Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
August 2, 2023

Administrator
Friendship Village Of Bloomington
8100 Highwood Drive
Bloomington, MN 55438

RE: CCN: 245229
Cycle Start Date: April 20, 2023

Dear Administrator:

On June 1, 2023 and June 30, 2023 the Minnesota Departments of Health and Public Safety, completed revisits to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 2, 2023

Administrator
Friendship Village Of Bloomington
8100 Highwood Drive
Bloomington, MN 55438

Re: Reinspection Results
Event ID: 0WWP12

Dear Administrator:

On June 1, 2023 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on April 20, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 3, 2023

Administrator
Friendship Village Of Bloomington
8100 Highwood Drive
Bloomington, MN 55438

RE: CCN: 245229
Cycle Start Date: April 20, 2023

Dear Administrator:

On April 20, 2023, 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 widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), 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:

Pete Cole, RN Unit Supervisor
Metro Team C District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: peter.cole@state.mn.us
Office/Mobile: (651) 249-1724

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 July 20, 2023 (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 October 20, 2023 (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/ltc_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.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 3, 2023

Administrator
Friendship Village Of Bloomington
8100 Highwood Drive
Bloomington, MN 55438

Re: State Nursing Home Licensing Orders
Event ID: 0WWP11

Dear Administrator:

The above facility was surveyed on April 17, 2023 through April 20, 2023 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a “suggested method of correction” has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Pete Cole, RN Unit Supervisor
Metro Team C District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: peter.cole@state.mn.us
Office/Mobile: (651) 249-1724

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.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245229	A. BUILDING ______ B. WING ______	C 04/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP VILLAGE OF BLOOMINGTON	**8100 HIGHWOOD DRIVE BLOOMINGTON, MN 55438**

(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
E 000	Initial Comments On 4/17/23 through 4/20/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was in compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 4/17/23 through 4/20/23, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. In addition to the recertification survey, the following complaint was reviewed The following complaint was reviewed with no deficiencies cited:. H52291327C (MN89823) 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		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/11/2023

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.

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	245229	A. BUILDING ______ B. WING ______	C **04/20/2023**

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F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the	F 550		5/31/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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FRIENDSHIP VILLAGE OF BLOOMINGTON	**8100 HIGHWOOD DRIVE BLOOMINGTON, MN 55438**

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F 550	Continued From page 2 exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide a dignified dining experience by failing to serve meals timely to residents at the same table which had the ability to affect all 25 residents living on the Maple Unit. Findings include: R8's admission Minimum Data Set (MDS) dated 2/6/23, indicated R8 was cognitively intact and needed set up assistance only with eating. R50's significant change MDS dated 3/28/23, indicated R50 had severe cognitive impairment and needed assistance with eating to include feeding the resident. R57's admission MDS dated 1/23/23, indicated R57 had moderate cognitive impairment and needed supervision with eating. Posted mealtimes for breakfast, lunch and dinner on the Maple Unit were 8:15 a.m., 12:15 p.m., and 6:15 p.m., respectively. During observation of the dinner meal on 4/17/23 at 6:10 p.m., residents were seated in the main dining area, waiting for dinner without any food or drink on the tables. The dining area consisted of multiple square tables that sat up to four residents. Food started being served to the residents at 6:31 p.m. Residents were being served in no particular order, and were not being served one table at a time. R8 was the first	F 550	It is the policy of Friendship Village of Bloomington to provide a dignified dining experience by serving meals timely to residents at the same table. To ensure on-going compliance, re-education of a timely serving residents at the same table will be completed for the dietary team. Director of Culinary and/or designee will complete random audit of the timeliness of meals served to resident at the same table three times a week for the first month, then random audits two times a week for the second month and random audits for the next four months. Results of the audits will be presented at the quarterly QAPI meetings. The Director of Culinary is responsible for on-going compliance. Date certain: 5/31/23	

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F 550	Continued From page 3	F 550		

resident to be served her meal at 6:31 p.m. and was finished with her meal before the rest of the residents at her table were served their food. R57, who shares a table with R8, was observed at 6:45 p.m., shaking her head, wondering out loud where her food was, stating the time as it was 30 minutes past when dinner should have been served.

