



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

June 17, 2022

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

RE: CCN: 245324
Cycle Start Date: May 19, 2022

Dear Administrator:

On May 27, 2022, we informed you that we may impose enforcement remedies.

On June 7, 2022, the Minnesota Department(s) of Health completed a survey and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F)), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Directed plan of correction, Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.
- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective August 1, 2022.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective August 1, 2022. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective August 1, 2022.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for

new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose a civil money penalty. You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

- Civil money penalty. (42 CFR 488.430 through 488.444)

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than \$11,292, has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by August 1, 2022, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, The Estates At Bloomington Llc will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from August 1, 2022. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.

- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by November 19, 2022 (six months after the

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

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

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at <https://dab.efile.hhs.gov> no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

**Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462**

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

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

The Estates At Bloomington LLC

June 17, 2022

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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

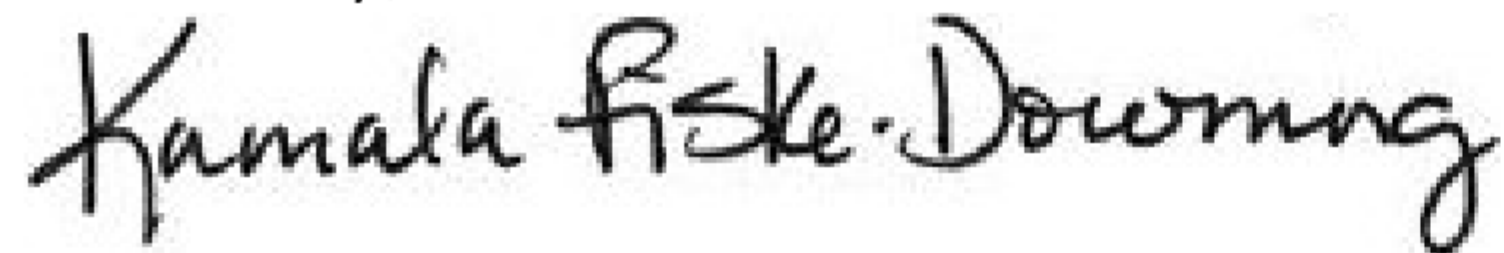
This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltr_idr.cfm

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
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: 07/07/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245324	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/07/2022
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT BLOOMINGTON LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 9200 NICOLLET AVENUE SOUTH BLOOMINGTON, MN 55420		
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F 000	INITIAL COMMENTS On 6/6/22, through 6/7/22, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The complaint H53241994C (MN83903), was found to be SUBSTANTIATED with a deficiency cited at (F880). In addition, the complaint H53242053C (MN83998) was SUBSTANTIATED 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 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control	F 880			7/1/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/27/2022

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

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F 880	Continued From page 1 program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct	F 880			

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F 880	Continued From page 2 contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the use of personal protective equipment (PPE) was implemented to prevent the spread of COVID 19 per guidance by the Centers for Disease Control (CDC) when staff were observed not wearing eye protection and appropriately using and handling other personal protective equipment (PPE) before and after assisting residents. This had the potential to affect all residents residing at the facility. Findings include: During the entrance to the facility on 6/6/22, at 7:50 a.m. registered nurse (RN)-A stated she was not certain of the number, but the facility currently had more than five residents who had tested positive of COVID positive and the rooms had signs at the doors and there was contact carts with PPE outside the rooms.	F 880	The facility currently has no residents on precautions. All like residents based off of record review and resident interview do not present with signs and symptoms of covid-19. Facility is following the CDC guidelines for enhanced respiratory precautions including donning/doffing, source control masks, and proper use of gowns. Transmission-based precautions grid/procedure was reviewed and remains current. Staff education has been initiated and will remain ongoing regarding CDC guidelines for transmission-based precautions, appropriate PPE usage and donning and doffing of PPE. The Director of Nursing or designee will		

