DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

				AND TRANSMITTAL IE SURVEY AGENCY	ID: OYY1 Facility ID: 00806
MEDICARE/MEDICAID PROVIDER NO. (L1) 245229 2.STATE VENDOR OR MEDICAID NO. (L2)	(L3) FR (L4) 81 0	ME AND ADDRESS OF FAC RIENDSHIP VILLAGE (00 HIGHWOOD DRIVI LOOMINGTON, MN	OF BLOO	MINGTON (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. Others
	01 Hosp (L34) 02 SNF/2		ORY 09 ESRD 10 NF 11 ICF/III 12 RHC	04 (L7) 13 PTIP 22 CLIA 14 CORF 0 15 ASC 16 HOSPICE	7. On-Site Visit 9. Other 8. Full Survey After Complaint FISCAL YEAR ENDING DATE: (L35) 12/31
11LTC PERIOD OF CERTIFICATION From (a): To (b): 12. Total Facility Beds 119 13. Total Certified Beds 66	A. (L18)	E FACILITY IS CERTIFIED In Compliance With Program Requirements Compliance Based On:1. Acceptable POC Not in Compliance with Prog Requirements and/or Appli	gram	And/Or Approved Waivers Of 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SN 5. Life Safety Code * Code: B *	6. Scope of Services Limit 7. Medical Director
14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 66 (L37) (L38)	19 SNF (L39)	ICF IID (L42) (L43)		15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)
16. STATE SURVEY AGENCY REMARKS (IF	APPLICABLE SHO	OW LTC CANCELLATION I	DATE):		
17. SURVEYOR SIGNATURE Shawn Soucek, HPR SWS		Date : 07/15/2015	(L19)	18. STATE SURVEY AGENCY	
PART II - 1	TO BE COMPI	LETED BY HCFA RE	GIONA	L OFFICE OR SINGLE S	TATE AGENCY
DETERMINATION OF ELIGIBILITY	(L21)	20. COMPLIANCE WITH RIGHTS ACT:	I CIVIL		ncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513) ::
	AGREEMENT GINNING DATE	24. LTC AGREEN ENDING DAT		26. TERMINATION ACTION: VOLUNTARY 00	` /

01/29/1980 01-Merger, Closure 05-Fail to Meet Health/Safety 02-Dissatisfaction W/ Reimbursement 06-Fail to Meet Agreement (L24) (L41) (L25) 03-Risk of Involuntary Termination 25. LTC EXTENSION DATE: 27. ALTERNATIVE SANCTIONS 04-Other Reason for Withdrawal 07-Provider Status Change A. Suspension of Admissions: (L44) 00-Active (L27) B. Rescind Suspension Date:

(L45)

28. TERMINATION DATE:

29. INTERMEDIARY/CARRIER NO.

03001

(L28)

(L28)

(L31)

31. RO RECEIPT OF CMS-1539

32. DETERMINATION OF APPROVAL DATE

(L33)

DETERMINATION APPROVAL

(L32)



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered June 29, 2015

Mr. Ronald Donacik, Administrator Friendship Village Of Bloomington 8100 Highwood Drive Bloomington, Minnesota 55438

RE: Project Number S5229025

Dear Mr. Donacik:

On June 11, 2015, a standard 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 constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

<u>Electronic Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

<u>Informal Dispute Resolution</u> - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), i.e., the plan of correction should be directed to:

Gayle Lantto, Unit Supervisor Metro D Survey Team Licensing and Certification Program Health Regulation Division Minnesota Department of Health Email: gayle.lantto@state.mn.us

Phone: (651) 201-3794 Fax: (651) 215-9697

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by July 21, 2015, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by July 21, 2015 the following remedy will be imposed:

• Per instance civil money penalties. (42 CFR 488.430 through 488.444)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

		TO BE COMPI			TE SURVEY AGENCY		cility ID: 00806		
MEDICARE/MEDICAID PROVID (L1) 245229 2.STATE VENDOR OR MEDICAID (L2)		3. NAME AND AL (L3) FRIENDSHI (L4) 8100 HIGHV (L5) BLOOMING	IP VILLAGE WOOD DRIV	OF BLOO	OMINGTON (L6) 55438	4. TYPE OF ACTION: 1. Initial 3. Termination 5. Validation	7 (L8) 2. Recertification 4. CHOW 6. Complaint 9. Other		
5. EFFECTIVE DATE CHANGE OF (L9)	OWNERSHIP	7. PROVIDER/SU 01 Hospital	PPLIER CATEC	GORY 09 ESRD	04 (L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint			
6. DATE OF SURVEY 07/2 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	4/2015 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/III 12 RHC	14 CORF D 15 ASC 16 HOSPICE	FISCAL YEAR ENDING 12/31	DATE: (L35)		
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12. Total Facility Beds 13. Total Certified Beds	119 (L18) 66 (L17)	Complianc1. A B. Not in Com		gram	And/Or Approved Waivers Of 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SN 5. Life Safety Code * Code: A	6. Scope of Service7. Medical Direct	ces Limit for		
14. LTC CERTIFIED BED BREAKDO	OWN				15. FACILITY MEETS				
18 SNF 18/19 SNF 66 (L37) (L38)	19 SNF (L39)	ICF (L42)	IID (L43)		1861 (e) (1) or 1861 (j) (1):	(L15)			
16. STATE SURVEY AGENCY REM	MARKS (IE APPI ICA	RI E SHOW ITC CA	NCELL ATION	DATE).					
TO. STATE SCREET ROLLING REA	natio (ii mi nate)	BEE SHOW ETC CI	ii (CLLLI II TOI (D11112).					
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL	Date:		
Gayle Lantto, HFE N	EII	0	7/27/2015	(L19)	Mark Meath	, Enforcement Specialist	08/25/2015 (L20)		
PA	RT II - TO BE	COMPLETED I	BY HCFA RI	EGIONA	L OFFICE OR SINGLE S	STATE AGENCY			
19. DETERMINATION OF ELIGIBI _X 1. Facility is Eligible to 2. Facility is not Eligible	Participate		IPLIANCE WITI HTS ACT:	H CIVIL	1. Statement of Financial Solvency (HCFA-2572) 2. Ownership/Control Interest Disclosure Stmt (HCFA-1513) 3. Both of the Above :				
22. ORIGINAL DATE	23. LTC AGREEN	MENT 24	4. LTC AGREEN	MENT	26. TERMINATION ACTION	: (L3	50)		
OF PARTICIPATION 01/29/1980	BEGINNING	DATE	ENDING DA	TE	VOLUNTARY 01-Merger, Closure		ARY et Health/Safety		
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs		et Agreement		
25. LTC EXTENSION DATE:	27. ALTERNATI				03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	OTHER	Status Change		
(L27)	_	n of Admissions:	(L44)			00-Active	ratus Change		
			(L45)						
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS				
		03001							
	(L28)			(L31)					
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION 07/20/2015	OF APPROVAI	DATE					

(L33)

DETERMINATION APPROVAL

(L32)



Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24 5229

August 25, 2015

Mr. David Miller, Administrator Friendship Village Of Bloomington 8100 Highwood Drive Bloomington, Minnesota 55438

Dear Mr. Miller:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective July 21, 2015 the above facility is certified for:

66 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all66 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Weath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health

Email: mark.meath@state.mn.us

Telephone: (651) 201-4118 Fax: (651) 215-9697



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered July 27, 2015

Mr. Ronald Donacik, Administrator Friendship Village Of Bloomington 8100 Highwood Drive Bloomington, Minnesota 55438

RE: Project Number S5229025

Dear Mr. Donacik:

On June 29, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on June 11, 2015. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On July 24, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on July 20, 2015 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on June 11, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 21, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on June 11, 2015, effective July 21, 2015 and therefore remedies outlined in our letter to you dated June 29, 2015, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Weath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesta Department of Health

Email: mark.meath@state.mn.us

Telephone: (651) 201-4118 Fax: (651) 215-9697

Form Approved OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1)	Provider / Supplier / CLIA / Identification Number 245229	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 7/24/2015
Name	of Facility		Street Address, City, State, Zip Code	
FRIENDSHIP VILLAGE OF BLOOMINGTON		I	8100 HIGHWOOD DRIVE	
			BLOOMINGTON. MN 55438	

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/ or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item		(Y5) [Date ((Y4)	Item		(Y5)	Date	(Y4)	ltem		(Y5)	Date
		Corr	ection					Correction					Correction
			npleted					Completed					Completed
ID Prefix	F0281	07/2	1/2015	I	D Prefix	F0282		07/21/2015		ID Prefix	F0323		07/21/2015
-	483.20(k)(3)(i)				-	483.20(k)(3)(ii)					483.25(h)		_
LSC					LSC				<u> </u>	LSC			_
		Ca.						Compostion					Competion
			rection apleted					Correction Completed					Correction Completed
ID Prefix	F0329		1/2015	ı	D Prefix	F0371		07/21/2015		ID Prefix	F0428		07/21/2015
Rea.#	483.25(I)				Rea.#	483.35(i)		-		Rea.#	483.60(c)		
LSC		_			LSC								_ _
		Corr	ection					Correction					Correction
			npleted					Completed					Completed
ID Prefix	F0441		1/2015	ı	D Prefix			Completed		ID Prefix			Completed
Reg. #	483.65				Reg. #			-		Reg. #			
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		Corr	ection					Correction					Correction
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ID Prefix				'	D Prefix					ID Prefix			_
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LSC					LSC				<u> </u>	LSC			_
		Corr	ection					Correction					Correction
		Com	npleted					Completed					Completed
ID Prefix				I	D Prefix					ID Prefix			_
Reg. #					Reg.#					Reg. #	-		
LSC					LSC					LSC			
Reviewed By	Review	ed By		Date	»:	Signature of	Surve	yor:				Date:	
State Agency	, GL/n	nm		07	/27/20	15		1550	7			07/24	1/2015
Reviewed By	Review	ed By		Date	:	Signature of	Surve	yor:				Date:	
CMS RO													
Followup to	Survey Completed on:						-				a Summary of		
	6/11/2015					Unco	rrecte	d Deficiencies	(CMS	5-2567) Sent	to the Facility?	YES	NO

Form Approved OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1)	Provider / Supplier / CLIA / Identification Number 245229	(Y2) Multiple Constr e A. Building B. Wing	N BUILDING 01	(Y3) Date of Revisit 7/20/2015
Name	of Facility		Street Address, City, State, Zip Code	
FR	IENDSHIP VILLAGE OF BLOOMINGTON	I	8100 HIGHWOOD DRIVE	
		•	BLOOMINGTON MN 55438	

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/ or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item		(Y5)	Date	(Y4)	Item	(Y5)	Date	(Y4) Item		(Y5)	Date
			Correction				Correction					Correction
			Completed				Completed					Completed
ID Prefix			07/15/2015		ID Prefix _		_		ID Prefix			_
Reg. #	NFPA 101				Reg.#				Reg. #			
LSC	K0038				LSC _				LSC			_
				1				+				
			Correction				Correction					Correction
			Completed				Completed					Completed
ID Prefix			-		ID Prefix		=		ID Prefix			_
Reg. #					Reg. #				Reg. #			
LSC					LSC _				LSC			_
			Correction				Correction					Correction
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ID Prefix					ID Prefix _		-		ID Prefix			_
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LSC	-				LSC _		_		LSC			
				-	_		•	+				
Reviewed By	,	Reviewed E	Зу	Da	ite:	Signature of Surve	yor:				Date:	
State Agency	,						=					
Reviewed By	,	Reviewed E	Зу	Da	ite:	Signature of Surve	yor:				Date:	
CMS RO												
Followup to	Survey Comple	ted on:				Check for any	Uncorrected	Defic	iencies. Was	a Summary of	1	
	6/10/2	2015								to the Facility?	YES	NO
				1								

Form CMS - 2567B (9-92) Page 1 of 1 Event ID: OYY122

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. 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, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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 September 11, 2015 (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). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement

of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by December 11, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. 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.