During observation of the same dinner meal on 4/17/23 at 6:32 p.m., R50 was sitting at a different table in the dining room without food or drink in front of her. The resident sitting next to R50 had their meal in front of them and R50 was attempting to grab at the food, becoming increasingly agitated. Licensed practical nurse (LPN)-A was holding R50's hands away from her neighbor's food, stating, "food is coming soon." R50 was heard replying, "hurry up." R50 continued to reach for other residents' food at the table until 6:52 p.m. when she was the last resident in the dining room served.

During an interview on 4/20/23 at 12:14 p.m., R8 stated meals are often late and having to eat her meal alone, while other residents at her table did not have food made her feel embarrassed and was very uncomfortable.

During an interview on 4/19/23 at 12:25 p.m., the healthcare dining manager (HDM) stated the expectation for serving residents in the dining area was to attempt to serve the residents who needed assistance with eating first and to serve all the residents at one table at the same time.

A policy titled Resident Meal Service, dated 1/1/21, indicated meals should be served in a sequence so that all persons at one table are

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FRIENDSHIP VILLAGE OF BLOOMINGTON	**8100 HIGHWOOD DRIVE BLOOMINGTON, MN 55438**

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F 550	Continued From page 4 served at the same time.	F 550		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:	F 655		5/15/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP VILLAGE OF BLOOMINGTON	8100 HIGHWOOD DRIVE BLOOMINGTON, MN 55438

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F 655	Continued From page 5 (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a baseline care plan was reviewed and provided timely to ensure knowledge of care and promote person-centered care planning for 1 of 1 resident (R318) reviewed for care planning. Findings include: R318's face sheet indicated R318 admitted to the facility 4/11/23. R318's admission cognition assessment dated 4/18/23, indicated R318 was cognitively intact. R318's diagnoses list dated 4/11/23, indicated R318's diagnoses included heart failure, kidney disease, diabetes, depression, retention of urine, need for assistance with personal care, and dysphagia (difficulty swallowing food or liquid). R318's baseline care plan initiated 4/13/23, signed as received by R318 on 4/18/23. R318's social service evaluation dated 4/18/23, indicated R318's discharge plan of care goal was to participate in discharge planning, During interview on 4/17/23 at 3:23 p.m., R318	F 655	It is the policy of Friendship Village of Bloomington that all residents have the right to a Baseline Care Plan being provided to the resident and/or the residents responsible party in a timely manner. The team members that are responsible for completing sections of the baseline care plan or providing the baseline care plan will be re-educated related to the formulation and timeliness of the baseline care plan per FVB policy. The resident or resident's responsible party will be provided with a summary of the baseline care plan in pursuant to 483.21(a)(3). Social Services Director will complete audit of all admissions in the last month to ensure current residents and/or responsible parties have received copies of the baseline care plan summary. Completion 5/12/23 To ensure on-going compliance random audits of 50% of admissions will be completed weekly for the first month by the Director of Social Services and/or designee for compliance of timeliness of baseline care plan summary. Then random audits of admission for the next five months with results presented at the	

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F 655	Continued From page 6	F 655		

stated, "I don't know what to expect here." R318 stated had been in the facility for a week and did not know what the plan was for his care or discharge and was not provided anything verbally or in writing. Family member (FM)-A stated not knowing what the plan for care or discharge was either. FM-A further stated staff had not met with R318 or any family members to review the plan of care and a care conference had not been scheduled yet.

During interview on 4/20/23 at 9:49 a.m., social work (SW)-A stated met with R318 on 4/18/23 and scheduled a care conference for 4/26/23. SW-A further stated her meeting and initial evaluation with R318, "was a little late and not done timely in this case." SW-A stated typically the baseline care plan would be discussed and offered to the resident within the first two days of admission.

During interview on 4/20/23 at 10:49 a.m., director of nursing (DON) stated expectation baseline care plan should be completed and offered to the resident and/or resident's family with 24-48 hours after admission. DON further stated the baseline care plan was developed from hospital documentation and meeting with the resident. The importance of the baseline care plan is for patient-centered care and for the resident to know what to expect.