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F 880	Continued From page 3 100 & 200 Wings: During continuous and random observations on 6/6/22, the following were observed throughout the facility: -At 7:50 a.m. a dietary aide (DA)-A was observed wearing a surgical mask with regular reading glasses as she pushed a beverage cart from the kitchen into the 100 Wing as she went past three residents in the hallway. -At 7:53 a.m. a Northwest respiratory staff (NWR)-A delivering Oxygen tanks was observed go down the 100 Wing and was wearing a surgical mask and his eye protection was on top of his head. At this same time NWR-B staff was observed to go down the 200 Wing wearing only a surgical mask with no eye protection. Both vendors were observed going in and out of resident rooms without proper PPE. -At 7:57 a.m. housekeeping staff was observed going in and out of resident rooms with residents in the rooms cleaning down the 200 Wing and was only wearing a surgical mask without eye protection. When asked about eye protection, she stated she had a face shield and was supposed to wear it but it was in the utility room. She then left the area and went to get it and applied it before proceeding. During tour of the facility on 6/6/22, at 7:58 a.m. PPE carts, small white trash cans and enhanced respiratory precautions signs which directed staff to wear a gown, N95 respirator or higher level respirator, eye protection (goggles or face shield) one pair of gloves and a sign for all visitors to see the nurse before entering the rooms were observed hanging on doors of the following resident room: R1, R6, R7, R10, R11 and R13.	F 880	complete audits of all shifts four times a week for one week, then twice a weekly for one week until compliance is met. QAPI committee will review results of audits and monitoring. Audits will consist of DON/Designee auditing proper use of donning/doffing PPE, aerosolized generating procedures, proper use of gowns, and source control masking for staff, visitors, and residents. At the successful completion of the DPOC, the facility will provide required documents as described in the DPOC, Checklist: Documents Required for Successful Completion of the Directed Plan		

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F 880	Continued From page 4 -At 7:59 a.m. licensed practical nurse (LPN)-A was observed inside R7's room and was wearing a blue disposal gown not tied in the back, a surgical mask and eye protection on top of her head as she administered medications to R7. LPN-A then came out of the room and approached the medication cart after cleansing her hands but never removed the gown, changed the mask and the eye protection remained on top of her head. -At 8:00 a.m. nursing assistant (NA)-C was observed coming out of R14's and R16's room and was wearing a surgical mask with regular reading glasses and her eye protection was hanging down her chest. When asked about the eye protection, NA-C stated she was supposed to wear them and was looking for them. -At 8:02 a.m. LPN-A verified all the resident rooms in the 100 Wing with PPE carts outside and signs on the doors had tested positive for COVID-19 which were R1, R6, R7, R10 and R13. -At 8:03 a.m. LPN-A was observed set up medications and she went into R6 and R10's room who both were COVID positive wearing still the blue plastic disposable gown which was not fastened in the back, with eye protection and a surgical mask. -At 8:10 a.m. LPN-A came out of R6 and R10's room and as she still wore all the PPE, she came into the hallway, then removed the gown outside the room, then went down the hallway and disposed the gown in a garbage can outside room R7's room. LPN-A was then observe washing her hands before she used a Super Sani-Cloth PDI cloth wipe to clean the vital sign machine. LPN-A never changed her mask and did not clean the eye protection after she had exited R6 and R10's room which had a enhanced	F 880			

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F 880	Continued From page 5 respiratory precautions sign. On 6/6/2022, at 8:24 a.m. NA-A and NA-C were observed passing breakfast trays down the 100 Wing which included the rooms with COVID positive residents. During the observation, the following was observed: -At 8:28 a.m. NA-C applied PPE and went into R7's room. -At 8:31 a.m. NA-C came out of room then took the right glove off then using the left gloved hand touched the doorknob and was heard tell R7 the door had to be closed as she shut it. NA-C then came out to the hallway then removed the left glove then proceeded to remove the gown, rolled it and disposed of it in the garbage can in the hallway and then cleansed her hands. NA-C then reached into the clean PPE cart took another gown, applied it and then entered R6's room which was a COVID room. -At 8:35 a.m. NA-C came out of R6's room into the hallway wearing the gown and gloves as she shut the door. NA-C then in the middle of the hallway removed the gown and rolled it up after removing the gloves and as she was attempting to dispose it into the trash can, she stated the garbage can was broken. NA-C was then observed use the cover to push the used gowns which were overflowing to the floor and then covered the trash can. NA-C then cleansed her hands after. During the entire observation of NA-C she was not wearing N95 respirator going into the COVID-19 positive rooms and did not clean her eye protection after coming out of the rooms. -At 8:40 a.m. NWR-B staff was observed go into R14 and R16's room wearing a surgical mask with no eye protection and during the observation, both residents were seated in wheelchairs as	F 880			

