DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: B0ZV

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00806

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245229**
2.STATE VENDOR OR MEDICAID NO.
(L2)

3. NAME AND ADDRESS OF FACILITY
(L3) **FRIENDSHIP VILLAGE OF BLOOMINGTON**
(L4) **8100 HIGHWOOD DRIVE**
(L5) **BLOOMINGTON, MN** (L6) **55438**

4. TYPE OF ACTION: **2** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **09/23/2021** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 04 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **66** (L18)
13.Total Certified Beds **66** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
__ 2. Technical Personnel
__ 3. 24 Hour RN
__ 4. 7-Day RN (Rural SNF)
__ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
66				
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Renee Blinderman, HFE NE II 11/08/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 12/02/2021 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
01/29/1980
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
October 20, 2021

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

RE: CCN: 245229
Cycle Start Date: September 23, 2021

Dear Administrator:

On September 23, 2021, 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" tag) and emergency preparedness deficiencies (those preceded by an "E" tag), i.e., the plan of correction should be directed to:

Kathleen Lucas, Assistant Program Manager
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: kathleen.lucas@state.mn.us
Office: (320) 223-7343 Mobile: (320) 290-1155

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 December 23, 2021 (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 March 23, 2022 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

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Licensing and Certification Program
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Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245229	A. BUILDING _____ B. WING _____	C 09/23/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 9/20/21, 9/21/21, 9/22/21, and 9/23/21, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 9/20/21, 9/21/21, 9/22/21, and 9/23/21, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was found to be SUBSTANTIATED H5229037C (MN75962), however no deficiencies were cited due to actions implemented by the facility prior to survey: The following complaints were found to be UNSUBSTANTIATED: H5229038C(MN70919), H5229039C (MN64672), H5229040C (MN64217) and H5229041C (MN64040). 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	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 10/29/2021

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 000	Continued From page 1 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess, consistently monitor, and implement care planned interventions to promote healing of a pressure ulcer and prevent further develop of pressure ulcers for 1 of 1 residents (R25) who had a pressure ulcer. Findings include: R25's quarterly Minimum Data Set (MDS) dated 8/3/21, included severe cognitive impairment with	F 686	The statements in the Plan of Correction do not constitute admission of agreement by the Provider of the truth of the facts alleged or the conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of the Federal and State Laws. F-686 It is the policy of Friendship Village of	11/5/21

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F 686	Continued From page 2 diagnoses including dementia and Parkinson's disease. R25 required extensive assistance with all activities of daily living (ADL's) and had a current stage 3 pressure ulcer (Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed.), which had not been present upon admission. R25's pressure ulcer/injury Care Area Assessment (CAA) dated 12/4/20, included, "[R25] is at increased risk for developing pressure related skin breakdown r/t [related to] has active unstageable [Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar] pressure wound on L [left] heel that originated as trauma." R25's care plan dated 8/19/21, included, "Potential for pressure injury development related to decreased mobility, S/P [status post] hip fx [fracture] and hx [history] of pressure injury to left heel." R25's goal was, "The resident will have intact skin, free from redness, blisters or discoloration by/through the review date." Staff were directed to, encourage [R25] to shift weight in the wheelchair every 15 minutes, pressure reducing device to bed and chair, and offload heels [keep them from lying flat on anything to relieve pressure]. R25's care plan dated 3/12/21, indicated R25,	F 686	Bloomington to comprehensively assess, consistently monitor, and implement care planned interventions to promote healing of a pressure ulcer and prevent further development of a pressure ulcer. The community will continue to assess each pressure ulcer weekly and implement all care planned interventions that will promote healing and prevent any new pressure ulcers from developing. It is also the Policy and Procedure to ensure that all Care Planned interventions for the prevention and healing of pressure ulcers is implemented and completed as defined on each individualized care plan for residents with pressure ulcers. To ensure on-going compliance re-education of the Nurses will be completed. Over the next quarter all pressure ulcers will be audited by the Director of Nursing or designee weekly to determine that the resident receives the necessary treatment and services, consistent with professional standards of practice to promote healing, prevent infection and prevent new ulcers from developing which includes comprehensive assessment and evaluation of interventions, and care plan review, pressure ulcer interventions which includes weekly assessment. There after pressure ulcers will be randomly audited for the next three months. Results of the audits will be presented at the quarterly QAPI meeting. The Director of Nursing is responsible for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 686	Continued From page 3 "has impaired skin integrity related to limited physical ability as evidenced by stage III injury to left heel." R25's goal was, the wound would decrease in size every week until resolved and the wound would be free of signs and symptoms of infection every day until resolved. Interventions included: assess and measure left heel weekly and blue boots (pressure relieving devices for heels) to bilateral feet at all times except for when completing her walking. R25's Visual/Bedside Kardex Report included, the need for extensive assistance to turn and reposition when in bed and was to wear, "Blue boots [pressure relieving] to bilateral feet at all times except for when completing her walking." R25's Wound Evaluation dated 6/24/21, at 5:00 p.m. included, left heel pressure ulcer measured at 0.51 centimeters (cm) by (x) 0.38 cm, with 90% slough (dead tissue separating from living tissue-typically gray and stringy) and 10% granulation (red/beefy) tissue. R25's medical record failed to include any wound evaluation between 6/24/21 and 7/15/21, 3 weeks later. R25's wound evaluation dated 7/15/21, included, left heel pressure ulcer measured at 0.76 cm x 0.6 cm, with 100% slough. This noted a decline in granulation tissue to complete slough tissue. R25's wound evaluation dated 7/22/21, included, left heel pressure ulcer measured at 0.57 cm x 0.44 cm, with 100% slough. R25's medical record lacked any wound evaluation again until 8/13/21, 3 weeks later.	F 686	on-going compliance. Date certain: 11/5/21	

