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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: SW0F

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00169

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

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

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

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

6. DATE OF SURVEY **01/24/2018** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **76** (L18)
13.Total Certified Beds **76** (L17)

10.THE FACILITY IS CERTIFIED AS:
x A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	76			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Eva Loch, Unit Supervisor 02/20/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 02/20/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
01111
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245324

February 20, 2018

Mr. Eric Andersen, Administrator
The Estates At Bloomington LLC
9200 Nicollet Avenue South
Bloomington, MN 55420

Dear Mr. Andersen:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective January 10, 2018 the above facility is certified for or recommended for:

76 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 76 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

Electronically delivered

February 20, 2018

Mr. Eric Andersen, Administrator
The Estates At Bloomington LLC
9200 Nicollet Avenue South
Bloomington, MN 55420

RE: Project Number S5324027

Dear Mr. Andersen:

On December 19, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on December 1, 2017. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On January 24, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on January 12, 2018 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on December 1, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 10, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 1, 2017, effective January 10, 2018 and therefore remedies outlined in our letter to you dated December 19, 2017, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions.
Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: SW0F

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00169

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

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

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

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

6. DATE OF SURVEY **12/01/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **76** (L18)
13.Total Certified Beds **76** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: B (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	76			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Laura Glenn, HFE NEII 01/08/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 01/26/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
01111
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

December 19, 2017

Ms. Kimberly Lyon, Administrator
The Estates At Bloomington LLC
9200 Nicollet Avenue South
Bloomington, MN 55420

RE: Project Number S5324027

Dear Ms. Lyon:

On December 5, 2017, a standard 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 constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically delivered CMS-2567, whereby corrections are required.

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.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

> **Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> **Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;**
>
> **Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;**
>
> **Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and**

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

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

Eva Loch, Unit Supervisor
Metro D Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: eva.loch@state.mn.us
Phone: (651) 201-3792
Fax: (651) 215-9697

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by January 10, 2018, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by January 10, 2018 the following remedy will be imposed:

- Per instance civil money penalty. (42 CFR 488.430 through 488.444)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have

been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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:

• Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

• Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC 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. 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, 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. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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 March 1, 2018 (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). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was

issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

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 June 1, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245324	A. BUILDING _____ B. WING _____	12/01/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted November 28 thru December 1, 2017 during a recertification survey. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	E 000		
E 039 SS=C	EP Testing Requirements CFR(s): 483.73(d)(2) (2) Testing. The [facility, except for LTC facilities, RNHCIs and OPOs] must conduct exercises to test the emergency plan at least annually. The [facility, except for RNHCIs and OPOs] must do all of the following: *[For LTC Facilities at §483.73(d):] (2) Testing. The LTC facility must conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the following:] (i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the [facility] experiences an actual natural or man-made emergency that	E 039		1/10/18

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

Electronically Signed | 12/29/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245324	A. BUILDING _____ B. WING _____	12/01/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 039	Continued From page 1 requires activation of the emergency plan, the [facility] is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based. (B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For RNHCIs at §403.748 and OPOs at §486.360] (d)(2) Testing. The [RNHCI and OPO] must conduct exercises to test the emergency plan. The [RNHCI and OPO] must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the [RNHCI's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. This REQUIREMENT is not met as evidenced by:	E 039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245324	A. BUILDING _____ B. WING _____	12/01/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 039	Continued From page 2 Based on interview and document review, the facility failed to ensure they conducted exercises to test their emergency plan at least annually, including participation in a full scale and table top exercises. The findings include: During interview with the administrator and environmental services director at 10:15 a.m. on 12/1/17, they confirmed that although the facility has developed a training plan for emergency procedures, they have not yet conducted any table top or full scale exercises.	E 039	• The facility conducted a tabletop exercise on December 18, 2017. • Executive Director and Director of Nursing will both join the Metro Health and Medical Preparedness Coalition. Facility will plan to attend the next community exercise scheduled for May 16, 2018. • Executive Director is responsible for compliance.	
F 000	INITIAL COMMENTS A recertification survey was conducted November 28 through December 1, 2017. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.	F 550		1/10/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245324	A. BUILDING _____ B. WING _____	12/01/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 3 §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide a dignified dining experience for 1 of 4 residents (R38) reviewed for dignity with care.	F 550	• R38's Care plan has been updated to reflect his wishes as expressed by his responsible party. • All residents who are unable to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245324	A. BUILDING _____ B. WING _____	12/01/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 4 Findings include: R38's quarterly minimum data set (MDS) dated 11/11/17, revealed R38 had severe cognitive impairment and was dependent on staff for activities of daily living (ADLs) such as bed mobility, eating, transferring and personal hygiene. R38's face sheet printed 12/1/17, indicated R38 had the following diagnoses: Parkinson's disease, delusional disorders, dementia with behavioral disturbance, and dysphagia. R38 was observed on 11/29/17, at 7:20 a.m. in the dining room sitting in a tilted back Broada (a type of positioninig chair) causing R38 to be seated in a near laying position. R38's foot rest was not on, his legs bent at his knees which were angled pointing out of the chair. R38's eyes were closed and his mouth was open. At this time there were 3 other residents in the dining room and staff were coming and going. R38 sat in front of an emergency fire exit door which left him visible down the entire length of the 200 hallway where several staff, visitors, and other residents were observed. On 11/29/17, at 7:47 a.m. the therapeutic recreational coordinator placed a pillow under R38's feet. However, R38 remained otherwise in the same position with his eyes closed and his mouth open. On 11/29/17, at 8:09 a.m. R38 was tilted up in his Broada chair by nursing assistant (NA)-H, who then assisted R38 to eat cooked cereal. While	F 550	express their dignity preferences have the potential to be affected. Their care plans have also been reviewed and updated. • Education has been provided to staff related to this plan of correction. Staff members will be required to sit while providing feeding assistance and speak in a respectful manner. Responsible parties have been contacted and dignity preferences obtained. Dignity preferences for all residents who have the potential to be affected will be assessed upon admission, quarterly and as needed; these preferences will be documented in the resident care plan. • Therapeutic Recreation Director designee will audit five (5) resident experiences weekly to ensure compliance with plan of correction. Social Services Director or designee will audit five (5) resident charts monthly to ensure dignity preferences are documented in the care plan. Audits will continue for no less than three (3) months. Audit results will be discussed at QAPI meeting; Frequency of audits will be adjusted as needed based upon the recommendations of the QAPI committee. • Executive Director and Director of Nursing Services are responsible for monitoring compliance. • Date of completion January 10, 2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245324	A. BUILDING _____ B. WING _____	12/01/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 5	F 550		

R38 was eating, NA-H was heard to state in a curt manner, "open up, open up." NA-H would then provide R38 another spoonful of cereal even if the resident was still eating the previous bite. During the observation, breakfast cereal was observed to drip off the spoon, and/or NA-H would shake the spoon slightly allowing cereal to fall on a protective towel layin across R38's chest.

On 11/30/17, at 12:08 p.m. R38 was observed in the dining room seated in the Broada chair, being fed by the therapeutic recreational coordinator. The therapeutic recreational coordinator was observed throughout the meal to stand to R38's right side while feeding R38.

R38 was observed on 11/30/17, at 5:23 p.m. in the dining room sitting in his Broada chair. R38 was visible down the entire length of the 200 hallway. R38's feet were hanging over the calf rest approximately 4 inches above his ankles with no foot rest/support. R38's head was tilted back with his eyes closed and his mouth was open.

