DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
May 15, 2025

Administrator
Friendship Village Of Bloomington
8130 Highwood Drive
Bloomington, MN 55438

RE: CCN: 245229
Cycle Start Date: March 27, 2025

Dear Administrator:

On May 1, 2025, the Minnesota Department of Health and Public Safety completed a revisit 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.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

May 15, 2025

Administrator
Friendship Village Of Bloomington
8130 Highwood Drive
Bloomington, MN 55438

Re: Reinspection Results
Event ID: 7W2Q12

Dear Administrator:

On May 1, 2025 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 March 27, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 11, 2025

Administrator
Friendship Village Of Bloomington
8130 Highwood Drive
Bloomington, MN 55438

RE: CCN: 245229
Cycle Start Date: March 27, 2025

Dear Administrator:

On March 27, 2025, 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:

Renee McClellan, Regional Operations Supervisor
Metro A District Office
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: renee.mcclellan@state.mn.us
Office: 651-201-4391 Mobile: 651-328-9282

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 June 27, 2025 (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 September 27, 2025 (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)

In accordance with 42 CFR 488.331 **and Minnesota Statute 144A.10 subd 15**, 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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:
https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

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Electronically delivered
April 11, 2025

Administrator
Friendship Village Of Bloomington
8130 Highwood Drive
Bloomington, MN 55438

Re: State Nursing Home Licensing Orders
Event ID: 7W2Q11

Dear Administrator:

The above facility was surveyed on March 24, 2025 through March 27, 2025 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:

Renee McClellan, Regional Operations Supervisor
Metro A District Office
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: renee.mcclellan@state.mn.us
Office: 651-201-4391 Mobile: 651-328-9282

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.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@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 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP VILLAGE OF BLOOMINGTON	8130 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 3/24/25 - 3/27/25, a survey for compliance with §483.73, Appendix Z, Emergency Preparedness Requirements for Long Term Care Facilities 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 3/24/25 - 3/27/25, 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. The following complaints were reviewed with no deficiencies cited: H52291740C (MN00105874). 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	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/18/2025

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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F 000	Continued From page 1 onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 552 SS=D	Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5) §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to inform in advance and obtain consent for psychotropic medication use for 1 of 5 residents reviewed for unnecessary medications. Findings include: R22's annual Minimum Data Set (MDS) dated 1/28/25, indicated R22 had severe cognitive impairment, felt down, depressed or hopeless 2-6	F 552	Facility timely submits this response and plan of correction pursuant to federal and state law requirements. This response and plan of correction are not admissions or an agreement that a deficiency exists or that the statement of deficiency was correctly cited or factually based, and it is also not to be construed as an admission against interest of the facility, the administrator or any employees, agents or other individuals who participated in the	4/22/25

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F 552	Continued From page 2 days of the 14 day look back period, required moderate to substantial assistance with most activities of daily living (ADLs) and was taking antipsychotic and antidepressant medication. R22's diagnoses included Alzheimer's, dementia, depression and hallucinations. R22's care plan dated 2/25/25, indicated R22 used antipsychotic and antidepressant medications and was at risk for behaviors related to hallucinations. R22's March, 2025 medication administration record (MAR) indicated: Escitalopram Oxalate Oral Tablet 5 MG (Lexapro). Give 1 tablet by mouth one time a day for anxiety AEB (as evidenced by) reports of anxiety, restless physical movements, repetitive questions about going to work or home, reports of visual hallucinations. R22's physician order indicated Lexapro original start date was 7/4/24. R22's electronic medical record lacked evidence of an informed consent for Lexapro. During interview on 3/27/25 at 10:09 a.m., licensed practical nurse (LPN)-A stated any resident on a psychotropic medication should have been informed of risks and benefits and have a signed informed consent by self or representative. During interview on 3/27/25 at 11:16 a.m., director of nursing (DON) stated expectation R22, or representative should have been provided informed consent for any psychotropic prior to starting the medication and that signed consent	F 552	drafting or who may be discussed or otherwise identified in the same. F552 It is the policy of Friendship Village of Bloomington to obtain informed consent prior to the initiation of any psychotropic medication. Consent for Resident R22's Lexapro was obtained on 4/14/25. An audit was conducted for all current residents receiving psychotropic medications to ensure that valid consents were obtained and are on file. Nurses have been re-educated on the requirement to obtain informed consent prior to the initiation of any psychotropic medication. To ensure continued compliance, the Director of Nursing (DON) and/or designee will conduct monthly audits for three months, followed by random quarterly audits for an additional three months to verify that consent is obtained prior to starting any new psychotropic medications. Audit results will be reviewed during QAPI meetings. The Director of Nursing is responsible for ongoing compliance. Date certain 4/22/25	

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F 552	Continued From page 3 should be in the resident chart. During interview on 3/27/25 at 1:54 p.m., consultant pharmacist (CP) stated R22 should have a signed consent for each of the psychotropic medications currently taking. During interview on 3/27/25 at 3:21 p.m., SS-A stated unable to locate a consent for Lexapro in R22's chart. Facility policy Antipsychotic Medication Use dated July 2022, indicated, "Residents [and/or resident representatives] will be informed of the recommendation, risks, benefits, purpose and potential adverse consequences of antipsychotic medication use."	F 552		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in	F 676		4/22/25

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F 676	Continued From page 4 accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure activities of daily living (ADLs) were completed, including shaving for 1 of 1 resident (R22) reviewed for grooming. Findings include: R22's annual Minimum Data Set (MDS) dated 1/28/25, indicated R22 had severe cognitive impairment, required partial to moderate assistance with personal hygiene including shaving, and did not exhibit rejection of care. R22's diagnoses included Alzheimer's, dementia, lack of coordination, and need for assistance with personal cares. R22's care plan dated 2/25/25, indicated R22 had an ADL self-care deficit related to diagnoses and	F 676	F676 It is the policy of Friendship Village of Bloomington to ensure residents' activities of daily living, including shaving, are completed according to their preferences and care plans. Resident R22 was shaved on 3/30/25 when a new razor was provided by the family. Nurses and CNAs have been re-educated on shaving procedures and the proper documentation of task completion or resident refusal. To ensure ongoing compliance, the DON and/or designee will perform monthly	

