



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 26, 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 June 17, 2022, we notified you a remedy was imposed. On July 12, 2022 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of July 12, 2022.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective August 1, 2022 did not go into effect. (42 CFR 488.417 (b))

In our letter of June 17, 2022, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from August 1, 2022 due to denial of payment for new admissions. Since your facility attained substantial compliance on July 12, 2022, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

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

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program

The Estates At Bloomington LLC

July 26, 2022

Page 2

Health Regulation Division

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245324	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/19/2022
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) COMPLETION DATE
F 000	INITIAL COMMENTS On 5/18/22, to 5/19/22, 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 following complaint was found to be SUBSTANTIATED: H53241610C (MN83531), with deficiencies cited at F610. The following complaint was found to be UNSUBSTANTIATED: H53241749C (MN83618). 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 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.	F 610			6/10/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

TITLE

(X6) DATE

06/06/2022

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.

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

PRINTED: 06/09/2022
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 05/19/2022
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F 610	Continued From page 1 §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to protect a resident following resident to resident abuse for 1 of 1 residents (R1) who was physically struck by her roommate and reviewed for abuse. Findings include: R1's quarterly Minimum Data Set (MDS) dated 4/22/22, identified R1 had diagnoses which included depression, chronic obstructive pulmonary disease (COPD) and peripheral vascular disease (PVD). The MDS identified R1 was cognitively intact and was independent with activities of daily living (ADL's) of transfers, ambulation and bed mobility. R1's care plan revised 5/18/22, revealed R1 was alert, oriented and was able to communicate her needs. On 5/18/22, at 2:12 p.m. during an interview, R1 indicated last week, she woke up from her nap after her roommate struck her on her legs with a plastic hanger and yelled, "get your fat butt up." R1 stated she immediately left the room and	F 610	On 5/19 R1 was moved to another room on a different unit away from R2. Past resident to resident reports reviewed to ensure immediate intervention of separating residents, moving rooms if needed due to being roommates, and increased monitoring was in place. When a similar incident occurs between two residents. Staff will move resident rooms if roommates and place on increased monitoring to ensure resident safety to prevent further incidents. Current staff educated on the facility abuse policy specific to implementing an intervention immediately after a resident to resident incident if they are roommates. Education included separating residents and moving one to another room, and increased monitoring for safety to prevent further incidents. Complaints of alleged abuse or neglect will be audited for appropriate intervention put in place fo resident safety. Audits will		

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F 610	Continued From page 2 informed facility staff. R1 stated her roommate suffered from Alzheimer's disease, had impaired memory and "could be mean". R1 indicated she had empathy for her roommate however, she did not always feel safe when in the room with her. R1 believed her roommate was unpredictable and R1 was concerned she would attempt to harm her again when she was sleeping. R1 indicated following the incident, facility staff had offered to move her to a different room and she declined. R1 stated she believed she should not have been expected to move to another room since she had been there first, however she did not want her roommate moved either. R1 indicated she did not want other residents of the facility to have to "put up with her roommate." R1 stated she tried to stay out of her room as often as possible, and staff would periodically check on her when she was in her room with her roommate. Review of R1's facility incident review and analysis report dated 5/18/22, revealed on 5/13/22, at 5:00 p.m., R1 had been sleeping, when her roommate (R2) yelled at her, called her "fat" and struck R1 with a clothes hanger. The report revealed R1 left the room and notified staff of the incident. The report identified staff had separated R1 and R2 and both residents expressed they felt safe. The incident report indicated R1 had no injuries, had been offered to move to another room and had been instructed to keep her distance from her roommate. The report lacked any interventions to ensure R1 was protected from her roommate when she was alone with her in their shared room. Review of R1's progress note dated 5/13/22, revealed R1 reported to the facility mental health worker and nursing assistants, she was	F 610	be done weekly x4 and monthly x2. Results will be reported to the QAPI committee to determine the need for further monitoring or compliance		

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F 610	Continued From page 3 "somewhat afraid of her roommate, who had woken her up the prior day during her afternoon nap by tapping her with a clothes hanger." The note indicated R1 had reported her roommate had been trying to keep her awake all night and had rummaged through her belongings. The note identified R1 had no injuries, and was offered to move to another room due to her safety concern. R1 had declined to change rooms and had indicated she did not want to discuss the incident any further. R1's medical record lacked a plan or intervention to prevent further abuse from occurring while the investigation into the incident was in progress. On 5/18/22, at 3:10 p.m. during an interview nursing assistant (NA)-A stated R1 had approached the nurses station on 5/13/22, and indicated her roommate had woken her up by striking her in the leg with a clothes hanger. NA-A indicated R1's roommate had a mean tone of voice towards her. NA-A stated R1 was able to express her needs and felt she was a reliable historian. NA-A indicated R1 had expressed she was "kind of afraid" following the incident. NA-A stated R1 was instructed by the nurse and mental health worker to stay away from her roommate and was offered to change rooms. NA-A indicated following the incident, staff were expected to frequently check on R1 and her roommate to make sure they maintained distance from each other. NA-A confirmed there was no formal process in place to prevent R1's roommate from striking her again. NA-A indicated R1 and her roommate were not supervised all of the time, and felt the physical abuse could occur again. On 5/18/22, at 3:15 p.m. during an interview	F 610			

