmacist (CP)-A stated he reviewed resident's orders monthly, which included reviewing for 14 day end dates on PRN antipsychotic medications. CP-A stated he sent over a pharmacy recommendation on 3/11/25, for an end date on the PRN quetiapine order. Director of nursing (DON) verified the order for PRN quetiapine was active and did not have the required 14 day stop date. Both CP-A and DON acknowledged PRN antipsychotic medications were to be limited to 14 days.<br><br>On 4/2/25 at 11:32 a.m., DON provided a copy of the pharmacy review. DON stated the doctor | 21535 | | |

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| 21535 | Continued From page 14<br><br>addressed it today and discontinued the medication. DON verified it had not been addressed prior to surveyor bringing to their attention.<br><br>During a follow up interview on 4/3/25 at 10:03 a.m., DON stated the expectation was when the orders were put in for a PRN antipsychotic, a 14-day end date would be entered also as this was part of processing the order.<br><br>A facility policy titled Psychotropic Medication Use Policy, dated 3/2025, indicated "Anti-psychotics: may only be used for 14 days. If the prescribing practitioner wishes to write a new order for the PRN anti-psychotic the resident must first be evaluated."<br><br>SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could educate staff on the importance of ensuring timely evaluation is provided by the physician or a justified reason for continuing past 14 days made according to regulation. Audits by staff and the onsulting pharmacy should be developed to monitor medications for adequate indications for use and appropriate timeframes made. The DON and/or designee should take those findings/education to the Quality Assurance Performance Improvement (QAPI) committee for a determined amount of time until the QAPI committee determines successful compliance or the need for ongoing monitoring.<br><br>TIME PERIOD FOR CORRECTION: 21 DAYS | 21535 | | |

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| | 245556 | A. BUILDING **1N - NEW BUILDING** B. WING _____ | **04/01/2025** |

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| **PRESBYTERIAN HOMES OF BLOOMINGTON** | **9889 PENN AVENUE SOUTH BLOOMINGTON, MN 55431** |

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| K 000 | INITIAL COMMENTS<br><br>FIRE SAFETY<br><br>An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 04/01/2025. 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.<br><br>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.<br><br>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.<br><br>PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:<br><br>IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. | K 000 | | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Electronically Signed | | 04/21/2025 |

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

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| K 000 | Continued From page 1<br>Healthcare Fire Inspections<br>State Fire Marshal Division<br>445 Minnesota St., Suite 145<br>St. Paul, MN 55101-5145, OR<br><br>By email to:<br>FM.HC.Inspections@state.mn.us<br><br>THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:<br><br>1. A detailed description of the corrective action taken or planned to correct the deficiency.<br><br>2. Address the measures that will be put in place to ensure the deficiency does not reoccur.<br><br>3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained.<br><br>4. Identify who is responsible for the corrective actions and monitoring of compliance.<br><br>5. The actual or proposed date for completion of the remedy.<br><br>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. | K 000 | | |

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| K 000 | Continued From page 2<br><br>The facility has a capacity of 98 beds and had a census of 89 at the time of the survey.<br><br>The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by: | K 000 | | |
| K 226 SS=D | Horizontal Exits<br>CFR(s): NFPA 101<br><br>Horizontal Exits<br>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.<br>18.2.2.5, 19.2.2.5<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to maintain fire barriers per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.2.5, 7.2.4.3.1, and 8.3.1.2. This deficient finding could have an isolated impact on the residents within the facility.<br><br>Findings include:<br><br>On 04/01/2025 at 10:59 AM, it was revealed by observation that there was a penetration in the fire wall that was not sealed above the fire doors on the second floor between the care center and atrium.<br><br>An interview with the Administrator Intern, | K 226 | To meet the requirements of NFPA 101 (2012 edition), Life Safety Code, sections 19.2.2.5, 7.2.4.3.1, and 8.3.1.2, the unsealed penetration in the firewall above the fire doors on the second floor between the care center and atrium will be sealed using 3M Fire Barrier Sealant CP 25WB or its equivalent. The Environmental Services Director (ESD) or its proxy will be responsible for ensuring this task is properly executed. This repair will be completed on or before 4/30/2025. The ESD and its staff will be responsible for ensuring any penetration in fire walls that are caused by staff, subcontractors, or others is promptly repaired using the | 4/30/25 |