On 11/30/17, at 7:01 p.m. family member (FM)-A stated during interview that R38 was a private person who would not want to be seated in a public area with his eyes closed and his mouth open. FM-A stated this was not dignified.

On 12/1/17, at 8:15 a.m. licensed practical nurse (LPN)-B agreed the described positioning, and feeding methods were undignified.

On 12/1/17, at 9:01 a.m. the social worker stated when a resident such as R38 was not able to make his needs known, the facility staff should gather information from the family, such as R38's wife, to ensure R38's dignity was promoted.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245324	A. BUILDING _____ B. WING _____	12/01/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 6 R38's record lacked information regarding his dignify preferences. Although requested, no facility policies regarding dignity were provided.	F 550		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to properly store medications for 1 of 1 resident (R299) reviewed who kept his inhaler in his possession. Findings include: R299's facesheet printed 11/30/17, indicated he was admitted to the facility on 11/14/17, due to an acute exacerbation of chronic obstructive pulmonary disease (COPD) and chronic congestive heart failure (CHF). A physician's order dated 11/30/17, indicated R299 had an order for albuterol sulfate HFA aerosol solution 108 (90 base) mcg/act inhaler, but did not indicate that the inhaler could be kept at the resident's bedside. R299's assessment for self administration of medications (SAM) dated 11/15/17, indicated R299 was safe to self administer nebulizers and inhalers, but also indicated the resident's medications should be stored by nursing.	F 554	• R299 has been re-assessed for self-administration of medication and demonstrates ability to self-administer his medication. He now has orders to sore medication at the bedside per policy. • All residents who wish to self-administer medications have the potential to be affected. Their care plans have also been reviewed and updated. • Education has been provided to all staff related to this plan of correction. All residents wishing to self-administer medications will be assessed to ensure that they can safely do so. Nursing staff will obtain a physician's order to allow medication to be stored at bedside if they can do so safely. A care plan for administration and storage will be developed for all residents who wish to self-administer. All residents or their responsible party will be educated related to facility policy upon admission, quarterly and as needed. Unauthorized medications	1/10/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245324	A. BUILDING _____ B. WING _____	12/01/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 554	Continued From page 7 R299 was observed at 5:15 p.m. on 11/30/17 to be resting on his bed. An albuterol sulfate inhaler was observed on the over the bed table. At that time, R299 stated he routinely kept the inhaler in his pocket so it was available when he needed it. R299 stated he'd gotten the inhaler after his admission to the facility. Registered nurse (RN)- E was informed about the inhaler in R299's room, and was subsequently observed to attempt to remove the inhaler from R299's room on 11/30/17 at 5:42 p.m. R299 became very angry and refused to allow RN-E to take the inhaler out of his room. Following her attempts to take the inhaler out of the room, RN-E was interviewed and stated she would check the physician orders and R299's care plan to determine whether it was okay for the resident to have the medications at his bedside. RN-E stated the facility's routine procedure was to secure the medication in the medication cart or medication storage room until it could be verified the person had been assessed and had orders to have the inhaler at the bedside. On 12/01/17, 11:14 a.m. the director of nursing (DON) was asked what his expectation was when staff found medication stored in a resident's room. The DON stated he would expect a self administration of medication assessment to be done, and for the medication to be kept locked in a drawer at the bedside if it was determined the resident was safe to have medication at the bedside. The DON said if a resident was not determined to be safe to have medication at the bedside, then the medication should be secured in the medication cart or medication storage room. The DON also stated the resident's physician and social services would be included	F 554	found in a resident's room will be removed from their possession and stored by nursing until an assessment can be completed. • Director of nursing or designee will audit five (5) residents weekly to ensure compliance with the plan of correction. Audits will continue for no less than three (3) months. Audit results will be discussed at QAPI meeting; Frequency of audits will be adjusted as needed based upon the recommendations of the QAPI committee • Executive Director and Director of Nursing are responsible for ensuring compliance. • Date of completion January 10, 2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245324	A. BUILDING _____ B. WING _____	12/01/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 554	Continued From page 8 to discuss interventions and safety. Although requested, the facility's policy for self administration of medication was not received.	F 554		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks,	F 676		1/10/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245324	A. BUILDING _____ B. WING _____	12/01/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 676	Continued From page 9 §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide bathing services for 1 of 8 residents (R13) reviewed for activities of daily living (ADLs) and bathing. Findings include: During an interview with R13 on 11/28/17, she stated that she had not had a bath in the past three weeks. She stated that staff have not come to her or offered her a bath and that she has a specific day she gets the bath and prefers to have this about 4:30 p.m. on that designated day. R13 also stated her hair had not been washed in the past three weeks and that she was tempted to go to the beauty shop and "just do it myself". On 11/29/17 at 1:00 p.m., the director of nursing (DON) stated he was not sure what R13's bathing program was, and stated he had not heard that R13 was not getting bathed. At that time, the DON looked in the computer for nursing assistant documentation and did not find any evidence the resident had been bathed. The DON stated all residents should receive a bath at least weekly. Upon schedule review, the DON verified R13 should have received an afternoon/evening bath on Thursdays each week, and stated he would look into why this had not occured. On 11/30/17 at 1:57 p.m., the DON stated he'd spoken with therapy who had determined R13 would be safe to independently bath and wash her hair. On 11/30/17 at 7:30 pm, R13 stated, "the bath was so good I did not want to ever get out. It felt	F 676	• R13's care plan and assessments have been completed and are up to date. • All residents have the potential to be affected. Their care plans have also been reviewed and updated. • Education has been provided to Social Services and Nursing Staff related to this plan of correction. All residents bathing preference will be assessed upon admission, quarterly and as needed. Initial care plan will reflect bathing preference and level of assistance required; care plan will be completed in compliance with existing regulation. Level of assistance required, and bathing preferences will be communicated to direct care staff through PCC and POC. Preferences and level of assistance will be reviewed quarterly at care conferences and as needed. • Director of nursing or designee will audit five (5) residents to ensure compliance with the plan of correction. Audits will continue for no less than three (3) months. Audit results will be discussed at QAPI meeting; Frequency of audits will be adjusted as needed based upon the recommendations of the QAPI committee. • Executive Director and Director of Nursing are responsible for ensuring compliance. • Date of completion January 10, 2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245324	A. BUILDING _____ B. WING _____	12/01/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 676	Continued From page 10 so good". On 12/01/17 at 9:29 p.m., licensed practical nurse (LPN) B stated the nurse manager conducts the initial assessment according to the minimum data set (MDS) assessment nurse list. LPN-B stated when they got new admissions, they would try to do as much they could at the time of the admission. Nursing notes from 9/18/17 indicated the resident was alert and oriented and could communicate her needs. The documentation indicated she could independently bath. The note from 9/21/17 indicated the resident required supervision and extensive assist of 1 for bathing. The nursing notes dated 10/6/17 indicated R13 could bath and grooms herself after staff set her up with supplies. The facility's policy Shower/Tub Bath dated 2/15, described how to provide a bath, but did not include resident choice for bathing mode or frequency.	F 676		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide assistance with activities of daily living for 2 out of 8 residents reviewed (R2, R30) for activities of daily living assistance. Findings include:	F 677	" Care plan for residents R2 and R30 have been updated to reflect their care needs and preferences. " All residents who require assistance with activities of daily living have the potential to be affected. Their care plans have also been reviewed and updated. " All residents requiring assistance with	1/10/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245324	A. BUILDING _____ B. WING _____	12/01/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 11 According to the admission sheet, R2 was admitted to the facility on 5/11/17. An assessment conducted 8/18/17, indicated R2 was severely cognitively impaired. On 11/29/17 at 8:43 a.m., 11/30/17 at 7:24 p.m., and 12/1/17 at 8:38 a.m., R2's fingernails were observed to be untrimmed and dirty. The nail polish R2 was wearing was chipped. During interview on 12/1/17, at 9:19 a.m. nursing assistant (NA)-I stated she gave R2 bed baths when she worked with her. NA-I further stated she was unsure what showering or bathing routine R2 was supposed to have because she an agency assigned staff. During interview on 12/1/17, at 9:26 a.m. NA-H stated he does not work with R2 on bath days and is unaware of her bathing routine. NA-H stated when he worked with R2 he completed perineal cares only. During interview on 12/1/17, at 10:05 a.m. licensed practical nurse (LPN)-B stated R2 was a total assist for bathing. LPN-B also stated R2 was pleasant and did not exhibit behaviors or refusal of cares. LPN-B stated R2 should be receiving baths or showers weekly and that her bathing needs should be reflected on the nursing assistant assignment sheet. A bathing assessment for R2 was requested but not provided. R2's skin logs from 9/13-11/29/17 indicated weekly bed baths only were given. R2's nursing assistant care sheet indicated her	F 677	eating will be assisted during regularly scheduled meal times, or per personal preferences. All residents bathing preference will be assessed upon admission, quarterly and as needed. Level of assistance required, and bathing preferences will be communicated to direct care staff through PCC and POC. " Director of nursing or designee will audit five (5) residents to ensure compliance with the plan of correction. Audits will continue for no less than three (3) months. Audit results will be discussed at QAPI meeting; Frequency of audits will be adjusted as needed based upon the recommendations of the QAPI committee. " Executive Director and Director of Nursing are responsible for ensuring compliance " Date of completion January 10, 2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245324	A. BUILDING _____ B. WING _____	12/01/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 12	F 677		