INFORMAL DISPUTE RESOLUTION

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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/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: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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:

Mr. Patrick Sheehan, Supervisor Health Care Fire Inspections State Fire Marshal Division pat.sheehan@state.mn.us

Telephone: (651) 201-7205

Fax: (651) 215-0525

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Email: mark.meath@state.mn.us

Telephone: (651) 201-4118 Fax: (651) 215-9697

PRINTED: 07/15/2015 FORM APPROVED OMB NO. 0938-0391

-	ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				ATE SURVEY OMPLETED
		245229	B. WING		6/11/2015
	PROVIDER OR SUPPLIER SHIP VILLAGE OF BL	OOMINGTON		STREET ADDRESS, CITY, STATE, ZIP CODE 8100 HIGHWOOD DRIVE BLOOMINGTON, MN 55438	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC 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 000	INITIAL COMMENT	-S	F 00	o l	
	as your allegation on Department's accept enrolled in ePOC, y at the bottom of the	of correction (POC) will serve from the otance. Because you are four signature is not required first page of the CMS-2567 ic submission of the POC will ion of compliance.			
F 281 SS=D	on-site revisit of you validate that substa regulations has bee your verification.	acceptable electronic POC, an air facility may be conducted to ntial compliance with the en attained in accordance with EVICES PROVIDED MEET STANDARDS	F 28	1	7/21/15
		led or arranged by the facility onal standards of quality.			
	by: Based on observat review, the facility fa injections were prop administration in ac instructions and sta residents (R68) who observed. This also one more other residents. Findings include: R68's insulin admin 6/8/15, at 5:29 p.m.	ion, interview and document ailed to ensure insulin perly prepared prior to cordance with manufacturer's indards of practice for 1 of 1 pse insulin administration was a had a potential of affecting ident who used insulin on that istration was observed on by a registered nurse (RN)-A. Is Novolog (used to manage		The statements made in the plan of correction do not constitute admission or 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/off executed solely because it is required by the provision of Federal and State laws. It is the policy of Friendship Village to ensure insulin injections are properly prepared in accordance with manufacturer's instructions. Regarding R68, immediate re-training was conduct with RN-A regarding following	r
ABORATOR'	/ DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE	(X6) DATE

ORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

07/08/2015

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.

-	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245229	B. WING		06/	11/2015	
	PROVIDER OR SUPPLIER SHIP VILLAGE OF BI			STREET ADDRESS, CITY, STATE, ZIP CO 8100 HIGHWOOD DRIVE BLOOMINGTON, MN 55438	-		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 281	Flexpen, (disposal RN-A attached the flexpen, dialed to skin with an alcoho the insulin to R68's pulled out the need the insulin. Immediately after interviewed regard removing air from after NovoFine netholding the needle seconds after adminad not primed the R68's insulin nor diskin to make sure administered. RN-primed the Flexpedo it." During an interview assistant director of that the expectation received insulin via the pen primed be director of nursing nurses were given and that her expedition, she expemanufacturer's received in administration. R68's physician or R68's physician R68's physician or R68's phys	age 1 as administered via a Novolog ole dial-a-dose insulin pen). NovoFine needle to the 5 units, wiped the resident's ol wipe and then administered is lower right quadrant. RN-A dile immediately after pushing deaving R68's room, RN-A was ling the lack of priming or the cartridge in the Flexpen edle was attached and lack of in the skin for at least six ministration. RN-A verified she is Flexpen prior to administering lid she hold the needle in the all medication was A further stated, "I've never in and I've never seen anyone on 6/10/15, at 12:36 p.m. the of nursing (ADON) explained in was that all residents who as a Flexpen should have had fore insulin was administered. W on 6/11/15, at 11:42 a.m. the (DON) explained that all onsite training on Flexpens etation was that the Flexpens e administering insulin. In cted the staff to follow the commendations on how hister insulin using Flexpens. ders dated 6/3/15, directed Novolog injections	F 2	manufacturer's instructions. new practice was initiated, where the attachment of the manufacturer specific instructions to the ord Electronic Record. Licensed be re-educated regarding mainstructions relating to insulin and the new practice that has initiated. To ensure future an compliance, audits will be conduring the 3rd Quarter, 2015 proper insulin administration reviewed at the upcoming Quassurance Committee Meetin Director of Nursing, ADON ar Supervisors will be responsibe future compliance.	nich outlines neturer's der in the nurses will nufacturer injections been d on-going nducted regarding via pen and ality ng. The		

	ENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		245229	B. WING _		06/11/2015		
	PROVIDER OR SUPPLIER	OOMINGTON		STREET ADDRESS, CITY, STATE, ZIP CODE 8100 HIGHWOOD DRIVE BLOOMINGTON, MN 55438			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLÉTION	1	
F 282 SS=D	with dinner, and to glucose of less than glucose of less than The Novolog Flexped directed priming wit administration of earliection small amo cartridge during nor and to ensure proposelector to select 2 pointing upwards, pway in. The dose semanufacturer's instinctude step-by-step complete the task. for at least 6 second pressed all the way pulled out from the the full dose has be 483.20(k)(3)(ii) SEPPERSONS/PER CATThe services provided by accordance with earcare. This REQUIREMENT by: Based on observate review, the facility for thostatic blood president (R76) reviews	units once a day at 6:00 p.m. hold the medication for blood in 150 milligrams/deciliters. en manufacturer's instruction the 2 units prior to ach injection. "Before each unts of air may collect in the smal use. To avoid injecting air er dosing: Turn the dose units, keep the needle wress the bush-button all the elector returns to 0." The ructions insert went on to be instructions on how to "Keep the needle in the skinds, and keep the push-button in until the needle has been skin. This will make sure that then given." RVICES BY QUALIFIED	F 28		olood orders. th, ce.		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	` '	(X3) DATE SURVEY COMPLETED	
		245229	B. WING _		06/	11/2015	
	PROVIDER OR SUPPLIER SHIP VILLAGE OF BL	OOMINGTON		STREET ADDRESS, CITY, STATE, ZIP CODE 8100 HIGHWOOD DRIVE BLOOMINGTON, MN 55438			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 282	indicated R76 had for the resident to 'mobility with no incatals/injuries." Medications known hypotension and/orincluding order chaincrease Seroquel day) and 37.5 mg a hallucinations, Sine and Trazodone 50 used to promote slindicated that on 1 on the Seroquel wi orthostatic blood prinstructions were the treatment administ of the ETARs from evidence the reside pressures had ever and when the reside of orthostatic hypotension and her son in atternation at the falls in the last 3 m has been increase helped. Res son fee benefitted [sic] his may increase her for During an interview stated R76 require	st revised on 12/15/14, a history of falls. The goal was 'maintain current level of crease in incident of to contribute to orthostatic r falls were prescribed for R76 anges dated 5/18/15, to 25 mg (milligrams) bid (twice a fat HS (hour of sleep) for emet for Parkinson's disease, mg (antidepressant commonly eep). The physician orders 1/20/14, R76 had been started th directions to monitor R76's ressure monthly. Although the cansferred to the electronic ration records (ETAR) review 11/14 through 5/15, lacked ent's orthostatic blood r been measured as ordered, lent had an existing diagnosis tension. Summary note 6/1/15, noted as held on that date with R76 ndance. "Nursing: Has had 3 onths. Res [resident] Seroquel d, which seems to have lest the Seroquel increase has Mother well, but understands it	F 28	antipsychotic medications to endition or or or order to ensure future compliance accord order to ensure future compliance education of licensed nursing be conducted to assure that structure activity policy relating to vital signs on residents receiving psychotropic medications. The Pharmacy Consultant will audit on antipsychotic medication du Quarter, 2015 to ensure orthos pressure monitoring has occur Director of Nursing Service and Pharmacy Consultant are responsure compliance.	e care ingly. In nce, g staff will aff are up to o orthostatic ng e DON and residents ring the 3rd static blood red. The d the		

	EMENT OF DEFICIENCIES PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	LE CONSTRUCTION (X	3) DATE SURVEY COMPLETED
		245229	B. WING		06/11/2015
	PROVIDER OR SUPPLIER SHIP VILLAGE OF BL	OOMINGTON		STREET ADDRESS, CITY, STATE, ZIP CODE 8100 HIGHWOOD DRIVE BLOOMINGTON, MN 55438	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 282	RN-B was unable to that R76's orthosta	cation of Seroquel. However, o provide any documentation tic blood pressure had been	F 282		
F 323 SS=D	DON verified no ortaken from 3/1/15 the explained the reason blood pressure were put into the facility's alert nursing staff to DON confirmed that pressure had a state the ETAR for nursing off by nursing as be documentation was blood pressures more RN-B stated the ETA administration recorresidents' care plar 483.25(h) FREE OF HAZARDS/SUPER The facility must enenvironment remains is possible; and	on 6/11/15, at 12:17 p.m. the chostatic blood pressures were of 6/11/15. The DON on for the missing orthostatic edue to a clerical error when a computer system that would be perform this function. The at R76 orthostatic blood at date of 11/20/14, and was on the graph of the system	F 323		7/21/15
	by: Based on observareview, the facility f	NT is not met as evidenced tion, interview and document ailed to assess and implement res after falls to minimize the		It is the policy of Friendship Village to ensure that the resident environment remains as free of accidents and haz	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION IG	` '	(X3) DATE SURVEY COMPLETED	
		245229	B. WING _		06/ ⁻	11/2015	
_	PROVIDER OR SUPPLIER SHIP VILLAGE OF BL			STREET ADDRESS, CITY, STATE, ZIP CO 8100 HIGHWOOD DRIVE BLOOMINGTON, MN 55438			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 323	Findings include: R76 was observed room. She was se of the observation. resident if she was without requesting independently stoo walked a few feet, floor and then back sat down. A nursin entered the room a needs for assistant NA-B stated R76 v standing or walking assistance" of one p.m. R76 was in the footrest in the raise R76's MDS dated was cognitively implementation with injury and the NA assignment directed staff to prowith the use of a few wheelchair for transmobility. R76's care plan last indicated R76 had for the resident to mobility with no incomposition.	for 1 of 5 residents (R76) cessary medication use. I on 6/10/15, at 1:33 p.m. in her rated in her recliner at the time. After the surveyor asked the able to stand on her own, the resident demonstrate, R76 od using her walker. R76 picked an item up from the ked up toward her recliner and g assistant (NA)-B then and was asked about R76's ce with standing and walking. Was not supposed to be g alone, but needed "stand by staff. At approximately 2:00 in recliner resting with the	F 32	as is possible and that each receives adequate supervisic assistance devices to prever Regarding R76, orthostatic by pressures were initiated on J 2015 per monthly standard of Moreover, we have audited reantipsychotic medications to orthostatic blood pressures a planned and monitored accoorder to ensure future complied re-education of licensed nurse be conducted to assure that date on facility policy relating vital signs on residents receipsychotropic medications. The Pharmacy Consultant will auton antipsychotic medication of Quarter, 2015 to ensure orth pressure monitoring has occupirector of Nursing Service and Pharmacy Consultant are resensure compliance.	on and ont accidents. blood lune 20th, of practice. residents with ensure that are care rdingly. In iance, sing staff will staff are up to to orthostatic ving the DON and dit residents during the 3rd ostatic blood urred. The and the		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		245229	B. WING _		06	/11/2015	
	PROVIDER OR SUPPLIER SHIP VILLAGE OF BL	OOMINGTON		STREET ADDRESS, CITY, STATE, ZIP COI 8100 HIGHWOOD DRIVE BLOOMINGTON, MN 55438	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 323	safety measures to changing positions areas free of obstrueasy reach. Instruct needed]Keep per bed to be in low polockedEstablish residentintroducir environment slowly Medications known hypotension and/or including order chaincrease Seroquel day) and 37.5 mg a hallucinations, Sine and Trazodone 50 used to promote slindicated that on 1 on the Seroquel wi orthostatic blood processes to seroquel with the seroquel wit	o reduce risk of falls (posture, use of handrails)Keep auctionKeep call light within to call for assistance prn [as resonal items within easy reach; sition and wheels daily routines for ng changes in routine or defaults." In to contribute to orthostatic refalls were prescribed for R76 anges dated 5/18/15, to 25 mg (milligrams) bid (twice a lat HS (hour of sleep) for emet for Parkinson's disease, mg (antidepressant commonly eep). The physician orders 1/20/14, R76 had been started th directions to monitor R76's	F 32	3			
	and her son in atte falls in the last 3 m has been increased helped. Res son fe	ndance. "Nursing: Has had 3 onths. Res (resident) Seroquel d, which seems to have els the Seroquel increase has Mother well, but understands it					
	experienced eight to 6/15. Seven of the and during three of head. It was determeight falls the residerecliner chair. The	revealed the resident falls in six months from 12/14 he the falls were unwitnessed, the falls the resident hit her nined that during six of the ent was transferring from her facility's incident icated that interdisciplinary					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		245229	B. WING			06/-	11/2015	
	PROVIDER OR SUPPLIER SHIP VILLAGE OF BL	OOMINGTON		STREET ADDRESS, CITY 8100 HIGHWOOD DRIV BLOOMINGTON, MI	VE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	((EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD NCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 323	the possible correlation existing diagnosis of nor the increased rupon rising with the medication. The assumed for ensuring of monitoring was complysician, and not after the sixth and physical therapy state determine whether appropriate, as well physician input into the pressure taken due medication of Serounable to provide a orthostatic blood precorded by staff. During an interview DON verified no or taken from 3/1/15 to explained the reast blood pressure well put into the facility's alert nursing staff to confirmed that R76 had a start date of for nursing to compursing as being condocumentation was blood pressures medication of the facility's 1/29/1 to facility is 1/29/1 to f	easures taken did not reflect ation with the resident's of orthostatic blood pressure, isk of a drop in blood pressure addition of antipsychotic resessment did not include the orthostatic blood pressure inpleted as ordered by the care plan changes were made, seventh fall, it was suggested aff complete a screening to an ambulation program was I as the need for family and R76's fall management plan. If on 6/11/15, at 8:24 a.m. RN-B id monthly orthostatic blood at to R76 use of antipsychotic quel. However, RN-B was any documentation that R76's ressure had been taken or a con 6/11/15. The DON on for the missing orthostatic redue to a clerical error when a computer system that would be perform this function. DON to orthostatic blood pressure 11/20/14, were on the ETAR olete and was signed off by ompleted, however, no available to show what the	F3	23				