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F 880	Continued From page 6 vendor approached them less than 6 feet distance. -At 8:41 a.m. NA-E was observed wheeling a resident out of the Subacute unit and NA-E had a face shield on however she had it flipped up to the top of her head. -At 8:44 a.m. NA-A went into R13's room to deliver the breakfast tray wearing a blue disposal gown, regular surgical mask and face shield. When she came out of the room at 8:45 a.m. she was not wearing a N95 respirator, she removed the gown in the hallway and did not change the mask. -At 9:13 a.m. NA-A was observed come out of the R7's after answering the call light in the room, she removed the gown outside the room and as she disposed the gown in the small garbage can she reached into the garbage can and pushed the gowns down then cleansed her hands with hand sanitizer before proceeding to leave the unit. Subacute Unit: On 6/6/22, at 9:20 a.m. RN-B and trained medication aide (TMA)-A were both observed standing at the medication carts by the nursing station and during the observation, both staff were wearing their eye protection on top of their heads and R3 was seated on the wheelchair between the two which was less than six feet. When asked about the PPE cart outside R11's room, RN-B stated R11 had tested positive for COVID-19. -At 9:22 a.m. the physical therapist (PT)-A was observed completing a session with R5 in the hallway walking beside R5 less than six feet, was wearing a surgical mask with reading glasses and had no eye protection. -At 9:23 a.m. RN-B was observed go into R4's room to administer medications and was only	F 880			

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(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 880	Continued From page 7 wearing a surgical mask without eye protection. During the observation, RN-B stood less than feet as he assisted R4. On 6/6/22, at 2:05 p.m. LPN-A was observed standing right next to resident with her eye protection on top of her head. During interview on 6/6/22, at 8:48 a.m. NA-A acknowledged she had been walking down the hallway with the same gown after leaving rooms with COVID-19 positive residents. NA-A stated, "I thought we can go into the room and if we did not touch them, we can come out of the room and go to another COVID room." NA-A acknowledged she was not wearing N95 mask going into the COVID rooms and she should have follow the precaution sign at the doors. During interview on 6/6/22, at 8:50 a.m. NA-C acknowledged she also did wear a regular mask into the COVID positive rooms instead of the N95 and had not changed the surgical mask between the room and even after. NA-C stated she got mixed information about what she was supposed to do regarding what PPE to use when going into COVID positive rooms. NA-C then asked surveyor what they were supposed to do and was directed to the director of nursing (DON). NA-C then was observed removed the regular mask she had used during the entire observation and applied a N95. During interview on 6/6/22, at 8:56 a.m. RN-A stated staff was supposed to wear a gown, gloves, shoe covers, goggles or face shield and N95 when going into COVID-19 positive rooms. RN-A further stated the staff was supposed to remove the gowns in the rooms and when they	F 880			

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

PRINTED: 07/07/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245324	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/07/2022
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F 880	Continued From page 8 came out of the room they would change the mask and clean the eye protection. During interview on 6/7/22, at 11:13 a.m. LPN-A acknowledged for not following the appropriate PPE usage and not following the precautions at the door. LPN-A stated she knew what to do but had not paid attention. LPN-A stated usually she removed the gown outside the room in the hallways as this was how they did it. LPN-A further stated "After you brought it up, we were told we are supposed to take it off in the room. It's hard to breath in those things and it's hard to go in and out of the room because there are two residents in the rooms so it takes time but that's not an excuse." During a follow up interview on 6/6/22, at 12:42 p.m. at 12:45 p.m. with the administrator and DON present, NA-C stated they did not know they were supposed to remove the gowns inside the room after being in a COVID-19 room. She acknowledged this was how they had done it the whole morning during the observations. The DON stated he had also gone over education with the staff and was going to do more education with staff. The DON also stated the staff was supposed to remove the gowns in the rooms and then were supposed to use the small trash cans to dispose the masks after leaving the rooms and staff was not supposed to walk down the hallway with the gowns worn in positive resident rooms. At 12:52 p.m. the DON and administrator both stated all staff was supposed to wear goggles/face shield and mask when in resident care areas and when getting in contact with residents they should have eye protection. During interview on 6/6/22, at 2:14 p.m. the DON	F 880			