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| K 226 | Continued From page 3<br>Regional Director of Engineering, and the Maintenance Engineer verified this deficient finding at the time of discovery. | K 226 | proper listed fireproofing methods. The Regional Engineering Manager (REM)will verify this repair is properly completed on or before 4/30/2025. | |
| K 321 SS=D | Hazardous Areas - Enclosure<br>CFR(s): NFPA 101<br><br>Hazardous Areas - Enclosure<br>Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door.<br>Describe the floor and zone locations of hazardous areas that are deficient in REMARKS.<br>19.3.2.1, 19.3.5.9<br><br>Area Automatic Sprinkler<br>Separation N/A<br>a. Boiler and Fuel-Fired Heater Rooms<br>b. Laundries (larger than 100 square feet)<br>c. Repair, Maintenance, and Paint Shops<br>d. Soiled Linen Rooms (exceeding 64 gallons)<br>e. Trash Collection Rooms (exceeding 64 gallons)<br>f. Combustible Storage Rooms/Spaces (over 50 square feet)<br>g. Laboratories (if classified as Severe Hazard - see K322)<br>This REQUIREMENT is not met as evidenced by: | K 321 | | 4/30/25 |

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|---|---|---|---|
| | 245556 | A. BUILDING **1N - NEW BUILDING** B. WING _____ | **04/01/2025** |

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

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| K 321 | Continued From page 4<br>Based on observation and staff interview, the facility failed to maintain hazardous rooms per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.1, 19.3.2.1.2, 19.3.2.1.3, and 19.3.2.1.5. This deficient finding could have an isolated impact on the residents within the facility.<br><br>Findings include:<br><br>On 04/01/2025 at 10:59 AM, it was revealed by observation that a section of the egress corridor in the basement, near stairwell A1, is being used as a storage room, and lacks fire separation from the rest of the building.<br><br>An interview with the Administrator Intern, Regional Director of Engineering, and the Maintenance Engineer verified this deficient finding at the time of discovery. | K 321 | To meet the requirements of NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.1, 19.3.2.1.2, 19.3.2.1.3, and 19.3.2.1.5, the section of the egress corridor<br>in the basement, near stairwell A1, that is used as a storage room, will no longer be used as a storage room. The ESD or its proxy will be responsible for removing the storage and shelving from the area and will be responsible for maintaining the corridor to NFPA requirements. A weekly task will be added to the Electronic Work Order System (EWOS) by the REM, which will require the ESD or its proxy to conduct weekly inspections of the area to ensure compliance with NFPA Hazardous Areas and Path of Egress requirements. The task will be created and activated on or before 4/30/2025 | |
| K 346<br>SS=F | Fire Alarm System - Out of Service<br>CFR(s): NFPA 101<br><br>Fire Alarm - Out of Service<br>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.<br>9.6.1.6<br>This REQUIREMENT is not met as evidenced by:<br>Based on a review of available documentation and staff interview, the facility failed to implement a fire alarm out-of-service policy per NFPA 101 (2012 edition), Life Safety Code, section 9.6.1.6. | K 346 | The Fire Alarm Control Panel<br>out-of-service policy will be made to comply with NFPA 101 (2012 edition), Life Safety Code, section 9.6.1.6 | 4/30/25 |