AND DUAN OF CODDECTION INDENTIFICATION NUMBER.		` '	E CONSTRUCTION (:	(X3) DATE SURVEY COMPLETED	
		245229	B. WING		06/11/2015
	PROVIDER OR SUPPLIER SHIP VILLAGE OF BL	OOMINGTON	8	TREET ADDRESS, CITY, STATE, ZIP CODE 100 HIGHWOOD DRIVE BLOOMINGTON, MN 55438	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 323	to assess the risk/b psychoactive drug t 483.25(I) DRUG RE	ent monitoring should be done benefit relationship of therapy." EGIMEN IS FREE FROM	F 323		7/21/15
SS=D	unnecessary drugs drug when used in duplicate therapy); without adequate mindications for its us adverse consequer should be reduced combinations of the Based on a compreresident, the facility who have not used given these drugs used therapy is necessary as diagnosed and crecord; and resident drugs receive gradus behavioral interven	g regimen must be free from . An unnecessary drug is any excessive dose (including or for excessive duration; or nonitoring; or without adequate se; or in the presence of nees which indicate the dose or discontinued; or any			
	by: Based on observative review the facility famonitoring and ratio	NT is not met as evidenced tion, interview and document alled to ensure adequate onale for continued use for cation for 1 of 5 residents		It is the policy of Friendship Village to ensure that the drug regimen of each resident will be reviewed at least one month by a licensed pharmacist.	h

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		` '	(X3) DATE SURVEY COMPLETED	
		245229	B. WING _		06/-	11/2015	
	PROVIDER OR SUPPLIER SHIP VILLAGE OF BL			STREET ADDRESS, CITY, STATE, ZIP CO 8100 HIGHWOOD DRIVE BLOOMINGTON, MN 55438			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE ADEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 329	Findings include: Medications known hypotension and/o including order chaincrease Seroquel day) and 37.5 mg a hallucinations, Sind and Trazodone 50 used to promote slindicated that on 1 on the Seroquel wi orthostatic blood pincidents revealed falls in six months three cases sustain A Care Conference a family meeting wand her son in atterfalls in the last 3 m has been increase helped. Res son fe benefitted [sic] his may increase her for R76's electronic trace (ETAR) indicated the pressures were to of each month, how the orthostatic blood taken. During an interview registered nurse (Fevidence in the research and providence in the providence in the research and providence in	n to contribute to orthostatic r falls were prescribed for R76 anges dated 5/18/15, to 25 mg (milligrams) bid (twice a at HS (hour of sleep) for emet for Parkinson's disease, mg (antidepressant commonly eep). The physician orders 1/20/14, R76 had been started th directions to monitor R76's ressure monthly. R76's fall the resident experienced eight from 12/14 to 6/15, and in ned an injury. E Summary note 6/1/15, noted as held on that date with R76 andance. "Nursing: Has had 3 onths. Res (resident) Seroquel d, which seems to have sels the Seroquel increase has Mother well, but understands it	F 32	Regarding R76, orthostatic by pressures were initiated on a 2015 per monthly standard of Moreover, we have audited antipsychotic medications to orthostatic blood pressures a planned and monitored accordinally, a comprehensive revisidents receiving psychotromedications was conducted target behaviors have been is staff to monitor on each residence of licensed nursing staff will to assure that staff are up to facility policy relating to orthosigns on residents receiving medications. The DON and Consultant will audit resident antipsychotic medication dur Quarter, 2015 to ensure orth pressure monitoring has occurred to ensure and the Pharmacy Cresponsible to ensure complete.	June 20th, of practice. residents with ensure that are care ordingly. View of opic Specific dentified for dent. In order, re-education be conducted date on ostatic vital psychotropic Pharmacy ts on ring the 3rd ostatic blood curred and as been ursing consultant are		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245229	B. WING			06/	11/2015
	PROVIDER OR SUPPLIER SHIP VILLAGE OF BL	OOMINGTON		810	REET ADDRESS, CITY, STATE, ZIP CODE 00 HIGHWOOD DRIVE LOOMINGTON, MN 55438	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 329	nursing then reportinursing (DON) no chad been complete explanation for the facility had a new cathe past they would problem. Although medication and mo 11/20/14, it had not In addition, target be identified for the us R76's EMAR dated monitor for "anxiety statements," there is provided for staff as staff was to record did not specify if ag pacing, pounding h During an interview explained that befor antipsychotic medic indicated if R76 was anxiety/agitation/pashould have docum progress note. RN-was not individualiz. The DON stated on were no indications identified. The facility's 1/29/0 policy read, "This facility read read read read read read read read	ed at 12:17 p.m. the director of orthostatic blood pressures of from 3/1/15 to 6/11/15. The missing data was that the computerized system, and in have been alerted to the the start date for the nitoring was ordered on been completed. ehaviors had not been e of antipsychotic medication. 6/15, indicated staff was to a lack of direction as to what specific symptoms if observed. (For example, it itation was evidenced by the fist, cursing, etc.) on 6/11/15, at 8:24 a.m. RN-B are R76 received her cation nursing staff had to sexhibiting any signs of ranoid statements and if so, tented those behaviors in a B confirmed the information	F3	29			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245229	B. WING		06/ ⁻	11/2015
	PROVIDER OR SUPPLIER SHIP VILLAGE OF BL	OOMINGTON		STREET ADDRESS, CITY, STATE, ZIP CODE 8100 HIGHWOOD DRIVE BLOOMINGTON, MN 55438		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 329 F 371 SS=D	psychoactive drug 483.35(i) FOOD PI STORE/PREPARE The facility must - (1) Procure food fro considered satisfact authorities; and	therapy." ROCURE, /SERVE - SANITARY om sources approved or ctory by Federal, State or local distribute and serve food	F 32			7/21/15
	by: Based on observareview the facility for residents (R42, R5 proper temperature 21 residents on the Eindings include: On 6/8/15, at 11:57 (DM) stated while I logs, "For dinner we temperatures." The temperatures had a through 6/7/15. In I there were missing dinner from Decem 2015, and also mis sporadically for breculinary director (A about the missing for the state of the state	NT is not met as evidenced tion, interview and document ailed to ensure 2 of 21 5) were served food at the e, while potentially affecting all e unit. Ya.m. the dietary manager cooking for food temperature e have a problem with food to been documented for 6/1 cooking back DM also verified food temperatures daily for other 1st, 2014 through May 31, sing food temperatures sakfast and lunch. Assistant CD) stated he had not known food temperatures in the log, wed the food temperature logs		It is the policy of Friendship Village store, prepare, distribute and serve under sanitary conditions. Regarding Resident #42 & #55, staff immediated discarded pureed ham, and cook purepared a new serving that exceed 140 degrees required per regulation ensure future compliance Dietary A will be re-educated regarding food temperatures and pan placement to ensure that temperatures reach the appropriate 140 degrees. Moreove tempereature logs will be monitored audited by the Dietary Manager dur 3rd Quarter, 2015 and the results we presented at the next quarterly Quarters and auditing of food temperatures that it is presented at the next quarterly Quarters and auditing of food temperatures that auditing of food temperatures that and auditing of food temperatures and auditing of food temperatures and services are services and services and services and services and services and services are services and services are services and services are services and servi	e food ng tely romptly ded the n. To sides o er, food d and ring the will be ality flanager	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245229	B. WING		 	06/	11/2015
	PROVIDER OR SUPPLIER SHIP VILLAGE OF BL	OOMINGTON		8100 H	T ADDRESS, CITY, STATE, ZIP CODE IIGHWOOD DRIVE MINGTON, MN 55438		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	ĸ	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 371	to the cooks about being documented. In the Linden dining p.m. a pan of puree an angle on top of the plate with pureed here to find the steam tall steam coming from was about to serve when surveyor asknown to be taken. The registered 124 deginam registered 134 pureed ham is not in the steam table but stated, "I will microsproceeded to do so were missing food dining room food to meals a week from June 8, 2015. On 6/9/15, at 7:59 at testing the temperate the steam table in the steam of the steam of the pureed sausage bareheated. DM further to be brought up to	nd that he had already talked the food temperatures not for the evening meal. If room on 6/8/15, at 12:21 and ham was observed sitting at the steam table and also a sam was observed placed on oble. There was no visible in the pan or plate of food. DA-A R42 and R55 the pureed ham red for the temperature of the he plate of pureed ham rees and the pan of pureed a degrees. ACD stated, "The hot enough." ACD also stated, I ham should not be on top of in the steam table." DA-A wave the pureed ham" and in DM at this time verified there temperature log three to five February 23, 2015 through a.m. it was observed DA-A atture of breakfast foods from the Linden dining room.	F3	71			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245229	B. WING _		06/	11/2015
	PROVIDER OR SUPPLIER	OOMINGTON		STREET ADDRESS, CITY, STATE, ZIP CODE 8100 HIGHWOOD DRIVE BLOOMINGTON, MN 55438		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 371	impaired cognition a eating. R42's carep at moderate nutrition Parkinson's disease Soft Thin Liquid Die 2/24/15, indicated Fimpaired and neede R55's careplan indicutritional risk r/t de depression, hospical diet." A 2/13/13 Temperaticare center/board a	5, indicated R42 had severely and needed supervision for lan indicated the resident was nal risk related to dementia, e, and weakness; Mechanical et." R55's quarterly MDS dated R55's cognition was severely ed assistance with eating. cated "[R55] is at moderate	F 3	71		
F 428 SS=D	temperatures of HC a quality assurance HCC/BCC. Policy: To be utilized for each of food items serve of hot foods in the brecord a variety of specified record. However, with the comminimum of 150 de minimum need to breheating, with the coware of the situation Aides, Cooks." 483.60(c) DRUG RIRREGULAR, ACT The drug regimen of reviewed at least or pharmacist.	CC/BCC buffet line; to provide of hot foods served in the The Temperature Record will meal, documenting a variety d. Procedure: Upon placement ouffet well, the Dietary Aide will ood temperatures on the ot food items should be a grees. Items not heated to the e returned to the kitchen for Cook responsible being made on. Responsibility: Dietary	F 4 <i>2</i>	28		7/21/15

