

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: 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 Estates At Bloomington LLC December 6, 2021 Page 2

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 Estates At Bloomington LLC December 6, 2021 Page 3

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.

The Estates At Bloomington LLC December 6, 2021 Page 4

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Minnesota Department of Health Licensing and Certification Program

Kumalu Fishe Downing

Program Assurance Unit Health Regulation Division

Telephone: (651) 201-4112 Fax: (651) 215-9697

Email: Kamala.Fiske-Downing@state.mn.us

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

PRINTED: 12/27/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245324	B. WING				C	
NAME OF I	PROVIDER OR SUPPLIER	240024	D. Wiita		REET ADDRESS, CITY, STATE, ZIP CODE	11/	10/2021	
					0 NICOLLET AVENUE SOUTH			
THE EST	TATES AT BLOOMING	STON LLC		BL	OOMINGTON, MN 55420			
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F 000	INITIAL COMMEN	TS	F 0	000				
	completed at your finvestigation. Your	andard abbreviated survey was facility to conduct a complaint facility was found to be NOT in 2 CFR Part 483, Requirements a Facilities.						
	UNSUBSTANTIAT H5324126C (MN78	ED, however a related						
	SUBSTANTIATED:	plaints were found to be : H5324127C (MN76942) encies were cited due to ed by the facility prior to survey.						
	as your allegation of Departments acception of the enrolled in ePOC, yet the bottom of the	of correction (POC) will serve of compliance upon the otance. Because you are your signature is not required the first page of the CMS-2567 aic submission of the POC will tion of compliance.						
F 609 SS=D	onsite revisit of you	ed Violations	F 6	609			12/16/21	
		onse to allegations of abuse, n, or mistreatment, the facility						
	. , , ,	ure that all alleged violations						
LABORATOR'	Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE		TITLE		(X6) DATE	

Electronically Signed 12/13/2021

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		` IDENTIFICATION NUMBER. `		TIPLE CONSTRUCTION	СОМ	(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2 9200 NICOLLET AVENUE SOUT BLOOMINGTON, MN 55420	ZIP CODE		
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F 609	mistreatment, inclusource and misappare reported imme hours after the allest that cause the alleserious bodily injurthe events that cause and do not the administrator officials (including adult protective se for jurisdiction in loaccordance with Sprocedures. §483.12(c)(4) Repinvestigations to the designated represaccordance with Survey Agency, wiincident, and if the appropriate correct This REQUIREME by: Based on interview failed to report alleresidents (R6) to thimmediately but not the potential to affer facility. Findings include: R6's Admission R6R6 had diagnoses (disorder that can disorder t	age 1 agect, exploitation or uding injuries of unknown propriation of resident property, diately, but not later than 2 agation is made, if the events gation involve abuse or result in y, or not later than 24 hours if use the allegation do not involve result in serious bodily injury, to if the facility and to other to the State Survey Agency and revices where state law provides ang-term care facilities) in tate law through established ort the results of all e administrator or his or her entative and to other officials in tate law, including to the State thin 5 working days of the alleged violation is verified tive action must be taken. NT is not met as evidenced w and record review, the facility gations of abuse for 1 of 4 and record review, the facility gations of abuse for 1 of 4 and record review. This had beet all 65 residents in the	F 6	Incident was reported to Department of Health or 14:00 and investigation Receptionist was re-edufacility Abuse Prohibition policy specific to the apprime frames. Current stare-educated on the facili Prohibition/Vulnerable Ato the appropriate report Complaints of alleged al will be audited for report	n 11/10/2021 at initiated. Icated on the n/Vulnerable Adult propriate reporting ff were also ity Abuse dult policy specific ting timeframes.		