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

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F 880	Continued From page 9 stated the staff was not supposed to use their bare hands to push used gowns in the garbage when full. He stated the staff was supposed to wear gloves and were to wash hands after. He further stated staff was supposed to wear N95's to go into COVID rooms and they had started on education, and he acknowledged he had made observations of staff doing the same that morning. The DON stated since 5/26/22, to 6/1/22, the facility had 9 resident who had tested positive for COVID-19 and two or three of them had contracted the virus from the community during the holiday weekend as the resident families had called the facility and requested the residents to be tested. The facility Use Personal Protective Equipment (PPE) When Caring for Patients with Confirmed or Suspected COVID-19 CDC adopted policy dated 3/30/20, directed "-PPE must be donned correctly before entering the patient area (e.g., isolation room, unit if cohorting). -PPE must remain in place and be worn correctly for the duration of work in potentially contaminated areas. PPE should not be adjusted (e.g., retying gown, adjusting respirator/facemask) during patient care. -Put on NIOSH-approved N95 filtering facepiece respirator or higher (use a facemask if a respirator is not available). If the respirator has a nosepiece, it should be fitted to the nose with both hands, not bent or tented. Do not pinch the nosepiece with one hand. Respirator/facemask should be extended under chin. Both your mouth and nose should be protected. Do not wear respirator/facemask under your chin or store in scrubs pocket between patients. * -Put on isolation gown. Tie all of the ties on the	F 880			

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F 880	Continued From page 10 gown. Assistance may be needed by another HCP..."	F 880			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 17, 2022

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

Re: Event ID: QEXX11

Dear Administrator:

The above facility survey was completed on June 7, 2022 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,

A handwritten signature in black ink that reads 'Kamala Fiske-Downing'.

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



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

June 17, 2022

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

RE: CCN: 245324
Cycle Start Date: May 19, 2022

Dear Administrator:

On May 27, 2022, we informed you that we may impose enforcement remedies.

On June 7, 2022, the Minnesota Department(s) of Health completed a survey and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F)), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Directed plan of correction, Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.
- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective August 1, 2022.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective August 1, 2022. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective August 1, 2022.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for

new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose a civil money penalty. You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

- Civil money penalty. (42 CFR 488.430 through 488.444)

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than \$11,292, has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by August 1, 2022, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, The Estates At Bloomington Llc will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from August 1, 2022. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.

- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by November 19, 2022 (six months after the

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

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

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at <https://dab.efile.hhs.gov> no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

**Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462**

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

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

The Estates At Bloomington LLC

June 17, 2022

Page 5

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

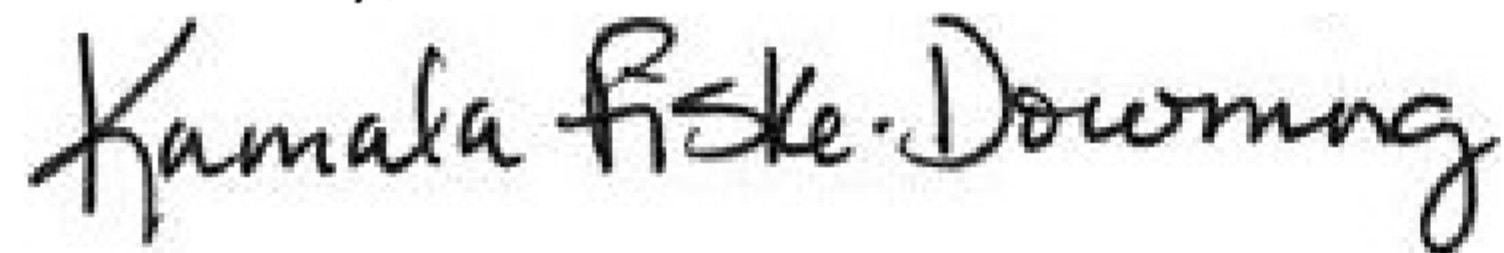
This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltr_idr.cfm

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
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 17, 2022

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

Re: Event ID: QEXX11

Dear Administrator:

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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,

A handwritten signature in black ink that reads 'Kamala Fiske-Downing'.

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
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 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00169	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/07/2022
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT BLOOMINGTON LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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
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 6/6/22, through 6/7/22, 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		

Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/27/22

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00169	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/07/2022
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT BLOOMINGTON LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 9200 NICOLLET AVENUE SOUTH BLOOMINGTON, MN 55420		
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2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H53241994C (MN83903) & H53242053C (MN83998) no licensing orders were issued. The Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000			