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING		E SURVEY PLETED
		245229	B. WING		06/	11/2015
	PROVIDER OR SUPPLIER SHIP VILLAGE OF BL	OOMINGTON		STREET ADDRESS, CITY, STATE, ZIP CODE 8100 HIGHWOOD DRIVE BLOOMINGTON, MN 55438		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		D BE	(X5) COMPLETION DATE
F 428	Continued From pa nursing, and these	ge 14 reports must be acted upon.	F 4	.28		
	by: Based on interview consultant pharmace facility staff was addrationale was provide antipsychotic medic (R76) reviewed for Findings include: R76's physician ord R76 was prescribed Seroquel 25 milligrated day at 2:00 p.m., 37 and 8:00 p.m. and The order included the resident's orthormonthly. In addition medications known orthostatic hypotents of the pressures were to be R76's fall incidents experienced eight for the R76's electronic tree (ETAR) indicated the pressures were to be	and document review, the sist (CP) failed to ensure equately monitoring and a ded for the continued use of sation for 1 of 5 residents unnecessary medication. Iters dated 6/1/15, indicated the antipsychotic medication ams (mg) by mouth one time a 7.5 mg twice daily at 8:00 a.m. 12.5 mg once daily as needed. direction to staff to monitor static blood pressures 1, R76 was prescribed other to potentially contribute to sion and/or falls including son's disease, and Trazodone ant commonly used to 12/14 ercases sustained an injury. atment administration record to eresident's orthostatic blood one measured on the 20th day rever, there was no evidence		It is the policy of Friendship Villat the Consultant Pharmacist will act monitor and provide a rationale for continued use of antipsychotic medication. Regarding R76, ortholood pressures were initiated on 20th, 2015 per monthly standard practice. Moreover, we have audresidents with antipsychotic medito ensure that orthostatic blood pare care planned and monitored accordingly. Finally, as part of oustandard monthly review, the Cor Pharmacist will specifically verify verbally report accurate monitorir orthostatic blood pressures and the behaviors during the monthly phase it review. In order to ensure furcompliance, re-education of licentursing staff will be conducted to that staff are up to date on facility relating to orthostatic vital signs or residents receiving psychotropic medications. The DON and Phase Consultant will audit residents on antipsychotic medication during the Quarter, 2015 to ensure orthostat pressure monitoring has occurred Director of Nursing Service and the Pharmacy Consultant are responsible.	equately r the ostatic June of ited cations essures r sultant and g for arget rmacy ure sed assure policy n macy ne 3rd ic blood l. The ne	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245229	B. WING			06/	11/2015
	PROVIDER OR SUPPLIER	OOMINGTON	,	8	TREET ADDRESS, CITY, STATE, ZIP CODE 100 HIGHWOOD DRIVE BLOOMINGTON, MN 55438		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 428	taken. During an interview registered nurse (Revidence in the resicompleted by nursinursing then reportenursing (DON) not had been complete. In addition, target bidentified for the us R76's EMAR dated monitor for "anxiety statements," there is provided for staff as staff was to record did not specify if ag pacing, pounding heuring an interview explained that beformedication, nursing whether the resider warranting the med behaviors should haprogress note. RN-was not individualiz verified on 6/11/15, information was lace. During an interview the facility's CP, he orthostatic blood primeasured related to use. A follow-up intithe CP the next day he reviewed R76's	on 6/11/15, at 8:24 a.m. a N)-B verified there was no dent's record this had been ng staff. The director of ed at 12:17 p.m. the director of orthostatic blood pressures d. ehaviors had not been e of antipsychotic medication. 6/15, indicated staff was to	F 4	128			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245229	B. WING		06.	/11/2015	
	ROVIDER OR SUPPLIER	OOMINGTON		STREET ADDRESS, CITY, STATE, ZIP CODE 8100 HIGHWOOD DRIVE BLOOMINGTON, MN 55438	·		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT ((EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 428	resident was unable	ere not taken because the e to stand. The CP did not ack of monitoring was noted	F 4	28			
F 441 SS=D	policy read, "This farefforts of physicians and professionals to objectives for review medication. Consist done to assess the psychoactive drug to	3, Psychoactive Medications acility supports the cooperative s, pharmacist, nursing staff o establish specific goals and w of the use of psychoactive tent monitoring should be risk/benefit relationship of therapy." I CONTROL, PREVENT	F 4	41		7/21/15	
	Infection Control Pr safe, sanitary and c	stablish and maintain an rogram designed to provide a comfortable environment and development and transmission ction.					
	Program under whi (1) Investigates, co in the facility; (2) Decides what pu should be applied to	stablish an Infection Control ch it - ntrols, and prevents infections rocedures, such as isolation, o an individual resident; and ord of incidents and corrective					
	determines that a reprevent the spread isolate the resident	tion Control Program esident needs isolation to of infection, the facility must					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245229	B. WING		06	/11/2015	
	PROVIDER OR SUPPLIER SHIP VILLAGE OF BL	OOMINGTON		STREET ADDRESS, CITY, STATE 8100 HIGHWOOD DRIVE BLOOMINGTON, MN 5543	E, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE	
F 441	from direct contact direct contact direct contact will tr (3) The facility mush ands after each dihand washing is indeprofessional practice. (c) Linens Personnel must hat transport linens so infection. This REQUIREMENT by: Based on observative review, the facility facility facility facility for infection monitoring for 1 of glucose monitoring. Findings include: R68's blood glucose 6/8/15 at 5:25 p.m. RN-A donned glove alcohol wipe and the RN-A then threw the can that was adjact sample of blood frostrip, and obtained strip from the blood strip from the blood strip from the sample of strip and obtained strip from the blood strip from the blood strip from the sample of strip and obtained strip from the sample of strip from the strip from the sample of sample o	ease or infected skin lesions with residents or their food, if ansmit the disease. It require staff to wash their rect resident contact for which dicated by accepted se. Indle, store, process and as to prevent the spread of tion, interview and document ailed to ensure used a properly disposed to minimize in during blood glucose 1 resident (R68) whose blood	F 4	It is the policy of Frienestablish and maintain Control Program designafe, sanitary and comenvironment and to he development and transand infection. Immedinatification of the nurs was retrieved and progrand RN-A was immedinedles. Moreover, lice the re-educated regard of sharps/needles. To compliance, audits will 3rd Quarter, 2015 and the upcoming Quality The Director of Nursin Supervisors will be restuture compliance.	n an Infection gned to provide a anfortable elp prevent the smission of disease iately, upon sing staff, the needle perly disposed of iately re-trained osal of insulin censed nurses will ling proper disposal of ensure future I occur during the I will be reported at Assurance Meeting.		
	Immediately after le	eaving R68's room, RN-A was					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245229	B. WING		0	6/11/2015	
NAME OF PROVIDER OR SUPPLIER FRIENDSHIP VILLAGE OF BLOOMINGTON				STREET ADDRESS, CITY, STATE, ZIP CO 8100 HIGHWOOD DRIVE BLOOMINGTON, MN 55438		1 00/11/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE ADDITIONAL DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 441	used sharp/needle she threw the used in a trash can. RN-needles in [designed to prever shouldn't have thrown buring an interview director of nursing (expectations was the must go in the share explained that she explained that she dispose of used share R68's physician or staff to test blood generated by 9:00 a.m., 11:30 a.m. An undated nursing long-term care titled medical Waste (Usbags, Suction Canis	ong the lack of disposing of a properly. RN-A verified that lancet and glucose test strip A stated, "I should have placed the sharps container at needle misuse/re-use]. I will the trash can." on 6/8/15, at 5:38 p.m. the DON) explained that the fact all used sharps/needles arps container. The DON did not expect the staff would arps in trash cans. Hers dated 6/3/15, directed lucose four times per day at m., 5:30 p.m., and 8:00 p.m. I procedure guide for d, "Disposal of Contaminated ed IV Bags, Tubing, Foley sters, etc.)" directed staff to ces on needles, then discard	F 4	41			

329024

PRINTED: 07/10/2015 FORM APPROVED OMB NO. 0938-0391

(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A: BUILDING 01 - MAIN BUILDING 01 B. WING. 245229 06/10/2015 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 8100 HIGHWOOD DRIVE FRIENDSHIP VILLAGE OF BLOOMINGTON **BLOOMINGTON, MN 55438** (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 K 000 INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC. AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey. Friendship Village of Bloomington was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY **DEFICIENCIES (K-TAGS) TO:** Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

Electronically Signed

By email to:

07/08/2015

(X6) DATE

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.

Facility ID: 00806

PRINTED: 07/10/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION NG 01 - MAIN BUILDING 01	(X3) DA	(X3) DATE SURVEY COMPLETED	
		245229	B. WING		06	/10/2015	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 8100 HIGHWOOD DRIVE BLOOMINGTON, MN 55438			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
K 000	Marian.Whitney@s THE PLAN OF CODEFICIENCY MUSTOLLOWING INFO 1. A description of to correct the defice 2. The actual, or p 3. The name and/oresponsible for corprevent a reoccurred responsible for corprevent a reoccurred at 2 dispulding with partial constructed at 2 dispulding was constructed building was constructed building was constructed buildings, the facility building. The building is fully has a fire alarm system corridors and system corrections are system.	PRRECTION FOR EACH ST INCLUDE ALL OF THE ORMATION: what has been, or will be, done siency. roposed, completion date. or title of the person rection and monitoring to ence of the deficiency. of Bloomington is a 2-story all basement. The building was different times. The original rructed in 1979 and was for Type V(111) construction. In was constructed and was of Type II(111) construction. In all building and the 1 addition on type allowed for existing ity was surveyed as one by fire sprinklered. The facility estem with smoke detection in spaces open to the corridors end for automatic fire ation. The facility has a s and had a census of 62 at	KO				
K 038	NOT MET as evide		К0	38		7/15/15	

Event ID: OYY121

PRINTED: 07/10/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
		245229	B. WING		06/	10/2015	
NAME OF PROVIDER OR SUPPLIER FRIENDSHIP VILLAGE OF BLOOMINGTON			STREET ADDRESS, CITY, STATE, ZIP CODE 8100 HIGHWOOD DRIVE BLOOMINGTON, MN 55438				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
K 038 SS=F	Exit access is arrar accessible at all tim 7.1. 19.2.1 This STANDARD is Based on observation facility failed to provaccordance with the 2000 NFPA 101, Separatice could affect Findings include: On facility tour betwon 06/10/2015, observe child safety gat leading to the extertion of the exterti	nged so that exits are readily nes in accordance with section s not met as evidenced by: tion and staff interview, the vide means of egress in e following requirements of ection 7.2.1.5.4. The deficient	K 03		e following 101, Section ate was fety concern tho was at urer had ction about uld provide ell as an . This e installed by s set to be ty le to test for one eport findings ctor of Plant		

