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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: OYY1

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00806

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

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

4. TYPE OF ACTION: **2** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **06/11/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 04 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **119** (L18)

13.Total Certified Beds **66** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Shawn Soucek, HPR SWS 07/15/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 07/16/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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;

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

Informal Dispute Resolution - 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

ID: OYY1

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00806

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

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

4. TYPE OF ACTION: **7** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **07/24/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 04 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **119** (L18)

13.Total Certified Beds **66** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Gayle Lantto, HFE NEII 07/27/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 08/25/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
07/20/2015
(L33)

DETERMINATION APPROVAL

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 Meath

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 Meath

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

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245229	A. Building B. Wing	7/24/2015

Name of Facility	Street Address, City, State, Zip Code
FRIENDSHIP VILLAGE OF BLOOMINGTON	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
ID Prefix **F0281** Reg. # **483.20(k)(3)(i)** LSC	Correction Completed **07/21/2015**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **07/21/2015**	ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **07/21/2015**
ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **07/21/2015**	ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **07/21/2015**	ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **07/21/2015**
ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **07/21/2015**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GL/mm	07/27/2015	15507	07/24/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
6/11/2015			

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245229	01 - MAIN BUILDING 01	7/20/2015

Name of Facility	Street Address, City, State, Zip Code
FRIENDSHIP VILLAGE OF BLOOMINGTON	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
ID Prefix Reg. # **NFPA 101** LSC K0038	Correction Completed **07/15/2015**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Followup to Survey Completed on: 6/10/2015		**Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?**	**YES**	**NO**

- 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, 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245229	A. BUILDING _____ B. WING _____	06/11/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure insulin injections were properly prepared prior to administration in accordance with manufacturer's instructions and standards of practice for 1 of 1 residents (R68) whose insulin administration was observed. This also had a potential of affecting one more other resident who used insulin on that wing. Findings include: R68's insulin administration was observed on 6/8/15, at 5:29 p.m. by a registered nurse (RN)-A. The medication was Novolog (used to manage	F 281	The statements made in the plan of correction do not constitute admission of agreement by the Provider of the truth of the facts alleged or the conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and/or executed solely because it is required by the 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 conducted with RN-A regarding following	7/21/15