Facility policy Baseline Care Plan dated 9/19/22, indicated, "All resident have the right to participate in establishing the expected goals and outcomes ...a Baseline Care Plan formulated and developed within 48 hours of admission ...Baseline Care Plan will be provided to the resident and/or the resident's representative as

quarterly QAPI meetings.
The Director of Social Services is responsible for on-going compliance.
Date Certain: 5/15/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245229	A. BUILDING ______ B. WING ______	C 04/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP VILLAGE OF BLOOMINGTON	**8100 HIGHWOOD DRIVE BLOOMINGTON, MN 55438**

(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 655	Continued From page 7 applicable."	F 655		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure effective collaboration between the facility and a contracted hospice organization that affected 2 of 2 residents (R12 and R25) reviewed for hospice services. Findings include: R12's admission Minimum Data Set (MDS) dated 1/18/23, indicated R12 was cognitively intact, needed limited assistance with toilet use, dressing and bed mobility and needed supervision with transfers and personal hygiene. The MDS also indicated R12 was receiving hospice care and had medical diagnoses to include respiratory failure and heart failure. R12's hospice tab in the medical chart lacked a calendar of planned hospice visits and visit notes left from hospice staff used for collaboration of care between the hospice staff and facility staff. The hospice tab contained one licensed practical	F 684	It is the policy of Friendship Village of Bloomington to provide quality of care. The community will continue to ensure effective collaboration between our community and Hospice agencies of the residents' choice. To ensure effective collaboration with the hospice provider of R12 and R25 a meeting was held with Fairview Accent Hospice on May 5th, 2023, the provider of Hospice services for both residents. Expectations that a calendar of planned hospice visit and visit notes be in the chat for each resident receiving hospice services was reiterated. Fairview Accent Leaders confirmed that this is their standard of practice. Ensuring reordering of medication timely was also discussed. It is a standard of practice for Fairview Accent Care to have the Hospice nurse check all hospice medication during their weekly visit and reorder as needed. Friendship Village of Bloomington was	5/15/23

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F 684	Continued From page 8 nurse (LPN) note from 3/29/23 and one registered nurse (RN) note from 2/23/23. R12's progress notes and medication administration record (MAR) indicated R12 missed 14 days of spironolactone (a medication used to treat symptoms of heart failure including fluid retention) a hospice covered medication from 3/7/23 to 3/20/23. R25's MDS, dated 1/27/23, indicated R25's cognition was unable to be assessed but R25 had short term and long term memory problems, needed extensive assistance with bed mobility, dressing and eating and was depended on staff for personal hygiene, toilet use and transfers. The MDS also indicated R25 was receiving hospice care and had medical diagnoses to include dementia and adult failure to thrive. R25's hospice tab in the medical chart lacked a calendar of planned hospice visits and visit notes left from hospice staff used for collaboration of care between the hospice staff and facility staff. The hospice tab contained one LPN note from 3/29/23 and one RN note from 1/21/23. During an interview on 4/17/23 at 2:34 p.m., family member (FM)-B stated he was unsure what hospice provided for R25 and had, "not heard too much from hospice." During an interview on 4/19/23 at 1:17 p.m., registered nurse (RN)-D stated she was unaware what hospice did for R12 and R25, what they provided or what disciplines came out to see them and stated hospice staff would, "just show up." RN-D further stated facility staff should communicate with hospice when a hospice	F 684	assigned a new Accent Care Hospice nurse affective May 8th, 2023. To ensure on-going compliance weekly audits of hospice charts for Accent Care hospice residents will be conducted for the first month, then monthly audit for the next five months. Random audits will also be conducted for all hospice providers over the same six-month period with the results presented at the quarterly QAPI meetings. The director of Nurisng is for on-going compliance. Date certain: 5/15/23	

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F 684	Continued From page 9 covered medication is running low to ensure medications were not missed. During an interview on 4/19/23 at 11:51 a.m., licensed practical nurse (LPN)-A stated the hospice nurse came out once a week, but not on a set day and the day changed weekly. LPN-A stated it would be expected to have a calendar of visits in the resident's hospice tab to help with collaboration of care. During observation and interview on 4/20/23 at 8:47 a.m., LPN- A was unable to locate a hospice calendar in R12's or R25's chart. LPN-A stated a calendar was needed so facility staff, "know when hospice is coming out." LPN- A was able to locate a list of hospice covered medications which indicated spironolactone was a hospice covered medication. During an interview on 4/20/23 at 12:30 p.m., the hospice RN case manager, RN-E, stated she based her visits off patient need so she did not have a set day to visit R12 or R25 and further confirmed there was not a calendar at the facility indicating when hospice staff would visit. RN-E stated she did not have any insight into why R12 missed 14 days of her spironolactone but was able to verify 30 tabs were not delivered to the facility until 3/19/23. RN-E stated there were refills available for this medication and was unsure why it was not reordered timely. During an interview on 4/20/23 at 10:36 a.m., the director of nursing (DON) stated it would be expected that the hospice providers communicate when they are coming out to see the residents and leave visit notes behind for facility staff to review. The DON stated without a current hospice	F 684		