Event ID: OYY121



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered June 29, 2015

Mr. Ronald Donacik, Administrator Friendship Village Of Bloomington 8100 Highwood Drive Bloomington, Minnesota 55438

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5229025

Dear Mr. Donacik:

The above facility was surveyed on June 8, 2015 through June 11, 2015 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately **contact Gayle Lantto at (651) 201-3794 or email: gayle.lantto@state.mn.us**.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

mark Weath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Email: mark.meath@state.mn.us

Telephone: (651) 201-4118

Fax: (651) 215-9697

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′		(X3) DATE SURVEY COMPLETED	
		00806	B. WING		06/11/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY,	STATE, ZIP CODE		
FRIENDS	SHIP VILLAGE OF BL	OOMINGTON	IGHWOOD DR IINGTON, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETE DATE	
2 000	Initial Comments		2 000			
	****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correspursuant to a surver found that the deficiency found that the deficiency form of corrected shall with a schedule of the Minnesota Department of the Minnesota Department of the Minnesota MN Rumber and MN Rumber and MN Rumber and MN Rumber and may of lack of compliance. re-inspection with a result in the assess	hether a violation has been	n			
	that may result fron orders provided tha the Department wit	hearing on any assessments n non-compliance with these at a written request is made to hin 15 days of receipt of a ent for non-compliance.				
Minnasota D	Department's staff, the following corrections are con make a copy of the original to the Minn	rs: th 11th, 2015, surveyors of the visited the above provider and tion orders are issued. When pleted, please sign and date se orders and return the esota Department of Health, ince Monitoring, Licensing are	nd n	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal softwa Tag numbers have been assigned to Minnesota state statutes/rules for Nurs Homes.		
		DER/SUPPLIER REPRESENTATIVE'S	SIGNATURE	TITLE	(X6) DATE	

07/08/15

Electronically Signed

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:) DATE SURVEY COMPLETED	
			D. WING				
		00806	B. WING		06/1	1/2015	
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
FRIENDS	SHIP VILLAGE OF BL	OOMINGTON	HWOOD DRI IGTON, MN				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 000	Continued From pa	ige 1	2 000				
	Certification Program, P.O. Box 64900 St. Paul, MN 55164-0900.			The assigned tag number appears far left column entitled "ID Prefix The state statute/rule out of complisted in the "Summary Statement Deficiencies" column and replaces Comply" portion of the correction of This column also includes the find which are in violation of the state is after the statement, "This Rule is r as evidence by." Following the surfindings are the Suggested Method Correction and Time period for Correction and Time period for Correction and Time period for Correction." THIS APPLIES FEDERAL DEFICIENCIES ONLY. WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION SOF MINNESOTA ST	Fag." liance is of the "To order. ings statute not met veyors d of rrection. DING OF THIS O DN FOR		
0.505	MN D 1 4050 040	501.00	0.505	STATUTES/RULES.		7/00/45	
2 565	MN Rule 4658.0409 Plan of Care; Use	5 Subp. 3 Comprehensive	2 565			7/20/15	
		omprehensive plan of care I personnel involved in the t.					
	by: Based on observat	ent is not met as evidenced ion, interview and document ailed to follow the care plan for		Corrected			

Minnesota Department of Health

STATE FORM 6899 If continuation sheet 2 of 20 OYY111

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(3) DATE SURVEY COMPLETED	
0080	06	B. WING		06/1	1/2015	
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
FRIENDSHIP VILLAGE OF BLOOMINGTO	ON	HWOOD DRI IGTON, MN				
(X4) ID SUMMARY STATEMENT OF PREFIX (EACH DEFICIENCY MUST BE PI TAG REGULATORY OR LSC IDENTIFY	RECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
orthostatic blood pressure moresident (R76) reviewed for unuse who had physician orders pressures. Findings include: R76's care plan last revised of indicated R76 had a history of for the resident to "maintain of mobility with no increase in infalls/injuries." Medications known to contrib hypotension and/or falls were including order changes date increase Seroquel 25 mg (minday) and 37.5 mg at HS (hour hallucinations, Sinemet for Parand Trazodone 50 mg (antide used to promote sleep). The indicated that on 11/20/14, R7 on the Seroquel with direction orthostatic blood pressure more instructions were transferred treatment administration record from the ETARs from 11/14 throevidence the resident's orthospressures had ever been meand when the resident had are of orthostatic hypotension. A Care Conference Summary a family meeting was held on and her son in attendance. "If alls in the last 3 months. Reshas been increased, which sehas been increased, which sehelped. Resident has sehelped. Resident ha	on 12/15/14, f falls. The goal was current level of cident of ute to orthostatic prescribed for R76 d 5/18/15, to ligrams) bid (twice a r of sleep) for arkinson's disease, epressant commonly physician orders 76 had been started as to monitor R76's porthly. Although the to the electronic ards (ETAR) review ugh 5/15, lacked static blood assured as ordered, a existing diagnosis or note 6/1/15, noted that date with R76 Nursing: Has had 3 is [resident] Seroquel eems to have roquel increase has	2 565	DEFICIENCY)			

Minnesota Department of Health

STATE FORM 6899 OYY111 If continuation sheet 3 of 20

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY LETED	
		00806	B. WING		06/1	1/2015
	PROVIDER OR SUPPLIER	OOMINGTON 8100 HIGH	DRESS, CITY, S HWOOD DRI IGTON, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 565	During an interview stated R76 required pressures taken du antipsychotic medic RN-B was unable to that R76's orthostat taken or recorded buring an interview DON verified no ort taken from 3/1/15 to explained the reaso blood pressure were put into the facility's alert nursing staff to DON confirmed that pressure had a starthe ETAR for nursing off by nursing as be documentation was blood pressures med RN-B stated the ET administration recorresidents' care plant SUGGESTED MET director of nursing (review and revise pto ensuring the care resident is develope a worlding care as dicare. The results committee meeting	a on 6/11/15, at 8:24 a.m. RN-B d monthly orthostatic blood e to R76's use of the cation of Seroquel. However, to provide any documentation tic blood pressure had been by staff. If on 6/11/15, at 12:17 p.m. the chostatic blood pressures were to 6/11/15. The DON on for the missing orthostatic e due to a clerical error when a computer system that would be perform this function. The at R76 orthostatic blood at date of 11/20/14, and was on any to complete and was signed being completed, however, no available to show what the easured. Both the DON and TAR and electronic medication and the considered part of a light of the considered part of a light of the considered part of a light of the considered staff and the considered by the written plan of ould be reviewed at the quality	2 565			

6899

Minnesota Department of Health STATE FORM

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY LETED
		00806	B. WING		06/1	1/2015
	PROVIDER OR SUPPLIER	OOMINGTON 8100 HIGH	DRESS, CITY, S HWOOD DRI			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 4	2 830			
2 830	Proper Nursing Car Subpart 1. Care in receive nursing car- custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from the	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ing home resident must be out possible unless there is a he attending physician that the in in bed or the resident	2 830			7/20/15
	by: Based on observati review, the facility fa appropriate measur risk for further falls reviewed for unnect Findings include: R76 was observed room. She was sea of the observation. resident if she was without requesting to independently stood walked a few feet, p floor and then back sat down. A nursing entered the room a	ent is not met as evidenced on, interview and document ailed to assess and implement res after falls to minimize the for 1 of 5 residents (R76) essary medication use. on 6/10/15, at 1:33 p.m. in her ated in her recliner at the time After the surveyor asked the able to stand on her own, the resident demonstrate, R76 dusing her walker. R76 bicked an item up from the ed up toward her recliner and gassistant (NA)-B then and was asked about R76's se with standing and walking.		corrected		

Minnesota Department of Health

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
	00806	B. WING		06/	11/2015	
NAME OF PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
FRIENDSHIP VILLAGE OF BL	COMINGTON	HWOOD DRI\ NGTON, MN 5				
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SECROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE	
standing or walking assistance" of one p.m. R76 was in the footrest in the raise R76's MDS dated was cognitively implement was staff for transferenced two factories one with injury and The NA assignment directed staff to provide the use of a focus with the use of a focus wheelchair for transmobility. R76's care plan last indicated R76 had for the resident to mobility with no including positions areas free of obstreasy reach. Instruct needed]Keep per bed to be in low policing to be in low policing environment slowly Medications known hypotension and/or including order challing order challing order challing and 37.5 mg a hallucinations, Sine	vas not supposed to be g alone, but needed "stand by staff. At approximately 2:00 e recliner resting with the ed position. 5/19/15, indicated the resident paired, required assistance of erring and mobility, and had alls since the last assessment, one without injury. It sheet for R76 dated 6/11/15, poide assistance of one staff pur wheeled walker or sfers, ambulation, and bed It revised on 12/15/14, a history of falls. The goal was "maintain current level of brease in incident of ventions included: "Instruct on or reduce risk of falls (posture, use of handrails)Keep uctionKeep call light within to call for assistance prn [as resonal items within easy reach; sition and wheels daily routines for ng changes in routine or					

Minnesota Department of Health

STATE FORM 6899 OYY111 If continuation sheet 6 of 20

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF CORRECTION PREFIX (EACH ODERICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF CORRECTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE 2 830 Continued From page 6 Used to promote sleep). The physician orders indicated that on 11/20/14, R76 had been started on the Seroquel with directions to monitor R76's orthostatic blood pressure monthly. A Care Conference Summary note 6/1/15, noted a family meeting was held on that date with R76 and her son in attendance. "Nursing: Has had 3 falls in the last 3 months. Res (resident) Seroquel has been increased, which seems to have helped. Res son feels the Seroquel increase has benefitted [sic] his Mother well, but understands it may increase her fall risk."			00806	B. WING		06/	11/2015
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 2 830 Continued From page 6 used to promote sleep). The physician orders indicated that on 11/20/14, R76 had been started on the Seroquel with directions to monitor R76's orthostatic blood pressure monthly. A Care Conference Summary note 6/1/15, noted a family meeting was held on that date with R76 and her son in attendance. "Nursing: Has had 3 falls in the last 3 months. Res (resident) Seroquel has been increased, which seems to have helped. Res son feels the Seroquel increase has benefitted [sic] his Mother well, but understands it may increase her fall risk."			OOMINGTON 8100 H	IGHWOOD DRI	VE		
used to promote sleep). The physician orders indicated that on 11/20/14, R76 had been started on the Seroquel with directions to monitor R76's orthostatic blood pressure monthly. A Care Conference Summary note 6/1/15, noted a family meeting was held on that date with R76 and her son in attendance. "Nursing: Has had 3 falls in the last 3 months. Res (resident) Seroquel has been increased, which seems to have helped. Res son feels the Seroquel increase has benefitted [sic] his Mother well, but understands it may increase her fall risk."	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
experienced eight falls in six months from 12/14 to 6/15. Seven of the the falls were unwitnessed, and during three of the falls the resident hit her head. It was determined that during six of the eight falls the resident was transferring from her recliner chair. The facility's incident documentation indicated that interdisciplinary team corrective measures taken did not reflect the possible correlation with the resident's existing diagnosis of orthostatic blood pressure, nor the increased risk of a drop in blood pressure upon rising with the addition of antipsychotic medication. The assessment did not include the need for ensuring orthostatic blood pressure monitoring was completed as ordered by the physician, and no care plan changes were made. After the sixth and seventh fall, it was suggested physical therapy staff complete a screening to determine whether an ambulation program was appropriate, as well as the need for family and physician input into R76's fall management plan. During an interview on 6/11/15, at 8:24 a.m. RN-B stated R76 required monthly orthostatic blood pressure taken due to R76 use of antipsychotic	2 830	used to promote ski indicated that on 11 on the Seroquel wit orthostatic blood promotes a family meeting was and her son in atterfalls in the last 3 me has been increased helped. Res son fee benefitted [sic] his I may increase her fall incidents experienced eight for 6/15. Seven of the and during three of head. It was determeight falls the residered recliner chair. The formal diagnosis of the increased recommendation indiction the increased recommendation. The as need for ensuring of monitoring was complysician, and no content of the sixth and aphysical therapy stated effective meeting an interview stated R76 required the sixth and sphysician input into the possible correlation.	eep). The physician orders 1/20/14, R76 had been starte th directions to monitor R76's ressure monthly. Summary note 6/1/15, noted as held on that date with R76 andance. "Nursing: Has had 3 onths. Res (resident) Seroqued, which seems to have els the Seroquel increase ha Mother well, but understands all risk." revealed the resident falls in six months from 12/14 are the falls were unwitnessed the falls the resident hit her nined that during six of the ent was transferring from her facility's incident cated that interdisciplinary easures taken did not reflect ation with the resident's of orthostatic blood pressure, addition of antipsychotic esessment did not include the orthostatic blood pressure mpleted as ordered by the eare plan changes were made seventh fall, it was suggested aff complete a screening to an ambulation program was I as the need for family and R76's fall management plant on 6/11/15, at 8:24 a.m. RN d monthly orthostatic blood	d de la company			

