Electronically delivered
December 6, 2021

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

RE: CCN: 245324
Cycle Start Date: November 10, 2021

Dear Administrator:

On November 10, 2021, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Nicole Osterloh, RN, Unit Supervisor
Marshall District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102
Marshall, Minnesota 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230
Mobile: (507) 251-6264 Mobile: (605) 881-6192

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

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

If substantial compliance with the regulations is not verified by February 10, 2022 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by May 10, 2022 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245324	A. BUILDING _____ B. WING _____	C 11/10/2021

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

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F 000	INITIAL COMMENTS On 11/10/21, a standard abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found to be NOT in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaints were found to be UNSUBSTANTIATED: H5324125C (MN73758). H5324126C (MN78203) was also UNSUBSTANTIATED, however a related deficicnecy was cited at F609. The following complaints were found to be SUBSTANTIATED: H5324127C (MN76942) however NO deficiencies were cited due to actions implemented by the facility prior to survey. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations	F 609		12/16/21

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

Electronically Signed | 12/13/2021

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F 609	Continued From page 1 involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to report allegations of abuse for 1 of 4 residents (R6) to the State Agency (SA) immediately but no later than 2 hours. This had the potential to affect all 65 residents in the facility. Findings include: R6's Admission Record dated 11/10/21, indicated R6 had diagnoses of Wernicke's encephalopathy (disorder that can affect balance and movement). R6's significant change Minimum Data Set (MDS)	F 609	Incident was reported to the Minnesota Department of Health on 11/10/2021 at 14:00 and investigation initiated. Receptionist was re-educated on the facility Abuse Prohibition/Vulnerable Adult policy specific to the appropriate reporting timeframes. Current staff were also re-educated on the facility Abuse Prohibition/Vulnerable Adult policy specific to the appropriate reporting timeframes. Complaints of alleged abuse or neglect will be audited for reporting in the	

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F 609	Continued From page 2 dated 10/8/21, indicated R6 had no cognitive deficits. R6's MDS indicated R6 required a walker, supervision with eating and bed mobility and was independent with all other activities of daily living (ADLs). R6's Care Area Assessment (CAA) dated 10/11/21, indicated R6 triggered for falls and psychotropic drug use. R6's care plan dated 5/20/21, indicated R6 was a vulnerable adult and at risk for abuse. Interventions indicated for staff to follow the facility vulnerable adult and abuse reporting policy. During an interview on 11/10/21, at 9:20 a.m. R6 stated on 11/9/21, she was sitting on her walker when R2 attempted to go around R6 with her walker. R6 stated she was unable to move fast enough, so R2 hit R6 with R2's walker causing pain to her right foot. R6 stated she told the receptionist immediately after it occurred, and receptionist told R6 she should report the incident to a nurse. R6 stated she later told a nurse about the incident but was unable to recall which nurse. R2's Admission Record dated 11/10/21, indicated R2 had diagnoses of polyneuropathy (weakness, numbness, or pain to peripheral nerves), dementia with behavioral disturbance, and major depressive disorder. R2's quarterly MDS dated 10/8/21, indicated R2 had no cognitive deficits. The MDS indicated R2 had no behaviors or negative moods during the assessment period and was independent with all ADLs.	F 609	appropriate timeframe. Audits will be done weekly x4 and monthly x2. Results will be reported to the QAPI committee to determine the need for further monitoring or compliance	

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F 609	Continued From page 3 R2's CAAs dated 7/9/21, indicated R2 triggered for mood, falls, and psychotropic drug use. R2's care plan dated 9/7/21, indicated R2 had occasional outbursts including verbal aggression. Interventions included encouraging resident to avoid situations or people who trigger behaviors. The care plan also indicated R2 had a history of resident-to-resident altercations. During an interview on 11/10/21, at 10:36 a.m. receptionist stated R6 told her on 11/9/21, between 12:00 p.m. and 1:00 p.m. that R2 ran over R6's foot. Receptionist stated she felt the incident was reportable because R6 was having pain and advised R6 to report the incident to a nurse. Although receptionist received abuse training and stated she should immediately report any alleged abuse to a nurse or manager, receptionist gave no reason for failing to report the incident. During an interview on 11/10/21, at 3:33 p.m. the DON stated staff, regardless of their department, should immediately report any allegations of abuse to a nurse who would then report immediately to management. The DON stated management would then report the allegation to the SA within two hours. During an interview on 11/10/21, at 3:45 p.m. the administrator stated all staff should immediately report any allegations of abuse to management, the DON, or the administrator so they can report to the SA within two hours and put interventions in place to keep the residents safe. The facility Abuse Prohibition/Vulnerable Adult Plan dated 8/26/21, indicated all staff were	F 609		

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F 609	Continued From page 4 responsible for reporting any situation considered abuse. The policy indicated a supervisor would be notified immediately to ensure the safety of the residents. The policy further indicated suspected abuse would be reported to the SA no later than two hours after forming the suspicion of abuse.	F 609		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 6, 2021

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

Re: Event ID: 1H8X11

Dear Administrator:

The above facility survey was completed on November 10, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 11/10/21, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	2 000		