bath days were on Wednesday evenings but did not indicate whether the resident should receive a shower or tub bath.

R2's care plan indicated the resident had a self-care deficit related to dementia. Interventions included bathing the resident by sponge bath only when a full bath or shower could not be tolerated.

The facility admission sheet indicated R30 had been admitted to the facility on 4/21/17. A Hospice Progress note indicated R30 had been admitted to hospice on 10/25/17.

On 11/28/17, at 10:30 a.m. R30 was observed to be attempting to independently eat breakfast in bed. The bedside table was observed in place over R30's bed and the resident was sitting up at about 60 degrees. R30 was noted to fidget with the bed controls, attempting to raise his head higher, however was unable to do this. He was asking for assistance to raise the head of his bed so he could reach his food. R30 was unable to answer more detailed interview questions due to confusion.

On 11/29/17, at 8:14 a.m. R30 was observed continuously from 8:14 a.m. to 9:14 a.m. No staff was observed to enter R30's room to assist him. At 8:14 a.m. a breakfast tray was delivered to R30. The tray remained on a bedside table located at the side of the resident's bed, R30 was sitting up at about 45 degrees. At 9:09 a.m. R30 was eating from the plate of food that he'd set on his stomach. There were large crumbs from the plate of food observed across his chest area. There was an unopened container also sitting on R30's stomach. R30 was reaching for a glass of orange juice from his bedside table. When asked

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245324	A. BUILDING _____ B. WING _____	12/01/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 13 whether he could drink from that position he stated, "I'm going to find out." R30 was observed to have difficulty reaching the orange juice and pushed the plate from his stomach back onto the bedside table. At that time, it was observed there was approximately 70% of food remaining on his plate. At 9:14 a.m. the juice remained untouched, R30 was resting with unopened cream of wheat still laying on his stomach and food crumbs on his chest. During interview on 11/30/17, at 7:07 p.m. nursing assistant (NA)-D stated R30 needed assistance with eating. NA-D stated sometimes he will eat bites of food if he is by himself but will not eat a full meal independently. During interview on 12/1/17, at 10:03 a.m. licensed practical nurse (LPN)-B stated R30 has declined recently due to being on hospice and now required assistance to eat. LPN-B stated staff were expected to offer help to residents who required assistance with eating. R30's nursing assistant care sheet indicated he required assist of 1 with eating.	F 677		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced	F 689		1/10/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245324	A. BUILDING _____ B. WING _____	12/01/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 14 by: Based on observation, interview and document review, the facility failed to ensure adequate supervision was provided to ensure safety while smoking for 1 of 1 resident reviewed for smoking (R9); and failed to ensure safety during the use of oxygen for 1 of 3 residents reviewed for oxygen use (R299). Findings include: According to the facility's admission sheet, R9 was admitted to facility on 3/22/16. The most recent minimum data set assessment dated 9/1/17, indicated R9 was cognitively intact. During an interview with R9 on 11/28/17 at 10:22 a.m., R9 stated he has no restrictions with smoking except that he was required to smoke on the facility's designated outdoor smoking patio. During the interview, it was observed R9 had two holes near the neckline of the Green Bay Packer jacket he was wearing. The holes measured approximately 1 inch by 2.5 inches and were located on either side of the zipper. R9 stated the holes were from smoking with the cigarette hanging out of his mouth while he was bending down to adjust his pants or shoes. However, stated it was his favorite jacket and he wore it often. When questioned, R9 was unsure when the burn holes had happened and there were no burns observed on his hands. On 11/30/17, at 11:57 a.m. R9 was observed independently wheeling himself down the hall with a cigarette in his hand. He was observed to proceed outside to the smoking patio and lit his cigarette.	F 689	• R9 has been reassessed for smoking safety and his care plan has been updated to include current smoking status. R299 discharged 12/13/17 per patient wishes. • All residents receiving oxygen therapy or who smoke have the potential to be affected. Their care plans have also been reviewed and updated. • Education has been provided to all staff regarding this plan of correction. Only Licensed nursing staff and certified nursing assistants will refill a portable liquid oxygen device. All residents will be assessed for smoking safety upon admission, quarterly and as needed. Interventions to ensure smoking safety will be care planned. Interventions to ensure smoking safety will be communicated to staff through POC and PCC. • Director of nursing or designee will audit five (5) staff members weekly to ensure compliance with the plan of correction. Audits will continue for no less than three (3) months. Audit results will be discussed at QAPI meeting; Frequency of audits will be adjusted as needed based upon the recommendations of the QAPI committee. • Executive Director and Director of Nursing are responsible for ensuring compliance. • Date of completion January 10, 2017	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245324	A. BUILDING _____ B. WING _____	12/01/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 15 During interview with licensed practical nurse (LPN)-B on 12/1/17 at 10:07 a.m., LPN-B said she'd never seen R9 smoke. She said if he did smoke, he must go off the property. LPN-B further explained that whenever she had completed R9's quarterly smoking assessments, R9 would tell her he doesn't smoke anymore. LPN-B stated she was unaware of any burn holes in R9's Green Bay Packer's jacket. R9's current care plan indicated he was at risk for a smoking related injury. Interventions included for staff to complete a smoking safety assessment per policy, to observe R9 for unsafe smoking behaviors, and to observe for attempts to obtain smoking materials from outside sources. Smoking evaluations conducted for R9 dated 8/29/17, and 11/28/17, indicated R9 had not been evaluated for safe smoking. No other smoking evaluations were provided. The facility's Resident Smoking Policy indicated the facility would evaluate residents to determine who is capable of smoking independently. It further indicated resident smoking would be monitored. On 11/28/17 at 9:46 a.m., R299 was observed to be sitting in his wheelchair in his room with liquid oxygen being administered via nasal cannula. On 11/29/17 at 8:39 a.m., a physical therapy assistant (PTA)-A was observed to fill a small	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245324	A. BUILDING _____ B. WING _____	12/01/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 16	F 689		

