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	06/24/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure medication orders received following a hospital visit were obtained, transcribed, and implemented timely for 1 of 3 residents (R110) reviewed for hospital return. The facility's failure resulted in a five-day delay in implementing an emergency department order increasing R110's torsemide dosage following treatment for worsening heart failure symptoms and placed the resident at risk for worsening fluid overload and respiratory compromise.Findings include: R110's admission Minimum Data Set, dated [DATE], identified R110 had moderate cognition and diagnoses included acute respiratory failure and hypoxia, heart failure, orthostatic hypotension, nonrheumatic tricuspid (valve) insufficiency, and atrial septal defect. R110 had shortness of breath or trouble breathing with exertion and received oxygen therapy and diuretics daily.R110's care plan dated 2/23/26 identified R110 required assistance of one staff for activities of daily living including bed mobility, transfers, toileting and ambulation. The plan identified R110 had an alteration in respiratory status and required oxygen via nasal cannula due to acute respiratory failure with hypoxia.R110's geriatric services provider visit dated 3/5/26, identified R110 was taking Torsemide (a medication used to treat fluid retention [edema] in people with medical conditions including heart failure) 5 mg daily.R110's emergency department note dated 3/6/26, identified R110's Torsemide was increased from 5 mg daily to 10 mg daily.R110's after visit summary from the 3/6/26 emergency room visit was requested although not received.R110's geriatric services provider visit dated 3/16/26, identified R110 was taking Torsemide 20 mg daily.R110's progress notes identified the following:n 3/3/26 at 7:45 a.m., R110 received torsemide 5 mg, one tablet by mouth in the morning.On 3/6/26 at 8:57 a.m., change of condition note: R110 was admitted to the facility with post right sided heart failure exacerbation. During the stay, R110's weight steadily increased, resident noted to have increased edema to bilateral lower extremities and upper extremities in the hands. Lungs were clear, resident denied shortness of breath, was noted to be using accessory muscles for respiration. Resident required oxygen via nasal cannula at 4 LPM (liters per minute), which was a change from baseline at 2 LPM. Updated doctor. R110 and wife agreed to transfer resident to ER for further assessment. R110 placed on non-rebreather face mask (a mask used to deliver high concentrations of oxygen quickly).On 3/6/26 at 21:39 p.m., R110 returned from the hospital in stable condition except R110's oxygen saturation (O2 sats) was 83% on 2 LPM oxygen. The note failed to identify if the doctor ordered any changes in medications.On 3/12/26 at 10:06 a.m., a progress note identified R110 started an increased dose of torsemide. The note did not identify the dosage administered.R110's progress notes dated 3/7/26 through 3/11/26 contained no evidence the emergency department order increasing torsemide had been obtained, reviewed, transcribed, or implemented.R110's Medication Administration Record dated 3/1/26 through 3/31/26, identified R110 received the following medications:3/1/26 through 3/11/26, R110 received Torsemide 5 mg tablet once daily in the morning. The order was discontinued on 3/11/26.3/12/26 through 3/13/26, R110 received Torsemide 5 mg two tablets (10 mg) by mouth in the morning. The order was started on 3/11/26 and discontinued 3/14/26.3/14/26, R110 received Torsemide 20 mg tablet once daily in the morning. The order was (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	started on 3/13/26 and discontinued 3/14/26.3/15/26 through 3/16/26, R110 received Torsemide 20 mg tablet once daily in the morning. The order started on 3/14/26 and discontinued 5/11/26.The facility continued administering torsemide 5 mg daily from 3/7/26 through 3/11/26 despite the emergency department order dated 3/6/26 increasing the medication to 10 mg daily. R110's quality concern form dated 6/15/26, identified the administrator received a voicemail from family member (FM)-A regarding concerns after R110's emergency room (ER) visit on 3/6/26. The report identified R110's Torsemide was increased, although the medication change was not completed until five days later. During interview on 6/23/26 at 11:02 a.m., FM-A stated on 3/6/26, R110 was sent to the ER and returned later the same day with medication changes. The ER doctor increased R110's Torsemide from 5 mg daily to 10 mg daily, although the facility didn't make the change until five days later. Then the day after the facility changed the resident's medication, the provider increased the residents Torsemide again to 20 mg daily. FM-A stated the facility failed to increase R110's Torsemide according to the doctor's orders.During interview on 6/23/26 at 5:54 p.m., registered nurse (RN)-A stated when a resident returned from the ER, the facility would receive the ER orders via fax or verbal order from the ER nurse. If the resident returned without paperwork, the receiving nurse would contact the hospital for orders. Either the health unit coordinator (HUC) or receiving nurse would enter the orders.During interview on 6/24/26 at 8:19 a.m., the director of nursing (DON) stated that when R110 returned from the ER on [DATE], the nurse did not receive the ER paperwork from the family. If the nurses don't receive paperwork from the hospital, they would assume there were no new orders. When asked the DON if it was the nurses' responsibility to contact the ER if they didn't receive paperwork, the DON stated, I will have to get back to you on that. At the time of survey exit, the DON failed to provide an answer.When interviewed on 6/24/26 8:51 a.m., RN-B stated generally, when a resident was readmitted by the ER, the ER would provide paperwork including an after-visit summary (AVS) identifying if there were any new orders. If a resident returned without paperwork, the receiving nurse should contact the ER and verify if there were new orders. When R110 returned from the ER on [DATE], the nurses should have contacted the ER for nurse-to-nurse report and/or request an AVS, and there should have been a chart note completed identifying what the new orders included. RN-B stated the risks of not knowing what happened during an ER visit, included potential changes in medications that could be missed which may cause changes in the resident's medical condition.On 6/24/26 at 10:35 a.m., the administrator stated the facility did not have a specific policy for readmissions. The administrator stated the facility did not have a policy to define the process for when residents returned without paperwork and were readmitted from the hospital; and they were still working on the investigation on what happened.A facility readmission policy was requested although not received.