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F 684	Continued From page 10 plan of care, visit notes, and visit calendar, the "collaboration piece can be difficult." A policy titled Hospice Services, revised on 2/19/19, indicated it was the responsibly of the facility to coordinate and communicate with the hospice provider to ensure the level of care provided is appropriately based on the individual resident's needs and the resident's needs are addressed and met 24 hours a day.	F 684		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure the high temperature dishwasher was reaching temperatures high enough for proper sanitation of dishware which had the ability	F 812	It is the policy of Friendship Village of Bloomington to ensure the high temperature dishwasher reaches temperatures for proper sanitation in	5/31/23

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F 812	Continued From page 11 to affect all 61 residents residing at the facility. Findings include: During observation and interview on 4/20/23 at 11 a.m., the facility's high temperature, dual temperature dishwasher reached a maxiumum wash temperature of 162 degrees Fahrenheit and a final rinse temperature of 144 degrees Fahrenheit. A subsequent cycle revealed a wash temperature of 158 degrees Fahrenheit and a final rinse temperature of 176 degrees Fahrenheit. Dietary aide (DA)-A indicated wash temperatures should be at least 150 degrees Fahrenheit and final rinse temperatures should be at least 180 degrees Fahrenheit. DA-A stated they would need to stop using the dishwasher and switch to using the 3 compartment sink for washing dishware. Review of the facility's temperature log for the month of April revealed 4/19/23 and 4/20/23 were left blank and one low wash temperature of 148 degrees Fahrenheit was recorded on 4/9/23. During an interview on 4/20/23 at 10:05 a.m., the kitchen coach (KC) stated the dishwasher should be reaching a temperature of a least 150 degrees Fahrenheit for the wash cycle and at least 180 degrees Fahrenheit for the final rinse cycle for proper sanitation. The KC confirmed the dishwasher was not reaching proper temperatures and confirmed both the low temperature reading recorded on 4/9/23 and the blank spaces on the temperature log for 4/19/23 and 4/20/23 and stated the expectation was that the dishwasher temperature should be monitored and recorded twice a day. The KC further stated he was not notified the dishwasher was not	F 812	accordance with the guidelines according to the U.S. department of Health and Humans services, Public Health Services, Food and Drug Administration Food Code and document at each meal service dish machine temperatures. To ensure on-going compliance re-education on for proper sanitation in accordance with the guidelines according to the U.S. department of Health and Humans services, Public Health Services, Food and Drug Administration Food Code and document dish machine temperatures for the high temperature dishwasher. Director of Culinary and/or designee will complete random audit of the documentation three times a week for the first month, then random audits two times a week for the second month and random audits for the next four months. Results of the audits will be presented at the quarterly QAPI meetings. The Director of Culinary is responsible for on-going compliance. Date certain: 5/31/23	

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F 812	Continued From page 12 reaching proper temperatures but should have been. During observation and interview on 4/20/23 at 11:20 a.m., the dishwasher continued to not reach proper temperatures. The wash cycle reached a high temperature of 90 degrees Fahrenheit for multiple cycles and the final rinse cycle reached a high temperature of 143 degrees Fahrenheit for multiple cycles. The director of culinary services confirmed these temperatures were not high enough for proper sanitation and directed staff to stop using the dishwasher. A policy titled Sanitation and Infection Prevention/Control - Dishmachine Temperatures, revised 1/23, indicated dishmachine wash and rinse water should be maintained at temperatures that meet guidelines established by the Food and Drug Administration. The policy further indicated proper temperatures for high temperature, dual temperature machines was 150 degrees Fahrenheit for the wash temperature and 180 - 194 degrees Fahrenheit for the final rinse temperature.	F 812		
F 849 SS=D	Hospice Services CFR(s): 483.70(o)(1)-(4) §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will	F 849		5/15/23

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F 849	Continued From page 13 arrange for the provision of hospice services when a resident requests a transfer. §483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter. (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death.	F 849		

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F 849	Continued From page 14 (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility. (J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility	F 849		

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F 849	Continued From page 15	F 849		

becomes aware of the alleged violation.
(K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff.