portable oxygen tank in R299's room, from a large liquid oxygen supply tank. R299 was sitting in his wheelchair next to the large tank of oxygen while PTA-A filled the portable tank. PTA-A was interviewed immediately after being observed to fill the small tank in R299's room. PTA-A acknowledged having filled the tank and of being unsure what the facility's policy was for filling portable oxygen tanks. PTA-A said she would not normally have filled the tang, but stated it was an emergency situation because R299's oxygen saturations dropped to 83% after activity and his portable tank was empty. PTA-A further confirmed being aware of the facility's oxygen filling room and again stated she would not normally fill a portable tank in the resident's room except in an emergency.

R299's facesheet indicated he had been admitted to the facility on 11/14/17 due to an acute exacerbation of chronic obstructive pulmonary disease (COPD) and chronic congestive heart failure (CHF). R299's physician orders dated 11/30/17, indicated an order for continuous oxygen at four to six liters per minute (lpm) to maintain his oxygen saturations (the level of oxygen in the blood) at greater than 90%. R299's care plan dated 11/30/17 included the use of oxygen in accordance with the orders as an intervention.

On 11/29/17, at 1:03 p.m. registered nurse (RN)-B was interviewed and stated that no one from therapy had made a report about R299's oxygen saturations having been low. When asked about the protocol for low oxygen saturations, RN-B stated that if R299's oxygen saturations were below 90%, the tank should be checked to make sure there was oxygen in it. In addition

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245324	A. BUILDING _____ B. WING _____	12/01/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 17	F 689		

RN-B verified the resident's oxygen dose was for 4-6 lpm. RN-B stated empty portable oxygen tanks are only to be filled in the oxygen filling room, and that it would never be okay to fill teh portable oxygen container in the resident room.

The director of nursing (DON) was interviewed on 11/29/17, at 1:10 p.m. He stated PTA-A should have gone to the nurse, nurse manager or himself to report the low oxygen saturations. Additionally the DON stated that nursing staff are trained when hired, and annually, about how and where to fill the portable oxygen tanks. The DON stated it was never okay to fill a portable oxygen tank in a resident room with the resident in the room, nor was it okay for a therapy assistant to fill an oxygen tank.

On 11/29/17, at 1:20 p.m. the physical therapy department supervisor (PT)-A stated he expected PTA-A to inform a nurse or therapist if a resident's oxygen saturations were low. PT-A stated PTA-A should have put R299 on the large tank until the portable was filled by nursing and should have notified the nurse. PT-A stated therapy assistants are trained to monitor oxygen saturation levels and blood pressures, and to assess and report findings to the nurse or a therapist.

The facility's Supplemental Oxygen Administration (13044) version #1 policy undated, indicated therapy staff are to collaborate with facility nursing staff regarding general guidelines used to assess a resident's use of supplemental oxygen. The policy also indicated that the procedure for administering and adjusting the liter flow of the oxygen was dictated by the physician orders.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245324	A. BUILDING _____ B. WING _____	12/01/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 18 The Aegis Therapy Skills Competency for Supplemental Oxygen Adminstration version number one not dated, was reviewed for PTA-A. The skills check off did not include any instruction for how or where to fill a portable oxygen canister.	F 689		
F 700 SS=E	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to assess and review for risks and benefits of the use of assistive devices including grab bars, for 4 of 9 residents (R6, R13, R29 & R36) reviewed for safety devices.	F 700	• Assessments for R6, R13, R36, R29 have been completed and care plans updated as needed. • All residents requiring assistance with bed mobility have the potential to be affected.	1/10/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245324	A. BUILDING _____ B. WING _____	12/01/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 700	Continued From page 19 Findings include: R6 was observed on 11/28/17 at 9:32 a.m., to have bilateral grab bars on her bed. At that time, R6 stated she uses the grab bar attached to her bed to pull herself up to a standing position enabling her to pivot transfer from the bed to her wheelchair. The medical record lacked any documented assessment of the potential risks, nor assessment of any alternatives for R6. R13 was observed on 11/28/17 at 1:16 p.m., to have bilateral grab bars on her bed. At that time, R13 stated she uses the grab bars to assist her with bed mobility, and to help her get from a lying to sitting position. The medical record lacked any documented assessment of the potential risk, nor assessment for alternatives for R13. R36 was observed on 11/28/17 at 2:40 p.m. to have bilateral grab bars on his bed. At that time, R36 stated he uses the grab bars to pull himself into bed from his chair, and to assist with positioning himself once in bed. R36 then demonstrated how he transferred into bed using the bilateral grab bars to get into bed, and then again to arrange his positioning while in bed. The medical record lacked any documented assessment of the potential risk, nor any assessment of alternatives options for R36. During interview with Minimum Data Set assessment nurse at 1:04 p.m., on 11/30/17, she verified there were no documented assessment	F 700	• Therefore, nursing department will assess each resident's need for bed mobility devices upon admission, quarterly and as needed. Bed rails will not be used for residents who have a significant safety risk factor. Bed rails will not be used unless there is no viable alternative. All residents requiring an assistive device for bed mobility will have a physician's order and appropriate interventions care planned per policy. Education has been provided to Maintenance Director and Nursing Staff related to this plan of correction. • Director of nursing or designee will audit five (5) residents weekly to ensure compliance with the plan of correction. Audits will continue for no less than three (3) months. Audit results will be discussed at QAPI meeting; Frequency of audits will be adjusted as needed based upon the recommendations of the QAPI committee. • Executive Director and Director of Nursing are responsible for ensuring compliance. • Date of completion January 10, 2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245324	A. BUILDING _____ B. WING _____	12/01/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 700	Continued From page 20	F 700		

for the use of assistive devices completed related to side rail or grab bar usage.

On 11/30/17, at 4:33 p.m. the director of nursing (DON) stated: it was "standard practice to complete assessments for side rails and grab bars for the residents".

On 12/01/17, at 9:29 a.m. licensed practical nurse (LPN)-B verified the nurses try to get the assessments done as soon after admission as possible. LPN-B acknowledged no assessments of the grab bar usage had been conducted for R6, R13 or R36.
R29's facesheet indicated that she was admitted to the facility on 10/4/17, with diagnoses including type 2 diabetes mellitus with diabetic neuropathy, end stage kidney disease and chronic anemia.

R29's care plan indicated that grab bars were to be used to assist with bed mobility.

On 11/28/17, at 3:29 p.m. R29 was observed to have side rails up on both sides of the bed. When the side rails were checked for secure fit, it was observed that the side rails were loose fitting on both sides. When asked about the side rails at that time, the resident stated she used the side rails to roll from side to side in bed.

Review of the medical record revelaed no assessment for the use of the side rail, nor alternatives.