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F 676	Continued From page 5 impaired balance. The care plan instructed staff to assist R22 with personal hygiene and cares. R22's Kardex printed 3/25/25, indicated R22 required assistance with cares and instructed staff to keep his routine as consistent as possible. R22's shaving task dated 2/24/25 through 3/24/25 indicated, "Resident *MUST* be shaved." A check mark was documented once each day under the "Yes" column. R22's March 2025, treatment administration record (TAR) indicated, "Document if resident was shaved ..." A check mark and yes or Y was documented twice a day each day in March through day shift on 3/25/25. During observation and interview on 3/24/25 at 1:38 p.m., R22 stated he preferred to be clean shaven and usually shaved every day. R22 had several day's growth of facial hair. During observation on 3/25/25 at 1:05 p.m., R22 was sitting in the dining room eating lunch. R22 was not shaved and had a several day's growth of facial hair. During interview on 3/25/25 at 2:36 p.m., nursing assistant (NA)-A stated NAs were responsible to assist residents with shaving per their preferences. If a resident preferred to shave daily, the NAs would assist the resident as needed. NA-A stated R22 could shave himself but needed assistance with set up and he did like to shave every day. NA-A stated the NAs had a task sheet on their iPad that they would sign off when specific tasks were completed. NA-A stated tasks should not be signed off as completed if not	F 676	audits for three months and then random quarterly audits for an additional three months to ensure residents are shaved per their preferences and that documentation reflects care provided or refused. Audit results will be reviewed during QAPI meetings. The Director of Nursing is responsible for ongoing compliance. Date certain 4/22/25	

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F 676	Continued From page 6 actually done. During interview on 3/25/25 at 2:58 p.m., registered nurse (RN)-A stated NAs were responsible to complete showers and other personal cares such as shaving with the residents, and they should be signing the task off when completed. RN-A confirmed there was a task in R22's TAR for the nurse to sign off to ensure R22 was shaved and could not explain why it was signed off when R22 had not been shaved. RN-A stated occasional residents would refuse some cares and that refusals should be documented as such in the TAR. During interview on 3/25/25 at 3:07 p.m., director of nursing (DON) stated expectation tasks should only be signed off as completed if actually done otherwise refusals or other reasons not completed should be documented. DON further stated expectation R22 would be clean shaven per his preference, but thought there might have been an issue with his shaver. Facility policy Activities of Daily Living (ADLs), Supporting dated March, 2018, indicated residents will be provided with care and services appropriate to maintain their ability to perform ADLs. Those residents who were unable to perform ADLs independently would receive services necessary to maintain good grooming and personal hygiene.	F 676		
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	F 684		4/22/25

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	8130 HIGHWOOD DRIVE BLOOMINGTON, MN 55438

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F 684	Continued From page 7 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 wounds were accurately assessed and reported appropriately when thought to be deteriorating for 1 of 3 residents reviewed for wound assessment and monitoring. Findings include: R32's quarterly Minimum Data Set (MDS) dated 2/25/25, indicated R32 had severe cognitive impairment, required substantial/maximal assistance with personal cares and mobility, was always incontinent of bowel and bladder, was at risk for developing pressure ulcers but did not have any at the time of the assessment. The MDS further indicated R32 did not exhibit physical or verbal behaviors towards others and did not reject cares. R32's diagnoses included dementia, type 2 diabetes, congestive heart failure, and kidney disease. R32's care plan revised 12/31/24, indicated R32 had potential for pressure ulcer development related to immobility, incontinence, and diabetes. The care plan instructed staff to "monitor/document/report PRN [as needed] any changes in skin status: appearance, color, wound healing, s/sx [signs/symptoms] of infection, wound size [length x width x depth], stage."	F 684	F684 It is the policy of Friendship Village of Bloomington to ensure wounds are thoroughly assessed and appropriately monitored, with timely communication to the wound team, provider, and responsible party regarding any changes. A comprehensive skin assessment was completed by the wound team on 3/27/25 (is this correct) for Resident R32 Nurses have been re-educated on timely notifying the wound care team, the resident's provider, and the family when there is a change in the wound’s condition. The DON and/or designee will conduct monthly audits for three months and random quarterly audits for an additional three months to ensure all wounds are properly assessed and monitored in a timely and accurate manner. Audit results will be reviewed during QAPI meetings. The Director of Nursing is responsible for ongoing compliance.	

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F 684	Continued From page 8 R32's Kardex printed 3/27/25, indicated, "Follow facility policies/protocols for the prevention/treatment of skin breakdown." R32's BRADEN (assessment for predicting skin breakdown risk) dated 2/24/25, indicated R32 was at moderate risk for developing a pressure ulcer. R32's skin check dated 2/26/25, indicated R32 had four skin issues: - bruising on left outer forearm, in-house acquired, wound is new - skin tear on left outer forearm, in-house acquired, wound is new - skin tear on left outer forearm, in-house acquired - abrasion on left gluteal fold, in-house acquired R32's skin check dated 3/5/25, indicated R32 had seven skin issues: -bruising on left outer forearm, stable, in-house acquired, unknown how long wound present - skin tear on left outer forearm, in-house acquired, wound is new - skin tear on left outer forearm, in-house acquired - abrasion on left gluteal fold, in-house acquired - skin tear on left outer wrist, in-house acquired, wound is new - scab, in-house acquired, unknown how long wound present, length 1cm, width 1cm - stage 2 pressure ulcer (partial-thickness skin loss involving the epidermis and/or dermis, presents as a shallow open ulcer, blister, or abrasion) on buttocks, increased exudate (fluid	F 684	Date certain 4/22/25	

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F 684	Continued From page 9	F 684		

that leaks out of blood vessels into surrounding tissue), in-house acquired, unknown how long wound present, wound not measured due to resident being combative.

R32's skin check dated 3/12/25, indicated three previous skin tear issues and one scab resolved. The other four skin issues indicated:
- stage 2 pressure ulcer-progress deteriorating on buttocks 3.4cm x 3cm x 0.1cm
- bruising on left outer forearm
- abrasion on left gluteal fold-progress stalled

R32's skin check dated 3/19/25, indicated three skin issues:
- stage 2 pressure ulcer on buttocks-partial thickness skin loss with exposed dermis (no measurements)
- bruising on left outer forearm
- abrasion on left gluteal fold

R32's March 2025, treatment administration record (TAR) indicated, "Left gluteal fold treatment: Cleanse with wound cleaner, pat dry and cover with Mepilex Border until healed every evening shift. Update provider with any concerns." Start date 2/15/25 (still active) and signed off as being completed every evening shift 3/1/25 through 3/26/25. R32's TAR further indicated left forearm skin tear wound care orders start date 2/4/25 and discontinued date 3/7/25. R32's TAR lacked evidence of any further active or discontinued wound treatment orders.