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F 610	Continued From page 4 licensed practical nurse (LPN)-A stated she had been present in the facility on the day R1 had notified staff she had been struck in the leg with a hanger by her roommate. LPN-A indicated R1 was very patient with R2. LPN-A stated R2 had dementia and would speak to R1 in a mean tone of voice at times. LPN-A indicated following the incident, staff were expected to frequently check on R1 and R2 to ensure they kept their distance. LPN-A stated R1 would attempt to stay out of her room as much as possible and they were frequently observed when in the room together. LPN-A confirmed there was no formal process in place for supervision to protect R1 from her roommate. On 5/18/22, at 3:40 p.m. during an interview the social service designee (SSD) indicated she had been made aware of the incident between R1 and R2 the following Monday. SSD indicated the facility leadership had met to discuss the incident, and had offered R1 to move to a room down a different wing. SSD stated R1 had declined and had stated she did not wish to move at all and did not request to have her roommate moved either. SSD indicated the facility administrator and DON were in the process of completing the investigation of the incident. On 5/18/22, at 3:44 p.m. during an interview mental health technician (MHT)-A confirmed she had been present when R1 reported her roommate had struck her on the legs with a hanger and called her fat. MHT-A indicated R1 had appeared upset, frustrated and had reported feeling somewhat afraid of her roommate. MHT-A stated R1 was assessed for injuries by the nurse on duty and had been offered to change rooms, though she declined. MHT-A indicated R1 and	F 610			

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F 610	Continued From page 5 her roommate were frequently checked on, though confirmed the facility did not have a formal process in place for supervision. On 5/19/22, at 9:58 a.m. during a follow-up interview, SSD indicated she was unaware of any discussion of R1's roommate being offered to change rooms since R1 was not willing to change her room. SSD indicated she was not aware of any formal system in place for supervision to ensure R1 was protected during the investigation. On 5/19/22, at 10:00 a.m. during a joint interview with the facility administrator and director of nursing (DON), they indicated they had been made aware of the incident immediately after R1 had reported the incident to facility staff. The administrator stated she had submitted the state agency report and they began their internal investigation of the incident. The DON stated R1 had been assessed for injury and had been instructed to stay away from her roommate to avoid any further altercations. The DON indicated R1 was offered to change rooms daily since the incident and had declined each time. DON stated following the incident, staff were educated to provide frequent checks/supervision to R1 and her roommate to ensure they maintained their distance. DON indicated R1 had no further concerns with her roommate and had never reported feeling afraid of her roommate. The DON stated the facility leadership had not offered to have R1's roommate change rooms due to her dementia and history of wandering. DON indicated R1 was instructed to attempt to stay out of her roommate's way and to report any further concerns with her roommate to facility staff. The DON confirmed there was no formal process in place to provide supervision of R1 and her	F 610			

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F 610	Continued From page 6 roommate during the investigation of the incident. Review of a facility policy titled, Abuse Prohibition/Vulnerable Adult Plan revised 4/11/22, identified the purpose of the policy was to ensure residents were free from abuse from anyone, which included other residents. The policy identified all reports of abuse were to be reported immediately to the facility administrator and state agency. The policy identified upon reports of abuse, staff were to take immediate actions/necessary steps to protect residents from possible subsequent incidents of misconduct while the matter was investigated. The policy identified in cases of resident to resident abuse, the abused resident would be removed to a safe environment and all other residents safety would be ensured.	F 610			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 27, 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 19, 2022, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

LeAnn Huseeth, RN, Unit Supervisor
Fergus Falls District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Road, Suite 300
Fergus Falls, Minnesota. 56537
Email: leann.huseeth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

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 August 19, 2022 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by November 19, 2022 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

The Estates At Bloomington LLC

May 27, 2022

Page 4

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink that reads "Kamala Fiske-Downing". The signature is written in a cursive, flowing style.

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



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Electronically delivered
May 27, 2022

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

Re: Event ID: WQVE11

Dear Administrator:

The above facility survey was completed on May 19, 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
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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 C 05/19/2022
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2 000	Initial Comments *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 5/18/22, to 5/19/22, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found to be in compliance with the MN State Licensure. The following complaint was found to be	2 000			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

TITLE

(X6) DATE

06/06/22

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 C 05/19/2022
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	Continued From page 1 SUBSTANTIATED: H53241610C (MN83531), however, NO licensing orders were issued. The following complaint was found to be UNSUBSTANTIATED: H53241749C (MN83618). 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			