On 11/30/17 at 2:00 p.m., registered nurse (RN)-D looked for an assessment and stated he didn't know why there was no side rail assessment in the chart. When RN-D checked with the nurse manager about the assessment,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245324	A. BUILDING _____ B. WING _____	12/01/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 700	Continued From page 21 the nurse manager told him she was just working on it at that time.	F 700		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide sufficient staff to meet the needs of the resident for 3 of 8 residents (R13, R15 & R 21) reviewed for assistance with care.	F 725	" Assessments for R13, R15 and R21 have been completed per facility policy. " All residents residing at this facility have the potential to be affected.	1/10/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245324	A. BUILDING _____ B. WING _____	12/01/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 22 Findings include: On 11/29/17 at 2:14 p.m. the director of nursing (DON) stated that staffing has been a challenge. When asked, he stated that they have added one more person to the day shift and p.m. shift to help due to the level of care the patients needed. When looking at staffing, they consider the straight census and the acuity of the resident and case mix index by facility and by wing. He explained that they have a daily meeting and discuss the staffing and if needed, he or other managers will help to cover the staffing gaps. They staff two nurses in the TCU due to the higher level of acuity and number of treatments such as dressing changes that are required. He stated that they have been using agency staff for a couple of months and this has helped. On the night of 11/28-29/17, they were not able to fill an open shift resulting in the staff working less one staff person and having to split the building for cares. He stated that at times like this, the nurses will do more of the direct cares and help the nursing assistants to meet the resident needs. He stated that on that night, they did work with the absolute minimum for the night shift. On 11/28/17, at 1:16 p.m. R13 reported that she had not had a bath in three weeks. "They do not have enough staff to take care of the residents. They are just too busy to do this". On 11/28/17, at 10:07 a.m. R21 stated the facility "is terribly understaffed. Some days you cannot find anyone". He further reported that his sheets on his bed had not been changed in months and felt this was due to staffing shortages.	F 725	" Therefore, facility will provide nursing staffing services according to the resident□s assessments and plan of care. Human Resources Director will work with corporate recruiter to assist in filling open positions. Interventions will include but are not limited to: attending job fairs, employment advertising and working with MDH approved staffing agencies as needed. Wages have been increased to compete effectively with surrounding facilities. A differential has implemented to encourage pickup of evening and overnight shifts. A committee has been created to develop and implement strategies for improving recruitment and retention activities. The committee will collect data and provide it to the QAPI committee for analysis. Recruitment and retention meeting will continue for no less than six (6) months. Frequency of the meetings will be adjusted as needed based upon the recommendations of the QAPI committee. " Executive Director and Human Resources Director are responsible for monitoring compliance. " Date of completion January 10, 2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245324	A. BUILDING _____ B. WING _____	12/01/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 23	F 725		

On 11/29/17, the director of nursing (DON) stated that he was not sure about the resident bath and had not heard that she was not getting bathed. He looked in the computer for nursing assistant documentation and did not find any evidence in the point of care system that the resident had been bathed. He verified that bathing should happen at least weekly. It was verified that R13 should have gotten a p.m. bath on Thursdays of each week. The DON stated that R 21 sleeps on his bed, but "Regardless of how he sleeps in or on his bed, they should be changed."

On 12/01/17, at 9:29 a.m. licensed practical nurse (LPN) B stated: "the nurse manager usually will do the assessments and initial assessments. The minimum data set (MDS) nurse will gather the information for when the assessments should be completed and will give this list to us. We try to make sure the documentation is getting done and the assessments are being completed. We try to do as much as possible. When we get a new admission, we will try to do as much can at the time of admission. We try to do as much as possible to get these done". Assessments were not completed for 3 of 3 residents (R6, R13, & R36). Care plans also lacked bathing for R13, grab bars for R6, R13, & R36.

On 11/29/17, at 1:00 p.m. R15 was interviewed and stated "just the other night" she had to wait an hour and a half for a pain pill. R15 stated her pain had increased as a result of the wait time.

On 11/30/17, at 6:11 p.m. family member (FM)-B stated staffing is not sufficient in the evenings to assure resident's get fed. FM-B stated he comes to feed his mother so he can be sure she is fed. FM-B stated the facility has two nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245324	A. BUILDING _____ B. WING _____	12/01/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 24 assistants and one nurse in the evening. Further, FM-B stated there are 4 residents in the dining room that need to be fed in addition to residents who eat in their rooms. On 11/30/17, at 6:25 p.m. NA-D stated there are 2 NAs on there hallway on the evening shift. NA-D stated there are approximately 8 residents that need to be fed dinner (4 in the dining room and 4 have room trays). NA-D stated she was thankful that residents' family members come to assist in feeding the residents. NA-D stated if the family members are not there they start at the top of the hallway and work down the length of the hallway to feed the residents. NA-D said she was unaware whether the last residents would eat or if their food was palatable. Further, NA-D stated if there are 2 NAs assigned on the shift each NA would have approximately 22-23 residents and therefore are not able to check and change all of the residents that need to be after breakfast. For example, NA-D stated when she cannot get to R38 after breakfast, he will be skipped and will be changed after lunch.	F 725		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by:	F 804		1/10/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245324	A. BUILDING _____ B. WING _____	12/01/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 804	Continued From page 25 Based on observation, interview and record review, the facility failed to provide meals at a palatable temperature and taste. This had the potential to impact all 48 residents and guests in the facility. Findings include: On 11/28/17, at 8:10 a.m. R44 stated the food was "OK sometimes and other times it was 'absolute crap.' " R44's minimum data set (MDS) assessment identified him as cognitively intact. On 11/28/17, at 8:30 a.m. R3 stated the food was "always cold" and didn't taste good. R3's 11/19/17, MDS identified him to have intact cognition. On 11/28/17, at 8:50 a.m. R37 stated the "food is bad and is always cold". R37 continued on to say the microwaves from the nursing units were taken away so the foods couldn't be re-heated unless the staff went to the kitchen. R37 stated when the microwaves were removed, they were just gone without warning or explanation. R37's quarterly MDS dated 11/10/17, identified he was cognitively intact. On 11/30/17, at 11:00 a.m. the culinary services manager (CSM) stated there was no formal process in place to monitor the distribution of meal trays. The CSM further stated cold food had been identified as a concern the facility was addressing through a quality improvement project. The CSM stated the meals were kept hot through the use of heated plate warmers with insulated lids. When the plate warmers were temped at that time, they registered at 212 degrees Fahrenheit. When the food was temped	F 804	• R44 is no longer at facility. R3, R37, R13, R19, R6, and R32 will have their food preferences re-evaluated. • All residents have the potential to be affected • Milk and cold beverages will be kept on beverage cart on ice and served when room tray is served. Microwaves will be returned to dining rooms. Hot bases will be brought to dining rooms during meals and used for residents who are not ready to eat immediately. Staff will be re-educated to keep heated bases and insulated covers on food until it is ready to be eaten, and to offer to warm resident's food if they feel it is cold. • Culinary Services Director or designee will interview at least 4 residents weekly to ensure satisfaction with food temperature and taste. • Executive Director and Culinary Services Director are responsible for monitoring compliance. • Date of Completion January 10, 2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245324	A. BUILDING _____ B. WING _____	12/01/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 804	Continued From page 26	F 804		

by the cook at tray line, all was over 150 degrees Fahrenheit (F). After all unit meal trays were passed, at 12:00 p.m. a test tray was reviewed. The chicken was 137.9 degrees F, macaroni and cheese was 142 degrees (F), and the peas with carrots was 140 degrees (F). The milk was 52.5 degrees (F). When tasted, the food was moist, flavorful and had good texture. The CSM stated she would develop a system to serve the milk/cold drinks colder for the room trays.