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2 000	Continued From page 1 The following complaints were found to be UNSUBSTANTIATED: H5324125C (MN73758). H5324126C (MN78203) was also UNSUBSTANTIATED, however a licensing order was issued at 1980. The following complaints were found to be SUBSTANTIATED: H5324127C (MN76942) however NO deficiencies were cited due to actions implemented by the facility prior to survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the	2 000		

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2 000	Continued From page 2 electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
21980	MN St. Statute 626.557 Subd. 3 Reporting - Maltreatment of Vulnerable Adults Subd. 3. Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4). (b) A person not required to report under the provisions of this section may voluntarily report	21980		12/16/21

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21980	Continued From page 3 as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to report allegations of abuse for 1 of 4 residents (R6) to the State Agency (SA) immediately but no later than 2 hours. This had the potential to affect all 65 residents in the facility. Findings include: R6's Admission Record dated 11/10/21, indicated R6 had diagnoses of Wernicke's encephalopathy	21980	Incident was reported to the Minnesota Department of Health on 11/10/2021 at 14:00 and investigation initiated. Receptionist was re-educated on the facility Abuse Prohibition/Vulnerable Adult policy specific to the appropriate reporting timeframes. Current staff were also re-educated on the facility Abuse Prohibition/Vulnerable Adult policy specific to the appropriate reporting timeframes.	

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21980	Continued From page 4 (disorder that can affect balance and movement). R6's significant change Minimum Data Set (MDS) dated 10/8/21, indicated R6 had no cognitive deficits. R6's MDS indicated R6 required a walker, supervision with eating and bed mobility and was independent with all other activities of daily living (ADLs). R6's Care Area Assessment (CAA) dated 10/11/21, indicated R6 triggered for falls and psychotropic drug use. R6's care plan dated 5/20/21, indicated R6 was a vulnerable adult and at risk for abuse. Interventions indicated for staff to follow the facility vulnerable adult and abuse reporting policy. During an interview on 11/10/21, at 9:20 a.m. R6 stated on 11/9/21, she was sitting on her walker when R2 attempted to go around R6 with her walker. R6 stated she was unable to move fast enough, so R2 hit R6 with R2's walker causing pain to her right foot. R6 stated she told the receptionist immediately after it occurred, and receptionist told R6 she should report the incident to a nurse. R6 stated she later told a nurse about the incident but was unable to recall which nurse. R2's Admission Record dated 11/10/21, indicated R2 had diagnoses of polyneuropathy (weakness, numbness, or pain to peripheral nerves), dementia with behavioral disturbance, and major depressive disorder. R2's quarterly MDS dated 10/8/21, indicated R2 had no cognitive deficits. The MDS indicated R2 had no behaviors or negative moods during the assessment period and was independent with all	21980	Complaints of alleged abuse or neglect will be audited for reporting in the appropriate timeframe. Audits will be done weekly x4 and monthly x2. Results will be reported to the QAPI committee to determine the need for further monitoring or compliance	

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	00169	A. BUILDING: _____ B. WING _____	C 11/10/2021

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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) COMPLETE DATE
21980	Continued From page 5 ADLs. R2's CAAs dated 7/9/21, indicated R2 triggered for mood, falls, and psychotropic drug use. R2's care plan dated 9/7/21, indicated R2 had occasional outbursts including verbal aggression. Interventions included encouraging resident to avoid situations or people who trigger behaviors. The care plan also indicated R2 had a history of resident-to-resident altercations. During an interview on 11/10/21, at 10:36 a.m. receptionist stated R6 told her on 11/9/21, between 12:00 p.m. and 1:00 p.m. that R2 ran over R6's foot. Receptionist stated she felt the incident was reportable because R6 was having pain and advised R6 to report the incident to a nurse. Although receptionist received abuse training and stated she should immediately report any alleged abuse to a nurse or manager, receptionist gave no reason for failing to report the incident. During an interview on 11/10/21, at 3:33 p.m. the DON stated staff, regardless of their department, should immediately report any allegations of abuse to a nurse who would then report immediately to management. The DON stated management would then report the allegation to the SA within two hours. During an interview on 11/10/21, at 3:45 p.m. the administrator stated all staff should immediately report any allegations of abuse to management, the DON, or the administrator so they can report to the SA within two hours and put interventions in place to keep the residents safe. The facility Abuse Prohibition/Vulnerable Adult	21980		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00169	A. BUILDING: _____ B. WING _____	C 11/10/2021

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21980	Continued From page 6 Plan dated 8/26/21, indicated all staff were responsible for reporting any situation considered abuse. The policy indicated a supervisor would be notified immediately to ensure the safety of the residents. The policy further indicated suspected abuse would be reported to the SA no later than two hours after forming the suspicion of abuse. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop/revise policies or procedures to ensure timely reporting of all allegations of abuse or neglect are within appropriate timeframes for reporting. The facility should re-educate staff identified in the citation to policies and procedures and audit all complaints of alleged abuse or neglect for a set determined time. The results of those audits should be taken to the Quality Assurance Performance Improvement (QAPI) committee to determine the need for further monitoring or compliance. TIME PERIOD FOR CORRECTION: 21 DAYS	21980		