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| K 346 | Continued From page 5<br>This deficient finding could have a widespread impact on the residents within the facility.<br><br>Findings include:<br><br>On 04/01/2025 between 09:15 AM and 12:30 PM, it was revealed by a review of available documentation that the fire alarm out-of-service policy that was provided at the time of the survey did not have contact information for the Deputy State Fire Marshal that shall be contacted in the event the fire alarm is out of service.<br><br>An interview with the Administrator Intern, Regional Director of Engineering, and the Maintenance Engineer verified this deficient finding at the time of discovery. | K 346 | requirements. The policy will be amended by the REM to include the requirement to notify the Deputy State Fire Marshals office, and the phone number. This change will be completed by 4/30/2025 | |
| K 354 SS=F | Sprinkler System - Out of Service<br>CFR(s): NFPA 101<br><br>Sprinkler System - Out of Service<br>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.<br>18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25)<br>This REQUIREMENT is not met as evidenced by:<br>Based on a review of available documentation | K 354 | The Fire Sprinkler out-of-service policy | 4/30/25 |

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| K 354 | Continued From page 6<br>and staff interview, the facility failed to implement a fire sprinkler out-of-service policy per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.5.1 and 9.7.5, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 15.5.2. This deficient finding could have a widespread impact on the residents within the facility.<br><br>Findings include:<br><br>On 04/01/2025 between 09:15 AM and 12:30 PM, it was revealed by a review of available documentation that the fire sprinkler system out-of-service policy that was provided at the time of the survey did not have contact information for the Deputy State Fire Marshal that shall be contacted in the event the fire sprinkler system is out of service.<br><br>An interview with the Administrator Intern, Regional Director of Engineering, and the Maintenance Engineer verified this deficient finding at the time of discovery. | K 354 | will be made to comply with NFPA 101 (2012 edition), Life Safety Code, section 9.6.1.6 requirements. The policy will be amended by the REM to include the requirement to notify the Deputy State Fire Marshal's office, and the phone number. This change will be completed on or before 4/30/2025 | |
| K 363 SS=D | Corridor - Doors<br>CFR(s): NFPA 101<br><br>Corridor - Doors<br>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 1 3/4 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 | K 363 | | 4/30/25 |

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| K 363 | Continued From page 7<br>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. Clearance between bottom of door and floor covering is not exceeding 1 inch. 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 5 lbf is applied. 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.<br><br>19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485<br>Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to maintain corridor doors per NFPA 101 (2012 edition), Life Safety Code, section 19.3.6.3.5. This deficient finding could have an isolated impact on the residents within the facility.<br><br>Findings include:<br><br>On 04/01/2025 at 11:49 AM, it was revealed by observation that the door to the clean linen room | K 363 | The non-functioning, latching door to the clean linen room in Pathway North will be made to meet the positive latching requirement of NFPA 101 (2012 edition), Life Safety Code, section 19.3.6.3.5. The ESD or its proxy will be responsible for conducting the repair to this door on or before 4/30/2025. The REM will ensure the PHS Policy for monthly fire door inspections is in the EWOS task list by | |

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| K 363 | Continued From page 8<br>in Pathway North would not positively latch.<br><br>An interview with the Administrator Intern, Regional Director of Engineering, and the Maintenance Engineer verified this deficient finding at the time of discovery. | K 363 | 4/30/2025 and that it is completed by the ESD or its proxy in a timely manner | |
| K 712<br>SS=F | Fire Drills<br>CFR(s): NFPA 101<br><br>Fire Drills<br>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.<br>19.7.1.4 through 19.7.1.7<br>This REQUIREMENT is not met as evidenced by:<br>Based on a review of available documentation and staff interview, the facility failed to conduct fire drills per NFPA 101 (2012 edition), Life Safety Code sections 19.7.1.6. This deficient finding could have a widespread impact on the residents within the facility.<br><br>Findings include:<br><br>On 04/01/2025 between 09:15 AM and 12:30 PM, it was revealed by a review of available documentation that at the time of the survey, the facility could not provide documentation showing that a fire drill was conducted during the second shift during the fourth quarter of 2024. | K 712 | Fire drills will be conducted to meet the requirements of NFPA 101 (2012 edition), Life Safety Code sections 19.7.1.6. The ESD or its proxy will be responsible for scheduling, conducting, and documenting fire drills to meet these requirements.<br>The REM and the ESD will develop a timing matrix for the drills and enter the drills into the EWOS task list as: Required Life Safety Code tasks. The REM will inspect the fire drill documentation during the document review portion of the Annual Facility Review (AFE) | 4/30/25 |

