DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
June 16, 2026

Administrator
Presbyterian Homes Of Bloomington
9889 PENN AVENUE SOUTH
BLOOMINGTON, MN 55431

RE: CCN: 245556
Cycle Start Date: April 24, 2026

Dear Administrator:

On June 12, 2026, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

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June 16, 2026

Administrator
Presbyterian Homes Of Bloomington
9889 PENN AVENUE SOUTH
BLOOMINGTON, MN 55431

Re: Reinspection Results
Event ID: 22F49E-H2

Dear Administrator:

On June 12, 2026 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on April 24, 2026. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 6, 2026

Administrator
Presbyterian Homes Of Bloomington
9889 PENN AVENUE SOUTH
BLOOMINGTON, MN 55431

RE: CCN:245556
Cycle Start Date: April 24, 2026

Dear Administrator:

On April 24, 2026, a survey was completed at your facility by the Minnesota Department of Health 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" and/or an "E" tag), i.e., the plan of correction should be directed to:

Lisa Krebs, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

If substantial compliance with the regulations is not verified by July 24, 2026 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by October 24, 2026 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social

Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution
This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.
A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

DEPARTMENT OF HEALTH

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Electronically delivered
May 6, 2026

Administrator
Presbyterian Homes Of Bloomington
9889 PENN AVENUE SOUTH
BLOOMINGTON, MN 55431

Re: State Nursing Home Licensing Orders
Event ID: 22F49E-H1

Dear Administrator:

The above facility survey was completed on April 24, 2026 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 one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the

statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

Lisa Krebs, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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

Please feel free to call me with any questions.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245556	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Presbyterian Homes Of Bloomington	**9889 PENN AVENUE SOUTH , BLOOMINGTON, Minnesota, 55431**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS On 4/22/26 to 4/24/26, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed: H55561097C (2971477) with deficiency cited at F842. 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.	F0000		06/10/2026
F0842 SS = D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5),483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that	F0842	This Plan of Correction and the responses to each F-Tag are submitted to maintain certification in the Medicare and Medicaid programs and constitute a credible allegation of compliance. The written responses do not constitute an admission of noncompliance or agreement with any findings stated under the F-Tags. The facility reserves the right to dispute all findings and deficiencies in any appropriate forum, including in an independent dispute resolution, or, if appealable remedies are subsequently imposed, by timely appeal to the Department Appeals Board. F0842 Resident Records Identifiable information. Based on interview and document review, the facility failed to maintain a complete and accurately documented medical record in accordance with accepted professional standards and practices for 2 of 3 residents (R1, R3) reviewed for change of	06/10/2026

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 reverse for further 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245556	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Presbyterian Homes Of Bloomington	**9889 PENN AVENUE SOUTH , BLOOMINGTON, Minnesota, 55431**

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F0842 SS = D	Continued from page 1 are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident;	F0842	Continued from page 1 condition and oxygen use. The facility reviewed the Medication Administration Policy and the Oxygen Administration Policy. These policies are current and in effect. Resident R1 (Discharged): The facility conducted a retrospective review of R1's medical record following discharge and identified gaps in documentation related to the clinical respiratory assessment and rationale for supplemental oxygen use on 2/11/26. No adverse outcomes identified related to the documentation deficiency. Staff involved in the resident's care received re-education on respiratory assessment requirements, documentation expectations when supplemental oxygen is initiated, discontinued, or resumed. Resident R3 (Discharged): The facility conducted a comprehensive retrospective review of R3's medical record following discharge and identified supplemental oxygen use during daytime hours that was not supported by the nursing staffs documentation. The facility verified that care provided during the resident's stay was clinically appropriate and identified no adverse outcomes related to the documentation deficiency. Staff involved received targeted re-education on ensuring complete and accurate documentation of respiratory status and interventions. The facility conducted a house-wide review to identify residents with the potential to be affected by the deficient practice, including all current residents with physician orders for supplemental oxygen, recent oxygen weaning, PRN oxygen use, or respiratory diagnoses. This review included medical records, physician orders, oxygen saturation logs, care plans, and nursing documentation to ensure oxygen use was supported by appropriate clinical assessments and aligned with current physician orders. Any discrepancies identified were immediately addressed through completion of focused nursing assessments, clarification or obtaining of physician orders, and updating of care plans and documentation to reflect accurate clinical indications and interventions. Residents identified with potential gaps were assessed to ensure respiratory status was stable, and needs were being met appropriately. Additionally, licensed nursing staff received re-education on focused respiratory assessments, documentation requirements, and timely provider notification for changes in condition.	06/10/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245556	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/24/2026