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

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	TIPLE CONSTRUCTION NG	СОМ	E SURVEY PLETED	
		245324	B. WING _			C 1 0/2021
	PROVIDER OR SUPPLIER	TON LLC		STREET ADDRESS, CITY, STATE, ZIP CO 9200 NICOLLET AVENUE SOUTH BLOOMINGTON, MN 55420		
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F 609	deficits. R6's MDS walker, supervision and was independed daily living (ADLs). R6's Care Area Ass 10/11/21, indicated psychotropic drug users of the control of the contro	cated R6 had no cognitive indicated R6 required a with eating and bed mobility ent with all other activities of sessment (CAA) dated R6 triggered for falls and use. Indicated R6 was a district at the district and abuse reporting and abuse reporting around R6 with her he was unable to move fast R6 with R2's walker causing at R6 stated she told the intelligence at the district and abuse reporting at R6 stated she told the intelligence at the should report the incident as the should report the incident as unable to recall which nurse. Cord dated 11/10/21, indicated of polyneuropathy (weakness, to peripheral nerves), avioral disturbance, and major	F 60	appropriate timeframe. Audit weekly x4 and monthly x2. Freported to the QAPI commit determine the need for further or compliance	Results will be ttee to	

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

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245324	B. WING				C 1 0/2021
	PROVIDER OR SUPPLIER	TON LLC		9	STREET ADDRESS, CITY, STATE, ZIP CODE 1200 NICOLLET AVENUE SOUTH BLOOMINGTON, MN 55420		
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F 609	R2's CAAs dated 7/ for mood, falls, and R2's care plan date occasional outburst Interventions includ avoid situations or part The care plan also resident-to-resident During an interview receptionist stated between 12:00 p.m over R6's foot. Recincident was report pain and advised R nurse. Although rectraining and stated any alleged abuse to receptionist gave not the incident. During an interview DON stated staff, reshould immediately abuse to a nurse wimmediately to man management would the SA within two her During an interview administrator stated report any allegation the DON, or the add to the SA within two place to keep the results.	/9/21, indicated R2 triggered psychotropic drug use. d 9/7/21, indicated R2 had is including verbal aggression. Ided encouraging resident to be people who trigger behaviors. Indicated R2 had a history of altercations. on 11/10/21, at 10:36 a.m. R6 told her on 11/9/21, . and 1:00 p.m. that R2 ran eptionist stated she felt the able because R6 was having 6 to report the incident to a peptionist received abuse she should immediately report to a nurse or manager, or reason for failing to report any allegations of the would then report any allegations of the would then report any allegation to ours. on 11/10/21, at 3:33 p.m. the egardless of their department, are port any allegations of the would then report any allegation to ours. on 11/10/21, at 3:45 p.m. the d all staff should immediately all staff should immediately and fabuse to management, ministrator so they can report to hours and put interventions in	F6	609			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODI 9200 NICOLLET AVENUE SOUTH BLOOMINGTON, MN 55420		10/2021
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F 609	abuse. The policy in notified immediately residents. The polic abuse would be rep	ge 4 orting any situation considered a supervisor would be to ensure the safety of the ey further indicated suspected ported to the SA no later than ning the suspicion of abuse.	F 6	09		



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

Minnesota Department of Health

Kumalu Fiske Downing

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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					11/1	0/2021
	PROVIDER OR SUPPLIER	9200 NIC	OLLET AVEN	STATE, ZIP CODE IUF SOUTH		
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2 000	Initial Comments		2 000			
	****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surve found that the defic herein are not corrected shall	Minnesota Statute, section ction order has been issued y. If, upon reinspection, it is iency or deficiencies cited ected, a fine for each violation be assessed in accordance ines promulgated by rule of artment of Health.				
	corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been compliance with all rule provided at the tag alle number indicated below. In several items, failure to the items will be considered Lack of compliance upon any item of multi-part rule will ment of a fine even if the item uring the initial inspection was				
	that may result from orders provided tha the Department witl	hearing on any assessments n non-compliance with these t a written request is made to nin 15 days of receipt of a nt for non-compliance.				
	at your facility by su Department of Heat found NOT in comp Licensure. Please in of correction you ha	TS: aplaint survey was conducted by the property of the Minnesota lth (MDH). Your facility was allowed with the MN State and the property of t				