Minnesota Department of Health

STATE FORM 6899 OYY111 If continuation sheet 7 of 20

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDING.			
		00806	B. WING		06/1	1/2015
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
FRIENDS	SHIP VILLAGE OF BL	OOMINGTON	HWOOD DRI IGTON, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	Continued From page 7		2 830			
	medication of Seroquel. However, RN-B was unable to provide any documentation that R76's orthostatic blood pressure had been taken or recorded by staff.					
	DON verified no or taken from 3/1/15 the explained the reason blood pressure were put into the facility's alert nursing staff to confirmed that R76 had a start date of for nursing to componursing as being continued that R76 had a start date of for nursing to componers as being continued that R76 had a start date of for nursing as a	on 6/11/15, at 12:17 p.m. the thostatic blood pressures were of 6/11/15. The DON on for the missing orthostatic redue to a clerical error when a computer system that would be perform this function. DON to orthostatic blood pressure 11/20/14, were on the ETAR olete and was signed off by completed, however, no as available to show what the easured.				
	The facility's 1/29/13, Psychoactive Medications policy regarding potential medication side effects indicated, "Consistent monitoring should be done to assess the risk/benefit relationship of psychoactive drug therapy."					
	The director of nurs and revise policies unnecessary medic monitoring and care education related to director of nursing ensure appropriate	THOD FOR CORRECTION: sing or designee, could review and procedures related to cations, assessments, e, and could provide staff of the care of resident. The could develop an audit tool to care is provided. The results be reviewed at the quality is.				
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one				

6899

Minnesota Department of Health STATE FORM

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ,	(X2) MULTIPLE CONSTRUCTION (X3) I		
		00806	B. WING	i	06/1	11/2015
NAME OF I	PROVIDER OR SUPPLIER	STRE	ET ADDRESS, C	ITY, STATE, ZIP CODE	·	
FRIENDS	SHIP VILLAGE OF BL	()()MIN(+I()N	HIGHWOOD OMINGTON, I			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETE DATE
21025	Continued From pa	ge 8	21025			
21025	MN Rule 4658.0615 Food Temperatures		21025			7/6/15
	40 degrees Fahren or below, or 150 de centigrade) or abov food" means any fo and temperature corapid and progressi toxigenic microorga. This MN Requiremby: Based on observative review the facility faresidents (R42, R55)	ent is not met as evidence ion, interview and documer ailed to ensure 2 of 21 5) were served food at the e, while potentially affecting	de) ees me ne d	corrected		
	Findings include:					
	On 6/8/15, at 11:57 a.m. the dietary manager (DM) stated while looking for food temperature logs, "For dinner we have a problem with food temperatures." The DM verified dinner food temperatures had not been documented for 6/1 through 6/7/15. In looking back DM also verified there were missing food temperatures daily for dinner from December 1st, 2014 through May 31, 2015, and also missing food temperatures sporadically for breakfast and lunch. Assistant culinary director (ACD) stated he had not known about the missing food temperatures in the log. DM stated he reviewed the food temperature logs every other week and that he had already talked to the cooks about the food temperatures not being documented for the evening meal.		/1 ed r 31, vn g. ogs			
		g room on 6/8/15, at 12:21 ed ham was observed sittin	g at			

Minnesota Department of Health

STATE FORM 6899 OYY111 If continuation sheet 9 of 20

Minnesota Department of Health

-	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			7. BOILBING.			
		00806	B. WING		06/1	1/2015
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
FRIEND	SHIP VILLAGE OF BL	COMINGION	HWOOD DRI NGTON, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21025	an angle on top of plate with pureed h top of the steam ta steam coming from was about to serve when surveyor ask ham to be taken. Tregistered 124 deg ham registered 134 pureed ham is not "The pan of pureed the steam table but stated, "I will micror proceeded to do so were missing food dining room food to meals a week from June 8, 2015. On 6/9/15, at 7:59 testing the temperate the steam table in t stated, "I microwave enough." The pure registered 134 deg registered 134 deg registered 134 deg registered 134 deg steamed food items instructed DA-A to pureed sausage bareheated. DM furth to be brought up to R42's significant ch (MDS) dated 4/16/impaired cognition eating. R42's carepat moderate nutritic Parkinson's diseas Soft Thin Liquid Die	the steam table and also a am was observed placed on ble. There was no visible in the pan or plate of food. DA-A R42 and R55 the pureed ham red for the temperature of the he plate of pureed ham rees and the pan of pureed degrees. ACD stated, "The hot enough." ACD also stated, ham should not be on top of the in the steam table." DA-A wave the pureed ham and b. DM at this time verified there temperatures in the Linden reperature log three to five a February 23, 2015 through a.m. it was observed DA-A atture of breakfast foods from the Linden dining room. DA-A rethe foods if they are not hot red eggs temperature rees and the pureed sausage rees. DM stated, "We want the served at 150 degrees" and take the pureed eggs and take the pureed eggs and take to the kitchen to be restated, "We want the foods the right temperature." The angle Minimum Data Set 15, indicated R42 had severely and needed supervision for blan indicated the resident was bral risk related to dementia, e, and weakness; Mechanical et." R55's quarterly MDS dated R55's cognition was severely				

Minnesota Department of Health

STATE FORM 6899 OYY111 If continuation sheet 10 of 20

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				DATE SURVEY COMPLETED	
		00806	B. WING		06/1	1/2015	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE			
FRIENDS	SHIP VILLAGE OF BL	DOMINGTON	IWOOD DRI GTON, MN				
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE	
21025	R55's careplan indinutritional risk r/t de depression, hospication diet." A 2/13/13 Temperaticare center/board a "Objective: To keep temperatures of HC a quality assurance HCC/BCC. Policy: be utilized for each of food items serve of hot foods in the krecord a variety of f specified record. Hominimum of 150 deminimum need to breheating, with the aware of the situation Aides, Cooks." SUGGESTED MET The dietary director training for all dietar tempatures. The quarter of the situation of the situation.	ed assistance with eating. cated "[R55] is at moderate ementia, psychosis, ept; Provide Mechanical soft ture Record - HCC/BC [health and care] Buffet Units accurate record of food CC/BCC buffet line; to provide of hot foods served in the The Temperature Record will meal, documenting a variety d. Procedure: Upon placement buffet well, the Dietary Aide will ood temperatures on the of food items should be a grees. Items not heated to the e returned to the kitchen for Cook responsible being made on. Responsibility: Dietary	21025				
	TIME PERIOD FOR days.	R CORRECTION: Seven (7)					
21390	Subp. 4. Policies a control program mu procedures which p	O Subp. 4 A-I Infection Control and procedures. The infection ust include policies and provide for the following: based on systematic data	21390			7/6/15	

Minnesota Department of Health

STATE FORM 6899 OYY111 If continuation sheet 11 of 20

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00806	B. WING		06/1	1/2015
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
FRIENDS	SHIP VILLAGE OF BL	OOMINGTON	HWOOD DRI IGTON, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
21390	residents; B. a system for control of outbreaks. C. isolation and reduce risk of trans. D. in-service exprevention and con. E. a resident himmunization progred defined in part 465 procedures of resident he prevention and F. the development of the prevention and F. the development of	r detection, investigation, and of infectious diseases; disprecautions systems to mission of infectious agents; ducation in infection trol; ealth program including an am, a tuberculosis program as 8.0810, and policies and lent care practices to assist in treatment of infections; ment and implementation of olicies and infection control a tuberculosis program as 3.0815; r reviewing antibiotic use; r review and evaluation of oct infection control, such as eptics, gloves, and cts; and maintaining awareness of of practice in infection control. ent is not met as evidenced on, interview and document ailed to ensure used a properly disposed to minimize in during blood glucose 1 resident (R68) whose blood	21390	corrected		
	6/8/15 at 5:25 p.m.	e testing was observed on by a registered nurse (RN)-A. es, wiped R68's finger with an				

Minnesota Department of Health

STATE FORM 6899 OYY111 If continuation sheet 12 of 20

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	00806		B. WING		06/1	1/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
FRIENDSHIP VILLAGE OF BLOOMINGTON			HWOOD DRI IGTON, MN			
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
21390	alcohol wipe and the RN-A then threw the can that was adjace sample of blood frostrip, and obtained strip from the blood threw the used glucadjacent to R68. Immediately after leinterviewed regardices used sharp/needle she threw the used in a trash can. RN-A the used needles in [designed to prever shouldn't have thrown During an interviewed director of nursing expectations was the "must go" in the she explained that she explain	en poked the resident's finger. e used lancet into the trash ent to R68. RN-A took a m R68 using a glucose test the reading, detached the test glucose machine and then cose test strip in the trash can eaving R68's room, RN-A was ng the lack of disposing of a properly. RN-A verified that lancet and glucose test strip A stated, "I should have placed the sharps container at needle misuse/re-use]. I will in the trash can." on 6/8/15, at 5:38 p.m. the DON) explained that the nat all used sharps/needles arps container. The DON did not expect the staff would arps in trash cans. lers dated 6/3/15, directed lucose four times per day at m., 5:30 p.m., and 8:00 p.m. I procedure guide for d, "Disposal of Contaminated ed IV Bags, Tubing, Foley sters, etc.)" directed staff to ces on needles, then discard	21390			

Minnesota Department of Health

STATE FORM 6899 OYY111 If continuation sheet 13 of 20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00806	B. WING		06/1	1/2015
	PROVIDER OR SUPPLIER SHIP VILLAGE OF BL	OOMINGTON 8100 HIG	DRESS, CITY, S HWOOD DRI IGTON, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21390	educated as necess could conduct rand compliance with sta and the results brou for review.	ge 13 sary. The director of nursing om audits to ensure and federal regulations, ught to the quality committee as CORRECTION: Seven (7).	21390			
21530	A. The drug regim reviewed at least mourrently licensed by This review must be Appendix N of the Surveyor Procedure Requirements in Lot the Department of Health Care Finance This standard is in available through the system. It is not sue B. The pharma irregularities to the and the attending pomust be acted upor physician visit, or supharmacist. For purpon' means the act report and the significant of nursing services C. If the attend with the pharmacist not provide adequation pharmacist believes being adversely after fer the matter to the if the medical direct physician. If the medical control of the significant is the medical direct physician. If the medical firect physician.	en of each resident must be onthly by a pharmacist y the Board of Pharmacy. e done in accordance with State Operations Manual, es for Pharmaceutical Service ong-Term Care, published by Health and Human Services, ing Administration, April 1992. corporated by reference. It is the Minitex interlibrary loan bject to frequent change. cist must report any director of nursing services hysician, and these reports to by the time of the next poner, if indicated by the proses of this part, "acted proceptance or rejection of the next proses of this part, "acted proceptance or rejection of the next proses of this part, "acted proceptance or rejection of the next proceptance or reje	21530			7/20/15