R32's electronic medical record (EMR) lacked evidence of any wound care team weekly rounding notes for any current skin issues.

During observation and interview on 3/25/25 at

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F 684	Continued From page 10 2:55 at p.m., nursing assistant (NA)-A was overheard requesting a new patch for R32 from a nurse. When interviewed, NA-A stated (R32) had a pressure wound on his backside and the patch was to keep it covered and protected. During observation and interview on 3/27/25 at 9:52 a.m., NA-B and NA-C into R32's room for a brief check and transfer. R32's wet and bm soiled brief removed and personal care completed. An uncovered nickel-sized open area (top layer of skin removed) was observed on R32's left gluteal fold. NA-C stated there should be Mepilex dressing covering the open area and could not explain why it was missing. NA-B stated thinking R32's wound had been open like this for 1-2 weeks. During interview on 3/27/25 at 11:05 a.m., licensed practical nurse (LPN)-A stated R32's wound on his buttock and on the left gluteal fold were actually the same wound and had probably been labeled wrong in documentation. LPN-A stated thinking the wound was from friction-sliding off his wheelchair-and not a pressure ulcer. LPN-A stated could not remember the last time she laid eyes on R32's bottom and was not aware of any open areas. LPN-A stated R32 was not receiving weekly wound rounds and only getting weekly skin checks by the assigned nurse. LPN-A stated expectation for staff to report any changes or new skin areas. LPN-A stated skin status changes could result in new orders for treatment and weekly wound round monitoring for wound pictures and measurements. During interview on 3/27/25 at 11:27 a.m., director of nursing (DON) stated was not aware of any open areas on R32's buttock. DON stated all	F 684		

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F 684	Continued From page 11 newly identified skin issues should have been reported to LPN-A. DON stated if a new stage 2 pressure ulcer had been identified and reported, the provider would be updated and new orders for treatment and wound round inclusion would potentially be initiated. DON stated all wounds should be rounded on and tracked for status changes with a goal for the wound to heal or at minimum not to deteriorate. During observation and interview on 3/27/25 at 11:44 a.m., LPN-A, registered nurse (RN)-D and DON entered R32's room to evaluate his wound status. LPN-A stated there was one wound on R32's bottom and it appeared superficial with granulation. LPN-A stated the wound bed and surrounding tissue were blanchable and did not feel it was a stage 2 pressure ulcer. RN-A and DON agreed with LPN-A's assessment. R32 appeared cooperative while wound pictures and measurements were taken. During interview on 3/27/25 at 12:15 p.m., LPN-C stated had just placed new dressing on R32's bottom this morning after NAs reported it missing. LPN-C stated had not worked with R32 in a while and could not identify the type of wound or how long it had been open. During interview on 3/27/25 at 3:32 p.m., nurse practitioner (NP) stated was initially informed of a friction abrasion on R32's bottom and had provided treatment orders. NP stated had not received any notification that the wound had changed or deteriorated or that there were any new pressure ulcers. NP stated had she been notified of any changes; she would have potentially provided new treatment orders and would expect R32 to be included on weekly	F 684		

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F 684	Continued From page 12 wound care team rounds. Facility policy Change in a Resident's Condition of Status dated 2/2021, indicated, "Our facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status." Facility policy Wound Care dated 4/1/22, indicated the facility would "utilize evidence-based clinical practices to provide pressure injury and wound treatments in our skilled nursing and rehabilitation health centers."	F 684		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following	F 880		4/22/25

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F 880	Continued From page 13 accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F 880		

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F 880	Continued From page 14 §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure hand hygiene was performed for 1 of 3 residents (R24) observed during personal cares and 1 of 1 residents (R24) observed during wound cares. Furthermore, the facility failed to ensure enhanced barrier precautions (EBP) were followed for 1 of 1 residents (R24) observed for EBP. Findings include: R24's quarterly Minimum Data Set, dated 3/18/25, indicated he had intact cognition and required partial to moderate assistance with personal hygiene. The MDS reported diagnoses of kidney failure, high blood pressure, depression and chronic pain. The MDS also reported his use of an indwelling urinary catheter and identified he had one venous ulcer. R24's care plan identified his catheter use and need for EBP. The care plan also indicated he had an activities of daily living (ADL) self-care performance deficit related to his left leg amputation and limited mobility. The care plan directed staff to provide extensive assistance with personal hygiene. Furthermore, the care plan reported a venous/stasis ulcer to his left shin and identified a goal to be free from signs and/or symptoms of infection. R24's treatment administration record (TAR)	F 880	F880 – It is the policy of Friendship Village of Bloomington to ensure hand hygiene is properly performed between glove changes. It is the policy of Friendship Village of Bloomington to use Enhanced Barrier Precautions (EBP) as required. • Nursing Assistant E received re-education on proper hand hygiene, including between glove changes on 4-16-25. • Nurse C received re-education on the correct application of Enhanced Barrier Precautions on 3-27-25. Nurses and CNAs have been re-educated on proper hand hygiene techniques and the correct use of Enhanced Barrier Precautions. The DON and/or designee will perform monthly audits for three months and random quarterly audits for an additional three months to ensure: • Hand hygiene is performed consistently, including between glove changes. • Enhanced Barrier Precautions are followed appropriately during wound care.	

