STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245324	A. Building B. Wing	04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Estates at Bloomington LLC	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)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure dignity was maintained for 2 of 2 residents (R9, R13) reviewed for dignity when staff failed to knock, introduced themselves, and wait for permission to enter resident rooms prior to entry.Findings include: R9R9's quarterly Minimum Data Set (MDS) dated [DATE] identified R9 with dementia, psychosis and dependent on staff for all cares. In addition, R9 was enrolled in hospice.R13R13's quarterly MDS dated [DATE] identified R13 was cognitively intact and had diagnoses of fibromyalgia, anxiety, depression and chronic pain.During observation and interview on 4/20/26 at 2:30 p.m., the State Agency (SA) surveyor was in process of screening R13 in their room which was shared with R9. The bedroom door to hallway was closed and a privacy curtain was pulled around R13 who was lying on bed. Nursing assistant (NA)-A entered the room with R9 who was seated in Broda wheelchair. During this time NA-A failed to knock, introduce herself, and wait for permission to enter the room. NA-A wheeled R9 into the middle of the room and then turned around and left the room without speaking. At 2:35 p.m., NA-A and NA-B entered room again without knocking. Both looked at SA and then exited room with R9. During interview both NA-A and NA-B verified they did not knock, introduce themselves, and wait for permission to enter the shared room. Both NA-A and NA-B stated it was important to knock before entering and NA-B stated, Did not think of it.During interview with R13 on 4/20/26 at 2:47 p.m., R13 stated most staff failed to knock and wait for permission to enter her room which she did not like. R13 stated an instance where a staff member popped her head into my room and the curtain [facing the hallway] while I was naked and she did not even knock or introduce herself. R13 was upset and verbalized this is my home. Why would anyone do that?During interview with director of nursing (DON) on 4/23/26 at 6:45 a.m., DON stated expectation of all staff to knock and wait for permission to enter any resident room.Facility policy was requested and not received.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245324	A. Building B. Wing	04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Estates at Bloomington LLC	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)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** During observation, interview, and record review, the facility failed to accommodate resident needs by ensuring the call light was accessible for 1 of 1 residents (R9) reviewed for call lights.Findings include:R9R9's quarterly Minimum Data Set (MDS) dated [DATE] identified R9 with impaired cognition, no limitation in upper extremity range of motion and dependent on staff for turning, repositioning, transfers, and all personal cares. R9's diagnoses include dementia. In addition, R9 was enrolled in hospice.During observation on 4/20/26 at 2:30 p.m., nursing assistant (NA)-A wheeled R9 into the middle of their room without placing a call light in reach and then turned around and left the room without speaking. R13's call light was on R13's bed which was approximately 15 feet away. During interview upon leaving R13's room, NA-A confirmed R13 was not able to use her legs and would not have been able to reach the call light while seated in the middle of the room. During observation on 4/21/26 at 9:00 a.m., R9 was lying in bed positioned partially on her right side. The head of the bed was elevated to 45 degrees, and two pillows were under her head. One pillow was positioned along the left side of her body, and one pillow was positioned to her right side. The call light was attached to bed sheet under right sided pillow hanging down to the bed frame and out of sight of R9.During interview with nursing assistant (NA)-A on 4/22/26 at 8:24 a.m., NA-A verbalized familiarity with taking care of R9 and, [R9] is able to use the call light. NA-A stated expectation of call light to be in reach of residents if they need assistance.During interview with director of nursing (DON) on 4/23/26 at 6:47 a.m., DON stated expectation of every resident should have a call light in reach and It is their lifeline to ask for help if needed.Facility policy titled Call Light, updated 5/16/23 identified, Call cords, buttons, or other communication devices must be placed where they are within reach of each resident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245324	A. Building B. Wing	04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Estates at Bloomington LLC	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)