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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) COMPLETION DATE
F 686	Continued From page 4	F 686		

R25's wound evaluation dated 8/13/21, included, left heel pressure ulcer measured at 0.84 cm x 0.63 cm, with 80% slough and 20% granulation tissue.

R25's wound evaluation dated 8/18/21, included, left heel pressure ulcer measured at 1.07 cm x 0.87 cm, but lacked evidence of tissue type. R25's medical record lacked another assessment of the wound until 9/2/21, 2 weeks later.

R25's wound evaluation dated 9/2/21, included, left heel pressure ulcer measured at 0.64 cm x 0.51 cm, with 30% slough and 70% granulation tissue. R25's medical record lacked any assessment of R25's pressure ulcer until 9/16/21, 2 weeks later.

R5's wound evaluation dated 9/16/21, included, left heel pressure ulcer measured at 1.52 cm x 1.23 cm, with 40% slough and 60% granulation tissue. This was noted to be larger in size and decline with additional slough.

On 9/21/21, at 5:30 p.m. a wound evaluation completed indicated R25's left heel pressure ulcer measured 0.72 cm x 0.51 cm, with 90% slough and 10% granulation tissue. The ulcer had declined again with additional slough.

During continuous observation on 9/22/21, from 7:49 a.m. to 10:22 a.m. R25 was up in wheelchair in the TV room with no boots on bilat feet. R25 had tennis shoes on and no foot pedals noted on wheelchair. At 8:18 a.m. R25 was taken to the dining room for breakfast. No positioning changes were offered to R25 and she continued with her tennis shoes on. R25 remained at the table in the

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	245229	A. BUILDING _____ B. WING _____	C 09/23/2021

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F 686	Continued From page 5	F 686		

dining room until 8:52 a.m. when she was taken to the TV room and placed at a table. R25 had not been offered or assisted with repositioning, and remained without the blue boots on. At 9:21 a.m. R25's family member (FM)-A mentioned R25 did not have the boots on her feet. FM-A wheeled R25 into her room and removed R25's tennis shoes and placed the offloading, blue boots on R25's feet. At 9:59 a.m. registered nurse (RN)-A brought R25 medication. RN-A did not offer or assist R25 with repositioning. At 10:22 a.m. R25 remained in the same position in her wheelchair with no staff attempts to reposition her. R25 had not been offered or assisted with repositioning for 2 hours and 33 minutes.

When interviewed on 9/22/21, at 10:22 a.m. nursing assistant (NA)-A stated, R25 should be toileted and repositioned every 2 hours. NA-A verified they had not repositioned R25 for over 2 and a half hours. NA-A verified R25 had not been assisted to wear the blue offload boots since she had gotten up this morning.

