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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Presbyterian Homes of Bloomington	9889 Penn Avenue South Bloomington, MN 55431

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE], 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 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 (continued on next page)

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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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 [DATE] 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 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.