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

Electronically Signed | 07/08/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245229	A. BUILDING _____ B. WING _____	06/11/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 1 diabetes) which was administered via a Novolog Flexpen, (disposable dial-a-dose insulin pen). RN-A attached the NovoFine needle to the flexpen, dialed to 6 units, wiped the resident's skin with an alcohol wipe and then administered the insulin to R68's lower right quadrant. RN-A pulled out the needle immediately after pushing the insulin. Immediately after leaving R68's room, RN-A was interviewed regarding the lack of priming or removing air from the cartridge in the Flexpen after NovoFine needle was attached and lack of holding the needle in the skin for at least six seconds after administration. RN-A verified she had not primed the Flexpen prior to administering R68's insulin nor did she hold the needle in the skin to make sure all medication was administered. RN-A further stated, "I've never primed the Flexpen and I've never seen anyone do it." During an interview on 6/10/15, at 12:36 p.m. the assistant director of nursing (ADON) explained that the expectation was that all residents who received insulin via a Flexpen should have had the pen primed before insulin was administered. During an interview on 6/11/15, at 11:42 a.m. the director of nursing (DON) explained that all nurses were given onsite training on Flexpens and that her expectation was that the Flexpens were primed before administering insulin. In addition, she expected the staff to follow the manufacturer's recommendations on how prepare and administer insulin using Flexpens. R68's physician orders dated 6/3/15, directed staff to administer Novolog injections	F 281	manufacturer's instructions. Moreover, a new practice was initiated, which outlines the attachment of the manufacturer's specific instructions to the order in the Electronic Record. Licensed nurses will be re-educated regarding manufacturer instructions relating to insulin injections and the new practice that has been initiated. To ensure future and on-going compliance, audits will be conducted during the 3rd Quarter, 2015 regarding proper insulin administration via pen and reviewed at the upcoming Quality Assurance Committee Meeting. The Director of Nursing, ADON and RN Supervisors will be responsible to ensure future compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245229	A. BUILDING _____ B. WING _____	06/11/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 2 subcutaneous of 6 units once a day at 6:00 p.m. with dinner, and to hold the medication for blood glucose of less than 150 milligrams/deciliters. The Novolog Flexpen manufacturer's instruction directed priming with 2 units prior to administration of each injection. "Before each injection small amounts of air may collect in the cartridge during normal use. To avoid injecting air and to ensure proper dosing: Turn the dose selector to select 2 units, keep the needle pointing upwards, press the bush-button all the way in. The dose selector returns to 0." The manufacturer's instructions insert went on to include step-by-step instructions on how to complete the task. "Keep the needle in the skin for at least 6 seconds, and keep the push-button pressed all the way in until the needle has been pulled out from the skin. This will make sure that the full dose has been given."	F 281		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow the care plan for orthostatic blood pressure monitoring for 1 of 1 resident (R76) reviewed for unnecessary drug use who had physician ordered orthostatic blood pressures.	F 282	It is the policy of Friendship Village to follow the care plan for orthostatic blood pressure monitoring per physician orders. Regarding R76, orthostatic blood pressures were initiated on June 20th, 2015 per monthly standard of practice. Moreover, we have audited residents with	7/21/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245229	A. BUILDING _____ B. WING _____	06/11/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 3 Findings include: R76's care plan last revised on 12/15/14, indicated R76 had a history of falls. The goal was for the resident to "maintain current level of mobility with no increase in incident of falls/injuries." Medications known to contribute to orthostatic hypotension and/or falls were prescribed for R76 including order changes dated 5/18/15, to increase Seroquel 25 mg (milligrams) bid (twice a day) and 37.5 mg at HS (hour of sleep) for hallucinations, Sinemet for Parkinson's disease, and Trazodone 50 mg (antidepressant commonly 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. Although the instructions were transferred to the electronic treatment administration records (ETAR) review of the ETARs from 11/14 through 5/15, lacked evidence the resident's orthostatic blood pressures had ever been measured as ordered, and when the resident had an existing diagnosis of orthostatic hypotension. 