During observation on 9/22/21, at 10:34 a.m. licensed practical nurse (LPN)-A came to room and offered to take R25 to the bathroom. LPN-A removed R25's boots and placed her tennis shoes on and transferred R25 to the toilet using contact guard assistance with a gait belt.

When interviewed on 9/22/21, at 10:39 a.m. RN-B stated, R25 should be repositioned and toileted every two hours and verified R25 had not been repositioned in over two and a half hours. Further, RN-B stated by not repositioning timely R25 could obtain a pressure ulcer.

When interviewed on 9/22/21, at 12:02 p.m.

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F 686	Continued From page 6 director of nursing (DON) verified the staff should have placed the offload blue boots on R25 and followed the care plan. DON verified R25's pressure ulcer could get worse without having the boots on per orders. Secondly, the DON verified R25 should have been repositioned or toileted every two hours. Further, the DON verified the wound evaluations should be completed weekly. The Lifespace prevention pressure ulcer/injuries policy dated 2/18/19, indicated to reposition resident every two hours as tolerated and to reposition residents dependent on staff for repositioning. The Lifespace wound care policy dated 1/1/17, indicated the facility will comply with current nursing standards, as well as state and federal guidelines related to the identification, treatment, and documentation of alterations of skin integrity of the residents.	F 686		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility	F 688		11/5/21

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F 688	Continued From page 7 receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide the assessed as needed transfer and ambulation program to maintain ability for 1 of 1 residents (R25) reviewed for mobility. Findings include: R25's quarterly Minimum Data Set (MDS) dated 8/3/21, included, severe cognitive impairment with diagnoses including dementia and Parkinson's disease. R25 required extensive assistance for transfers and ambulation. R25's fall risk Care Area Assessment (CAA) dated 12/2/21, included R25 required extensive assistance for transfers and staff were to ambulate her to assist with restlessness and reduce falls. R25's care plan dated 6/26/21, included, she required, "patience in the morning and allow resident to stand up with assistance. Encourage to participate in transfer." R25's risk for falls care plan directed staff to, "Ambulation program: At 1000 [10:00 a.m.] and 1600 [4:00 p.m.] Ambulate resident with contact guard assist, transfer belt, 2 wheeled walker and bring wheelchair behind." R25's Visual/Bedside Kardex report dated 9/21/21, included an ambulation program: at 10:00 a.m. and 4:00 p.m. ambulate resident using contact guard assist, transfer belt, two-wheeled	F 688	F-688 It the policy of Friendship Village of Bloomington to follow each individualized care plan for each resident to determine and follow the transfer status. It is also the policy of Friendship Village of Bloomington to complete each ambulation program for those residents who require assistance with their ambulation program. The Nurses and Nursing Assistants will receive re-education on accessing the Kardex/Care Plan to determine transfer status for all residents as well as those residents who are on an ambulation program according to their individualized plan of care. All residents have been reviewed for their current individualized ambulation programs and transfer status. To ensure on-going compliance random ambulation programs will be audited weekly x 1 month, and then monthly x 5 months. Results of these audits will be brought to the quarterly QAPI meeting. In addition, random audits will be conducted weekly x 1month that the care plan was followed for transferring a resident, and then random audits will be completed monthly x 5 months. Results of these audits will be brought to the quarterly QAPI meeting.	

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F 688	Continued From page 8 walker, and bring wheelchair behind. Further, R25 was to wear shoes while ambulating. In addition, R25 was to be transferred using contact guard assist, a walker and transfer belt. R25's ADL report dated 9/2021, lacked evidence of R25 walking in corridor from 9/7/21 through 9/22/21. R25 was continuously observed on 9/21/21, from 9:45 a.m. to 10:21 a.m. staff did not offer or attempt to ambulate R25. R25 sat in her wheelchair. At 10:21 a.m. nursing assistant (NA)-C brought R25 to her room, brought in a sit to stand mechanical lift, and utilized the lift to transfer R25 to bed. R25 was continuously observed until 12:38 a.m. and no attempt to ambulate her had occurred. When interviewed on 9/21/21, at 12:38 p.m. NA-B stated, information on how to transfer R25 would be on the care plan and Kardex. NA-B was not aware R25 was on an ambulation program and verified she had not been assisted to ambulate today. NA-B stated R25 should be transferred with contact guard assist, not a mechanical lift. This is to help her maintain her transfer ability. When interviewed on 9/21/21, at 12:51 p.m. NA-C stated R25's information on transfers and ambulation would be on the Kardex. NA-C stated she was unaware of how R25 was to transfer and not aware on an ambulation program until she consulted the Kardex with the surveyor. NA-C stated staff had not ambulated R25 today and she had not been transferred correctly today. When interviewed on 9/21/21, at 12:55 p.m. registered nurse (RN)-A verified if R25 was	F 688	The Director of Nursing is responsible for on-going compliance. Date certain: 11/5/21	