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Presbyterian Homes Of Bloomington	**9889 PENN AVENUE SOUTH , BLOOMINGTON, Minnesota, 55431**

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F0842 SS = D	Continued from page 2 (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to maintain a complete and accurately documented medical record in accordance with accepted professional standards and practices for 2 of 3 residents (R1, R3) reviewed for change of condition and oxygen use. Findings include: R1’s admission Minimum Data Set (MDS) dated 2/4/26, indicated R1 had intact cognition and diagnoses of coronary artery disease, hypertension, kidney disease, pneumonia, chronic obstructive pulmonary disease, and respiratory failure. R1’s MDS indicated R1 used continuous oxygen therapy. R1’s Comprehensive Data Collection Review dated 1/29/26, indicated R1 had right sided pneumonia, ordered antibiotics, crackles to left lower lobe, and supplemental oxygen at two liters per minute. R1’s physician order dated 1/31/26, indicated R1 used continuous supplemental oxygen at two liters per minute via nasal cannula to keep oxygen saturation over 89% (percent). R1’s physician order dated 2/4/26, directed staff to wean R1’s supplemental oxygen as able. R1’s Skilled Documentation dated 2/6/26, indicated R1’s supplemental oxygen was weaned. R1’s oxygen saturation was 92% at room air (RA). R1’s Oxygen Saturation Summary, indicated R1 was on room air 2/6/26 at 11:44 a.m.; however, R1 had oxygen via nasal cannula on 2/11/26 at 3:22 a.m. and 9:46 a.m., was on room air on 2/11/26 at 4:26 p.m., and oxygen via nasal cannula on 2/12/26 at 6:19 a.m. and 7:50 a.m..	F0842	Continued from page 2 These actions ensure residents with the potential to be affected are protected and that the facility achieves and maintains compliance with accepted professional standards and practices. The facility completed a root cause analysis which identified inconsistent documentation of focused respiratory assessments via progress notes, and unclear clinical indications for oxygen use. To prevent recurrence, all licensed nurses were re-educated on the execution of completing focused nursing respiratory assessments for when supplemental oxygen is initiated, discontinued, or resumed, including documenting this within a progress note, and oxygen use protocols in line with our Medication Administration Policy and Oxygen Administration Policy. To ensure compliance, the Director of Nursing or designee will conduct audits of residents with oxygen use, reviewing physician orders, documentation, and care plan alignment. Audits will be completed weekly for four weeks with immediate follow-up and re-education for any identified concerns. Results will be monitored through the QAPI process to ensure sustained compliance and prevent recurrence. Date for Deficiency Correction: June 10, 2026	06/10/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245556	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/24/2026

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Presbyterian Homes Of Bloomington	**9889 PENN AVENUE SOUTH , BLOOMINGTON, Minnesota, 55431**

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F0842 SS = D	Continued from page 3 R1's Progress Notes dated 2/6/26 through 2/12/26, indicated R1's vital signs were stable and/or within normal limits (besides a 100.6 degrees Fahrenheit temperature on 2/11/26); however, did not specify reason or respiratory indication for R1's supplemental oxygen use on 2/11/26. R1's Occupational Therapy Treatment Encounter Note dated 2/11/26, indicated R1 reported a "rough night" and needed supplemental oxygen related to shortness of breath and was weaned off the supplemental oxygen again. R1's Physical Therapy Treatment Encounter Note dated 2/12/26, indicated R1 reported she had a fever, felt "awful", and needed supplemental oxygen at one liter per minute last night. R1's Discharge Summary note dated 2/12/26, indicated R1 did not have a drop in oxygen saturation level and was not sure if supplemental oxygen use was for shortness of breath or anxiety. R1's General Note dated 2/12/26, indicated nurse practitioner (NP)-A met with R1 and completed a lung assessment. R1's lung sounds were clear with consistent diminished sounds in bases, and NP-A removed R1's supplemental oxygen. R1's physician order dated 2/12/26, indicated R1 used supplement oxygen as needed at two liters per minute via nasal cannula to keep oxygen saturation above 89%. During interview on 4/22/26 at 3:31 p.m., registered nurse (RN)-A stated staff followed physician's orders for supplemental oxygen use and reapplied supplemental oxygen if oxygen saturation was not maintained at the order specified level. RN-A was not sure why R1 had supplemental oxygen after weaned. During interview on 4/23/26 at 2:49 p.m., RN-B did not remember R1, or the reason supplemental oxygen was applied to R1 on 2/11/26. RN-B stated residents need to be assessed for supplemental oxygen use by listening to lung sounds and checking oxygen saturation. RN-B stated they would assess if oxygen intervention was successful and call the provider if intervention was not successful. During interview on 4/23/26 at 3:02 p.m., physical therapist (PT)-B and physical therapy assistant (PTA)-C reviewed R1's therapy notes. PT-B stated R1 functionally progressed well with therapy. PT-B	F0842		06/10/2026