§483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident.
The designated interdisciplinary team member is responsible for the following:
(i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services.
(ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family.
(iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians.
(iv) Obtaining the following information from the hospice:
(A) The most recent hospice plan of care specific

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F 849	Continued From page 16 to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is not met as evidenced by: Based on interview and record review, a facility contracted hospice agency failed to ensure a hospice covered medication was reordered timely for 1 of 1 resident (R12) reviewed for medications resulting in R12 missing 14 days of a medication. Findings include: R12's admission Minimum Data Set (MDS), dated 1/18/23, indicated R12 was cognitively intact,	F 849	It is the policy of Friendship Village of Bloomington to work in coordination with the hospice providers of resident's choice to provide quality of care. The community will continue to ensure that Hospice agencies of residents' choice are reordering medication in a timely manner. A meeting was held with Fairview Accent Hospice on May 5th, 2023, the provider of Hospice services for this resident. It is a	

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F 849

Continued From page 17

needed limited assistance with toilet use, dressing and bed mobility and needed supervision with transfers and personal hygiene. The MDS also indicated R12 was receiving hospice care and had medical diagnoses to include respiratory failure and heart failure.

R12's progress notes and medication administration record (MAR) indicated R12 missed 14 days of spironolactone (a medication used to treat symptoms of heart failure including fluid retention) a hospice covered medication from 3/7/23 to 3/20/23.

R12's MAR indicated R12 was given as needed (PRN) hydromorphone for shortness of breath 6 out of the 7 times that month from 3/7/23 to 3/20/23 when R12 was not receiving spironolactone. R12 received PRN hydromorphone on 3/7/23, 3/8/23, twice on 3/14/23 and twice on 3/18/23.

During an interview on 4/20/23 at 8:10 a.m., licensed practical nurse (LPN)-B stated the process for reordering medications was to reorder when there was a five-day supply left. LPN-B stated medications are either reordered through through their documentation system or through hospice if the resident was on hospice and the medication was hospice covered.

During an interview and observation on 4/19/23 at 11:51 a.m., LPN-A stated it would be expected that the nurses follow up on medication refill requests from hospice if the medication is not received timely. LPN-A stated if hospice was not able to get the medication reordered timely, the nurses should reorder the medication from the facility's pharmacy. LPN-A further stated she

F 849

standard of practice for Fairview Accent Care to have the Hospice nurse check all hospice covered medication during their weekly visit and reorder medication as needed. Friendship Village of Bloomington was assigned a new Accent Care Hospice nurse affective May 8th, 2023.
To ensure hospice covered medications are reordered timely Accent Care hospice residents' medication will be audited bi-weekly for one month and monthly for next five months. Random audits will also be conducted for all hospice providers over the same six-month period with the results presented at the quarterly QAPI meetings.
The Director of Nursing is responsible for on-going compliance.
Date certain: 5/15/23

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F 849	Continued From page 18 would have concerns about R12 missing spironolactone for 14 days due to R12's frequent shortness of breath. LPN- A was able to locate a list of hospice covered medications in R12's chart which indicated Spironolactone was a hospice covered medication. During an interview on 4/20/23 at 12:30 p.m., the hospice RN case manager, RN-E confimred spironolactone was a hospice covered medication but stated she did not have any insight into why R12 missed 14 days of her spironolactone. RN-E was able to verify 30 tablets of spironolactone were not delivered to the facility until 3/19/23 through Enclara Pharmacia, the hospice pharmacy. RN-E stated there were refills available for this medication and was unsure why it was not reordered timely. During an interview on 4/20/23 at 8:24 a.m., the facility pharmacist stated if the facility was unable to get a medication filled, he would expect the staff to email him immediately for follow up on the missing medication. During an interview on 4/20/23 at 10:36 a.m., the director of nursing (DON) stated it would be expected for staff to reach out to hospice first to reorder hospice covered medications and to follow up and reach out to the pharmacy if the medication was not received. The DON further stated she would have concerns if any medication was missed for 14 days and confirmed R12 had breathing issues. A policy titled Reordering, Changing, and Discontinuing Orders, revised on 1/1/22, indicated facility staff should review reorder status of medications for potential issues and pharmacy	F 849		