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| K 712 | Continued From page 9<br><br>An interview with the Administrator Intern, Regional Director of Engineering, and the Maintenance Engineer verified this deficient finding at the time of discovery. | K 712 | | |
| K 901 SS=F | Fundamentals - Building System Categories CFR(s): NFPA 101<br><br>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)<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on a review of available documentation and staff interview, the facility failed to conduct fire drills per NFPA 101 (2012 edition), Life Safety Code sections 19.7.1.6. This deficient finding could have a widespread impact on the residents within the facility.<br><br>Findings include:<br><br>On 04/01/2025 between 09:15 AM and 12:30 PM, it was revealed by a review of available documentation that the NFPA 99 risk assessment provided at the time of the survey did not include Chapter 11 of NFPA 99 (2012 edition), Health Care Facilities Code.<br><br>An interview with the Administrator Intern, | K 901 | The NFPA 99 risk assessment documentation will be amended to include Chapter 11 of NFPA 99 (2012 Edition) Health Care Facilities Code Category 1 through 4 requirements. This policy will be amended on or before 4/30/2025 The REM will be responsible for ensuring the documentation has all the required elements by 4/30/2025 | 4/30/25 |

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| K 901 | Continued From page 10<br>Regional Director of Engineering, and the Maintenance Engineer verified this deficient finding at the time of discovery. | K 901 | | |
| K 914 SS=E | Electrical Systems - Maintenance and Testing CFR(s): NFPA 101<br><br>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 less than or equal to 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 less than or equal to 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.<br>6.3.4 (NFPA 99)<br>This REQUIREMENT is not met as evidenced by:<br>Based on a review of available documentation and staff interview, the facility failed to conduct the electrical testing and maintenance per NFPA 99 Standards for Health Care Facilities 2012 edition, section 6.3.3.2 , 6.3.4.1.3, and 6.3.4.2.1.2. This deficient finding could have a patterned impact on the residents within the facility. | K 914 | The facility will conduct the required electrical testing and maintenance per NFPA 99 Standards for Health Care Facilities 2012 edition, section 6.3.3.2 , 6.3.4.1.3, and 6.3.4.2.1.2 in a timely manner and provide complete documentation of completion. The REM will ensure this required task is properly | 4/30/25 |

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| K 914 | Continued From page 11<br><br>Findings include:<br><br>On 04/01/2025 between 09:15 AM and 12:30 PM, it was revealed by a review of available documentation that the testing report for the electrical receptacles in resident rooms on the third floor was dated 10-17, so it could not be verified that they were tested within the last year.<br><br>An interview with the Administrator Intern, Regional Director of Engineering, and the Maintenance Engineer verified this deficient finding at the time of discovery. | K 914 | entered in the EWOS to notify the ESD or its proxy of the task due at the proper time of year. The ESD or its proxy will be responsible for the timely completion of this task. The REM will verify completion of the task during the document review portion of the AFR | |

*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered

May 12, 2025

Administrator
Presbyterian Homes Of Bloomington
9889 Penn Avenue South
Bloomington, MN  55431

RE:  CCN: 245556
Cycle Start Date: April 3, 2025

Dear Administrator:

On April 11, 2025, we informed you that we may impose enforcement remedies.

On May 1, 2025, the Minnesota Department of Public Safety completed a revisit and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

The deficiency not corrected is as follows:

K0321 - Hazardous Areas - Enclosure

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(ies) listed below to the CMS location for imposition.  The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective July 3, 2025

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective July 3, 2025.  They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective July 3, 2025.

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.

**The CMS location may determine to impose other remedies such as a Civil Money Penalty.**

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 $13,343, 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.

If you have not achieved substantial compliance by July 3, 2025, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Presbyterian Homes Of Bloomington will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from July 3, 2025. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

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. 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.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by October 3, 2025 (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 § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, 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
202-795-7490

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 Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to tamika.brown@cms.hhs.gov.

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