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F0842 SS = D	Continued from page 4 stated they wanted to see R1 weaned off oxygen to eliminate the oxygen tubing as a tripping hazard, and R1 was anxious about weaning her oxygen. Therapy usually removed oxygen during their sessions as able but returned supplemental oxygen via nasal cannula back onto residents after their therapy sessions. Nursing was able to fully wean residents and remove supplemental oxygen. R3's diagnoses list dated 4/24/26 included encephalopathy, Parkinson's disease, chronic atrial fibrillation and pulmonary hypertension. R3's care plan dated 4/16/26 included an alteration in respiratory status focus with interventions including but not limited to assist with applying continuous positive airway pressure (CPAP) and provide oxygen per nasal cannula see orders for liters per minute. R3's Brief Interview for Mental Status assessment dated 4/17/26 indicated no cognitive impairments. R3's provider order dated 4/18/26 instructed supplemental oxygen at one liter per minute via nasal cannula nocturnal to keep saturations above 91%. R3's provider note dated 4/16/26 instructed supplemental oxygen one liter at night if not wearing CPAP machine. R3's nursing MDS note dated 4/21/26 at 10:20 a.m. indicated R3 reported no shortness of breath or trouble breathing and the medical record and staff interviews indicated shortness of breath (SOB) appeared to be absent or well controlled with current medications. R3's oxygen saturation summary for April 2026 indicated R3 was on room air during the day and used supplemental oxygen at night until 4/21/26 when documentation indicated R3 oxygen saturation was 98% on supplemental oxygen at 3:22 p.m. R3 utilized supplemental oxygen until 4/23/26 at 8:49 a.m. R3's skilled documentation dated 4/22/26 at 6:26 p.m. indicated R3's vital signs were stable. R3 denied SOB. R3's physical therapy (PT) note dated 4/22/26 at 12:38 p.m. indicated R3 was on one liter supplemental oxygen upon arrival for the PT session. R3's oxygen saturation was 96% at the beginning of the session. R3 was placed on room air	F0842		06/10/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245556	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Presbyterian Homes Of Bloomington	**9889 PENN AVENUE SOUTH , BLOOMINGTON, Minnesota, 55431**

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F0842 SS = D	Continued from page 5 during the session and maintained oxygen saturation of 96-99% on room air while participating with the OT/PT session. During an interview on 4/23/2026 at 11:31 a.m., R3's family member (FM) stated R3 utilized supplemental oxygen at night because she did not like wearing the CPAP mask. R3 was utilizing supplemental oxygen during a care conference on 4/21/26 but FM did not know why. During an interview on 4/23/2026 at 2:58 p.m., registered nurse (RN)-A stated R3 utilized supplemental oxygen at night and during the day when she was in bed because she did not like to wear her CPAP mask. RN-A would assess the resident, notify a provider, and write a nurse's note if a resident needed supplemental oxygen due to low oxygen saturations. During interview on 4/24/26 at 12:17 p.m., RN-C reviewed R1's progress notes and verified nursing documentation did not address the reason or assessment for R1's supplemental oxygen use on 2/11/26. RN-C stated staff should update the provider and use a house standing order or obtain a new order if R3 used supplemental oxygen during the day, in addition to the ordered nighttime use. RN-C reviewed R3's progress notes and stated they were not sure why R3 had supplemental oxygen use during the day. During interview on 4/24/26 at 3:58 p.m., the director of nursing (DON) expected staff to complete a respiratory assessment, use house standing orders, and contact provider as needed for changes in supplemental oxygen use. Staff were to document assessments and actions in a progress note. The DON stated documentation was important for resident safety, continuation of care, and provider review. The facility Skilled Documentation policy dated 4/2021, instructed staff to complete a daily skilled documentation progress note for residents who had a skilled nursing need on a skilled stay. The daily progress note was individualized and completed based on the primary diagnosis/reason for skilled stay and other pertinent diseases and conditions.	F0842		06/10/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **04/24/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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20000	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 4/22/26 to 4/24/26, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with MN State Licensure, and the following licensing orders were issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed. The following complaint was reviewed: H55561097C (2971477) with a licensing order issued at 20625.	20000		06/10/2026