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FRIENDSHIP VILLAGE OF BLOOMINGTON	**8100 HIGHWOOD DRIVE** **BLOOMINGTON, MN 55438**

(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 849	Continued From page 19 response.	F 849		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00806	A. BUILDING: ______ B. WING ______	C 04/20/2023

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2 000	Initial Comments	2 000		

*****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 4/17/23 through 4/20/23, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was not in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and

Minnesota Department of Health

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2 000	Continued From page 1	2 000		

identify the date when they will be completed.

Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE

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2 000	Continued From page 2 IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
21160	MN Rule 4658.0675 Subp. 6 Mechanical Cleaning and Sanitizing; Hot Water Subp. 6. Hot water sanitization. Machines using hot water for sanitizing may be used provided that wash water and pumped rinse water are kept clean and water is maintained at not less than the temperature specified by NSF International Standard No. 3, incorporated by reference in subpart 2, under which the machine is evaluated. A pressure gauge must be installed with a valve immediately adjacent to the supply side of the control valve in the final rinse line provided that this requirement does not pertain to a dishwashing machine with a pumped final rinse. This MN Requirement is not met as evidenced by: Based on observation and interview, the facility failed to ensure the high temperature dishwasher was reaching temperatures high enough for proper sanitation of dishware which had the ability to affect all 61 residents residing at the facility. Findings include: During observation and interview on 4/20/23 at 11 a.m., the facility's high temperature, dual temperature dishwasher reached a maxiumum wash temperature of 162 degrees Fahrenheit and a final rinse temperature of 144 degrees Fahrenheit. A subsequent cycle revealed a wash temperature of 158 degrees Fahrenheit and a final rinse temperature of 176 degrees Fahrenheit. Dietary aide (DA)-A indicated wash	21160	corrected	5/31/23

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21160	Continued From page 3	21160		

temperatures should be at least 150 degrees Fahrenheit and final rinse temperatures should be at least 180 degrees Fahrenheit. DA-A stated they would need to stop using the dishwasher and switch to using the 3 compartment sink for washing dishware.

Review of the facility's temperature log for the month of April revealed 4/19/23 and 4/20/23 were left blank and one low wash temperature of 148 degrees Fahrenheit was recorded on 4/9/23.

During an interview on 4/20/23 at 10:05 a.m., the kitchen coach (KC) stated the dishwasher should be reaching a temperature of a least 150 degrees Fahrenheit for the wash cycle and at least 180 degrees Fahrenheit for the final rinse cycle for proper sanitation. The KC confirmed the dishwasher was not reaching proper temperatures and confirmed both the low temperature reading recorded on 4/9/23 and the blank spaces on the temperature log for 4/19/23 and 4/20/23 and stated the expectation was that the dishwasher temperature should be monitored and recorded twice a day. The KC further stated he was not notified the dishwasher was not reaching proper temperatures but should have been.

During observation and interview on 4/20/23 at 11:20 a.m., the dishwasher continued to not reach proper temperatures. The wash cycle reached a high temperature of 90 degrees Fahrenheit for multiple cycles and the final rinse cycle reached a high temperature of 143 degrees Fahrenheit for multiple cycles. The director of culinary services confirmed these temperatures were not high enough for proper sanitation and directed staff to stop using the dishwasher.