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F 880	Continued From page 15 dated 3/27/25, indicated the following wound care order: - "wound on right lower leg, cleanse with wound cleanser. Leave on bed 1 - 5 min. [sic, minutes] Apply skin prep to peri wound skin. Allow to dry completely (not tacky). Then apply thin layer, Xeroform over open leg wound. Only apply on wound bed. Cover with ABD Pad. Hold in place with Kerlix. Apply a white wound sock over Kerlix before applying low stretch wrap to his foot to help with edema" two times a day. Hand Hygiene and Personal Cares During observation on 3/26/25 at 11:35 a.m., R24 was lying in bed and nursing assistant (NA)-D and NA-E were performing personal cares with gowns and gloves on. NA-E set up a basin with water and washcloths at the bedside. The NAs helped R24 remove his hospital gown over his head and then pulled down his incontinence brief. NA-E used one hand to secure the catheter tubing while using the other hand to wash his peri-area. NA-E used a new corner of a folded washcloth to wipe his groin and then each thigh/inner leg. Next, NA-E used a new washcloth to wipe down each of R24's legs, starting at his hip level and wiping down. NA-E did not change gloves or perform hand hygiene. NA-D assisted him onto his left, and he grabbed the grab bar with his hands and pulled himself over. R24 had a tan-colored foam dressing covering his coccyx and the bottom portion of the dressing was not intact. Continuing with the same gloves, NA-E used a new washcloth to wipe his back, then cleansed his buttocks. NA-E rolled the briefs and linen under his body and using the same gloved hands, applied cream to his bottom and around	F 880	Audit results will be reviewed during QAPI meetings. The Director of Nursing is responsible for ongoing compliance. Date certain 4/22/25	

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F 880	Continued From page 16 the foam dressing. Next, R24 was assisted to turn over the pile of rolled briefs and linen onto his other side and NA-D pulled the linen and briefs through so he could lay flat on his back again. NA-D fastened the tabs on the brief and NA-E doffed the gloves before donning new gloves without performing hand hygiene. Together, the NAs helped guide his arms into his t-shirt and pulled it over his head and pulled it down in the back. The NAs assist him onto his back per his comfort and NA-E gave him a washcloth for him to wash his hands. Per interview on 3/26/25 at 11:52 a.m., NA-E stated to prevent the spread of infection, staff should perform hand hygiene before entering a resident's room, during resident cares, and with any glove change. NA-E also stated staff should wear appropriate personal protective equipment (PPE). NA-E verified staff should wash in a clean to dirty manner or change gloves between dirty and clean during personal hygiene cares. NA-E confirmed a missed opportunity for hand hygiene during cares when going from dirty to clean and not changing gloves. Hand Hygiene, EBP and Wound Care During observation of wound care on 3/27/25 at 10:32 a.m., registered nurse (RN)-C knocked and entered R24's room without a gown or gloves on and asked him if wound cares could be performed. He was agreeable and RN-C donned clean gloves but not a gown. RN-C placed an absorbent pad underneath his right leg and began removing the tape and wrapped gauze from his wound. R24 asked RN-C if he could have pain medication and RN-C offered to bring him his medication before starting the dressing	F 880		

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F 880	Continued From page 17 change. He stated he would prefer to have his pain medication first. RN-C finished removing the wrapped gauze, leaving the padded dressing to cover his leg wound, doffed the gloves the doorway and exited the room. At 10:41 a.m., RN-C knocked and entered the room with a paper medication cup. RN-C assessed his pain and gave him the cup before going to the bathroom and performing hand washing. RN-C donned clean gloves but did not don a gown. At his bedside, RN-C sprayed wound cleanser over the padded dressing to remove it, then removed the yellowed-colored petroleum dressing from the wound beds. RN-C asked R24 how he was feeling and, with the same gloved hands, began to spray the wound with the wound cleanser before patting it dry with clean, dry gauze. RN-C repeated the spray and patting dry with gauze three times. Next, RN-C doffed the gloves, performed handwashing at the bathroom sink, and donned clean gloves. RN-C then applied liquid from a blue bottle labeled "Vashe" to a clean gauze and dabbed it onto each wound bed on R24's right shin. With gloved hands, RN-C walked over to his dresser and opened the top drawer, then closed the drawer and came back to his bedside and began applying more of the "Vashe" to the gauze, then dabbing it onto his wound beds. RN-C explained the Vashe had to dry for 5 minutes before it could be covered with the padded dressing. R24 asked for a drink of water, and RN-C assisted him lifting his water pitcher to his mouth with the same gloved hands. RN-C conversed with him about the TV program he was watching and doffed the gloves, did not perform hand hygiene and donned new gloves. RN-C cut new pieces of the petroleum gauze and laid them overtop the wound beds on his right shin. Next, RN-C applied the padded dressing,	F 880		

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F 880	Continued From page 18 then wrapped his right lower leg with the rolled gauze. As RN-C was about to tear a piece of tape off the roll, the petroleum gauze fell onto the floor and with gloved hands, RN-C picked up the dressing from the floor and threw it away in the garbage. Without changing gloves, RN-C tore two pieces of tape from the roll and applied them to the wrapped gauze on R24's leg. RN-C then doffed gloves and performed hand washing at the sink. Per interview on 3/27/25 at 10:59 a.m. with RN-C, hand hygiene should be performed before starting resident cares, between glove changes, if gloves are soiled, and when finished with cares. RN-C verified R24 was on EBP and stated staff were expected to wear gown and gloves when performing wound care and catheter care. RN-C stated it was important to perform hand hygiene and follow EBP to prevent the spread of infection and for resident safety. RN-C stated "I should have worn a gown" during wound cares. RN-C indicated changing gloves during wound care but acknowledged missed hand hygiene opportunities. Per interview at 3/27/25 at 1:09 p.m. with RN-D, a nurse lead, and the infection preventionist (IP), staff were expected to perform hand hygiene, or "foam in and out", when going in and out of resident rooms and when changing gloves. RN-D and IP expected staff to perform peri-cares in a clean-to-dirty manner or, if gloves become dirty or soiled, to change gloves and perform hand hygiene. RN-D and IP stated PPE for EBP should be worn during wound care and expected staff to perform hand hygiene after going from a dirty dressing or area to a clean dressing or area and with glove changes.	F 880		