F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to provide a written transfer notice and notice of bed hold for 1 of 1 residents (R4) reviewed for hospitalization.Findings include:R4's admissions Minimum Data Set, dated [DATE] identified R4 with impaired cognition, required assistance with all personal cares, and diagnoses of hemiplegia (form of paralysis affecting one side of the body), diabetes and anxiety.R4's electronic medical record (EMR) progress notes lacked indication of a hospitalization or emergency room visit since admission to facility on 2/18/26.R4's hospital after visit summary dated 4/14/26, identified R4 was transferred to the emergency room for diarrhea.During interview with R4 on 4/20/26 at 1:27 p.m., R4 stated she had had a hospitalization for diarrhea recently but did not know what the date was. In addition, R4 could not recall whether she was offered or provided a transfer form or bed hold notice at the time of the emergency room visit.R4's emergency contact was called on 4/22/26 at 11:25 a.m., with no answer.During interview with registered nurse (RN)-C on 4/22/26 at 11:50 a.m., RN-C stated expectations of staff to offer and provide a signed transfer form and bed hold to resident or guardian to accompany the resident to the hospital upon transfer for higher level of treatment. Also, the nurse is expected to document in the electronic medical record (EMR) that they offered and provided the transfer form and bed hold to the resident or guardian in a progress note. If the nurse left a message, then the nurse was to document that a message was left, and the facility was expected to follow up with the resident or guardian until they received an answer. RN-C stated the original transfer form and bed hold should be downloaded into the EMR under the Forms tab by the facility. RN-C verified that he was the nurse that sent R4 to the hospital on 4/14/26. RN-C stated he believed he had called and left a message with R4's guardian but did not document it. During interview with licensed practical nurse (LPN)-A on 4/22/26 at 12:01 p.m., LPN-A stated expectations of nursing staff to offer and provide a signed transfer form and bed hold to accompany the resident to the hospital upon transfer for higher level of treatment. Also, the nurse is expected to document in the electronic medical record (EMR) that they offered and provided the forms to the resident or guardian in a progress note. If the nurse left a message, then the nurse was to document that a message was left, and the facility was expected to follow up with the resident or guardian until they received an answer.During interview with director of nursing (DON) on 4/22/26 at 1:22 p.m., the DON stated expectation of staff to offer and provide a signed transfer form and bed hold to accompany the resident to the hospital upon transfer for higher level of treatment and the nurse was expected to document it in a progress note. If the nurse left a message, then the nurse was to document that a message was left, and the facility was expected to follow up with the resident or guardian until they received an answer. DON verified R4's EMR did not have a transfer form or bed hold notice and that facility failed to follow up on obtaining it. DON stated, should be done.Facility policy titled Bed-Holds and Returns, updated 2/26/26 identified, Prior to a transfer, written information will be given to the residents and the resident representatives that explains in detail: a. The rights and limitations of the resident regarding bed-holds;b. The reserve bed payment policy as indicated by the state plan (Medicaid residents);c. The facility per diem rate required to hold a bed (non-Medicaid residents), or to hold a bed beyond the state bed-hold period (Medicaid residents); andd. The details of the transfer (per the Notice of Transfer).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245324	A. Building B. Wing	04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Estates at Bloomington LLC	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)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to develop and implement, or revise as needed, a comprehensive, person-centered care plan with individualized interventions for 1 of 1 resident (R67) reviewed for fluid management, related to the resident's diagnosis of polydipsia (excessive, persistent thirst or compulsive, excessive water consumption) and ongoing fluid-seeking behaviors Findings include:R67's quarterly Minimum Data Set (MDS), dated [DATE], indicated R67 was admitted to the care facility on 10/25 and had severe cognitive impairment. R67's Diagnoses, dated 10/25/24, indicated R67 had a diagnosis of polydipsia. R67's care plan, dated 10/29/24, indicated a risk versus benefit form was completed and on file for R67 for not following the recommended diet related to the diagnosis of polydipsia. The care plan also indicated R67 was observed trying to get drinks from other residents and drinking water out of the bathroom sink. The care plan contained interventions, dated 3/24/25 of an 1800 milliliter fluid restriction and to offer fluids and snacks between meals. The care plan however lacked any updated or resident specific interventions to reduce fluid seeking behaviors and to increase R67's comfort related to polydipsia despite R67's continued repeated attempts to obtain more fluids. R67's April 2026 Treatment Administration Record (TAR), indicated R67's fluid intake and fluid seeking behaviors were being monitored but lacked resident specific interventions to assist with R67's fluid seeking behavior. During observation and interview on 4/21/26 at approximately 1:30 p.m., R67 was pacing between her room and hallway, asking to get into the bathroom. A sign hung on R67's door indicating to keep door closed and not allow R67 access to the bathroom. Two unnamed staff members were talking and stated R67's bathroom door remained lock to prevent R67 from drinking water from the bathroom sink, the other stating I think she needs more reminders. During an interview on 4/22/26 at 9:30 a.m., nursing assistant (NA)-C stated staff monitored R67's food and fluid intake during meals and tracked intake as part of care. The NA-C reported that fluids provided in R67's room were thickened and offered in small cups, and when R67 requested