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." During an interview on 6/11/15, at 8:24 a.m. RN-B stated R76 required monthly orthostatic blood pressures taken due to R76's use of the	F 282	antipsychotic medications to ensure that orthostatic blood pressures are care planned and monitored accordingly. In order to ensure future compliance, re-education of licensed nursing staff will be conducted to assure that staff are up to date on facility policy relating to orthostatic vital signs on residents receiving psychotropic medications. The DON and Pharmacy Consultant will audit residents on antipsychotic medication during the 3rd Quarter, 2015 to ensure orthostatic blood pressure monitoring has occurred. The Director of Nursing Service and the Pharmacy Consultant are responsible to ensure compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245229	A. BUILDING _____ B. WING _____	06/11/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 4 antipsychotic 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. During an interview on 6/11/15, at 12:17 p.m. the DON verified no orthostatic blood pressures were taken from 3/1/15 to 6/11/15. The DON explained the reason for the missing orthostatic blood pressure were due to a clerical error when put into the facility's computer system that would alert nursing staff to perform this function. The DON confirmed that R76 orthostatic blood pressure had a start date of 11/20/14, and was on the ETAR for nursing to complete and was signed off by nursing as being completed, however, no documentation was available to show what the blood pressures measured. Both the DON and RN-B stated the ETAR and electronic medication administration records were considered part of a residents' care plan.	F 282		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to assess and implement appropriate measures after falls to minimize the	F 323	It is the policy of Friendship Village to ensure that the resident environment remains as free of accidents and hazards	7/21/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245229	A. BUILDING _____ B. WING _____	06/11/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 5 risk for further falls for 1 of 5 residents (R76) reviewed for unnecessary medication use. Findings include: R76 was observed on 6/10/15, at 1:33 p.m. in her room. She was seated in her recliner at the time of the observation. After the surveyor asked the resident if she was able to stand on her own, without requesting the resident demonstrate, R76 independently stood using her walker. R76 walked a few feet, picked an item up from the floor and then backed up toward her recliner and sat down. A nursing assistant (NA)-B then entered the room and was asked about R76's needs for assistance with standing and walking. NA-B stated R76 was not supposed to be standing or walking alone, but needed "stand by assistance" of one staff. At approximately 2:00 p.m. R76 was in the recliner resting with the footrest in the raised position. R76's MDS dated 5/19/15, indicated the resident was cognitively impaired, required assistance of two staff for transferring and mobility, and had experienced two falls since the last assessment, one with injury and one without injury. The NA assignment sheet for R76 dated 6/11/15, directed staff to provide assistance of one staff with the use of a four wheeled walker or wheelchair for transfers, ambulation, and bed mobility. R76's care plan last revised on 12/15/14, indicated R76 had a history of falls. The goal was for the resident to "maintain current level of mobility with no increase in incident of falls/injuries." Interventions included: "Instruct on	F 323	as is possible and that each resident receives adequate supervision and assistance devices to prevent accidents. Regarding R76, orthostatic blood pressures were initiated on June 20th, 2015 per monthly standard of practice. Moreover, we have audited residents with antipsychotic medications to ensure that orthostatic blood pressures are care planned and monitored accordingly. In order to ensure future compliance, re-education of licensed nursing staff will be conducted to assure that staff are up to date on facility policy relating to orthostatic vital signs on residents receiving psychotropic medications. The DON and Pharmacy Consultant will audit residents on antipsychotic medication during the 3rd Quarter, 2015 to ensure orthostatic blood pressure monitoring has occurred. The Director of Nursing Service and the Pharmacy Consultant are responsible to ensure compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245229	A. BUILDING _____ B. WING _____	06/11/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 6	F 323		