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

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20000	Continued from page 1 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 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.	20000		06/10/2026
20625	Clinical Record Contents; In General CFR(s): MN Rule 4658.0450 Subp. 1 A-P Subpart 1. In general. Each resident's clinical record, including nursing notes, must include: A. the condition of the resident at the time of admission; B. temperature, pulse, respiration, and blood	20625	This Plan of Correction and the responses to each F-Tag are submitted to maintain certification in the Medicare and Medicaid programs and constitute a credible allegation of compliance. The written responses do not constitute an admission of noncompliance or agreement with any findings stated under the F-Tags. The facility reserves the right to dispute all findings and deficiencies in any appropriate forum, including in an independent dispute resolution, or, if appealable remedies are subsequently imposed, by timely appeal to the	06/10/2026

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20625	Continued from page 2 pressure, according to part 4658.0520, subpart 2, item I; C. the resident's height and weight, according to part 4658.0520, subpart 2, item J; D. the resident's general condition, actions, and attitudes; E. observations, assessments, and interventions provided by all disciplines responsible for care of the resident, with the exception of confidential communications with religious personnel; F. significant observations on, for example, behavior, orientation, adjustment to the nursing home, judgment, or moods; G. date, time, quantity of dosage, and method of administration of all medications, and the signature of the nurse or authorized persons who administered the medication; H. a report of a tuberculin test within the three months prior to admission, as described in part 4658.0810; I. reports of laboratory examinations; J. dates and times of all treatments and dressings; K. dates and times of visits by all licensed health care practitioners; L. visits to clinics or hospitals; M. any orders or instructions relative to the comprehensive plan of care; N. any change in the resident's sleeping habits or appetite; O. pertinent factors regarding changes in the resident's general conditions; and P. results of the initial comprehensive resident assessment and all subsequent comprehensive assessments as described in part	20625	Continued from page 2 Department Appeals Board. Based on interview and document review, the facility failed to maintain a complete and accurately documented medical record in accordance with accepted professional standards and practices for 2 of 3 residents (R1, R3) reviewed for change of condition and oxygen use. The facility reviewed the Medication Administration Policy and the Oxygen Administration Policy. These policies are current and in effect. Resident R1 (Discharged): The facility conducted a retrospective review of R1’s medical record following discharge and identified gaps in documentation related to the clinical respiratory assessment and rationale for supplemental oxygen use on 2/11/26. No adverse outcomes identified related to the documentation deficiency. Staff involved in the resident’s care received re-education on respiratory assessment requirements, documentation expectations when supplemental oxygen is initiated, discontinued, or resumed. Resident R3 (Discharged): The facility conducted a comprehensive retrospective review of R3’s medical record following discharge and identified supplemental oxygen use during daytime hours that was not supported by the nursing staffs documentation. The facility verified that care provided during the resident’s stay was clinically appropriate and identified no adverse outcomes related to the documentation deficiency. Staff involved received targeted re-education on ensuring complete and accurate documentation of respiratory status and interventions. The facility conducted a house-wide review to identify residents with the potential to be affected by the deficient practice, including all current residents with physician orders for supplemental oxygen, recent oxygen weaning, PRN oxygen use, or respiratory diagnoses. This review included medical records, physician orders, oxygen saturation logs, care plans, and nursing documentation to ensure oxygen use was supported by appropriate clinical assessments and aligned with current physician orders. Any discrepancies identified were immediately addressed through completion of focused nursing assessments, clarification or obtaining of physician orders, and updating of care	06/10/2026