fluids, staff provided thickened liquids in small amounts using the small medication cups. The NA-C further stated the resident frequently requested fluids.During an interview on 4/22/26 at 10:43 a.m., registered nurse (RN)-B stated R67's fluid intake was monitored due to a history of hospitalization for aspiration concerns and returned to the facility with aspiration pneumonia and fluid retention while on furosemide. The RN reported the resident was currently on daily weights and a fluid restriction. The RN further stated staff manage R67's excessive thirst through frequent redirection when she requested additional fluids; however, the resident continued to request fluids frequently and became upset and call staff names when additional fluids were not provided. The RN indicated R67 was provided fluids in the form of pudding, ice cream, supplements, and one water jug per shift. The RN also stated the resident's bathroom door was kept closed and a commode was used as part of management. During an interview on 4/23/26 at 9:00 a.m., nurse manager and registered nurse (RN)-D and the director of nursing (DON) stated R67's fluid intake was monitored and when the resident reported feeling thirsty, staff provided recommended fluids. The nurse manager reported staff were aware of the resident's excessive thirst and a risk-versus-benefit approach was utilized, including direction for float staff to check with the nurse; however, they acknowledged the resident's polydipsia was not specifically care planned. The Nurse Manager further stated interventions such as lemon oral swabs were available but had not been trialed to address the resident's thirst. It was also stated that while the behavior was documented in the nutrition section of the record, it lacked individualized interventions to guide staff in managing the resident's excessive fluid-seeking behavior and should be care planned so new staff know how to address R67's polydipsia. A facility policy titled Care Planning, revised 11/2024, indicated, The interdisciplinary team (IDT), in conjunction with the resident and the resident representative, will develop and (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245324	A. Building B. Wing	04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Estates at Bloomington LLC	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)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	implement a comprehensive individualized care plan no later than the 21st day of admission of the resident. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245324	A. Building B. Wing	04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Estates at Bloomington LLC	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)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure accurate and complete respiratory care documentation and resident-specifc ordered settings for the use and management of a BIPAP device (bilevel positive airway pressure device - a non-invasive ventilation machine to helps in breathing) for 1 of 1 resident (R17) reviewed for respiratory care. Findings include:R17's quarterly Minimum Data Set (MDS), dated [DATE], indicated R17 was admitted to the facility on [DATE], had a Brief Interview for Mental Status (BIMS) score of 14 (indicating intact cognition), and utilized a non-invasive mechanical ventilator.R17's physician orders, printed 4/23/26, indicated an order for a BIPAP machine to be applied at bedtime (HS), to remain on during nocturnal hours, and to be removed in the morning. Additional orders directed staff to change the BIPAP water daily, including emptying, drying, and refilling the chamber with distilled water to the fill line without overfilling each evening shift. Weekly orders included cleaning the BIPAP water chamber with gentle soap and allowing it to air dry, as well as cleaning the BIPAP mask and tubing with gentle soap and warm water and allowing them to air dry every Sunday on the evening shift. The orders, however, lacked specific BIPAP settings and did not include clear direction for staff to verify or maintain prescribed settings.During an interview on 4/22/26 at 10:43 a.m., registered nurse (RN)-B stated that for residents with a CPAP or BIPAP, the machines typically arrived pre-set and staff were instructed not to adjust the settings unless there was a malfunction. RN-B stated nurses checked the machine to ensure the settings remained as originally set, particularly for residents who may attempt to alter the device; however, no documented settings were identified for R17 to verify accuracy.During an interview on 4/23/26 at 9:00 a.m., nurse manager and registered nurse (RN)-D stated when a BIPAP was ordered, the facility typically faxed the order to a respiratory company (such as Northwest Respiratory), who then came to the facility to set up the machine. RN-D stated staff were expected to have specific settings documented in the orders and that nurses assisted residents with donning and doffing the BIPAP and ensuring the setting are correct. RN-D further stated she had recently reviewed R17's record and was unable to locate documentation identifying the respiratory company responsible for setup or the specific BIPAP settings, noting R17 was the only resident for whom this information could not be found and that follow-up was in progress.A facility policy on respiratory care/BIPAP care was requested and not received.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245324	A. Building B. Wing	04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Estates at Bloomington LLC	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)