safety measures to reduce risk of falls (posture, changing positions, use of handrails)...Keep areas free of obstruction...Keep call light within easy reach. Instruct to call for assistance prn [as needed]...Keep personal items within easy reach; bed to be in low position and wheels locked....Establish daily routines for resident--introducing changes in routine or environment slowly."

Medications known to contribute to orthostatic hypotension and/or falls were prescribed for R76 including order changes dated 5/18/15, to increase Seroquel 25 mg (milligrams) bid (twice a day) and 37.5 mg at HS (hour of sleep) for hallucinations, Sinemet for Parkinson's disease, and Trazodone 50 mg (antidepressant commonly 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."

R76's fall incidents revealed the resident 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245229	A. BUILDING _____ B. WING _____	06/11/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 7	F 323		

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 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.

During an interview on 6/11/15, at 12:17 p.m. the DON verified no orthostatic blood pressures were taken from 3/1/15 to 6/11/15. The DON explained the reason for the missing orthostatic blood pressure were due to a clerical error when put into the facility's computer system that would alert nursing staff to perform this function. DON confirmed that R76 orthostatic blood pressure had a start date of 11/20/14, were on the ETAR for nursing to complete and was signed off by nursing as being completed, however, no documentation was available to show what the blood pressures measured.

The facility's 1/29/13, Psychoactive Medications policy regarding potential medication side effects

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245229	A. BUILDING _____ B. WING _____	06/11/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 8 indicated, "Consistent monitoring should be done to assess the risk/benefit relationship of psychoactive drug therapy."	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure adequate monitoring and rationale for continued use for antipsychotic medication for 1 of 5 residents	F 329	It is the policy of Friendship Village to ensure that the drug regimen of each resident will be reviewed at least once per month by a licensed pharmacist.	7/21/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245229	A. BUILDING _____ B. WING _____	06/11/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 9 (R76) reviewed for unnecessary medication use. Findings include: Medications known to contribute to orthostatic hypotension and/or falls were prescribed for R76 including order changes dated 5/18/15, to increase Seroquel 25 mg (milligrams) bid (twice a day) and 37.5 mg at HS (hour of sleep) for hallucinations, Sinemet for Parkinson's disease, and Trazodone 50 mg (antidepressant commonly 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. R76's fall incidents revealed the resident experienced eight falls in six months from 12/14 to 6/15, and in three cases sustained an injury. 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." R76's electronic treatment administration record (ETAR) indicated the resident's orthostatic blood pressures were to be measured on the 20th day of each month, however, there was no evidence the orthostatic blood pressures had ever been taken. During an interview on 6/11/15, at 8:24 a.m. a registered nurse (RN)-B verified there was no evidence in the resident's record this had been completed by nursing staff. The director of	F 329	Regarding R76, orthostatic blood pressures were initiated on June 20th, 2015 per monthly standard of practice. Moreover, we have audited residents with antipsychotic medications to ensure that orthostatic blood pressures are care planned and monitored accordingly. Finally, a comprehensive review of residents receiving psychotropic medications was conducted. Specific target behaviors have been identified for staff to monitor on each resident. In order to ensure future compliance, re-education of licensed nursing staff will be conducted to assure that staff are up to date on facility policy relating to orthostatic vital signs on residents receiving psychotropic medications. The DON and Pharmacy Consultant will audit residents on antipsychotic medication during the 3rd Quarter, 2015 to ensure orthostatic blood pressure monitoring has occurred and target behavior monitoring has been identified. The Director of Nursing Service and the Pharmacy Consultant are responsible to ensure compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245229	A. BUILDING _____ B. WING _____	06/11/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 10	F 329		