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F 880	Continued From page 19 Per interview on 3/27/25 at 3:19 p.m. with licensed practical nurse (LPN)-A, staff were expected to perform hand hygiene during personal cares and wound cares in addition to wearing appropriate PPE for a resident on EBP. Per facility policy titled Handwashing/Hand Hygiene revised 8/19, the facility considered hand hygiene the primary means to prevent the spread of infection and directed staff to perform handwashing when hands were visibly soiled and after contact with a resident with infectious diarrhea. The policy directed staff to use an alcohol-based hand rub (ABHR) or soap and water before and after direct contact with residents, before performing any non-surgical invasive procedures, before and after handling an invasive device (for example, urinary catheters), before handling clean or soiled dressings or gauze pads, before moving from a contaminated body site to a clean body site during reside care, after contact with a resident's intact skin, after contact with blood or bodily fluids, after contact with objects (medical equipment) in the immediate vicinity of the resident, after removing gloves, before and after entering isolation precaution settings, and remove and disposing of PPE. Per facility policy titled Enhanced Barrier Precautions revised 4/5/24, EBP would be implemented for residents with chronic wounds, including pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers. The policy indicated all team members would wear appropriate PPE (gown and gloves) for high-contact resident care, including wound care.	F 880		

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	245229	A. BUILDING _____ B. WING _____	C 03/27/2025

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2 000	Initial Comments *****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 3/24/25 - 3/27/25, 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	2 000		

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2 000	Continued From page 1 identify the date when they will be completed. The following complaints were reviewed: H52291740C (MN00105874). No citations were issued. 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.	2 000		

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2 000	Continued From page 2 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.	2 000		
2 850	MN Rule 4658.0520 Subp. 2 D Adequate and Proper Nursing Care; Shaving Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: D. Assistance with or supervision of shaving of all residents as necessary to keep them clean and well-groomed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure activities of daily living (ADLs) were completed, including shaving for 1 of 1 resident (R22) reviewed for grooming. Findings include: R22's annual Minimum Data Set (MDS) dated 1/28/25, indicated R22 had severe cognitive impairment, required partial to moderate assistance with personal hygiene including shaving, and did not exhibit rejection of care. R22's diagnoses included Alzheimer's, dementia, lack of coordination, and need for assistance with personal cares.	2 850	It is the policy of Friendship Village of Bloomington to ensure residents' activities of daily living, including shaving, are completed according to their preferences and care plans. Resident R22 was shaved on 3/30/25 when a new razor was provided by the family. Nurses and CNAs have been re-educated on shaving procedures and the proper documentation of task completion or resident refusal. To ensure ongoing compliance, the DON and/or designee will perform monthly	4/22/25

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2 850	Continued From page 3 R22's care plan dated 2/25/25, indicated R22 had an ADL self-care deficit related to diagnoses and impaired balance. The care plan instructed staff to assist R22 with personal hygiene and cares. R22's Kardex printed 3/25/25, indicated R22 required assistance with cares and instructed staff to keep his routine as consistent as possible. R22's shaving task dated 2/24/25 through 3/24/25 indicated, "Resident *MUST* be shaved." A check mark was documented once each day under the "Yes" column. R22's March 2025, treatment administration record (TAR) indicated, "Document if resident was shaved ..." A check mark and yes or Y was documented twice a day each day in March through day shift on 3/25/25. During observation and interview on 3/24/25 at 1:38 p.m., R22 stated he preferred to be clean shaven and usually shaved every day. R22 had several day's growth of facial hair. During observation on 3/25/25 at 1:05 p.m., R22 was sitting in the dining room eating lunch. R22 was not shaved and had a several day's growth of facial hair. During interview on 3/25/25 at 2:36 p.m., nursing assistant (NA)-A stated NAs were responsible to assist residents with shaving per their preferences. If a resident preferred to shave daily, the NAs would assist the resident as needed. NA-A stated R22 could shave himself but needed assistance with set up and he did like to shave every day. NA-A stated the NAs had a task sheet on their iPad that they would sign off when specific tasks were completed. NA-A stated tasks	2 850	audits for three months and then random quarterly audits for an additional three months to ensure residents are shaved per their preferences and that documentation reflects care provided or refused. Audit results will be reviewed during QAPI meetings. The Director of Nursing is responsible for ongoing compliance. Date certain 4/22/25	

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2 850	Continued From page 4 should not be signed off as completed if not actually done. During interview on 3/25/25 at 2:58 p.m., registered nurse (RN)-A stated NAs were responsible to complete showers and other personal cares such as shaving with the residents, and they should be signing the task off when completed. RN-A confirmed there was a task in R22's TAR for the nurse to sign off to ensure R22 was shaved and could not explain why it was signed off when R22 had not been shaved. RN-A stated occasional residents would refuse some cares and that refusals should be documented as such in the TAR. During interview on 3/25/25 at 3:07 p.m., director of nursing (DON) stated expectation tasks should only be signed off as completed if actually done otherwise refusals or other reasons not completed should be documented. DON further stated expectation R22 would be clean shaven per his preference, but thought there might have been an issue with his shaver. Facility policy Activities of Daily Living (ADLs), Supporting dated March, 2018, indicated residents will be provided with care and services appropriate to maintain their ability to perform ADLs. Those residents who were unable to perform ADLs independently would receive services necessary to maintain good grooming and personal hygiene. SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could educate responsible staff to residents were shaved according to their personal preference. The DON or designee could conduct audits of resident cares to ensure their personal hygiene	2 850		

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2 850	Continued From page 5 needs are met consistently. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 850		
2 915	MN Rule 4658.0525 Subp. 6 A Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident is given the appropriate treatments and services to maintain or improve abilities in activities of daily living unless deterioration is a normal or characteristic part of the resident's condition. For purposes of this part, activities of daily living includes the resident's ability to: (1) bathe, dress, and groom; (2) transfer and ambulate; (3) use the toilet; (4) eat; and (5) use speech, language, or other functional communication systems; and This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure activities of daily living (ADLs) were completed, including shaving for 1 of 1 resident (R22) reviewed for grooming. Findings include: R22's annual Minimum Data Set (MDS) dated	2 915	It is the policy of Friendship Village of Bloomington to ensure residents' activities of daily living, including shaving, are completed according to their preferences and care plans. Resident R22 was shaved on 3/30/25 when a new razor was provided by the family.	4/22/25