6899

Minnesota Department of Health STATE FORM

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3)			X3) DATE SURVEY COMPLETED		
		00806		B. WING		06/1	1/2015
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE	•	
FRIENDS	SHIP VILLAGE OF BL	OOMINGTON		HWOOD DRI			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENC		ID ID	PROVIDER'S PLAN OF CORRECTI	ON	(X5)
PREFIX TAG		' MUST BE PRECEDED E SC IDENTIFYING INFORI		PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	COMPLETE DATE
21530	Continued From pa	ge 14		21530			
	justification for the ophysician does not must be referred for assessment and as by part 4658.0070. The medical director must refer the mattrassessment and as a sessment and as This MN Requirement by: Based on interview consultant pharmac facility staff was addrationale was provide antipsychotic medic (R76) reviewed for	change the order, it review to the qual surance committee of the attending phor, the consulting pler directly to the quasurance committee ent is not met as eand document revolute (CP) failed to exequately monitoring ded for the continue eation for 1 of 5 res	the matter ity e required ysician is narmacist ality e. videnced ew, the nsure y and a ed use of idents		corrected		
	Findings include:						
	R76's physician ord R76 was prescribed Seroquel 25 milligra day at 2:00 p.m., 37 and 8:00 p.m. and The order included the resident's ortho monthly. In addition medications known orthostatic hypotens Sinemet for Parkins 50 mg (antidepress promote sleep).	d the antipsychotic ams (mg) by mouth 7.5 mg twice daily 12.5 mg once daily direction to staff to static blood pressure, R76 was prescrib to potentially contrision and/or falls incon's disease, and	medication one time a at 8:00 a.m. as needed. monitor res ed other ibute to eluding Trazodone				
	R76's fall incidents experienced eight f to 6/15, and in three R76's electronic tre (ETAR) indicated th	alls in six months for cases sustained a atment administrat	rom 12/14 an injury. ion record				

Minnesota Department of Health

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		A. BUILDING:		00	
	00806	B. WING		06/1	1/2015
NAME OF PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	TATE, ZIP CODE		
FRIENDSHIP VILLAGE OF BLOOMI	INGION	HWOOD DRI'			
(X4) ID SUMMARY STATEMEN PREFIX (EACH DEFICIENCY MUST TAG REGULATORY OR LSC IDE	FBE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
nursing (DON) no orthoshad been completed. In addition, target behavior identified for the use of a R76's EMAR dated 6/15, monitor for "anxiety/agita statements," there was a provided for staff as to we staff was to record if obsidid not specify if agitation pacing, pounding her fist. During an interview on 6, explained that before R7 medication, nursing staff whether the resident was warranting the medication behaviors should have be progress note. RN-B cowas not individualized ar verified on 6/11/15, at 12 information was lacking in During an interview on 6, the facility's CP, he report orthostatic blood pressure.	easured on the 20th day, there was no evidence ssures had ever been //11/15, at 8:24 a.m. a verified there was no s record this had been aff. The director of 12:17 p.m. the director of static blood pressures iors had not been antipsychotic medication. Indicated staff was to ation/paranoid a lack of direction what specific symptoms served. (For example, it in was evidenced by the cursing, etc.) //11/15, at 8:24 a.m. RN-B of received antipsychotic f should have indicated sexhibiting behaviors on use. If so, those been documented in a nfirmed the information and specific. The DON 2:17 p.m. that the in R76's record. //10/15, at 3:00 p.m. with red the resident's	21530	DETIMIENT)		

Minnesota Department of Health

STATE FORM 6899 OYY111 If continuation sheet 16 of 20

-	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00806	B. WING		06/11/2015	
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
FRIENDS	SHIP VILLAGE OF BL	DOMINGTON	IWOOD DRI GTON, MN			
(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
21530	he reviewed R76's said in 5/15, it was blood pressures we resident was unable recall whether the late on other monthly vision other monthly vision of the facility's 1/29/0 policy read, "This farefforts of physicians and professionals to objectives for review medication. Consisted one to assess the psychoactive drug to SUGGESTED MET. The director of nurse could review and refor proper monitoring could be educated nursing could monit basis to ensure controlled."	medication regime. The CP noted the resident's orthostatic are not taken because the eto stand. The CP did not ack of monitoring was noted sits. 3, Psychoactive Medications acility supports the cooperative s, pharmacist, nursing staff of establish specific goals and w of the use of psychoactive tent monitoring should be risk/benefit relationship of	21530			
21535	MN Rule4658.1315 Drug Usage; Gener	Subp.1 ABCD Unnecessary	21535			7/20/15
	Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued.					

Minnesota Department of Health

STATE FORM 6899 OYY111 If continuation sheet 17 of 20

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00806	B. WING		06/1	1/2015
	PROVIDER OR SUPPLIER SHIP VILLAGE OF BL	OOMINGTON 8100 HIGI	DRESS, CITY, S HWOOD DRI IGTON, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
21535	In addition to the d part 4658.1310, the with provisions in the Code of Federal Ref 483.25 (1) found in Operations Manual Long-Term Care Fade Department of Health Care Finance This standard is included available through the system and the Stasubject to frequent This MN Requirement by: Based on observation review the facility fade monitoring and rational antipsychotic medic (R76) reviewed for Findings include: Medications known hypotension and/or including order chain increase Seroquel 2 day) and 37.5 mg and hallucinations, Sine and Trazodone 50 mused to promote stein indicated that on 11 on the Seroquel with orthostatic blood princidents revealed to	rug regimen review required in e nursing home must comply le Interpretive Guidelines for egulations, title 42, section Appendix P of the State, Guidance to Surveyors for acilities, published by the lith and Human Services, sing Administration, April 1992. corporated by reference. It is not met as evidenced on, interview and document alled to ensure adequate onale for continued use for eation for 1 of 5 residents unnecessary medication use. to contribute to orthostatic falls were prescribed for R76 nges dated 5/18/15, to 25 mg (milligrams) bid (twice a t HS (hour of sleep) for met for Parkinson's disease, mg (antidepressant commonly eep). The physician orders /20/14, R76 had been started h directions to monitor R76's essure monthly. R76's fall the resident experienced eight rom 12/14 to 6/15, and in	21535	corrected		

Minnesota Department of Health STATE FORM

Minnesota Department of Health

STATEME	NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
	00806		B. WING		06/1	1/2015
	NAME OF PROVIDER OR SUPPLIER FRIENDSHIP VILLAGE OF BLOOMINGTON 8100 HIG BLOOMI					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
21535	A Care Conference a family meeting wa and her son in atterfalls in the last 3 me has been increased helped. Res son fee benefitted [sic] his I may increase her falls in dicated the pressures were to be of each month, how the orthostatic blootaken. During an interview registered nurse (Revidence in the rescompleted by nursi nursing then report nursing (DON) not had been complete explanation for the facility had a new complete the past they would problem. Although medication and mo 11/20/14, it had not lin addition, target be identified for the us R76's EMAR dated monitor for "anxiety statements," there is provided for staff as staff was to record did not specify if ag	Summary note 6/1/15, noted as held on that date with R76 ndance. "Nursing: Has had 3 on ths. Res (resident) Seroquel d, which seems to have els the Seroquel increase has Mother well, but understands it all risk." atment administration record he resident's orthostatic blood be measured on the 20th day wever, there was no evidence d pressures had ever been a long staff. The director of held at 12:17 p.m. the director of held at 12:17 p.m. the director of horthostatic blood pressures d from 3/1/15 to 6/11/15. The missing data was that the computerized system, and in have been alerted to the the start date for the nitoring was ordered on been completed. ehaviors had not been e of antipsychotic medication. 6/15, indicated staff was to	21535			

Minnesota Department of Health

STATE FORM 6899 OYY111 If continuation sheet 19 of 20

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ` `		(X3) DATE COMP	SURVEY LETED	
			A. BUILDING:			
		00806	B. WING		06/1	1/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
FRIEND	SHIP VILLAGE OF BL	OOMINGTON	HWOOD DRI IGTON, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21535	explained that beforantipsychotic medicindicated if R76 was anxiety/agitation/pashould have docum progress note. RN-was not individualize. The DON stated or were no indications identified. The facility's 1/29/0 policy read, "This fast efforts of physicians and professionals to objectives for review medication. Consist done to assess the psychoactive drug to sufficient to ensure for appropriate interest to ensure importance of monimedications. The Drandomly audit resist adequate monitoring place.	re R76 received her cation nursing staff had to s exhibiting any signs of tranoid statements and if so, nented those behaviors in a B confirmed the information and specific. 16/11/15, at 12:17 p.m. there is for targeted behaviors 3, Psychoactive Medications acility supports the cooperative s, pharmacist, nursing staff to establish specific goals and w of the use of psychoactive tent monitoring should be risk/benefit relationship of	21535			

Minnesota Department of Health STATE FORM



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered June 29, 2015

Mr. Ronald Donacik, Administrator Friendship Village Of Bloomington 8100 Highwood Drive Bloomington, Minnesota 55438

Re: Enclosed State Boarding Care Home Licensing Orders - Project Number S5229025

Dear Mr. Donacik:

The above facility survey was completed on June 11, 2015 for the purpose of assessing compliance with Minnesota Department of Health Boarding Care Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Boarding Care Homes.

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

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

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

Friendship Village Of Bloomington June 29, 2015 Page 2

When all orders are corrected, the order form should be acknowledged electronically and submitted to this office at Minnesota Department of Health.

We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Gayle Lantto at (651) 201-3794 or email: gayle.lantto@state.mn.us.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

mark Weath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Email: mark.meath@state.mn.us

Telephone: (651) 201-4118

Fax: (651) 215-9697

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:		E CONSTRUCTION (X:	DATE SURVEY COMPLETED	
		00806	B. WING		06/11/2015	
_	PROVIDER OR SUPPLIER	OOMINGTON 8100 HIGI	DRESS, CITY, HWOOD DR IGTON, MN			
(X4) ID PREFIX TAG	PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
3 000 INITIAL COMMENTS		3 000				
	****ATTENTIC	DN*****				
	BOARDING CARE HOME LICENSING CORRECTION ORDER					
	144A.10, this corre- pursuant to a surve found that the defic herein are not corre- not corrected shall	Minnesota Statute, section ction order has been issued y. If, upon reinspection, it is iency or deficiencies cited ected, a fine for each violation be assessed in accordance ines promulgated by rule of artment of Health.				
	corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been compliance with all a rule provided at the tag ule number indicated below. In the several items, failure to the items will be considered a Lack of compliance upon any item of multi-part rule will ment of a fine even if the item uring the initial inspection was				
	that may result fron orders provided tha the Department wit	hearing on any assessments non-compliance with these at a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	of this Department's provider and the fol issued. When corr sign and date, mak return the original to	TS: Oth and 11th, 2015 surveyors is staff, visited the above lowing correction orders are ections are completed, please is a copy of these orders and on the Minnesota Department of		Minnesota Department of Health is documenting the State Licensing Correction Orders using federal soft Tag numbers have been assigned to Minnesota state statutes/rules for Nu Homes.		
	epartment of Health Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE	(X6) DATE	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed 07/08/15