nursing then reported at 12:17 p.m. the director of nursing (DON) no orthostatic blood pressures had been completed from 3/1/15 to 6/11/15. The explanation for the missing data was that the facility had a new computerized system, and in the past they would have been alerted to the problem. Although the start date for the medication and monitoring was ordered on 11/20/14, it had not been completed.

In addition, target behaviors had not been identified for the use of antipsychotic medication. R76's EMAR dated 6/15, indicated staff was to monitor for "anxiety/agitation/paranoid statements," there was a lack of direction provided for staff as to what specific symptoms staff was to record if observed. (For example, it did not specify if agitation was evidenced by pacing, pounding her fist, cursing, etc.)
During an interview on 6/11/15, at 8:24 a.m. RN-B explained that before R76 received her antipsychotic medication nursing staff had to indicated if R76 was exhibiting any signs of anxiety/agitation/paranoid statements and if so, should have documented those behaviors in a progress note. RN-B confirmed the information was not individualized and specific.

The DON stated on 6/11/15, at 12:17 p.m. there were no indications for targeted behaviors identified.

The facility's 1/29/03, Psychoactive Medications policy read, "This facility supports the cooperative efforts of physicians, pharmacist, nursing staff and professionals to establish specific goals and objectives for review of the use of psychoactive medication. Consistent monitoring should be done to assess the risk/benefit relationship of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245229	A. BUILDING _____ B. WING _____	06/11/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 11 psychoactive drug therapy."	F 329		
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure 2 of 21 residents (R42, R55) were served food at the proper temperature, while potentially affecting all 21 residents on the unit. 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	F 371	It is the policy of Friendship Village to store, prepare, distribute and serve food under sanitary conditions. Regarding Resident #42 & #55, staff immediately discarded pureed ham, and cook promptly prepared a new serving that exceeded the 140 degrees required per regulation. To ensure future compliance Dietary Aides will be re-educated regarding food temperatures and pan placement to ensure that temperatures reach the appropriate 140 degrees. Moreover, food tempereature logs will be monitored and audited by the Dietary Manager during the 3rd Quarter, 2015 and the results will be presented at the next quarterly Quality Assurance Meeting. The Dietary Manager will be responsible for the re-training of staff and auditing of food temperatures.	7/21/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245229	A. BUILDING _____ B. WING _____	06/11/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 12	F 371		

every other week and that he had already talked to the cooks about the food temperatures not being documented for the evening meal.

In the Linden dining room on 6/8/15, at 12:21 p.m. a pan of pureed ham was observed sitting at an angle on top of the steam table and also a plate with pureed ham was observed placed on top of the steam table. There was no visible steam coming from the pan or plate of food. DA-A was about to serve R42 and R55 the pureed ham when surveyor asked for the temperature of the ham to be taken. The plate of pureed ham registered 124 degrees and the pan of pureed ham registered 134 degrees. ACD stated, "The pureed ham is not hot enough." ACD also stated, "The pan of pureed ham should not be on top of the steam table but in the steam table." DA-A stated, "I will microwave the pureed ham" and proceeded to do so. DM at this time verified there were missing food temperatures in the Linden dining room food temperature log three to five meals a week from February 23, 2015 through June 8, 2015.

On 6/9/15, at 7:59 a.m. it was observed DA-A testing the temperature of breakfast foods from the steam table in the Linden dining room. DA-A stated, "I microwave the foods if they are not hot enough." The pureed eggs temperature registered 134 degrees and the pureed sausage registered 133 degrees. DM stated, "We want the steamed food items served at 150 degrees" and instructed DA-A to take the pureed eggs and pureed sausage back to the kitchen to be reheated. DM further stated, "We want the foods to be brought up to the right temperature."