On 11/30/17, at 12:30 p.m. the CSM stated she did not know why the microwaves had been removed and was not part of that discussion. In order for food to be warmed, staff would need to bring the trays down to the kitchen for reheating. At 12:53 p.m. the director of nursing (DON) stated the microwaves were removed from the nursing units due to a concern that confused residents may use them and get burned. At 4:00 p.m. the administrator stated they were working on the concern of cold food through a quality improvement project. She said they had just developed the project, so it was a work in progress.

On 11/30/17, at 6:35 p.m., the CSM stated the steam table was not brought down to the dining room for supper as there was a concern about ensuring the food was hot when served. By utilizing the plate warmers with lids, the food could be maintained at appropriate temperature for a longer period of time until resident's arrived to the dining room and staff was available to assist them.

On 11/29/17, at 1:00 p.m. a resident council meeting took place where R13, R19, R6, R9, and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245324	A. BUILDING _____ B. WING _____	12/01/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 804	Continued From page 27 R32 were in attendance. The resident's complained the facility's food was not palatable. Further, R13, R19, R6, R9, and R32 stated when their food was served it was cold. They stated the facility had taken away the microwaves approximately a week ago so there was no method to re-heat the food.	F 804		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (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. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the resident refrigerator and freezer available on the Garden Unit, for any resident's use, was maintained in a clean and sanitary manner. This had the potential to affect any residents who used the unit to store their food.	F 812	• The cited refrigerator has been cleaned and disinfected per facility policy. • All residents who bring in food from outside sources have the potential to be affected. • Housekeeping will clean and disinfect the refrigerator weekly and as needed.	1/10/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245324	A. BUILDING _____ B. WING _____	12/01/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 28 Findings include: During initial observation on 11/28/17, at 9:01 a.m. the Garden Room refrigerator had tan, cream, purple spillage, crumbs, and build up throughout the entire refrigerator. The inside of the door contained 3 shelves all which were observed to have build up and spillage on them. The freezer was observed to contain a 10 x 10 centimeter of purple spillage, crumbs, and other build up throughout the freezer area. On 11/28/17, at 9:04 a.m. licensed practical nurse (LPN)-D verified how soiled the Garden Room refrigerator and freezer was. LPN-D stated nursing monitored the food but was unaware whose responsibility it was to clean it. On 11/28/17, at 9:06 a.m. the culinary services director (CSD) stated the Garden Room refrigerator needed to be cleaned but was unaware who was responsible to clean the unit. On the same day, at 9:13 a.m. nursing assistant (NA)-B was interviewed and stated nursing did not do anything with the refrigerator/freezer in the Garden Room. NA-B stated the dietary department was supposed to label food items and monitor the expiration dates. NA-B was unaware who was responsible to clean the unit. On 11/28/17, at 10:50 a.m. the housekeeping manager stated housekeeping deep cleans the refrigerator/freezer unit in the Garden Room once a month. The housekeeping manager stated the dietary department was to perform day to day cleaning. The housekeeping manager acknowledged how dirty the refrigerator/freezer	F 812	The Dietary Director or designee will complete an audit three (3) times weekly to ensure compliance with the plan of correction. Audits will continue for no less than three (3) months. Audit results will be discussed at QAPI meeting; Frequency of audits will be adjusted as needed based upon the recommendations of the QAPI committee. • Executive Director and Culinary Services Director are responsible for ensuring compliance. • Date of completion January 10, 2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245324	A. BUILDING _____ B. WING _____	12/01/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 29 was. On 11/30/17, at 5:30 p.m. the director of nursing (DON) stated dietary staff were to monitor the fridge/freezer from the Garden Room, and perform cleaning along with housekeeping to complete a deep clean routinely. On 12/1/17, at 8:19 a.m. the CSD stated the Garden Room refrigerator/freezer was for the residents' personal food items. The CSD stated the dietary department does not have involvement with this unit and stated she was unaware who was responsible for cleaning it. The facility's policy titled "Refrigerator" revised 9/12, indicated to clean per schedule of the facility. The facility's policy titled "Handling Food Brought in for Resident's Individual Consumption" dated 1/17, indicated the refrigerator and freezer cleanliness will be maintained by facility staff. Spills are to be cleaned promptly. Cleaning of the refrigerator will occur weekly.	F 812		
F 813 SS=D	Personal Food Policy CFR(s): 483.60(i)(3) §483.60(i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to have a process in place to ensure food was safely prepared and consumed for 1 of 1 (R21) residents reviewed	F 813	" R21 has been educated on facility policy related to facility personal food policy. " All residents who bring personal food	1/10/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245324	A. BUILDING _____ B. WING _____	12/01/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 813	Continued From page 30 who brought individual food into the facility. Findings include: R21's quarterly Minimum Data Set (MDS) dated 10/11/17, indicated R21 needed supervision and set up assistance with eating. R21's nursing progress notes included diagnoses of: mental disorders due to known physiological condition, anxiety disorder, unspecified psychosis, gastro-esophageal reflux disease, attention-deficit hyperactivity disorder, chronic obstructive pulmonary disease, and major depressive disorder. During initial observation on 11/28/17, at 9:01 a.m. the Garden Room freezer contained several packages labeled for R21 that contained raw hamburger, chicken, tenderloin, and sirloin steak. The findings were confirmed by licensed practical nurse (LPN)-D. On 11/28/17, at 9:13 a.m. nursing assistant (NA)-B was interviewed and stated R21 leaves the facility frequently to go grocery shop. NA-B stated she was aware that R21 took food from the freezer/refrigerator to the microwave but was unaware if R21 had raw food. On the same day, at 10:03 a.m. R21 stated he leaves the facility to go grocery shopping often. R21 stated he had several packages of hamburger, steak, and other raw food that he takes to a facility microwave to cook/heat it and eat for lunch and/or dinner. R21 stated he does this independently (without staff assistance) and cooks the food until it is no longer red and appeared to be done. R21 stated he does not have a system or time frames to ensure the food	F 813	into the facility have the potential to be affected. " Residents are prohibited from storing or preparing potentially hazardous foods such as raw meat, game or fish. The dietary department will be responsible for procurement, preparation and storage of potentially hazardous foods. Residents will be educated on personal food policy upon admission and as needed. • Culinary Services Director or designee will audit the contents of the resident refrigerator daily. Audits will continue for no less than three (3) months. Audit results will be discussed at QAPI meeting; Frequency of audits will be adjusted as needed based upon the recommendations of the QAPI committee. " Executive Director and Culinary Services Director are responsible for ensuring compliance. " Date of completion January 10, 2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245324	A. BUILDING _____ B. WING _____	12/01/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 813	Continued From page 31 is thoroughly cooked and safe for consumption. On 12/1/17, at 8:24 a.m. LPN-D stated she was aware of R21 warming up food during the late hours of the day. LPN-D was unaware of a process in place to ensure R21 was safely consuming his microwaved food. On 12/1/17, at 8:28 a.m. Registered Nurse (RN)-A was interviewed and stated R21 eats breakfast at the facility, however, eats his groceries for lunch and dinner. RN-A was aware that R21 had microwaved a raw pork loin to consume. RN-A was aware R21 had hamburger patties and stated "so he must cook raw meat in the microwave". RN-A was unaware of a facility process or policy in place to ensure R21 was consuming food safely. On 12/1/17, at 8:54 a.m. the director of nursing (DON) stated he expected staff to assist R21 with warming up food until there was a process and individualized care plan in place. The DON stated he expected dietary to assist and educate R21 on warming up raw food items. The facility's policy titled "Handling Food Brought in for Resident's Individual Consumption" dated 1/17, indicated that all food must be clean, free from spoilage, and safe for human consumption. Further, the policy stated resident's food brought in will be assessed by facility staff.	F 813		
F 836 SS=B	License/Comply w/ Fed/State/Locl Law/Prof Std CFR(s): 483.70(a)-(c) §483.70(a) Licensure. A facility must be licensed under applicable State and local law.	F 836		1/10/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245324	A. BUILDING _____ B. WING _____	12/01/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 836	Continued From page 32 §483.70(b) Compliance with Federal, State, and Local Laws and Professional Standards. The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. §483.70(c) Relationship to Other HHS Regulations. In addition to compliance with the regulations set forth in this subpart, facilities are obliged to meet the applicable provisions of other HHS regulations, including but not limited to those pertaining to nondiscrimination on the basis of race, color, or national origin (45 CFR part 80); nondiscrimination on the basis of disability (45 CFR part 84); nondiscrimination on the basis of age (45 CFR part 91); nondiscrimination on the basis of race, color, national origin, sex, age, or disability (45 CFR part 92); protection of human subjects of research (45 CFR part 46); and fraud and abuse (42 CFR part 455) and protection of individually identifiable health information (45 CFR parts 160 and 164). Violations of such other provisions may result in a finding of non-compliance with this paragraph. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the supplemental nursing service agency (SNSA) utilized by the facility was registered with the Minnesota commissioner, as required. This had the potential to affect approximately 12 residents who received services from the supplemental staff.	F 836	• All staffing agencies currently working at the facility are now verified to be licensed and registered. • All residents who receive care from supplementary staff have the potential to be affected. • The Staffing Coordinator and Human Resources Director as well as annLeo,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245324	A. BUILDING _____ B. WING _____	12/01/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 836	Continued From page 33 Findings include: During the entrance conference on 11/28/17, at 8:46 a.m. the administrator stated the facility utilized Datino LLC staffing agency to provide nursing coverage. On 11/30/17, at 5:30 p.m the administrator verified that Datino LLC was not listed as a currently registered SNSA on the State of Minnesota's approved SNSA list. On 12/1/17, at 10:28 a.m. the administrator confirmed licensed practical nurse (NA)-J had worked at the facility on 11/28/17, from 1:00 p.m to 10:00 p.m. and had provided care to residents. Communication from a health program representative at the Minnesota Department of Health indicated that Datino LLC had not been licensed and registered since they had relocated 9/21/17.	F 836	the facility's vendor management organization have been educated on utilizing the MDH's Directory of Registered Supplemental Nursing Services Agencies website to check that each agency sending staff to The Estates of Bloomington is from an approved staffing agency. • Audits will be completed weekly to ensure that the facility is not using anyone from an agency that is not listed on the MDH's Director of Registered Supplemental Nursing Services Agencies website. Audits will continue for no less than 3 months or until the facility is not using agency staff any longer. Audit results will be discussed at the QAPI meeting, frequency of audits will be adjusted as needed based on the recommendations of the QAPI committee. • Executive Director is responsible for ensuring compliance. • Date of completion January 10, 2018	