TITLE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00806	B. WING		06/11/2015	
	PROVIDER OR SUPPLIER	OOMINGTON 8100 HIGH	ORESS, CITY, S HWOOD DRI IGTON, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
3 000	Health; Licensing a Box 64900, St. Paul BOARDING CARE LICENSING CORR In accordance with 144A.10, this correspond to a surve found that the deficit herein are not corrected shall with a schedule of the Minnesota Departments of the Minnesota Departments of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess that was violated ducorrected. You may request a that may result from orders provided that the Department with notice of assessments.	nd Certification Program; P.O. II, Minnesota 55164-0900. HOME RECTION ORDER Minnesota Statute, section ction order has been issued y. If, upon reinspection, it is iency or deficiencies cited ected, a fine for each violation be assessed in accordance ines promulgated by rule of artment of Health. The ther a violation has been compliance with all erule provided at the tagule number indicated below. In the items will be considered Lack of compliance upon any item of multi-part rule will ment of a fine even if the item uring the initial inspection was the aring on any assessments in non-compliance with these at a written request is made to the initial inspection was the initial inspection of a sent for non-compliance.	3 601	The assigned tag number appears far left column entitled "ID Prefix". The state statute/rule number and corresponding text of the state statut out of compliance is listed in the "Summary Statement of Deficience column and replaces the "To Comportion of the correction order. The column also includes the findings are in violation of the state statute statement, "This Rule is not met a evidenced by." Following the sumfindings are the Suggested Method Correction and the Time Period Form Correction. PLEASE DISREGARD THE HEAD THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES THE FEDERAL DEFICIENCIES ONLY. WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION STATUTES/RULES.	Tag." the tute/rule ies" ply" his s which after the s veyors d of or DING OF THIS O DN FOR	7/20/15
	(a) A boarding care	e home must establish and				

6899

Minnesota Department of Health STATE FORM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					B) DATE SURVEY COMPLETED	
		00806	B. WING		06/	11/2015
	PROVIDER OR SUPPLIER SHIP VILLAGE OF BL	OOMINGTON 8100 HI	DDRESS, CITY, GHWOOD DR INGTON, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF O (EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
3 601	control program actuberculosis infectic issued by the Unite Control and Preven Division of Tuberculosis Elir CDC's Morbidity an Report (MMWR). Tuberculosis infectic that covers all paid and contractors, studen volunteers. The Department of assistance regarding of The guidelines.	nensive tuberculosis infection cording to the most current on control guidelines d States Centers for Disease ation (CDC), mination, as published in ad Mortality Weekly his program must include a con control plan unpaid employees, ts, residents, and Health shall provide technicating implementation				
	by: Based on interview facility failed to ens	ent is not met as evidenced and document review, the ure 1 of 7 employees (E)-5 ed annual immunizations was culosis (TB).		corrected		
	results dated 2/17/noted the facility had of TST for E-5 in mas required. The re	n test (TST or Mantoux) 14, were reviewed. It was Id failed to document the resu illimeters (mm) of induration esults were circled as erpretation of the skin test.	lt			

Minnesota Department of Health

STATE FORM 6899 OYY111 If continuation sheet 3 of 7

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					SURVEY LETED	
			A. BUILDING.			
		00806	B. WING		06/1	1/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
FRIENDS	SHIP VILLAGE OF BL	OOMINGTON	HWOOD DRI IGTON, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
3 601	Continued From pa	.ge 3	3 601			
	directed, "The diam should be measure reactions should be induration, even the no induration is four recorded." On 6/11/15, at 11:2 nursing said she harecorded, and states	antoux Skin Testing policy neter of the indurated area and across the forearmAll recorded in millimeters of ose classified as negative. If and, '0 mm' should be				
3 945	results of a Mantoux recorded as 'negative/0 millimeters.' There should have been a number in millimeters."		3 945			7/20/15
3 343	3 945 MN Rule 4655.6400 Subp. 1 Adequate Care; Care in General Subpart 1. Care in general. Each patient or resident shall receive nursing care or personal and custodial care and supervision based on individual needs. Patients and residents shall be encouraged to be active, to develop techniques for self-help, and to develop hobbies and interests. Nursing home patients shall be up and out of bed as much as possible unless the attending physician states in writing on the patient 's medical record that the patient must remain in bed.		3 3 7 2			7/20/13
	by: Based on observat review, the facility f	ent is not met as evidenced ion, interview and document ailed to ensure staff properly ninimize the risk of infectious		corrected		

Minnesota Department of Health

STATE FORM 6899 OYY111 If continuation sheet 4 of 7

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED				
		00806	B. WING		06/	11/2015			
NAME OF PROVIDER OR SUPPLIER FRIENDSHIP VILLAGE OF BLOOMINGTON STREET ADDRESS, CITY, STATE, ZIP CODE 8100 HIGHWOOD DRIVE BLOOMINGTON, MN 55438									
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE			
3 945	transmission for 2 c whose personal car whose personal car Findings include: R7 was assisted intal:00 a.m. by a nur donned gloves and pad, placed the pad and proceeded to preported the incontinum amount of stool. Wha-F had the resid and provided period adjusted incontiner removed the gloves washing, NA-F don assisted R7 with shrazor. NA-F then rewithout hand washing gloves, and assisted the 7:45 a.m. by NA-F, independently while using the toilet R10 provided periodary washing hands and assist with changing to closet and removed gloves and washing hands and assist with changing to closet and removed gloves and took out bra ar with dressing NA-F wash her hands, but bathroom with R10 toothpaste on the toto R10 to brush tee complete the task.	of 12 residents (R7, R10)							

Minnesota Department of Health

STATE FORM 6899 OYY111 If continuation sheet 5 of 7

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED							
		A. BUILDING:									
	00806	B. WING		06/1	1/2015						
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE											
FRIENDSHIP VILLAGE OF BLOOMINGTON 8100 HIGHWOOD DRIVE BLOOMINGTON, MN 55438											
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						
Continued From page 5		3 945									
In an interview with nursing (ADON) on 11:30 a.m. it was convashed hands after. The Perineal Care staff to perform har policy protocol. The undated Stand Care Workers policy "gloves must be vequipment, when hody fluids, mucouskin, or when hand with blood or body between client confremoved, thorough Gloves DO NOT tate. MN Rule 144.651 Sof HCF Bill of Right. Subd. 30. Protein Patients and reside reasonable access available rights pro	the assistant director of 6/11/15, at approximately onfirmed the staff should have r glove removal. policy dated 2014, directed and hygiene according to facility dard Precautions for all Health by directed staff as follows: worn when cleaning reusable aving direct contact with blood, as membrane or non-intact ling equipment contaminated fluidsGloves will be changed tacts. When gloves are hand washing is required. When place of hand washing." Subd. 30 Patients & Residents is contact and advocacy services. The shall have the right of at reasonable times to any tection services and advocacy	31930			7/1/15						
assistance in under protecting the rights in other law. This r opportunity for priva the patient and a re- protection service of This MN Requirem by:	rstanding, exercising, and so described in this section and sight shall include the atte communication between expresentative of the rights or advocacy service.		corrected								
	SUMMARY STA (EACH DEFICIENCY REGULATORY OR LETTE CONTINUED FROM PARTIES AND	ORROGERICTION DOBOSE CHACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 5 In an interview with the assistant director of nursing (ADON) on 6/11/15, at approximately 11:30 a.m. it was confirmed the staff should have washed hands after glove removal. The Perineal Care policy dated 2014, directed staff to perform hand hygiene according to facility policy protocol. The undated Standard Precautions for all Health Care Workers policy directed staff as follows: "gloves must be worn when cleaning reusable equipment, when having direct contact with blood, body fluids, mucous membrane or non-intact skin, or when handling equipment contaminated with blood or body fluidsGloves will be changed between client contacts. When gloves are removed, thorough hand washing is required. Gloves DO NOT take the place of hand washing." MN Rule 144.651 Subd. 30 Patients & Residents of HCF Bill of Rights Subd. 30. Protection and advocacy services. Patients and residents shall have the right of reasonable access at reasonable times to any available rights protection services and advocacy services so that the patient may receive assistance in understanding, exercising, and protecting the rights described in this section and in other law. This right shall include the opportunity for private communication between the patient and a representative of the rights protection service or advocacy service. This MN Requirement is not met as evidenced	ORONIDER OR SUPPLIER STREET ADDRESS, CITY, S SHIP VILLAGE OF BLOOMINGTON SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 5 In an interview with the assistant director of nursing (ADON) on 6/11/15, at approximately 11:30 a.m. it was confirmed the staff should have washed hands after glove removal. The Perineal Care policy dated 2014, directed staff to perform hand hygiene according to facility policy protocol. The undated Standard Precautions for all Health Care Workers policy directed staff as follows: "gloves must be worn when cleaning reusable equipment, when having direct contact with blood, body fluids, mucous membrane or non-intact skin, or when handling equipment contaminated with blood or body fluidsGloves will be changed between client contacts. When gloves are removed, thorough hand washing is required. 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This MN Requirement is not met as evidenced by:	OBORDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE SHIP VILLAGE OF BLOOMINGTON SUMMARY STATEMENT OF DEFICIENCIES (FACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 5 In an interview with the assistant director of nursing (ADON) on 6/11/15, at approximately 11:30 a.m. it was confirmed the staff should have washed hands after glove removal. The Perineal Care policy dated 2014, directed staff to perform hand hygiene according to facility policy protocol. The undated Standard Precautions for all Health Care Workers policy directed staff as follows: "gloves must be worn when cleaning reusable equipment, when having direct contact with blood, body fluids, mucous membrane or non-intact skin, or when handling equipment contaminated with blood or body fluidsGloves will be changed between client contacts. When gloves are removed, thorough hand washing is required. Gloves DO NOT take the place of hand washing." MN Rule 144.651 Subd. 30 Patients & Residents of HCF Bill of Rights Subd. 30. Protection and advocacy services. Patients and residents shall have the right of reasonable access at reasonable times to any available rights protection services and advocacy services so that the patient may receive assistance in understanding, exercising, and protecting the rights described in this section and in other law. This right shall include the opportunity for private communication between the patient and a representative of the rights protection service or advocacy service. This MN Requirement is not met as evidenced by:	OR CORRECTION ON THE CONTROL OF COMPANY STATE AND PROPER TO SHOULD BE A BUILDING: PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 8100 HIGHWOOD DRIVE BLOOMINGTON, MN 55438 SUMMARY STATEMENT OF DEFICIENCIES (ACAT DEFICIENCY MIST BE PRECEIBED BY FULL REGULATORY OF LSC DENTIFYING INFORMATION) Continued From page 5 In an interview with the assistant director of nursing (ADON) on 6/11/15, at approximately 11:30 a.m., it was confirmed the staff should have washed hands after glove removal. The Perineal Care policy dated 2014, directed staff to perform hand hygiene according to facility policy protocol. 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This MN Requirement is not met as evidenced by:						

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STATE FORM 6899 OYY111 If continuation sheet 6 of 7

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

AND DUAN OF CODDECTION IDENTIFICATION NUMBER.	LTIPLE CONSTRUCTION DING:	(X3) DATE SURVEY COMPLETED									
00806 B. WING	à	06/11/2015									
	PRESS, CITY, STATE, ZIP CODE										
FRIENDSHIP VILLAGE OF BLOOMINGTON 8100 HIGHWOOD DRIVE BLOOMINGTON, MN 55438											
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREF	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE										
failed to ensure correction orders and notice of non-compliance from the prior state survey of the boarding care (BC) unit were posted in public view. This had the potential to affect all residents and visitors to the facility. On 6/8/15 during the initial facility tour, a posting of results from the 4/11/13 state survey of the BC unit could not be found available for viewing by the public. The assistant director of nursing (ADON) during an interview on 6/9/15, at 3:24 p.m. expressed surprise that the survey book (containing the prior survey results) was not present "in its usual location," on a table at the entrance to the BC unit. She indicated she had already looked in the survey book on the long term care unit and not found the BC results. She also said she had called the administrator, who she said told her it would be on the entryway table. The ADON clarified, "I would expect it to be thereI'm not sure why it's not."	,										

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STATE FORM 6899 OYY111 If continuation sheet 7 of 7