R42's significant change Minimum Data Set

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245229	A. BUILDING _____ B. WING _____	06/11/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 13 (MDS) dated 4/16/15, indicated R42 had severely impaired cognition and needed supervision for eating. R42's careplan indicated the resident was at moderate nutritional risk related to dementia, Parkinson's disease, and weakness; Mechanical Soft Thin Liquid Diet." R55's quarterly MDS dated 2/24/15, indicated R55's cognition was severely impaired and needed assistance with eating. R55's careplan indicated "[R55] is at moderate nutritional risk r/t dementia, psychosis, depression, hospice pt; Provide Mechanical soft diet." A 2/13/13 Temperature Record - HCC/BC [health care center/board and care] Buffet Units "Objective: To keep accurate record of food temperatures of HCC/BCC buffet line; to provide a quality assurance of hot foods served in the HCC/BCC. Policy: The Temperature Record will be utilized for each meal, documenting a variety of food items served. Procedure: Upon placement of hot foods in the buffet well, the Dietary Aide will record a variety of food temperatures on the specified record. Hot food items should be a minimum of 150 degrees. Items not heated to the minimum need to be returned to the kitchen for reheating, with the Cook responsible being made aware of the situation. Responsibility: Dietary Aides, Cooks."	F 371		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of	F 428		7/21/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245229	A. BUILDING _____ B. WING _____	06/11/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 14 nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the consultant pharmacist (CP) failed to ensure facility staff was adequately monitoring and a rationale was provided for the continued use of antipsychotic medication for 1 of 5 residents (R76) reviewed for unnecessary medication. Findings include: R76's physician orders dated 6/1/15, indicated R76 was prescribed the antipsychotic medication Seroquel 25 milligrams (mg) by mouth one time a day at 2:00 p.m., 37.5 mg twice daily at 8:00 a.m. and 8:00 p.m. and 12.5 mg once daily as needed. The order included direction to staff to monitor the resident's orthostatic blood pressures monthly. In addition, R76 was prescribed other medications known to potentially contribute to orthostatic hypotension and/or falls including Sinemet for Parkinson's disease, and Trazodone 50 mg (antidepressant commonly used to promote sleep). R76's fall incidents revealed the resident experienced eight falls in six months from 12/14 to 6/15, and in three cases sustained an injury. R76's electronic treatment administration record (ETAR) indicated the resident's orthostatic blood pressures were to be measured on the 20th day of each month, however, there was no evidence the orthostatic blood pressures had ever been	F 428	It is the policy of Friendship Village that the Consultant Pharmacist will adequately monitor and provide a rationale for the continued use of antipsychotic medication. Regarding R76, orthostatic blood pressures were initiated on June 20th, 2015 per monthly standard of practice. Moreover, we have audited residents with antipsychotic medications to ensure that orthostatic blood pressures are care planned and monitored accordingly. Finally, as part of our standard monthly review, the Consultant Pharmacist will specifically verify and verbally report accurate monitoring for orthostatic blood pressures and target behaviors during the monthly pharmacy exit review. In order to ensure future compliance, re-education of licensed nursing staff will be conducted to assure that staff are up to date on facility policy relating to orthostatic vital signs on residents receiving psychotropic medications. The DON and Pharmacy Consultant will audit residents on antipsychotic medication during the 3rd Quarter, 2015 to ensure orthostatic blood pressure monitoring has occurred. The Director of Nursing Service and the Pharmacy Consultant are responsible to ensure compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245229	A. BUILDING _____ B. WING _____	06/11/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 15	F 428		

taken.

During an interview on 6/11/15, at 8:24 a.m. a registered nurse (RN)-B verified there was no evidence in the resident's record this had been completed by nursing staff. The director of nursing then reported at 12:17 p.m. the director of nursing (DON) no orthostatic blood pressures had been completed.

In addition, target behaviors had not been identified for the use of antipsychotic medication. R76's EMAR dated 6/15, indicated staff was to monitor for "anxiety/agitation/paranoid statements," there was a lack of direction provided for staff as to what specific symptoms staff was to record if observed. (For example, it did not specify if agitation was evidenced by pacing, pounding her fist, cursing, etc.)