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2 915	Continued From page 6 1/28/25, indicated R22 had severe cognitive impairment, required partial to moderate assistance with personal hygiene including shaving, and did not exhibit rejection of care. R22's diagnoses included Alzheimer's, dementia, lack of coordination, and need for assistance with personal cares. R22's care plan dated 2/25/25, indicated R22 had an ADL self-care deficit related to diagnoses and impaired balance. The care plan instructed staff to assist R22 with personal hygiene and cares. R22's Kardex printed 3/25/25, indicated R22 required assistance with cares and instructed staff to keep his routine as consistent as possible. R22's shaving task dated 2/24/25 through 3/24/25 indicated, "Resident *MUST* be shaved." A check mark was documented once each day under the "Yes" column. R22's March 2025, treatment administration record (TAR) indicated, "Document if resident was shaved ..." A check mark and yes or Y was documented twice a day each day in March through day shift on 3/25/25. During observation and interview on 3/24/25 at 1:38 p.m., R22 stated he preferred to be clean shaven and usually shaved every day. R22 had several day's growth of facial hair. During observation on 3/25/25 at 1:05 p.m., R22 was sitting in the dining room eating lunch. R22 was not shaved and had a several day's growth of facial hair. During interview on 3/25/25 at 2:36 p.m., nursing assistant (NA)-A stated NAs were responsible to	2 915	Nurses and CNAs have been re-educated on shaving procedures and the proper documentation of task completion or resident refusal. To ensure ongoing compliance, the DON and/or designee will perform monthly audits for three months and then random quarterly audits for an additional three months to ensure residents are shaved per their preferences and that documentation reflects care provided or refused. Audit results will be reviewed during QAPI meetings. The Director of Nursing is responsible for ongoing compliance. Date certain 4/22/25	

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2 915	Continued From page 7 assist residents with shaving per their preferences. If a resident preferred to shave daily, the NAs would assist the resident as needed. NA-A stated R22 could shave himself but needed assistance with set up and he did like to shave every day. NA-A stated the NAs had a task sheet on their iPad that they would sign off when specific tasks were completed. NA-A stated tasks should not be signed off as completed if not actually done. During interview on 3/25/25 at 2:58 p.m., registered nurse (RN)-A stated NAs were responsible to complete showers and other personal cares such as shaving with the residents, and they should be signing the task off when completed. RN-A confirmed there was a task in R22's TAR for the nurse to sign off to ensure R22 was shaved and could not explain why it was signed off when R22 had not been shaved. RN-A stated occasional residents would refuse some cares and that refusals should be documented as such in the TAR. During interview on 3/25/25 at 3:07 p.m., director of nursing (DON) stated expectation tasks should only be signed off as completed if actually done otherwise refusals or other reasons not completed should be documented. DON further stated expectation R22 would be clean shaven per his preference, but thought there might have been an issue with his shaver. Facility policy Activities of Daily Living (ADLs), Supporting dated March, 2018, indicated residents will be provided with care and services appropriate to maintain their ability to perform ADLs. Those residents who were unable to perform ADLs independently would receive services necessary to maintain good grooming	2 915		

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2 915	Continued From page 8 and personal hygiene. SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could educate responsible staff to provide care based on residents' comprehensively assessed needs and personal preference. The DON or designee could conduct audits of resident cares to ensure their personal hygiene needs are met consistently. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 915		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure hand hygiene was performed for 1 of 3 residents (R24) observed during personal cares and 1 of 1 residents (R24) observed during wound cares. Furthermore, the facility failed to ensure enhanced barrier precautions (EBP) were followed for 1 of 1 residents (R24) observed for EBP. Findings include: R24's quarterly Minimum Data Set, dated 3/18/25, indicated he had intact cognition and	21375	It is the policy of Friendship Village of Bloomington to ensure hand hygiene is properly performed between glove changes. It is the policy of Friendship Village of Bloomington to use Enhanced Barrier Precautions (EBP) as required. • Nursing Assistant E received re-education on proper hand hygiene, including between glove changes on 4-16-25. • Nurse C received re-education on the correct application of Enhanced Barrier Precautions on 3-27-25.	4/22/25

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21375	Continued From page 9 required partial to moderate assistance with personal hygiene. The MDS reported diagnoses of kidney failure, high blood pressure, depression and chronic pain. The MDS also reported his use of an indwelling urinary catheter and identified he had one venous ulcer. R24's care plan identified his catheter use and need for EBP. The care plan also indicated he had an activities of daily living (ADL) self-care performance deficit related to his left leg amputation and limited mobility. The care plan directed staff to provide extensive assistance with personal hygiene. Furthermore, the care plan reported a venous/stasis ulcer to his left shin and identified a goal to be free from signs and/or symptoms of infection. R24's treatment administration record (TAR) dated 3/27/25, indicated the following wound care order: - "wound on right lower leg, cleanse with wound cleanser. Leave on bed 1 - 5 min. [sic, minutes] Apply skin prep to peri wound skin. Allow to dry completely (not tacky). Then apply thin layer, Xeroform over open leg wound. Only apply on wound bed. Cover with ABD Pad. Hold in place with Kerlix. Apply a white wound sock over Kerlix before applying low stretch wrap to his foot to help with edema" two times a day. Hand Hygiene and Personal Cares During observation on 3/26/25 at 11:35 a.m., R24 was lying in bed and nursing assistant (NA)-D and NA-E were performing personal cares with gowns and gloves on. NA-E set up a basin with water and washcloths at the bedside. The NAs helped R24 remove his hospital gown over his	21375	Nurses and CNAs have been re-educated on proper hand hygiene techniques and the correct use of Enhanced Barrier Precautions. The DON and/or designee will perform monthly audits for three months and random quarterly audits for an additional three months to ensure: • Hand hygiene is performed consistently, including between glove changes. • Enhanced Barrier Precautions are followed appropriately during wound care. Audit results will be reviewed during QAPI meetings. The Director of Nursing is responsible for ongoing compliance. Date certain 4/22/25	

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21375	Continued From page 10 head and then pulled down his incontinence brief. NA-E used one hand to secure the catheter tubing while using the other hand to wash his peri-area. NA-E used a new corner of a folded washcloth to wipe his groin and then each thigh/inner leg. Next, NA-E used a new washcloth to wipe down each of R24's legs, starting at his hip level and wiping down. NA-E did not change gloves or perform hand hygiene. NA-D assisted him onto his left, and he grabbed the grab bar with his hands and pulled himself over. R24 had a tan-colored foam dressing covering his coccyx and the bottom portion of the dressing was not intact. Continuing with the same gloves, NA-E used a new washcloth to wipe his back, then cleansed his buttocks. NA-E rolled the briefs and linen under his body and using the same gloved hands, applied cream to his bottom and around the foam dressing. Next, R24 was assisted to turn over the pile of rolled briefs and linen onto his other side and NA-D pulled the linen and briefs through so he could lay flat on his back again. NA-D fastened the tabs on the brief and NA-E doffed the gloves before donning new gloves without performing hand hygiene. Together, the NAs helped guide his arms into his t-shirt and pulled it over his head and pulled it down in the back. The NAs assist him onto his back per his comfort and NA-E gave him a washcloth for him to wash his hands. Per interview on 3/26/25 at 11:52 a.m., NA-E stated to prevent the spread of infection, staff should perform hand hygiene before entering a resident's room, during resident cares, and with any glove change. NA-E also stated staff should wear appropriate personal protective equipment (PPE). NA-E verified staff should wash in a clean to dirty manner or change gloves between dirty and clean during personal hygiene cares. NA-E	21375		

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21375	Continued From page 11 confirmed a missed opportunity for hand hygiene during cares when going from dirty to clean and not changing gloves. Hand Hygiene, EBP and Wound Care During observation of wound care on 3/27/25 at 10:32 a.m., registered nurse (RN)-C knocked and entered R24's room without a gown or gloves on and asked him if wound cares could be performed. He was agreeable and RN-C donned clean gloves but not a gown. RN-C placed an absorbent pad underneath his right leg and began removing the tape and wrapped gauze from his wound. R24 asked RN-C if he could have pain medication and RN-C offered to bring him his medication before starting the dressing change. He stated he would prefer to have his pain medication first. RN-C finished removing the wrapped gauze, leaving the padded dressing to cover his leg wound, doffed the gloves the doorway and exited the room. At 10:41 a.m., RN-C knocked and entered the room with a paper medication cup. RN-C assessed his pain and gave him the cup before going to the bathroom and performing hand washing. RN-C donned clean gloves but did not don a gown. At his bedside, RN-C sprayed wound cleanser over the padded dressing to remove it, then removed the yellowed-colored petroleum dressing from the wound beds. RN-C asked R24 how he was feeling and, with the same gloved hands, began to spray the wound with the wound cleanser before patting it dry with clean, dry gauze. RN-C repeated the spray and patting dry with gauze three times. Next, RN-C doffed the gloves, performed handwashing at the bathroom sink, and donned clean gloves. RN-C then applied liquid from a blue bottle labeled "Vashe" to a clean gauze and dabbed it onto each wound bed	21375		

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	00806	A. BUILDING: _____ B. WING _____	C 03/27/2025

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21375	Continued From page 12 on R24's right shin. With gloved hands, RN-C walked over to his dresser and opened the top drawer, then closed the drawer and came back to his bedside and began applying more of the "Vashe" to the gauze, then dabbing it onto his wound beds. RN-C explained the Vashe had to dry for 5 minutes before it could be covered with the padded dressing. R24 asked for a drink of water, and RN-C assisted him lifting his water pitcher to his mouth with the same gloved hands. RN-C conversed with him about the TV program he was watching and doffed the gloves, did not perform hand hygiene and donned new gloves. RN-C cut new pieces of the petroleum gauze and laid them overtop the wound beds on his right shin. Next, RN-C applied the padded dressing, then wrapped his right lower leg with the rolled gauze. As RN-C was about to tear a piece of tape off the roll, the petroleum gauze fell onto the floor and with gloved hands, RN-C picked up the dressing from the floor and threw it away in the garbage. Without changing gloves, RN-C tore two pieces of tape from the roll and applied them to the wrapped gauze on R24's leg. RN-C then doffed gloves and performed hand washing at the sink. Per interview on 3/27/25 at 10:59 a.m. with RN-C, hand hygiene should be performed before starting resident cares, between glove changes, if gloves are soiled, and when finished with cares. RN-C verified R24 was on EBP and stated staff were expected to wear gown and gloves when performing wound care and catheter care. RN-C stated it was important to perform hand hygiene and follow EBP to prevent the spread of infection and for resident safety. RN-C stated "I should have worn a gown" during wound cares. RN-C indicated changing gloves during wound care but acknowledged missed hand hygiene	21375		

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21375	Continued From page 13 opportunities. Per interview at 3/27/25 at 1:09 p.m. with RN-D, a nurse lead, and the infection preventionist (IP), staff were expected to perform hand hygiene, or "foam in and out", when going in and out of resident rooms and when changing gloves. RN-D and IP expected staff to perform peri-cares in a clean-to-dirty manner or, if gloves become dirty or soiled, to change gloves and perform hand hygiene. RN-D and IP stated PPE for EBP should be worn during wound care and expected staff to perform hand hygiene after going from a dirty dressing or area to a clean dressing or area and with glove changes. Per interview on 3/27/25 at 3:19 p.m. with licensed practical nurse (LPN)-A, staff were expected to perform hand hygiene during personal cares and wound cares in addition to wearing appropriate PPE for a resident on EBP. Per facility policy titled Handwashing/Hand Hygiene revised 8/19, the facility considered hand hygiene the primary means to prevent the spread of infection and directed staff to perform handwashing when hands were visibly soiled and after contact with a resident with infectious diarrhea. The policy directed staff to use an alcohol-based hand rub (ABHR) or soap and water before and after direct contact with residents, before performing any non-surgical invasive procedures, before and after handling an invasive device (for example, urinary catheters), before handling clean or soiled dressings or gauze pads, before moving from a contaminated body site to a clean body site during reside care, after contact with a resident's intact skin, after contact with blood or bodily fluids, after contact with objects (medical equipment) in the	21375		

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21375	Continued From page 14 immediate vicinity of the resident, after removing gloves, before and after entering isolation precaution settings, and remove and disposing of PPE. Per facility policy titled Enhanced Barrier Precautions revised 4/5/24, EBP would be implemented for residents with chronic wounds, including pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers. The policy indicated all team members would wear appropriate PPE (gown and gloves) for high-contact resident care, including wound care. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), infection preventionist (IP), or designee could review facility policy and procedures regarding Enhanced Barrier Precautions (EBP) for the resident and provide staff education regarding the policies and educate staff on the appropriate PPE to wear. Furthermore, the DON, IP or designee could review facility policy and procedures regarding handwashing and provide staff education regarding the policies and procedures. They could also do environmental rounds and audits, and provide re-education anytime EBP are placed or when missed opportunities for handwashing are identified. The DON, IP or designee could take those findings/education to the Quality Assurance Performance Improvement (QAPI) committee for a determined amount of time, until the QAPI committee determines successful compliance or the need for ongoing monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21375		

