

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 09/04/2024
NAME OF PROVIDER OR SUPPLIER The Estates at Bloomington LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 9200 Nicollet Avenue South Bloomington, MN 55420	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49618</p> <p>Based on interview and record review, the facility failed to verify orders written by a provider for one of one resident (R1) reviewed. R1 had orders for wound care treatments and the facility thought the orders were written in error but did not verify the orders with the provider.</p> <p>Findings include:</p> <p>R1's medical records indicated R1 was admitted to the facility on [DATE] with a primary diagnosis of cellulitis of right lower limb. R1's additional diagnoses included venous insufficiency, muscle weakness, chronic kidney disease stage three, and anemia.</p> <p>R1's wound care progress note dated 7/24/24 indicated nurse practitioner (NP) ordered staff to clean vascular ulcer dorsum second interdigital on R1's right side daily and paint daily with Betadine.</p> <p>R1's wound care progress note dated 7/31/24 indicated nurse practitioner (NP) ordered staff to clean vascular ulcer dorsum second interdigital on R1's right side daily and paint daily with Betadine.</p> <p>R1's treatment administration record dated July 2024 indicated R1 did not have an order for staff to clean vascular ulcer dorsum second interdigital on R1's right side daily and paint daily with Betadine.</p> <p>During an interview on 9 /4/24 at 2:11 p.m., registered nurse (RN)-C stated once the wound care nurse sees the resident with the wound care provider, the wound care nurse would update or change the resident's orders and treatment plans.</p> <p>During an interview on 9/4/24 at 2:35 p.m., RN-A stated once the wound care provider see's the residents who have wounds, the clinical manager (CM) would review the plan written by the plan, notes, and instructions and she would make orders based off those plans, notes, and instructions.</p> <p>During an interview on 9/4/24 at 2:40 p.m., CM stated once the facility received the wound provider progress notes, CM would enter new orders and update the treatment plan. CM stated if there were not new orders from the wound care provider, the facility would continue with the current care plan. CM stated the provider note transcriber would not remove treatment plan recommendations on the wound progress notes. CM stated, I think the wound care provider, or her transcriber made a mistake by putting the treatment recommendations in that wound progress note from 7/24/24 and 7/31/24.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 9/4/24 at 3:32 p.m., the nurse practitioner (NP) stated if she had written orders for a resident and there was questions or confusion from the facility nursing staff, her expectation would be for the nurses to clarify orders with me. NP stated if she had written orders, her expectation is that those orders would be followed. NP stated the nurses did not clarify orders from 7/24/24 or 7/31/234 with her.</p> <p>During an interview on 9/4/24 at 4:04 p.m., the administrator stated her expectation is the facility would follow orders written by the provider. The administrator stated if a nurse did not understand orders written by the provider, the nurse should go to the CM or the provider to clarify them.</p> <p>A treatment order policy was requested, and none was received.</p>		