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been	F 883		1/10/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245324	A. BUILDING _____ B. WING _____	12/01/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 883	Continued From page 34 immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive	F 883		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245324	A. BUILDING _____ B. WING _____	12/01/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 883	Continued From page 35 the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 5 residents (R300) reviewed for immunizations, received or was offered the influenza vaccine. Findings include: According to the facility facesheet, R300 was admitted to the facility on 11/19/17, with a history of falls and diagnoses of Rhabdomyosis, and Type 2 Diabetes Mellitus. R300's immunization record dated 11/20/17, indicated R300 had received appropriate pneumonia vaccinations, but had not received an influenza vaccine since 12/14/15. There was no documentation in R300's record to indicate the influenza vaccination had been offered to the R300 since 2015. On 12/1/17, 9:10 a.m. the director of nursing (DON), who is also the infection preventionist for the facility, was interviewed about the facility's influenza vaccination program. The DON stated all residents are informed about the influenza vaccination, and consent forms are signed and placed in the residents' charts. Recommendations made by the Centers for Disease Control and Prevention in the Prevention and Control of Seasonal Influenza with Vaccines 2017-18 dated 10/11/17, recommends that anyone age 6 months or older receive the influenza vaccination unless it is contraindicated. R300's consent for vaccination was requested, but was not provided.	F 883	• R300 immunization status has been updated per resident preference. • All residents have the potential to be affected. • All current willing and eligible residents have been vaccinated per CDC & MDH regulations. Vaccination status of all admissions will be audited at the daily IDT clinical meeting. Education has been provided to Health Information Management, Nursing Staff and Social Services related to this plan of correction. Nursing management will be responsible for ensuring follow through with clinical IDT recommendations per CDC and MDH guidelines. Health Information Management officer will be responsible for informing the IDT of missing vaccinations and maintaining electronic records of immunization history. IDT will review immunization status quarterly at care conferences and provide recommendations as needed. DNS or designee will audit five (5) residents weekly to ensure compliance with the plan of correction. Audits will continue for no less than three (3) months. Audit results will be discussed at QAPI meeting; Frequency of audits will be adjusted as needed based upon the recommendations of the QAPI committee. • Executive Director and Director of Nursing are responsible for ensuring compliance. • Date of completion January 10, 2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245324	A. BUILDING _____ B. WING _____	12/01/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 909 SS=D	Resident Bed CFR(s): 483.90(d)(3) §483.90(d)(3) Conduct Regular inspection of all bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify areas of possible entrapment. When bed rails and mattresses are used and purchased separately from the bed frame, the facility must ensure that the bed rails, mattress, and bed frame are compatible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain assistive bed devices to prevent falls/safety for 4 of 9 residents (R6, R13, R36) reviewed for accidents. Findings include: During an interview on 11/28/17, at 9:32 a.m., R6 was noted to have bilateral grab bars on her bed. Both bars were loose and moved easily when tested. They were not secure to the frame of the bed. During an interview on 11/28/17, at 1:16 p.m. R13 was noted to have bilateral grab bars on her bed. Both bars were loose and moved easily when tested. They were not secure to the frame of the bed. During an interview on 11/28/17, at 2:40 p.m. R36, was noted to have bilateral grab bars on the bed. Both bars were loose and moved easily when tested. They were not secure to the frame of the bed. R36 stated that he does use the grab bars and was witnessed to have used them to pull himself into bed and to arrange his positioning while in bed. Once he was in the bed,	F 909	" All residents with bed mobility devices have the potential to be affected. All beds with such devices were assessed to ensure they were in functional order. " Education has been provided to Nursing Staff, Maintenance Director, Social Services and Housekeeping related to this plan of correction. All affected residents (R6, R13, R36, and R29) within the 2567 side rails have been addressed to work, as determined by the manufacturers recommendations. Equipment will be monitored daily by staff during routine cares, with MDS assessments and as needed. Maintenance will be updated and address work orders as needed. " Maintenance Director or designee will complete a monthly audit of resident beds or bed mobility devices to ensure compliance with this POC. Audits will continue for no less than three (3) months and be documented within Facility Maintenance tracker, Direct Supply Building TELS. Audit results will be	1/10/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245324	A. BUILDING _____ B. WING _____	12/01/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 909	Continued From page 37 he was able to reach the grab bar and pull himself over. In this movement, it was noted that the rail was loose and moved approximately two inches laterally, but also was able to move at the top of the bar toward and away from the bed. The grab bar was not secure to the frame. The rail was loose and when questioned, R36 stated, "It has been like that since I moved in here". On 11/28/17, at 3:29 p.m. R29 was observed to have side rails up on both sides of the bed. When the side rails were checked for secure fit, it was observed that the side rails were loose fitting on both sides. When asked about the side rails at that time, the resident stated she used the side rails to roll from side to side in bed. On 11/29/17, at 8:13 a.m. the interim administrator stated this is the way the rails are and they fit this way because the rails are designed to come down to a side rail position and be up for the grab bar. During an interview 11/29/17, at 9:40 a.m. the maintenance director stated "they were a poor design" and they would be loose when asked about rails for R6 and R13. Following this, the maintenance director was observed to evaluate the grab bar for R36 and stated he was not aware of it being loose. The maintenance director stated he had no preventative maintenance program for side rails or grab bars and there was no policy or procedure for this system.	F 909	discussed at QAPI meeting; Frequency of audits will be adjusted as needed based upon the recommendations of the QAPI committee. " Executive Director and Maintenance Director are responsible for ensuring compliance. " Date of completion January 10, 2018	
F 921 SS=C	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional,	F 921		1/10/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245324	A. BUILDING _____ B. WING _____	12/01/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 921	Continued From page 38 sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure a sanitary kitchen environment for food preparation and distribution. This had the potential to effect all 48 residents currently in house who receive their meals from the kitchen. Findings include: On 11/30/17, at 10:48 a.m. during tour with the culinary services manager (CSM), the following was observed. The large range stove top had 3 separate panels that could be lifted up. When raised up, the edges of each panel contained thick dried food debris and grease build up. The knobs on the front of the range contained a thick film of grease and dried food. The bottom panels under the oven doors were soiled with food debris and dried grease. Additionally, inside the oven the bottom rack had a worn off finish which was not cleanable. The sides and bottom on the inside of the oven were splattered with a dried dark substance. At that time, the CSM concurred with the findings and stated they had cleaned the stovetop and oven to the best of their ability. The CSM further stated the range may require a professional cleaning service. The kitchen also had a broken screen located in the window by the waterless steamer and can opener. The bottom of the screen couldn't latch and was pushed away from window frame approximately 3.5 inches. The screen was also heavily soiled with a thick, dark black substance, dirt, and white cottonwood type pollen. The screen by the mixer was also dirty with dirt, and a	F 921	" The large range stove top and oven identified in the 12/01/17 has been cleaned per manufacturer□s recommendations. Direct Supply Building TELS preventative maintenance tasks have been reviewed with the Maintenance Director and Culinary Services Director by the Administrator. Cleaning of the range hoods has been designated as a quarterly task. These audits and completion of Direct Supply Building TELS will be reviewed by the Facility QAPI Committee for continued compliance. " The broken screen identified in the 12/01/17 survey has been replaced by the Maintenance Director. The Administrator and Maintenance Director have completed physical plant rounds utilizing Physical Plant Rounds Audit Tools. Physical plant rounds with the Administrator and Maintenance Director will be completed on a bi-weekly basis for three months. Review of these audits will be reviewed by the Facility QAPI Committee. Continuing frequency of these audits will be reviewed and determined by the Facility QAPI Committee. " Front-line staff have been educated on the appropriate use of submitting work orders to the Maintenance Director via Direct Supply Building TELS to assist with preventative maintenance and equipment functioning. " The Administrator and Culinary	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245324	A. BUILDING _____ B. WING _____	12/01/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 921	Continued From page 39 white cottonwood type pollen. The CSM stated the screen by the can opener was broken and would need to be repaired. The CSM also agreed both screens were soiled and in need of cleaning. On 11/30/17, at 7:00 p.m., the maintenance director stated he had only been in the position for a couple of weeks. He stated there were some preventative maintenance plans in place, but this was something he needed to work on. "I'll get on it. We can get it cleaned up."	F 921	Services Director have together conducted an audit utilizing a kitchen observation audit tool. This audit tool will be completed by the Administrator and Culinary Services Director on a monthly basis for three months. Audits will be reviewed and shared with the QAPI committee on a monthly basis. Continuing frequency of the audits will further be determined by the Facility QAPI committee " Executive Director and Culinary Services Director are responsible for monitoring compliance. " Dates of Completion January 10, 2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245324	A. BUILDING **01 - MAIN BUILDING 01** B. WING ___	**12/05/2017**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on December 05, 2017. At the time of this survey, The Estates at Bloomington was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, the Health Care Facilities Code. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145	K 000		