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21160	Continued From page 4 A policy titled Sanitation and Infection Prevention/Control - Dishmachine Temperatures, revised 1/23, indicated dishmachine wash and rinse water should be maintained at temperatures that meet guidelines established by the Food and Drug Administration. The policy further indicated proper temperatures for high temperature, dual temperature machines was 150 degrees Fahrenheit for the wash temperature and 180 - 194 degrees Fahrenheit for the final rinse temperature. SUGGESTED METHOD OF CORRECTION: The dietary manager, registered dietician, or administrator, could ensure dishwasher wash, rinse and sanitize cycles are maintained at appropriate temperatures for proper sanitation. The facility could update or create policies and procedures and educate staff on these changes and perform competencies. The dietary manager, registered dietician, or administrator could perform audits and report audit findings to the Quality Assurance Performance Improvement (QAPI) for further recommendations or to determine compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21160		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility.	21805		5/31/23

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21805	Continued From page 5 This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to provide a dignified dining experience by failing to serve meals timely to residents at the same table which had the ability to affect all 25 residents living on the Maple Unit. Findings include: R8's admission Minimum Data Set (MDS) dated 2/6/23, indicated R8 was cognitively intact and needed set up assistance only with eating. R50's significant change MDS dated 3/28/23, indicated R50 had severe cognitive impairment and needed assistance with eating to include feeding the resident. R57's admission MDS dated 1/23/23, indicated R57 had moderate cognitive impairment and needed supervision with eating. Posted mealtimes for breakfast, lunch and dinner on the Maple Unit were 8:15 a.m., 12:15 p.m., and 6:15 p.m., respectively. During observation of the dinner meal on 4/17/23 at 6:10 p.m., residents were seated in the main dining area, waiting for dinner without any food or drink on the tables. The dining area consisted of multiple square tables that sat up to four residents. Food started being served to the residents at 6:31 p.m. Residents were being served in no particular order, and were not being served one table at a time. R8 was the first resident to be served her meal at 6:31 p.m. and was finished with her meal before the rest of the residents at her table were served their food.	21805	corrected	

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21805	Continued From page 6	21805		

R57, who shares a table with R8, was observed at 6:45 p.m., shaking her head, wondering out loud where her food was, stating the time as it was 30 minutes past when dinner should have been served.

During observation of the same dinner meal on 4/17/23 at 6:32 p.m., R50 was sitting at a different table in the dining room without food or drink in front of her. The resident sitting next to R50 had their meal in front of them and R50 was attempting to grab at the food, becoming increasingly agitated. Licensed practical nurse (LPN)-A was holding R50's hands away from her neighbor's food, stating, "food is coming soon." R50 was heard replying, "hurry up." R50 continued to reach for other residents' food at the table until 6:52 p.m. when she was the last resident in the dining room served.

During an interview on 4/20/23 at 12:14 p.m., R8 stated meals are often late and having to eat her meal alone, while other residents at her table did not have food made her feel embarrassed and was very uncomfortable.

During an interview on 4/19/23 at 12:25 p.m., the healthcare dining manager (HDM) stated the expectation for serving residents in the dining area was to attempt to serve the residents who needed assistance with eating first and to serve all the residents at one table at the same time.

A policy titled Resident Meal Service, dated 1/1/21, indicated meals should be served in a sequence so that all persons at one table are served at the same time.

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21805	Continued From page 7 SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON), or designee could develop and implement a plan of care by the interdisciplinary team to ensure residents dignity is being maintained. The facility could update policies and procedures, educate staff on these changes, and audit to ensure resident(s) dignity are maintained. The results of these audits will be reviewed by the quality assurance committee to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21805		

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	245229	A. BUILDING **02 - FRENDSHIP VILLAGE OF BLOOMINGTON NEW BLDG** B. WING ____________	**04/18/2023**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 04/18/2023. At the time of this survey, FRIENDSHIP VILLAGE OF BLOOMINGTON was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/11/2023

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.

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K 000	Continued From page 1	K 000		

Healthcare Fire Inspections
State Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101-5145, OR

By email to:
FM.HC.Inspections@state.mn.us

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A detailed description of the corrective action taken or planned to correct the deficiency.

2. Address the measures that will be put in place to ensure the deficiency does not reoccur.

3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained.

4. Identify who is responsible for the corrective actions and monitoring of compliance.

5. The actual or proposed date for completion of the remedy.

FRIENDSHIP VILLAGE OF BLOOMINGTON is a 3 story building with full basement.

The building was constructed in 2022 and was determined to be of Type II (111) construction.

The facility is fully protected throughout by an automatic sprinkler system and has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification.