During an interview on 6/11/15, at 8:24 a.m. RN-B explained that before R76 received antipsychotic medication, nursing staff should have indicated whether the resident was exhibiting behaviors warranting the medication use. If so, those behaviors should have been documented in a progress note. RN-B confirmed the information was not individualized and specific. The DON verified on 6/11/15, at 12:17 p.m. that the information was lacking in R76's record.

During an interview on 6/10/15, at 3:00 p.m. with the facility's CP, he reported the resident's orthostatic blood pressures should have been measured related to the antipsychotic medication use. A follow-up interview was conducted with the CP the next day, at which time the CP verified he reviewed R76's medication regime. The CP said in 5/15, it was noted the resident's orthostatic

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245229	A. BUILDING _____ B. WING _____	06/11/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 16 blood pressures were not taken because the resident was unable to stand. The CP did not recall whether the lack of monitoring was noted on other monthly visits. The facility's 1/29/03, Psychoactive Medications policy read, "This facility supports the cooperative efforts of physicians, pharmacist, nursing staff and professionals to establish specific goals and objectives for review of the use of psychoactive medication. Consistent monitoring should be done to assess the risk/benefit relationship of psychoactive drug therapy."	F 428		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a	F 441		7/21/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245229	A. BUILDING _____ B. WING _____	06/11/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 17 communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure used a sharp/needle was properly disposed to minimize the risk for infection during blood glucose monitoring for 1 of 1 resident (R68) whose blood glucose monitoring was observed. Findings include: R68's blood glucose testing was observed on 6/8/15 at 5:25 p.m. by a registered nurse (RN)-A. RN-A donned gloves, wiped R68's finger with an alcohol wipe and then poked the resident's finger. RN-A then threw the used lancet into the trash can that was adjacent to R68. RN-A took a sample of blood from R68 using a glucose test strip, and obtained the reading, detached the test strip from the blood glucose machine and then threw the used glucose test strip in the trash can adjacent to R68. Immediately after leaving R68's room, RN-A was	F 441	It is the policy of Friendship Village to establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. Immediately, upon notification of the nursing staff, the needle was retrieved and properly disposed of and RN-A was immediately re-trained regarding proper disposal of insulin needles. Moreover, licensed nurses will be re-educated regarding proper disposal of sharps/needles. To ensure future compliance, audits will occur during the 3rd Quarter, 2015 and will be reported at the upcoming Quality Assurance Meeting. The Director of Nursing, ADON, and RN Supervisors will be responsible to ensure future compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245229	A. BUILDING _____ B. WING _____	06/11/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 18 interviewed regarding the lack of disposing of a used sharp/needle properly. RN-A verified that she threw the used lancet and glucose test strip in a trash can. RN-A stated, "I should have placed the used needles in the sharps container [designed to prevent needle misuse/re-use]. I shouldn't have thrown it in the trash can." During an interview on 6/8/15, at 5:38 p.m. the director of nursing (DON) explained that the expectations was that all used sharps/needles "must go" in the sharps container. The DON explained that she did not expect the staff would dispose of used sharps in trash cans. R68's physician orders dated 6/3/15, directed staff to test blood glucose four times per day at 9:00 a.m., 11:30 a.m., 5:30 p.m., and 8:00 p.m. An undated nursing procedure guide for long-term care titled, "Disposal of Contaminated medical Waste (Used IV Bags, Tubing, Foley bags, Suction Canisters, etc.)" directed staff to engage safety devices on needles, then discard needles into the sharps container.	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245229	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/10/2015**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 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 By email to:	K 000	EPOC	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245229	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/10/2015**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Friendship Village of Bloomington is a 2-story building with partial basement. The building was constructed at 2 different times. The original building was constructed in 1979 and was determined to be of Type V(111) construction. In 2003, an addition was constructed and was determined to be of Type II(111) construction. Because the original building and the 1 addition met the construction type allowed for existing buildings, the facility was surveyed as one building. The building is fully fire sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which are monitored for automatic fire department notification. The facility has a capacity of 66 beds and had a census of 62 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 038	NFPA 101 LIFE SAFETY CODE STANDARD	K 038		7/15/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245229	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/10/2015**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 038 SS=F	Continued From page 2 Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide means of egress in accordance with the following requirements of 2000 NFPA 101, Section 7.2.1.5.4. The deficient practice could affect the residents. Findings include: On facility tour between 10:00 AM and 11:30 AM on 06/10/2015, observation revealed that there are child safety gates both of the exit stairs leading to the exterior exits in the Linden Wing. This deficient practice was verified by the administrator at the time of the inspection.	K 038	Friendship Village provides means of egress in accordance with the following requirements of 2000 NFPA 101, Section 7.2.1.5.4. As cited, a baby gate was recently installed due to a safety concern with one particular resident who was at risk for wandering. Manufacturer had been contacted prior to inspection about installation of the appropriate wanderguard system that would provide security for the resident as well as an appropriate means of egress. This equipment is scheduled to be installed by July 15th and the baby gate is set to be removed at that time. Security Coordinator will be responsible to test wanderguard system weekly for one month after installation and report findings to the Risk Committee. Director of Plant Operations is responsible to ensure compliance.	