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

Electronically Signed — 12/29/2017

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245324	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/05/2017**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 St. Paul, MN 55101-5145, OR By email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. The Estates at Bloomington is a 1-story building with a partial basement. The building was constructed at 3 different times with original building being constructed in 1957 and was determined to be of Type II (111) construction. In 1963, an addition was constructed and was determined to be of Type II (111) construction. Then in 1999, an addition was constructed and was determined to be Type II (111) construction. The facility is fully protected throughout by an automatic fire sprinkler system and has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 58 beds and had a census of 52 at time of the survey.	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245324	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/05/2017**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 353 SS=C	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and document review, the facility did not maintain and test their automatic fire sprinkler system in accordance with NFPA 25 and the 2012 LSC NFPA 101. 9.7.5, 9.7.7, 9.7.8. This deficient practice could effect all 52 residents. Findings include: On a facility tour between the hours of 1100 and 1500 on December 05, 2017, document review revealed that the facility could not provide	K 353	" Summit Company has completed a quarterly sprinkler test " The facility will have fire sprinkler drain tests and flow alarm tests completed quarterly as required and appropriately documented within Direct Supply Building TELS by the Director of Maintenance. " Quarterly sprinkler testing has been reviewed with the Maintenance Director via Direct Supply Building TELS. The Maintenance Director is responsible of ensuring records are upkept of required	1/10/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245324	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/05/2017**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 353	Continued From page 3 evidence of a quarterly fire sprinkler drain test or flow alarm test for the second quarter of 2017. This deficient practice was verified by the Director of Maintenance at the time of discovery.	K 353	testing. " The Director of Maintenance is responsible for compliance " Date of compliance: January 10, 2018	
K 521 SS=F	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility's heating, ventilation, and air conditioning in not in compliance with the 2012 LSC NFPA 101 9.2, 19.5.2.1 and NFPA 90A. This deficient practice could effect all 52 residents. Findings include: On a facility tour between the hours of 1100 and 1500 on December 05, 2017, document review revealed that the facility could not provide evidence of a current smoke or fire damper test from within the last four years. This deficient practice was verified by the Director of Maintenance at the time of discovery.	K 521	" Summit Company has completed the smoke damper test. " The facility will be in compliance with fire damper testing per regulations " Quarterly sprinkler testing has been reviewed with the Maintenance Director via Direct Supply Building TELS. The Maintenance Director is responsible of ensuring records are upkept of required testing. " The Director of Maintenance is responsible for compliance " Date of compliance: January 10, 2018	1/10/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245324	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/05/2017**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE