Electronically Delivered

April 4, 2023

Licensee
Friendship Village Bloomington
8130 Highwood Drive
Bloomington, MN 55438

RE: Project Number(s) SL37122015

Dear Licensee:

The Minnesota Department of Health completed an evaluation on March 3, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

LICENSING ORDERS
The enclosed State Form documents the state licensing orders. The Department of Health documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines and enforcement actions based on the level and scope of the violations; **however, no immediate fines are assessed for this evaluation of your facility**.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up evaluations. The licensee is not required to submit a plan of correction for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.

- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS
In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by the Department of Health within 15 calendar days of the correction order receipt date.

A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

Please address your cover letter for reconsideration requests to:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,

Jess Schoenecker, Supervisor
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-3789 Fax: 651-281-9796
JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37122	A. BUILDING: _____ B. WING _____	03/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP VILLAGE BLOOMINGTON	8130 HIGHWOOD DRIVE BLOOMINGTON, MN 55438

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0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL37122015-0 On February 27, through March 2, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 65 active residents all receiving services under the Assisted Living with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is 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. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared according to the Minnesota Food Code. This had the potential to affect all 65 residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: Please refer to the additional documentation included in the "Food and Beverage Establishment Inspection Reports," dated March 1, 2023. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including	0 800		

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0 800	Continued From page 2 walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On March 2, 2023, at approximately 10:00 a.m., survey staff toured the facility with the Director of Community Services (DCS)-H. During the facility tour, survey staff observed the following: It was observed that the trash chute door on the first, second, and third floors did not self-latch. The trash chute door should close and latch completely to maintain the fire resistance integrity of the trash chute system. It was observed that the door from the memory	0 800		

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0 800	Continued From page 3 care to the courtyard did not latch automatically. During the facility tour, DCS-H visually verified these deficient findings at the time of discovery. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one	0 810		

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0 810	Continued From page 4 evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to provide a maintained fire safety and evacuation plan that showed the location and number of resident rooms and failed to provide required employee training on fire safety and evacuation. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: An interview and record review were conducted on March 2, 2023, at approximately 10:00 a.m. with the Licensed Assisted Living Director (LALD)-D and Director of Community Services (DCS)-H on the fire safety, and evacuation plan, fire safety and evacuation training for the facility, and fire safety, and evacuation drills for the facility. Record review indicated that employees did not receive training twice per year after initial hire. During the interview, LALD-D stated that the	0 810		

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0 810	Continued From page 5 licensee provided annual training to employees, but not twice per year after the initial hire, on the fire safety and evacuation plan, as required by statute. With a further review of the Emergency Disaster Manual provided by LALD-D, it was observed that the Emergency Disaster Manual did not include any employee training requirements on fire safety and evacuation plan. During the interview, LALD-D verified this deficient condition and confirmed that there was no further documented training for the staff on the fire safety and evacuation plan as required by statute. On March 2, 2023, at approximately 10:00 a.m., survey staff toured the facility with the Director of Community Services (DCS)-H. During the facility tour, it was observed that the posted fire safety and evacuation plan did include the number of resident rooms. This deficient condition was visually verified by DCS-H accompanying the tour. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation;	01060		

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01060	Continued From page 6 (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation to the resident, legal representative, or designated representative and failed to provide the	01060		

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01060	Continued From page 7 notification to the Office of Ombudsman for Long-Term Care (OOLTC) of the emergency relocation greater than four days for one of one resident (R7). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R7 was admitted to licensee on April 11, 2022. R7's Progress Notes dated February 7, 2023, at 12:17 p.m., indicated R7 had an emergency relocation to the hospital at 11:00 a.m. due to cognition and inability to ambulate. R7's Progress Notes dated February 11, 2023, at 2:37 p.m., indicated R7 was still at the hospital with continued confusion and required assistance with walking and eating. R7's Progress Notes dated February 23, 2023, at 11:06 a.m., indicated a care conference was done discussing R7's weight, plan to continue physical therapy when R7 returned home. R7 was scheduled to discharge from transitional care unit (TCU) on February 28, 2023. R7's record lacked a written notice with the required statutory content was provided to resident or to the OOLTC as noted below; In the event of an emergency relocation, the	01060		

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01060	Continued From page 8 facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section. On February 27, 2023, at 2:26 p.m., director of nursing (DON)-A acknowledged R7's record lacked the required written notice and the OOLTC was not provided a copy of the notice when R7 did not return to the facility within four (4) days. DON-A was unaware of this requirement and	01060		

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01060	Continued From page 9 indicated it had not been done for any resident with an emergency relocation. The licensee's Contract Termination policy dated August 1, 2022, under the emergency relocation, indicated the licensee would provide a written notice that contained the above information. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01440 SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer.	01440		

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01440	Continued From page 10 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a registered nurse (RN) conducted direct supervision of staff performing a delegated task within 30 days of providing services for one of one unlicensed staff (unlicensed personnel (ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-B was hired June 18, 2022. On February 28, 2023, at 10:08 a.m., ULP-B was observed providing cares for residents. ULP-B's employee record lacked documentation of a 30-day RN supervision. On February 27, 2023, at 10:31 a.m., during the entrance conference director of nursing (DON)-A stated she was responsible for 30-day RN supervisions for ULPs. On February 28, 2023, at 12:03 p.m., DON-A stated she was unable to locate ULP-B's 30-day RN supervision documentation but was still searching for it. On February 28, 2023, at 2:01 p.m., RN-G stated	01440		

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01440	Continued From page 11 they were unable to locate ULP-B's 30-day RN supervision documentation. The licensee's Supervision of Unlicensed Personnel policy dated August 1, 2022, indicated, "Direct supervision of unlicensed staff providing delegated nursing tasks, delegated treatments or assigned therapy tasks must be performed within 30 days after the person begins work for our facility and has been trained and determined competent to perform all the tasks assigned. The RN will directly supervise staff performing delegated nursing tasks and the appropriate licensed health professional will supervise unlicensed staff performing any delegated treatments or assigned therapies." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440		
01460 SS=D	144G.63 Subdivision 1 Orientation of staff and supervisors All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure staff	01460		

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01460	Continued From page 12	01460		

providing services completed an orientation to assisted living facility licensing requirements and regulations before providing services for one of two employees (unlicensed personnel (ULP)-B).

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally).

The findings include:

ULP-B was hired June 18, 2022.

On February 28, 2023, at 10:08 a.m., ULP-B was observed providing cares for residents.

ULP-B's employee record lacked documentation orientation to assisted living regulations was completed.

On February 27, 2023, at 10:31 a.m., during the entrance conference director of nursing (DON)-A stated she was responsible for providing orientation for new ULPs.

On February 28, 2023, at 12:03 p.m., DON-A stated she was unable to locate ULP-B's orientation to assisted living regulations. DON-A stated it should have been signed off on the licensee's 1.01 Assisted Living Statute and Rule Overview form.

The licensee's Assisted Living and Assisted Living with Memory Care Orientation, All Staff policy dated August 1, 2022, indicated, "All assisted

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(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) COMPLETE DATE
01460	Continued From page 13 living employees must complete an orientation to assisted living facility licensing requirements and regulations before providing services to residents." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01460		
01470 SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care	01470		

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01470	Continued From page 14 Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of two employees (unlicensed personnel (ULP)-B) received orientation to all required assisted living regulation content. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an	01470		

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01470	Continued From page 15 isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-B was hired June 18, 2022. On February 28, 2023, at 10:08 a.m., ULP-B was observed providing cares for residents. ULP-B's employee record lacked documentation of orientation to principles of person-centered care. On February 27, 2023, at 10:31 a.m., during the entrance conference the director of nursing (DON)-A stated she was responsible for providing orientation for new ULP's. On February 28, 2023, at 12:03 p.m., DON-A stated she was unable to locate ULP-B's principles of person-centered care orientation. On February 28, 2023, at 2:01 p.m., registered nurse (RN-G) stated they were unable to locate ULP-B's principles of person-centered care orientation. The licensee's Assisted Living and Assisted Living with Memory Care Orientation - All Staff policy, dated August 1, 2022, indicated newly hired staff would receiving training in required topics which included, "Principles of person-centered planning and service delivery and how they apply to direct support services." No further information was provided.	01470		

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01470	Continued From page 16 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01540 SS=D	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the required eight (8) hours of dementia care training was completed for direct-care employees within 80 hours of employment start date for one of two employees (unlicensed personnel (ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of	01540		

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01540	Continued From page 17 residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-B was hired on June 18, 2022. On February 28, 2023, at 10:08 a.m., ULP-B was observed providing cares for residents. ULP-B's employee record lacked documentation of the required eight (8) hours of dementia care training to be completed within 80 hours of employment start date; no documented hours were provided. On February 27, 2023, at 10:31 a.m., during the entrance conference director of nursing (DON)-A stated she was responsible for providing dementia training for new ULPs. On February 28, 2023, at 12:03 p.m., DON-A stated she had been unable to locate required dementia training documentation for ULP-B but would continue to search for it. On February 28, 2023, at 2:01 p.m., registered nurse (RN-G) stated they were unable to locate required dementia training documentation for ULP-B. The licensee's Assisted Living and Assisted Living with Memory Care Orientation -All Staff policy, dated August 1, 2022, indicated newly hired staff would receive training in required topics which included dementia. No further information was provided.	01540		

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01540	Continued From page 18 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01540		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed a comprehensive assessment that included all areas required on the uniform assessment tool for three of five residents (R2, R5, R6). Additionally, licensee failed to include all	01620		

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01620	Continued From page 19 physical devices on the RN comprehensive assessment for R5. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R2 R2 was admitted on February 20, 2023. R2's service plan last reviewed on February 20, 2023, indicated R2 received services for medication management, toileting, social engagement, and mobility. R2's record included an order dated February 20, 2023, for compression stocking to be applied every morning and removed at bedtime for edema. R2's ALF/MN: Comprehensive Evaluation/ISP-V2 dated February 20, 2023, lacked a list of treatments as required on the uniform assessment tool. R5 R5 admitted on June 17, 2022. R5's service plan last reviewed on December 29, 2022, indicated R5 received medication management, assistance with toileting, and support to make appropriate decisions about care	01620		

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01620	Continued From page 20 and environment. R5's ALF/MN: Comprehensive Evaluation/ISP-V2 (also known as licensee's 90-day RN assessment) dated December 15, 2022, lacked an assessment to include bilateral (two) side rails as part of the physical device assessment. R5's Restraint/Entrapment Assessment was last reviewed on January 26, 2023, by a licensed practical nurse (LPN), not a RN. R6 R6 admitted on October 30, 2021. R6's service plan last reviewed on December 30, 2022, indicated R6 received assistance with showers and medication set up. R5 and R6's ALF/MN: Comprehensive Evaluation/ISP-V2 dated December 15, 2022, and December 13, 2022, respectively, lacked the following requirements on the uniform assessment tool: -the resident's personal lifestyle preferences; -instrumental activities of daily living; -list of treatments; and -risk indicators. During an interview on February 28, 2023, at 3:31 p.m., director of nursing (DON)-A indicated the RN comprehensive assessment does not include treatment assessments/plan. DON-A also indicated that R5's bilateral side rails were not included in the most recent 90-day assessment. The licensee's Initial and On-going Nursing Assessment of Residents policy dated August 1, 2022, indicated the RN would complete comprehensive assessments to include all	01620		

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01620	Continued From page 21 required content of the uniform assessment tool. The licensee's 1.11 Siderails training policy dated March 1, 2022, indicated when side rails are in use, the RN would conduct an assessment to identify the intended purpose of the side rail and the risks regarding the use of the side rail. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01640 SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan.	01640		

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01640	Continued From page 22 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the current service plan included a signature or other authentication by the resident and the facility to document agreement on the services to be provided for five of five residents (R2, R3, R4, R5, R6). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R2 R2 was admitted on February 20, 2023. R2's diagnoses included diabetes mellites type 2 and chronic kidney disease. R2's service plan last reviewed on February 20, 2023, lacked a signature or authentication by the resident or by the facility documenting agreement on the services to be provided. R3 R3 was admitted on December 14, 2022. R3's diagnoses included Alzheimer's Disease and dementia. R3's service plan last reviewed on February 17, 2023, lacked a signature or authentication by the	01640		

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01640	Continued From page 23	01640		

resident or by the facility documenting agreement on the services to be provided.

R4
R4 was admitted on February 16, 2021.

R4's diagnoses included aftercare following joint replacement surgery and dementia with behavioral disturbance.

R4's service plan last reviewed on October 7, 2022, lacked a signature or authentication by the resident or by the facility documenting agreement on the services to be provided.

R5
R5 was admitted on June 17, 2022.

R5's diagnoses included localized edema (swelling in one area of the body), hypertension (high blood pressure), hemiplegia (paralysis of one side) following cerebrovascular disease (lack of blood flow to brain) affection left non-dominant side, and Alzheimer's Disease with late onset.

R5's service plan last reviewed December 29, 2022, lacked a signature or other authentication by the resident or by the facility, documenting agreement on the services to be provided.

R6
R6 was admitted on October 30, 2021.

R6's diagnoses included repeated falls, atrial fibrillation (irregular heart rate), hypertension (high blood pressure), and major depressive disorder.

R6's service plan last reviewed December 30, 2022, lacked a signature or other authentication

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01640	Continued From page 24 by the resident or by the facility, documenting agreement on the services to be provided. During an interview on February 28, 2023, at 10:15 a.m., director of nursing (DON)-A indicated the licensee did not have signed service agreements for any current resident, only assisted living contracts. DON-A indicated the licensee was working on getting electronic signatures through their Point Click Care (charting software). During an interview on February 28, 2023, at 11:25 a.m., licensed assisted living director (LALD)-D stated they had service plans in Point Click Care but did not have signed service agreements. The licensee's Contents of Service Plans policy dated August 1, 2022, indicated service plans and any revisions to service plans will have a signature or other authentication by the licensee and by the resident. Other authentication could be email confirming accepting terms of a service agreement or other method deemed appropriate by the licensee. No further information was provided. TIME PERIOD TO CORRECT- Twenty-one (21) days	01640		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access.	01880		

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01880	Continued From page 25 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to monitor the temperature of the medication storage refrigerator to ensure medications which required refrigeration were stored according to manufacturers' directions for three or three residents (R9, R10, R11). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On February 27, 2023, at 1:22 p.m., the medication refrigerator was observed with licensed practical nurse (LPN)-C. The refrigerator had a digital thermometer built into the very bottom front of the refrigerator and only visible once the door was opened; it read 40.6 degrees Fahrenheit (F). LPN-C stated they were unsure where temperature log sheets were or how frequently the temperature was to be checked. LPN-C reviewed the contents of the refrigerator with the surveyor and the following medications were observed: - R9's Lantus SoloStar injection pen 100 unit (u)/milliliter (ml) 3ml prefilled pen; - R10's Latanoprost 0.005% drops ophthalmic solution; 2.5 ml bottle; - R11's Trulicity Latex Free 0.75 milligram (mg) dose; and	01880		

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01880	Continued From page 26 Manufacturer directions for Lantus SoloStar injection pen revised December 2020, indicated unopened pens could be stored refrigerated (36-46 degrees Fahrenheit (F)) until the expiration date, or at room temperature (below 86 degrees F) for 28 days. Manufacturer directions on the box for Latanoprost Ophthalmic Solution box packaging indicated to store unopened bottles under refrigeration at 36-46 F. Manufacturer directions for Trulicity pen injector, revised December 2022, indicated, "Store Trulicity in the refrigerator at 36°F to 46°F (2°C to 8°C). If needed, each single-dose pen can be kept at room temperature, not to exceed 86°F (30°C) for a total of 14 days. Do not freeze Trulicity. Do not use Trulicity if it has been frozen." On February 27, 2023, at 1:30 p.m., LPN-E stated they had never been asked to monitor the medication refrigerator temperature. LPN-E stated it was probably supposed to be done by the overnight shift. On February 27, 2023, at 1:35 p.m., licensed assisted living director (LALD)-D, registered nurse (RN)-G and LPN-C all acknowledged they lacked medication refrigerator temperature monitoring and were actively addressing the issue. On February 27, 2023, at 2:20 p.m., director of nursing (DON)-A stated she was aware the medication refrigerator required monitoring and lacked temperature logs. DON-A stated the overnight nursing staff were responsible for checking the medication refrigerator	01880		

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	37122	A. BUILDING: _____ B. WING _____	03/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01880	Continued From page 27 temperatures daily and recording the temperatures. DON-A stated there was a nursing shift check-off form they used and believed the task was included on the form. On February 27, 2023, at 2:45 p.m., DON-A provided the nursing shift check-off form and stated it did not include medication refrigerator temperature monitoring. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01910 SS=F	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition.	01910		

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01910	Continued From page 28 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide documentation in the resident's record regarding the disposition of medication for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 was discharged on January 6, 2023. R1's Medication Administration Record dated December 2022, indicated R1 received the following medications prior to discharge: - aspirin; - losartan potassium (lowers blood pressure); -seroquel (aggression); -tylenol; - voltaren gel (topical pain relief); -bisacodyl suppository (laxative); -lorazepam (anxiety); -Miralax powder (laxative); -morphine, and -senna-docusate (stool softer). R1's MC Discharge Summary dated January 9, 2023, indicated all medications had been sent with the resident. R1's record lacked documentation in resident's	01910		

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01910	Continued From page 29 record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. On February 27, 2023, at 2:27 p.m., director of nursing (DON)-A stated a scanner was used to scan all medications to track the required above content when they destroy medications, but this wasn't being done when a resident transferred to another facility with their medications. DON-A stated that nowhere in R1's medical chart was documentation of the medications that were sent with resident/family. The licensees undated Medication Management Policy indicated "when the resident is deceased, or services are terminated, all current medications may be given to the resident's representative for disposal." The licensee's Disposition or Disposal of Medication policy dated August 1, 2022, indicated the licensee would document in the resident's record the name of the person to whom the medications were given, the time and date, the name of each medication, and the amount of medication remaining. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
01940 SS=F	144G.72 Subd. 3 Individualized treatment or therapy managemen	01940		

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01940	Continued From page 30 For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop an individual treatment management plan to include all required content for two of five residents (R2, R5). This practice resulted in a level two violation (a	01940		

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01940	Continued From page 31 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R2 R2 was admitted on February 20, 2023. R2's unsigned service plan printed on February 20, 2023, indicated R2 required assistance with dressing and undressing. R2's signed treatment orders dated February 20, 2023, indicated R2 required compression stocking assistance to apply them each morning and to remove them at bedtime. R2's record lacked a treatment management plan for compression stockings. R5 R5 was admitted on June 17, 2022. R5's unsigned service plan printed on December 29, 2022, indicated R5 received medication management, assistance with toileting, and support to make appropriate decisions about care, and environment. R5's signed treatment orders dated December 29, 2022, instructed R5 to apply Tubigrips daily in the morning and remove at bedtime for lower extremity edema (swelling).	01940		

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01940	Continued From page 32 R5's record lacked a treatment management plan for Tubigrip socks. On February 28, 2023, at approximately 3:20 p.m., director of nursing (DON)-A stated they did not have treatment management plans for any of the residents receiving treatment or therapies. DON-A stated they were in the process of getting treatment management plans integrated with their new service plan process. DON-A indicated the licensee did not have a treatment plan for any resident as it isn't included on their comprehensive assessment. The licensee's Resident Pre-Admission Assessment & Monitoring Process-Nursing policy dated August 1, 2022, indicated the resident record would include an evaluation of the resident's treatments, if any and complete the treatment and therapy management plan if the licensee provides services related to the resident's treatments. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01950 SS=D	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment	01950		

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01950	Continued From page 33 or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) specified, in writing, specific instructions for each resident's treatment, and documented those instructions in the resident's record for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: On February 28, 2023, R2 was observed wearing compression stockings. R2's service plan printed on February 28, 2023, indicated R2 had a diagnosis of chronic kidney disease stage 3A that required assistance with dressing and undressing.	01950		

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01950	Continued From page 34 R2's signed treatment orders dated December 20, 2023, and medication administration record/treatment administration record (MAR/TAR) for February 2023, indicated R2's compression stockings were to be applied every morning and removed at bedtime. R2's record lacked the following instructions; -how to apply the compression stockings; -what signs and symptoms should be monitored; and -when to notify the nurse. On February 28, 2023, at 3:08 pm., director of nursing (DON)-A stated the treatment orders for R2's compression stockings should have included instruction on how to apply the compression stockings and a description of symptoms which would require unlicensed personnel (ULP) to notify the nurse. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		
02110 SS=F	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans,	02110		

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02110	Continued From page 35 including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the required policies and procedures for assisted living with dementia care (ALFDC) were provided to residents, or the residents' legal and designated representatives, at the time of move in for five of five residents (R2, R3, R4, R5, R6). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive	02110		

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02110	Continued From page 36 or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R2 was admitted on February 20, 2023, R3 was admitted on December 14, 2022. R4 was admitted on February 16, 2021. R5 was admitted on June 17, 2022. R6 was admitted on October 30, 2021. On February 28, 2023, R2, R3, R4, R5 and R6's records lacked evidence the licensee provided the residents, or residents' legal and designated representative, with the dementia care policies required under the ALFDC license. On February 28, 2023, at 2:25 p.m., licensed assisted living director (LALD)-D stated they did not have documentation confirming required dementia care policies were provided to residents, or residents' legal and designated representative. LALD-D stated they did not have dementia care policies required under the ALFDC license. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02110		
02310 SS=D	144G.91 Subd. 4 (a) Appropriate care and services	02310		

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02310	Continued From page 37 (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards for side rails for one of one resident (R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On February 28, 2023, at 10:15 a.m., the surveyor and director of nursing (DON)-A observed R5 to have bilateral (two) side rails. DON-A indicated the side rails are assessed every 90 days and indicated the risk and benefits had been discussed. R5 was admitted to licensee on June 17, 2022. R5's medical record included diagnoses of localized edema, hypertension (high blood pressure), hemiplegia (paralysis of one side) following cerebrovascular disease (lack of blood flow to brain) affection left non-dominant side,	02310		

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02310	Continued From page 38 and Alzheimer's Disease with late onset. R5's medical record lacked documentation that risks and benefits had been discussed with the resident and/or resident's representative. On February 28, 2023, at 12:43 p.m., DON-A stated he/she had called R5's family but forgot to document the discussion. The licensee's Devices and Device Assessment policy dated July 5, 2022, indicated documentation will be entered in resident's record to included: -results of the assessment -discussion with resident/responsible party regarding risks and benefits and alternatives considered/recommended; and -decision made/outcome of discussion. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		

Minnesota Department of Health
Food, Pools, & Lodging Services
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *03/01/23*
Time: 10:00:00
Report: 8041231043

Food and Beverage Establishment Inspection Report

Location:
Friendship Village Bloomington
8130 Highwood Drive
Bloomington, MN55438
Hennepin County, 27

Establishment Info:
ID #: 0037491
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 9528309400
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

The following orders were issued during this inspection.

3-500B Microbial Control: hot and cold holding

3-501.16A2 ** Priority 1 **

MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.

CUT MELON, PANCAKE & WAFFLE BATTER PREPARED EARLIER IN THE DAY, HELD AT ROOM TEMPERATURE DURING BREAKFAST SERVICE, THEN RETURNED TO THE COOLER MEASURED 50-55 DEG F. DISCARDED DURING INSPECTION.

Comply By: 03/01/23

4-500 Equipment Maintenance and Operation

4-501.11AB

MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.

GASKET ON THE UPRIGHT COOLER IN THE FINISHING KITCHEN IS TORN.

Comply By: 03/16/23

Surface and Equipment Sanitizers

Quaternary Ammonia: = 200 ppm at Degrees Fahrenheit
Location: sani bucket in memory care
Violation Issued: No

Utensil Surface Temp.: = at 171 Degrees Fahrenheit
Location: memory care dish machine
Violation Issued: No

Utensil Surface Temp.: = at 172 Degrees Fahrenheit
Location: finishing kitchen dish machine
Violation Issued: No

Utensil Surface Temp.: = at 163 Degrees Fahrenheit
Location: main kitchen dish machine
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 32 Degrees Fahrenheit - Location: memory care upright cooler: milk
Violation Issued: No

Process/Item: Cold Holding
Temperature: 38 Degrees Fahrenheit - Location: finishing kitchen cooler: tartar sauce
Violation Issued: No

Process/Item: Cold Holding
Temperature: 35 Degrees Fahrenheit - Location: finishing kitchen grill drawer: tuna salad
Violation Issued: No

Process/Item: Cold Holding
Temperature: 38 Degrees Fahrenheit - Location: finishing kitchen grill drawer: egg salad
Violation Issued: No

Process/Item: Hot Holding
Temperature: 158 Degrees Fahrenheit - Location: fwe cabinet: rice
Violation Issued: No

Process/Item: Hot Holding
Temperature: 164 Degrees Fahrenheit - Location: fwe cabinet: puree soup
Violation Issued: No

Process/Item: Cold Holding
Temperature: 50 Degrees Fahrenheit - Location: walk-in cooler: french toast batter
Violation Issued: Yes

Process/Item: Cold Holding
Temperature: 54 Degrees Fahrenheit - Location: walk-in cooler: pancake batter
Violation Issued: Yes

Process/Item: Cold Holding
Temperature: 37 Degrees Fahrenheit - Location: walk-in cooler: beef stew
Violation Issued: No

Process/Item: Cold Holding
Temperature: 37 Degrees Fahrenheit - Location: walk-in cooler: chicken caprese
Violation Issued: No

Process/Item: Hot Holding
Temperature: 162 Degrees Fahrenheit - Location: steam table: bok choy
Violation Issued: No

Type: Full
Date: *03/01/23*
Time: 10:00:00
Report: 8041231043
Friendship Village Bloomington

Food and Beverage Establishment Inspection Report

Process/Item: Cold Holding
Temperature: 41 Degrees Fahrenheit - Location: line cooler: liquid egg
Violation Issued: No

Process/Item: Cold Holding
Temperature: 55 Degrees Fahrenheit - Location: true 2 door cooler: cut melon
Violation Issued: Yes

Process/Item: Cold Holding
Temperature: 38 Degrees Fahrenheit - Location: true 2 door cooler: leek soup
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	1	0	1

Inspection was completed with Michael Beckfield (Admin. Intern), Jennifer Bever (Administrator), Darwin Goetz (Director) and Jaime Sierra (Chef). Anna Bohnen was the lead Health Regulation Division Nurse Evaluator.

Establishment has a kitchen on the main floor, a finishing kitchen on the 2nd floor and a serving kitchen in memory care.

Discussed the following:
-Employee illness policy and logging requirements
-Reporting foodborne illness complaints to the health department
-Cooling and re-heating methods
-Glove-use and bare hand contact
-Vomit clean-up procedures
-Highly susceptible population restrictions
-Proper cold holding
-Violations on this report

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Minnesota Department of Health inspection report number 8041231043 of 03/01/23.

Certified Food Protection Manager: Jaime Edison Sierra

Certification Number: fm55078 Expires: 10/11/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
Darwin Goetz
Director

Signed: Sarah Conboy
Sarah Conboy
Public Health Sanitarian III
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