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contact guard assist the nursing assistants should not use a sit-to stand to transfer the resident. RN-A stated if a resident was on an ambulation program twice a day the expectation would be for the staff to complete the ambulation program. Further, stated if R25 was to weak to continue doing an ambulation program or transfer with contact guard the care plan should be modified to reflect the changes. If R25's care plan was not followed for type of transfer and ambulation, she may lose the ability to transfer and ambulate.

When interviewed on 9/21/21, at 1:01 p.m. licensed practical nurse supervisor/manager (LPN)-A stated R25 was able to transfer with contact guard assist and the staff should be following the care plan with transfers and the ambulation program or R25 could lose her ability.

During continuous observation on 9/22/21, from 7:49 a.m. to 10:22 a.m. R25 remained in her wheel chair and no attempt to ambulate her was made by staff.

When interviewed on 9/22/21, at 12:02 p.m. the director of nursing (DON) verified the staff should transfer and ambulate R25 per the care plan. Further, DON stated the family has requested the staff continue to attempt to transfer and ambulate R25 per the care plan.

A facility policy was requested, but not provided by the facility.

FIRE SAFETY SURVEY REPORT
CRUCIAL DATA EXTRACT
(TO BE USED WITH CMS-2786 FORMS)

PROVIDER NUMBER	FACILITY NAME	SURVEY DATE
K1 245229	**FRIENDSHIP VILLAGE OF BLOOMINGTON**	*K4 **09/23/2021**

K6 DATE OF PLAN APPROVAL

K3 : MULTIPLE CONSTRUCTION

TOTAL NUMBER OF BUILDINGS 1

NUMBER OF THIS BUILDING 01

[A]

A BUILDING
B WING
C FLOOR
D APARTMENT UNIT

LSC FORM INDICATOR

Health Care Form		
12	2786 R	2012 EXISTING
13	2786 R	2012 NEW

ASC Form		
14	2786 U	2012 EXISTING
15	2786 U	2012 NEW

ICF/MR Form		
16	2786 V, W, X	2012 EXISTING
17	2786 V, W, X	2012 NEW

*K7 [12] SELECT NUMBER OF FORM USED FROM ABOVE

(Check if K321 or K351 are marked as not applicable in the 2786 M, R, T, U, V, W, X, Y and Z.)

K321: [3] K351: [3]

COMPLETE IF ICF/MR IS SURVEYED UNDER CHAPTER 21

SMALL (16 BEDS OR LESS)

K8: [ ]

1 PROMPT
2 SLOW
3 IMPRACTICAL

LARGE

K8: [ ]

4 PROMPT
5 SLOW
6 IMPRACTICAL

APARTMENT HOUSE

K8: [ ]

7 PROMPT
8 SLOW
9 IMPRACTICAL

ENTER E-SCORE HERE

K5: [ ] e.g 2.5

*K9 : FACILITY MEETS LSC BASED ON: (*Check all that apply*)

A1	A2	A3	A4	A5
[ ]	[X]	[ ]	[ ]	[ ]
(COMP. WITH ALL PROVISIONS)	(ACCEPTABLE POC)	(WAIVERS)	(FSES)	(PERFORMANCE BASED DESIGN)

FACILITY DOES NOT MEET LSC:

B. [ ]

K180:

A.	B.	C.
[X]	[ ]	[ ]
FULLY SPRINKLERED (All required areas are sprinklered)	PARTIALLY SPRINKLERED (Not all required areas are sprinklered)	NONE (No sprinkler system)

*MANDATORY