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20625	Continued from page 3 4658.0400. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to maintain a complete and accurately documented medical record in accordance with accepted professional standards and practices for 2 of 3 residents (R1, R3) reviewed for change of condition and oxygen use. Findings include R1's admission Minimum Data Set (MDS) dated 2/4/26, indicated R1 had intact cognition and diagnoses of coronary artery disease, hypertension, kidney disease, pneumonia, chronic obstructive pulmonary disease, and respiratory failure. R1's MDS indicated R1 used continuous oxygen therapy. R1's Comprehensive Data Collection Review dated 1/29/26, indicated R1 had right sided pneumonia, ordered antibiotics, crackles to left lower lobe, and supplemental oxygen at two liters per minute. R1's physician order dated 1/31/26, indicated R1 used continuous supplemental oxygen at two liters per minute via nasal cannula to keep oxygen saturation over 89% (percent). R1's physician order dated 2/4/26, directed staff to wean R1's supplemental oxygen as able. R1's Skilled Documentation dated 2/6/26, indicated R1's supplemental oxygen was weaned. R1's oxygen saturation was 92% at room air (RA). R1's Oxygen Saturation Summary, indicated R1 was on room air 2/6/26 at 11:44 a.m.; however, R1 had oxygen via nasal cannula on 2/11/26 at 3:22 a.m. and 9:46 a.m., was on room air on 2/11/26 at 4:26 p.m., and oxygen via nasal cannula on 2/12/26 at 6:19 a.m. and 7:50 a.m.. R1's Progress Notes dated 2/6/26 through 2/12/26, indicated R1's vital signs were stable and/or within normal limits (besides a 100.6 degrees Fahrenheit temperature on 2/11/26); however, did not specify reason or respiratory indication for R1's supplemental oxygen use on 2/11/26. R1's Occupational Therapy Treatment Encounter Note dated 2/11/26, indicated R1 reported a "rough night" and needed supplemental oxygen related to shortness of breath and was weaned off the	20625	Continued from page 3 plans and documentation to reflect accurate clinical indications and interventions. Residents identified with potential gaps were assessed to ensure respiratory status was stable, and needs were being met appropriately. Additionally, licensed nursing staff received re-education on focused respiratory assessments, documentation requirements, and timely provider notification for changes in condition. These actions ensure residents with the potential to be affected are protected and that the facility achieves and maintains compliance with accepted professional standards and practices. The facility completed a root cause analysis which identified inconsistent documentation of focused respiratory assessments via progress notes, and unclear clinical indications for oxygen use. To prevent recurrence, all licensed nurses were re-educated on the execution of completing focused nursing respiratory assessments for when supplemental oxygen is initiated, discontinued, or resumed, including documenting this within a progress note, and oxygen use protocols in line with our Medication Administration Policy and Oxygen Administration Policy. To ensure compliance, the Director of Nursing or designee will conduct audits of residents with oxygen use, reviewing physician orders, documentation, and care plan alignment. Audits will be completed weekly for four weeks with immediate follow-up and re-education for any identified concerns. Results will be monitored through the QAPI process to ensure sustained compliance and prevent recurrence. Date for Deficiency Correction: June 10, 2026	06/10/2026

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20625	Continued from page 4 supplemental oxygen again. R1's Physical Therapy Treatment Encounter Note dated 2/12/26, indicated R1 reported she had a fever, felt "awful", and needed supplemental oxygen at one liter per minute last night. R1's Discharge Summary note dated 2/12/26, indicated R1 did not have a drop in oxygen saturation level and was not sure if supplemental oxygen use was for shortness of breath or anxiety. R1's General Note dated 2/12/26, indicated nurse practitioner (NP)-A met with R1 and completed a lung assessment. R1's lung sounds were clear with consistent diminished sounds in bases, and NP-A removed R1's supplemental oxygen. R1's physician order dated 2/12/26, indicated R1 used supplement oxygen as needed at two liters per minute via nasal cannula to keep oxygen saturation above 89%. During interview on 4/22/26 at 3:31 p.m., registered nurse (RN)-A stated staff followed physician's orders for supplemental oxygen use and reapplied supplemental oxygen if oxygen saturation was not maintained at the order specified level. RN-A was not sure why R1 had supplemental oxygen after weaned. During interview on 4/23/26 at 2:49 p.m., RN-B did not remember R1, or the reason supplemental oxygen was applied to R1 on 2/11/26. RN-B stated residents need to be assessed for supplemental oxygen use by listening to lung sounds and checking oxygen saturation. RN-B stated they would assess if oxygen intervention was successful and call the provider if intervention was not successful. During interview on 4/23/26 at 3:02 p.m., physical therapist (PT)-B and physical therapy assistant (PTA)-C reviewed R1's therapy notes. PT-B stated R1 functionally progressed well with therapy. PT-B stated they wanted to see R1 weaned off oxygen to eliminate the oxygen tubing as a tripping hazard, and R1 was anxious about weaning her oxygen. Therapy usually removed oxygen during their sessions as able but returned supplemental oxygen via nasal cannula back onto residents after their therapy sessions. Nursing was able to fully wean residents and remove supplemental oxygen. During interview on 4/24/26 at 12:17 p.m., RN-C reviewed R1's progress notes and verified nursing documentation did not address the reason or	20625		06/10/2026