F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure non-pharmacological interventions were attempted and recorded prior to the administration of as-needed (PRN) narcotic/opioid and non-narcotic medication to help facilitate person-centered care planning and reduce the risk of complication (i.e., constipation, sedation) for 2 of 6 residents (R5, R28) reviewed for unnecessary medication use. Findings include: R5 R5's admission Minimum Data Set (MDS) assessment, dated 3/19/26, identified R5 had intact cognition with no hallucinations, delusions, verbal or physical behaviors. R5 did reject cares 1-3 times during observation period. In addition, the MDS outlined R5 received both scheduled and PRN pain medications during the review; however, did not receive any non-medication intervention for pain. Further, R5 indicated they had occasional pain which they rated at four (4) out of 10 (10 being the worst possible). R5's care plan, initiated on 3/17/26, identified R5 had an alteration in pain due to low back pain with a list goal of adequate relief from pain as evidenced by verbalization and freedom from signs/signs of non-verbal indicators of pain. The care plan listed intervention to help R5 meet this goal which included, provide non-medicinal forms of pain relief such as positioning, rest, massage, etc., and pain medication as ordered my MD, and document on effectiveness of pain medication. R5's April Medication and Treatment Administration Report (MAR/TAR) for 4/1/26 to 4/22/26 was reviewed and identified the following relevant information: -hydrocodone-acetaminophen 5-325 mg tablet – give one tablet by mouth as needed for severe pain twice a day for 10 days, separate doses by at least 6 hours with a start date of 3/23/26 and end date of 4/6/26 which had been administered 5 times. One administration was marked with an I which indicated ineffective and one with an U which indicated unknown per follow-up code guide. The remaining 3 administrations were documented with an e indicated effective. All administrations were documented with pain scale. There was no documentation with administration of a nonpharmacological intervention being offered prior to administration. - hydrocodone-acetaminophen 5-325 mg tablet – give one tablet by mouth as needed for severe pain for 7 days with a start date of 4/6/26 and end date of 4/13/26 which had been administered 5 times. Administrations documented with an e indicating effective along with a pain scale prior to administration. There was no documentation on the MAR of nonpharmacological interventions prior to administration. -hydrocodone-acetaminophen (opioid pain medication)5-325 milligram (mg) tablet – give one tablet by mouth as needed for pain for 10 days with a start date of 4/13/26 and end date of 4/24/26 which had been administered 6 times. Administrations documented with an e indicating effective along with a pain scale prior to administration. There was no documentation on the MAR of nonpharmacological interventions prior to administration. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245324	A. Building B. Wing	04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Estates at Bloomington LLC	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)
F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-methocarbamol (medication used to relieve pain) 600 mg tablet – give 600 mg by mouth as needed for pain / spasms with a start date of 3/19/26 which had been administered 22 times. The MAR/TAR lacked any orders or documentation for nonpharmacological interventions offered or attempted prior to administration of PRN medication administrated for pain. R5's progress notes, dated 4/1/26 to 4/22/26, were reviewed. Progress notes lacked evidence of nonpharmacological interventions being offered or attempted prior to administration of PRN pain medication. R5's medical record was reviewed and lacked evidence of what, if any, non-pharmacological interventions were offered or attempted prior to the administration of the PRN narcotic medication all the administered doses from 4/1/26 to 4/22/26. During an observation and interview on 4/20/26 at 3:22 p.m., R5 was observed lying in bed. R5 stated he had chronic pain and took muscle relaxants and narcotics to manage the pain. During the interview, R5 was administered pain medication (hydrocodone-acetaminophen and methocarbamol). During the observation, R5 was asked about a pain scale but was not offered any nonpharmacological interventions prior to the administration. R5 stated sometimes they will sometimes offer him alternatives prior to pain medications which are helpful such as putting a pillow underneath him to help reposition him. During an interview on 4/22/26 at 2:05 p.m., registered nurse (RN)-C stated when a resident reported pain, an assessment would be completed which included location of pain and vital signs. RN-C stated they would offer PRN pain medication and contact the provider if needed. RN-C stated if the resident was offered any non-pharmacological interventions, it would be documented on the MAR/TAR or in a progress note. During an interview on 4/23/26 at 9:14 a.m., licensed practical nurse care coordinator (LPN)-B stated the expectation would be a nurse completed a full evaluation on a resident when pain was reported. LPN-B stated the expectation would be a nonpharmacological intervention would be offered and documented prior to administration of PRN pain medications. During a follow up interview on 4/23/26 at 9:51 a.m., LPN-B