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21825	Continued From page 15	21825		
21825	MN St. Statute 144.651 Subd. 9 Patients & Residents of HC Fac.Bill of Rights Subd. 9. Information about treatment. Residents shall be given by their physicians complete and current information concerning their diagnosis, treatment, alternatives, risks, and prognosis as required by the physician's legal duty to disclose. This information shall be in terms and language the residents can reasonably be expected to understand. Residents may be accompanied by a family member or other chosen representative, or both. This information shall include the likely medical or major psychological results of the treatment and its alternatives. In cases where it is medically inadvisable, as documented by the attending physician in a resident's medical record, the information shall be given to the resident's guardian or other person designated by the resident as a representative. Individuals have the right to refuse this information. Every resident suffering from any form of breast cancer shall be fully informed, prior to or at the time of admission and during her stay, of all alternative effective methods of treatment of which the treating physician is knowledgeable, including surgical, radiological, or chemotherapeutic treatments or combinations of treatments and the risks associated with each of those methods. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to inform in advance and obtain	21825	It is the policy of Friendship Village of Bloomington to obtain informed consent	4/22/25

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21825	Continued From page 16 consent for psychotropic medication use for 1 of 5 residents reviewed for unnecessary medications. Findings include: R22's annual Minimum Data Set (MDS) dated 1/28/25, indicated R22 had severe cognitive impairment, felt down, depressed or hopeless 2-6 days of the 14 day look back period, required moderate to substantial assistance with most activities of daily living (ADLs) and was taking antipsychotic and antidepressant medication. R22's diagnoses included Alzheimer's, dementia, depression and hallucinations. R22's care plan dated 2/25/25, indicated R22 used antipsychotic and antidepressant medications and was at risk for behaviors related to hallucinations. R22's March, 2025 medication administration record (MAR) indicated: Escitalopram Oxalate Oral Tablet 5 MG (Lexapro). Give 1 tablet by mouth one time a day for anxiety AEB (as evidenced by) reports of anxiety, restless physical movements, repetitive questions about going to work or home, reports of visual hallucinations. R22's physician order indicated Lexapro original start date was 7/4/24. R22's electronic medical record lacked evidence of an informed consent for Lexapro. During interview on 3/27/25 at 10:09 a.m., licensed practical nurse (LPN)-A stated any resident on a psychotropic medication should have been informed of risks and benefits and	21825	prior to the initiation of any psychotropic medication. Consent for Resident R22's Lexapro was obtained on 4/14/25. An audit was conducted for all current residents receiving psychotropic medications to ensure that valid consents were obtained and are on file. Nurses have been re-educated on the requirement to obtain informed consent prior to the initiation of any psychotropic medication. To ensure continued compliance, the Director of Nursing (DON) and/or designee will conduct monthly audits for three months, followed by random quarterly audits for an additional three months to verify that consent is obtained prior to starting any new psychotropic medications. Audit results will be reviewed during QAPI meetings. The Director of Nursing is responsible for ongoing compliance. Date certain 4/22/25	

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21825	Continued From page 17 have a signed informed consent by self or representative. During interview on 3/27/25 at 11:16 a.m., director of nursing (DON) stated expectation R22, or representative should have been provided informed consent for any psychotropic prior to starting the medication and that signed consent should be in the resident chart. During interview on 3/27/25 at 1:54 p.m., consultant pharmacist (CP) stated R22 should have a signed consent for each of the psychotropic medications currently taking. During interview on 3/27/25 at 3:21 p.m., SS-A stated unable to locate a consent for Lexapro in R22's chart. Facility policy Antipsychotic Medication Use dated July 2022, indicated, "Residents [and/or resident representatives] will be informed of the recommendation, risks, benefits, purpose and potential adverse consequences of antipsychotic medication use." SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON), or designee could develop and implement measure to ensure informed consent is provided prior to the initiation of any new treatment and evidence of that consent be available in the resident's medical record. The facility could update policies and procedures, educate staff on these changes, and audit periodically to ensure the needs of resident(s) are maintained. The facility should perform measurable audits and report the	21825		

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21825	Continued From page 18 findings of those audits to the Quality Assessment and Performance Improvement (QAPI) committee to ensure compliance and determine the need for further improvement. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21825		

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	245229	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/25/2025**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted on 03/25/2025, by the Minnesota Department of Public Safety, State Fire Marshal Division. 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. Healthcare Fire Inspections	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/18/2025

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 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. Building Info: 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	K 000		

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K 000	Continued From page 2 automatic fire department notification. The facility has a capacity of 66 beds and had a census of 63 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 930 SS=F	Gas Equipment - Liguid Oxygen Equipment CFR(s): NFPA 101 Gas Equipment - Liquid Oxygen Equipment The storage and use of liquid oxygen in base reservoir containers and portable containers comply with sections 11.7.2 through 11.7.4 (NFPA 99). 11.7 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to safely store liquid oxygen per NFPA 99 (2012 edition), Health Care Facilities Code, section 11.7.4. These deficient finding could have an isolated impact on the residents within the facility. Findings include: On 03/25/2025 between 9:00AM and 11:00 AM, it was revealed by observation in resident room 202 there were two liquid oxygen containers, one was being used while the other was being stored in the room. Oxygen tank was removed during the survey. An interview with the Administrator and Maintenance Director verified these deficient findings at the time of discovery.	K 930	K 930 - Gas Equipment - Liquid Oxygen Equipment CFR(s): NFPA 101 It is the policy of the facility to safely store liquid oxygen per NFPA 99 (2012 edition), Health Care Facilities Code, section 11.7.4. The second liquid oxygen container was removed from room 202 by Administrator when Fire Marshall was present on 3/25/25. Oxygen vendor was contact and reeducated on delivery expectations. Nurses and CNAs were reeducation on safe storage of liquid oxygen.	4/22/25

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K 930	Continued From page 3	K 930	The Administrator and/or designee will conduct monthly audits for three months and random quarterly audits for an additional three months to ensure safely store liquid oxygen. The Administrator is responsible for ongoing compliance. Date certain 4/22/25	