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed 12/13/21

STATE FORM 6899 If continuation sheet 1 of 7 1H8X11

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '			(X3) DATE SURVEY COMPLETED		
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		00169		B. WING			C 1 0/2021
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	The following compuNSUBSTANTIATI H5324126C (MN78 UNSUBSTANTIATI was issued at 1980 The following compsuBSTANTIATED: however NO deficie actions implemented The Minnesota Deptocumenting the Sorders using Federal have been assigned statutes/rules for Nature transportation of the status of Deficiencies of Deficiencies of Deficiencies of Deficiencies of Deficiencies of Deficiencies of Comply portion of column also included violation of the status of This Rule is not mathematical transportation. You have agreed to receipt of State lice the Minnesota Deptormational Bullet https://www.health.complex.comp	ED: H5324125 3203) was also ED, however a blaints were for H5324127C (I encies were cit ed by the facilit bartment of He tate Licensing ral software. Ta d to Minnesota ursing Homes. Is in the far-left e state statute. If in the "Summ umn and repla the correction es the findings e statute after et as evidence lings are the Son and Time Po participate in ensure orders of artment of Hea tin 14-01, avail	c (MN73758). licensing order und to be MN76942) ed due to y prior to survey. alth is Correction ag numbers a state . The assigned column entitled /rule out of nary Statement .ces the "To order. This which are in the statement, by." Following uggested eriod for the electronic consistent with alth able at				
	on/infobulletins/ib14 orders are delineated Department of Heated you electronically. is necessary for State enter the word "CO"	4_1.html> The ed on the attace lth orders bein Although no plate Statutes/RuRRECTED" in	e State licensing ched Minnesota g submitted to an of correction ules, please the box				
	available for text. Y	ou must then it	ndicate in the				

Minnesota Department of Health

STATE FORM 6899 1H8X11 If continuation sheet 2 of 7

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
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		00169	B. WING			0/2021
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2 000	heading completion be corrected prior to the Minnesota Deprise enrolled in ePOC not required at the state form. PLEASE DISREGATOURTH COLUMN "PROVIDER'S PLATOURTH COLUMN TO FEDE THIS WILL APPEA	ensure process, under the a date, the date your orders will be electronically submitting to artment of Health. The facility and therefore a signature is bottom of the first page of ARD THE HEADING OF THE WHICH STATES, IN OF CORRECTION." THIS ERAL DEFICIENCIES ONLY. R ON EACH PAGE.	2 000			12/16/21
21980	Maltreatment of Vu Subd. 3. Timing of reporter who has revulnerable adult is lor who has knowled has sustained a phreasonably explained information to the condividual is a vulnerable the individual is a vulnerable to admission, unless (1) the individual was another facility and believe the vulnerable previous facility; or (2) the reporter k that the individual is in section 626.5572 (b) A person not	of report. (a) A mandated eason to believe that a being or has been maltreated, dge that a vulnerable adult ysical injury which is not ed shall immediately report the ommon entry point. If an erable adult solely because mitted to a facility, a mandated ired to report suspected e individual that occurred prior	21980			12/16/21

Minnesota Department of Health

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
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	9200 NIC			IUE SOUTH		
THE EST	TATES AT BLOOMING	TONIIC	GTON, MN			
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21980	known or suspected knows or has reason been made to the control (d) Nothing in this reporter from also reagency. (e) A mandated reason to believe the 626.5572, subdivision. If the retime believes that a agency will determine the reported error with the criteria under set 17, paragraph (c), control (directly to the lead a how the event mee 626.5572, subdivision (5). The lead agent with the criteria under set 17.	es. Is section requires a report of dimaltreatment, if the reporter on to know that a report has ommon entry point. Is section shall preclude a eporting to a law enforcement eporter who knows or has not an error under section on 17, paragraph (c), clause make a report under this reporter or a facility, at any in investigation by a lead ne or should determine that was not neglect according to ection 626.5572, subdivision clause (5), the reporter or a facility point or agency information explaining the criteria under section on 17, paragraph (c), clause ney shall consider this making an initial disposition of	21980			
	by: Based on interview failed to report alleg residents (R6) to th immediately but no	and record review, the facility gations of abuse for 1 of 4 e State Agency (SA) later than 2 hours. This had ct all 65 residents in the		Incident was reported to the Minne Department of Health on 11/10/20/14:00 and investigation initiated. Receptionist was re-educated on the facility Abuse Prohibition/Vulnerable policy appoints to the appropriate re-	21 at he le Adult	
		cord dated 11/10/21, indicated of Wernicke's encephalopathy		policy specific to the appropriate re timeframes. Current staff were als re-educated on the facility Abuse Prohibition/Vulnerable Adult policy to the appropriate reporting timefra	specific	