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K 000	Continued From page 2 The facility has a capacity of 66 beds and had a census of 64 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidence by:	K 000		
K 353 SS=D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____________________ b) Who provided system test ____________________________ c) Water system supply source __________________________ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to maintain the sprinkler system in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 9.7.5, 9.7.6 and NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 5.2.1.1.1. This deficient finding could have an isolated impact on	K 353	It is the policy of Friendship Village of Bloomington to maintain and test the sprinkler system in accordance with NFPA 101 (2012 edition). Life Safety Code, sections 9.7.5, 9.7.6 and NFPA 25 (2011 edition) Standard of the Inspection, testing and maintenance of Water-Based Fire Protection Systems, Section 5.2.1.1.1.	5/15/23

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K 353	Continued From page 3 the residents within the facility. Findings include: On 04/18/2023 between 9:30 AM and 2:30 PM, it was revealed by observation that the sprinkler heads in the Kitchen Area of the facility exhibited signs of debris loading An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 353	Cleaning of the sprinklers took place on May 4th, 2023, by an outside vendor. Cleaning of the sprinklers in the kitchen was added to the annual cleaning performed by the outside vendor. To ensure ongoing compliance monthly audits will be conducted of the kitchen sprinklers for the next six months by the Director of Community Service and/or designee to ensure minimal sign of debris loading, with results presented at the quarterly QAPI meetings. The Director of Community Servies is responsible for on-going compliance. Date Certain: 5/15/23	
K 374 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 NEW Doors in smoke barriers have at least a 20 minute fire protection rating or are at least 1-3/4 inch thick solid bonded core wood. Required clear widths are provided per 18.3.7.6(4) and (5). Nonrated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal-sliding doors comply with 7.2.1.14. Swinging doors shall be arranged so that each door swings in an opposite direction. Doors shall be self-closing and rabbets, bevels, or astragals are required at the meeting edges. Positive latching is not required. 18.3.7.6, 18.3.7.7, 18.3.7.8 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the	K 374	It is the policy of Friendship Village of	5/15/23

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K 374	Continued From page 4 facility failed to maintain the smoke barrier doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.8 and 7.1.10.2.1, 8.5.4.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 04/18/2023 between 9:30 AM and 2:30 PM, it was revealed by observation during the tour of the facility that upon testing of the smoke barrier doors adjacent to Room LD243, the door assembly did not close to resist the passage of smoke. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 374	Bloomington to maintain smoke barrier doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.8, 7.1.10.2 and 8.5.4.1. Smoke barrier doors adjected to Room LD243 was adjusted on April 18th, 2023 to ensure proper closer to resist the passage of smoke. To ensure ongoing compliance monthly audits will be conducted of the random smoke barrier doors for the next six months by the Director of Community Service and/or designee to ensure minimal sign of debris loading, with results presented at the quarterly QAPI meetings. The Director of Community Services is responsible for on-going compliance. Date Certain: 5/15/23	
K 923 SS=D	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual	K 923		5/31/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245229	A. BUILDING **02 - FRENDSHIP VILLAGE OF BLOOMINGTON NEW BLDG** B. WING ______	**04/18/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP VILLAGE OF BLOOMINGTON	**8100 HIGHWOOD DRIVE** **BLOOMINGTON, MN 55438**

(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
K 923	Continued From page 5 cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain proper medical gas storage and management per NFPA 99 (2012 edition), Health Care Facilities Code, sections 11.6.5.2. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 04/18/2023 between 9:30 AM and 2:30 PM, it was revealed by observation that in the Med Gas Storage Room, Room 363, there was mixed storage of empty and full cylinders. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 923	It is the policy of Friendship to maintain proper medical gas storage and management per NFPA 99 (2012) Health Care Facilities Code, section 11.6.5.2. On April 18th, the mixed storage of empty and full cylinders was immediately addressed and corrected. Team members that work with medical gas will be reeducated on the requirement to store empty and full cylinders separately. To ensure ongoing compliance weekly audits of each medical gas storage room will be conducted for 4 weeks and then random audits will be conducted monthly for the next 5 months. The Director of Community Services is responsible for on-going compliance. Date Certain: 5/31/23	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245229	A. BUILDING **02 - FRENDSHIP VILLAGE OF BLOOMINGTON NEW BLDG** B. WING ______	**04/18/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP VILLAGE OF BLOOMINGTON	**8100 HIGHWOOD DRIVE** **BLOOMINGTON, MN 55438**

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