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20625	Continued from page 5 assessment for R1's supplemental oxygen use on 2/11/26. RN-C stated staff should update the provider and use a house standing order or obtain a new order if R3 used supplemental oxygen during the day, in addition to the ordered nighttime use. RN-C reviewed R3's progress notes and stated they were not sure why R3 had supplemental oxygen use during the day. R3's diagnoses list dated 4/24/26 included encephalopathy, Parkinson's disease, chronic atrial fibrillation and pulmonary hypertension. R3's care plan dated 4/16/26 included an alteration in respiratory status focus with interventions including but not limited to assist with applying continuous positive airway pressure (CPAP) and provide oxygen per nasal cannula see orders for liters per minute. R3's Brief Interview for Mental Status assessment dated 4/17/26 indicated no cognitive impairments. R3's provider order dated 4/18/26 instructed supplemental oxygen at one liter per minute via nasal cannula nocturnal to keep saturations above 91%. R3's provider note dated 4/16/26 instructed supplemental oxygen one liter at night if not wearing CPAP machine. R3's nursing MDS note dated 4/21/26 at 10:20 a.m. indicated R3 reported no shortness of breath or trouble breathing and the medical record and staff interviews indicated shortness of breath (SOB) appeared to be absent or well controlled with current medications. R3's oxygen saturation summary for April 2026 indicated R3 was on room air during the day and used supplemental oxygen at night until 4/21/26 when documentation indicated R3 oxygen saturation was 98% on supplemental oxygen at 3:22 p.m. R3 utilized supplemental oxygen until 4/23/26 at 8:49 a.m. R3's skilled documentation dated 4/22/26 at 6:26 p.m. indicated R3's vital signs were stable. R3 denied SOB. R3's physical therapy (PT) note dated 4/22/26 at 12:38 p.m. indicated R3 was on one liter supplemental oxygen upon arrival for the PT session. R3's oxygen saturation was 96% at the	20625		06/10/2026

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20625	Continued from page 6 beginning of the session. R3 was placed on room air during the session and maintained oxygen saturation of 96-99% on room air while participating with the OT/PT session. During an interview on 4/23/2026 at 11:31 a.m., R3's family member (FM) stated R3 utilized supplemental oxygen at night because she did not like wearing the CPAP mask. R3 was utilizing supplemental oxygen during a care conference on 4/21/26 but FM did not know why. During an interview on 4/23/2026 at 2:58 p.m., registered nurse (RN)-A stated R3 utilized supplemental oxygen at night and during the day when she was in bed because she did not like to wear her CPAP mask. RN-A would assess the resident, notify a provider, and write a nurse's note if a resident needed supplemental oxygen due to low oxygen saturations. During interview on 4/24/26 at 3:58 p.m., the director of nursing (DON) expected staff to complete a respiratory assessment, use house standing orders, and contact provider as needed for changes in supplemental oxygen use. Staff were to document assessments and actions in a progress note. The DON stated documentation was important for resident safety, continuation of care, and provider review. The facility Skilled Documentation policy dated 4/2021, instructed staff to complete a daily skilled documentation progress note for residents who had a skilled nursing need on a skilled stay. The daily progress note was individualized and completed based on the primary diagnosis/reason for skilled stay and other pertinent diseases and conditions SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee should review and revise policies and procedures related to ensuring resident records are true and accurate, including assessments and interventions. The director of nursing or designee should educate staff and perform measurable audits. The results of those audits should be taken to QAPI to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20625		06/10/2026