Minnesota Department of Health

STATE FORM 6899 1H8X11 If continuation sheet 4 of 7

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00160			C	
NAME OF		00169			11/10	0/2021
	PROVIDER OR SUPPLIER	9200 NICO	DRESS, CITY, S DLLET AVEN	STATE, ZIP CODE IUE SOUTH		
THE ESTATES AT BLOOMINGTON LLC			GTON, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
21980	Continued From pa	ge 4	21980			
	(disorder that can a	ffect balance and movement).				
	dated 10/8/21, indic deficits. R6's MDS i walker, supervision and was independe daily living (ADLs). R6's Care Area Ass 10/11/21, indicated psychotropic drug u	inge Minimum Data Set (MDS) cated R6 had no cognitive indicated R6 required a with eating and bed mobility ent with all other activities of essment (CAA) dated R6 triggered for falls and use. d 5/20/21, indicated R6 was a		Complaints of alleged abuse or newill be audited for reporting in the appropriate timeframe. Audits will weekly x4 and monthly x2. Results reported to the QAPI committee to determine the need for further monor compliance	be done s will be	
	vulnerable adult and Interventions indica					
	stated on 11/9/21, s when R2 attempted walker. R6 stated s enough, so R2 hit F pain to her right foo receptionist immedi receptionist told R6 to a nurse. R6 state	on 11/10/21, at 9:20 a.m. R6 she was sitting on her walker I to go around R6 with her he was unable to move fast R6 with R2's walker causing t. R6 stated she told the lately after it occurred, and she should report the incident ed she later told a nurse about is unable to recall which nurse.				
	R2 had diagnoses of numbness, or pain	cord dated 11/10/21, indicated of polyneuropathy (weakness, to peripheral nerves), avioral disturbance, and major r.				
	had no cognitive de had no behaviors o	dated 10/8/21, indicated R2 ficits. The MDS indicated R2 r negative moods during the and was independent with all				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. BUILDING	:		С	
		00169	B. WING			0/2021	
NAME OF	PROVIDER OR SUPPLIER	STRE	ET ADDRESS, CITY,	STATE, ZIP CODE			
THE ESTATES AT BLOOMINGTON LTC			NICOLLET AVE OMINGTON, MN				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	ΓΙΟΝ SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
21980	Continued From pa	age 5	21980				
	ADLs.						
		7/9/21, indicated R2 triggered psychotropic drug use.	ed				
	occasional outburs Interventions include avoid situations or The care plan also resident-to-resident During an interview receptionist stated	ed 9/7/21, indicated R2 had ts including verbal aggress ded encouraging resident to people who trigger behavior indicated R2 had a history t altercations. y on 11/10/21, at 10:36 a.m R6 told her on 11/9/21, and 1:00 p.m. that R2 rar	ion. ors. of				
	over R6's foot. Rec incident was report pain and advised R nurse. Although rec training and stated any alleged abuse	ceptionist stated she felt the able because R6 was having to report the incident to a ceptionist received abuse she should immediately reto a nurse or manager, o reason for failing to repo	e ng a port				
	DON stated staff, re should immediately abuse to a nurse w immediately to mar	on 11/10/21, at 3:33 p.m. egardless of their department of the report any allegations of the would then report the DON stated of then report the allegation tours.	ent,				
	administrator stated report any allegatio the DON, or the ad to the SA within two place to keep the re	on 11/10/21, at 3:45 p.m. d all staff should immediate ons of abuse to manageme lministrator so they can repo hours and put intervention esidents safe.	ely nt, ort ns in				

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PRINTED: 12/27/2021 **FORM APPROVED** Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: ___ C B. WING 00169 11/10/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 9200 NICOLLET AVENUE SOUTH THE ESTATES AT BLOOMINGTON LLC **BLOOMINGTON, MN 55420** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 21980 Continued From page 6 21980 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

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