verified there were no documented non-pharmacological interventions for R5 prior to administration of PRN pain medications. R28 R28's Minimum Data Set (MDS), dated [DATE], indicated R28 was admitted to the facility on [DATE], had a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition, and received PRN pain medication. The MDS further indicated R28 did not receive non-medication pain interventions. R28's care plan, initiated 2/20/26, indicated the resident was to receive non-pharmacological pain interventions, including positioning, rest, massage, and other comfort measures. However, the electronic medical record lacked documentation identifying resident-specific non-pharmacological interventions that had been attempted, what interventions were effective, or what interventions were ineffective for R28's pain management. Record review of physician orders indicated Cymbalta (Duloxetine) 60 mg daily for fibromyalgia and (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245324	A. Building B. Wing	04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Estates at Bloomington LLC	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)
F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Methocarbamol (a muscle relaxant) 500 mg every 6 hours as needed for pain/spasm. The record lacked any individualized, resident-specific non-pharmacological interventions associated with the PRN (as needed) pain regimen. R28's Medication Administration Record (MAR) and Treatment Administration Record (TAR) indicated R28 received 7 doses of Methocarbamol in April, with no corresponding documentation of non-pharmacological pain interventions provided prior to administration. During an interview on 4/22/26 at 10:43 a.m., registered nurse (RN)-B stated that when residents requested pain medication, they may receive PRN medication as needed. RN-B stated non-pharmacological interventions should be offered prior to PRN administration and documented in the MAR/TAR. RN-B stated residents with pain should have an associated order to offer specific non-pharmacological interventions and document via number association in the MAR/TAR. During an interview on 4/23/26 at 9:00 a.m., the nurse manager and (RN-D) and the Director of Nursing (DON) stated the expectation was that non-pharmacological pain interventions, such as repositioning, distraction, and other comfort measures, were to be implemented and documented prior to or in conjunction with PRN pain medication use. RN-D further stated that individualized non-pharmacological interventions should be identified in the care plan and documented to reflect what is effective or ineffective. At 9:52 a.m. on 4/23/26, follow-up with the DON indicated that non-pharmacological interventions for R28's muscle relaxer use could not be located, and the DON acknowledged that interventions must be documented to determine effectiveness and guide ongoing care. A facility policy titled Pain Management Protocol, dated 3/23/23, identified nursing will evaluate for appropriate non-pharmacological interventions to address the individual's pain.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245324	A. Building B. Wing	04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Estates at Bloomington LLC	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)
F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** During observation and interview, the facility failed to maintain a safe, comfortable, and homelike environment for 2 of 2 residents (R9, R13) reviewed whose main bedroom ceiling light did not function properly.Findings include: R9R9's quarterly Minimum Data Set (MDS) dated [DATE] identified R9 with impaired cognition, no limitation in upper extremity range of motion and dependent on staff for turning, repositioning, transfers, and all personal cares. R9's diagnoses include dementia. In addition, R9 was enrolled in hospice. R13R13's quarterly MDS dated [DATE] identified R13 with intact cognition and diagnoses of fibromyalgia, anxiety, depression and chronic pain.During observation and interview with R13 on 4/20/26 at 2:31 p.m., R13 pointed to flickering ceiling light and stated it had not worked for a long time. R13 stated she was frustrated, to have that strobe light [NAME] on and off which caused her headaches. R13 stated she had to currently use the pull string light over the head of her bed instead, otherwise the room was dark. During interview with nursing assistant (NA)-D on 4/22/26 at 1:39 p.m., NA-D stated expectation of staff to use the electronic messaging system, called TELS, to request maintenance repairs. NA-D stated all staff were trained and aware of putting in requests for maintenance to address. NA-D stated she was aware of R9 and R13's ceiling light not working for at least a month. No one likes [their light] flickering.During interview with director of nursing (DON) on 4/23/26 at 6:50 a.m., DON stated expectations of all staff to use the electronic messaging system, called TELS, to request maintenance repairs. DON stated the maintenance director (MT-D) would then receive the requests and prioritize them and address them.During interview with MT-D on 4/23/26 at 10:31 a.m., MT-D stated expectations of all staff to use the electronic messaging system, called TELS, to request maintenance repairs. He would then prioritize the requests and address them. MT-D verified no TELS requests were ever submitted for R9 and R13's ceiling light. I cannot fix something if it is not in the TELS system.Facility policy on reporting maintenance concerns was requested and not received.