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the 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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00806	A. BUILDING: _____ B. WING _____	06/11/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On June 8th through 11th, 2015, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance Monitoring, Licensing and	2 000	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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00806	A. BUILDING: _____ B. WING _____	06/11/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 1 Certification Program, P.O. Box 64900 St. Paul, MN 55164-0900.	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow the care plan for	2 565	Corrected	7/20/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00806	A. BUILDING: _____ B. WING _____	06/11/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 565	Continued From page 2 orthostatic blood pressure monitoring for 1 of 1 resident (R76) reviewed for unnecessary drug use who had physician ordered orthostatic blood pressures. Findings include: R76's care plan last revised on 12/15/14, indicated R76 had a history of falls. The goal was for the resident to "maintain current level of mobility with no increase in incident of falls/injuries." Medications known to contribute to orthostatic hypotension and/or falls were prescribed for R76 including order changes dated 5/18/15, to increase Seroquel 25 mg (milligrams) bid (twice a day) and 37.5 mg at HS (hour of sleep) for hallucinations, Sinemet for Parkinson's disease, and Trazodone 50 mg (antidepressant commonly 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. Although the instructions were transferred to the electronic treatment administration records (ETAR) review of the ETARs from 11/14 through 5/15, lacked evidence the resident's orthostatic blood pressures had ever been measured as ordered, and when the resident had an existing diagnosis of orthostatic hypotension. 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."	2 565		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00806	A. BUILDING: _____ B. WING _____	06/11/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 565	Continued From page 3 During an interview on 6/11/15, at 8:24 a.m. RN-B stated R76 required monthly orthostatic blood pressures taken due to R76's use of the antipsychotic 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. During an interview on 6/11/15, at 12:17 p.m. the DON verified no orthostatic blood pressures were taken from 3/1/15 to 6/11/15. The DON explained the reason for the missing orthostatic blood pressure were due to a clerical error when put into the facility's computer system that would alert nursing staff to perform this function. The DON confirmed that R76 orthostatic blood pressure had a start date of 11/20/14, and was on the ETAR for nursing to complete and was signed off by nursing as being completed, however, no documentation was available to show what the blood pressures measured. Both the DON and RN-B stated the ETAR and electronic medication administration records were considered part of a residents' care plan. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to ensuring the care plan for each individual resident is developed and followed. The DON could develop a system to educate staff and develop a monitoring system to ensure staff are providing care as directed by the written plan of care. The results could be reviewed at the quality committee meetings. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00806	A. BUILDING: _____ B. WING _____	06/11/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 4	2 830		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to assess and implement appropriate measures after falls to minimize the risk for further falls for 1 of 5 residents (R76) reviewed for unnecessary medication use. Findings include: R76 was observed on 6/10/15, at 1:33 p.m. in her room. She was seated in her recliner at the time of the observation. After the surveyor asked the resident if she was able to stand on her own, without requesting the resident demonstrate, R76 independently stood using her walker. R76 walked a few feet, picked an item up from the floor and then backed up toward her recliner and sat down. A nursing assistant (NA)-B then entered the room and was asked about R76's needs for assistance with standing and walking.	2 830	corrected	7/20/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00806	A. BUILDING: _____ B. WING _____	06/11/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 5 NA-B stated R76 was not supposed to be standing or walking alone, but needed "stand by assistance" of one staff. At approximately 2:00 p.m. R76 was in the recliner resting with the footrest in the raised position. R76's MDS dated 5/19/15, indicated the resident was cognitively impaired, required assistance of two staff for transferring and mobility, and had experienced two falls since the last assessment, one with injury and one without injury. The NA assignment sheet for R76 dated 6/11/15, directed staff to provide assistance of one staff with the use of a four wheeled walker or wheelchair for transfers, ambulation, and bed mobility. R76's care plan last revised on 12/15/14, indicated R76 had a history of falls. The goal was for the resident to "maintain current level of mobility with no increase in incident of falls/injuries." Interventions included: "Instruct on safety measures to reduce risk of falls (posture, changing positions, use of handrails)...Keep areas free of obstruction...Keep call light within easy reach. Instruct to call for assistance prn [as needed]...Keep personal items within easy reach; bed to be in low position and wheels locked....Establish daily routines for resident--introducing changes in routine or environment slowly." Medications known to contribute to orthostatic hypotension and/or falls were prescribed for R76 including order changes dated 5/18/15, to increase Seroquel 25 mg (milligrams) bid (twice a day) and 37.5 mg at HS (hour of sleep) for hallucinations, Sinemet for Parkinson's disease, and Trazodone 50 mg (antidepressant commonly	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00806	A. BUILDING: _____ B. WING _____	06/11/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE 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." R76's fall incidents revealed the resident 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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00806	A. BUILDING: _____ B. WING _____	06/11/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 7 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. During an interview on 6/11/15, at 12:17 p.m. the DON verified no orthostatic blood pressures were taken from 3/1/15 to 6/11/15. The DON explained the reason for the missing orthostatic blood pressure were due to a clerical error when put into the facility's computer system that would alert nursing staff to perform this function. DON confirmed that R76 orthostatic blood pressure had a start date of 11/20/14, were on the ETAR for nursing to complete and was signed off by nursing as being completed, however, no documentation was available to show what the blood pressures measured. 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." SUGGESTED METHOD FOR CORRECTION: The director of nursing or designee, could review and revise policies and procedures related to unnecessary medications, assessments, monitoring and care, and could provide staff education related to the care of resident.The director of nursing could develop an audit tool to ensure appropriate care is provided. The results of the audits could be reviewed at the quality committee meetings. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00806	A. BUILDING: _____ B. WING _____	06/11/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21025	Continued From page 8	21025		
21025	MN Rule 4658.0615 Food Temperatures Potentially hazardous food must be maintained at 40 degrees Fahrenheit (four degrees centigrade) or below, or 150 degrees Fahrenheit (66 degrees centigrade) or above. "Potentially hazardous food" means any food subject to continuous time and temperature controls in order to prevent the rapid and progressive growth of infectious or toxigenic microorganisms. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure 2 of 21 residents (R42, R55) were served food at the proper temperature, while potentially affecting all 21 residents on the unit. 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. In the Linden dining room on 6/8/15, at 12:21 p.m. a pan of pureed ham was observed sitting at	21025	corrected	7/6/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00806	A. BUILDING: _____ B. WING _____	06/11/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21025	Continued From page 9	21025		

an angle on top of the steam table and also a plate with pureed ham was observed placed on top of the steam table. There was no visible steam coming from the pan or plate of food. DA-A was about to serve R42 and R55 the pureed ham when surveyor asked for the temperature of the ham to be taken. The plate of pureed ham registered 124 degrees and the pan of pureed ham registered 134 degrees. ACD stated, "The pureed ham is not hot enough." ACD also stated, "The pan of pureed ham should not be on top of the steam table but in the steam table." DA-A stated, "I will microwave the pureed ham" and proceeded to do so. DM at this time verified there were missing food temperatures in the Linden dining room food temperature log three to five meals a week from February 23, 2015 through June 8, 2015.

On 6/9/15, at 7:59 a.m. it was observed DA-A testing the temperature of breakfast foods from the steam table in the Linden dining room. DA-A stated, "I microwave the foods if they are not hot enough." The pureed eggs temperature registered 134 degrees and the pureed sausage registered 133 degrees. DM stated, "We want the steamed food items served at 150 degrees" and instructed DA-A to take the pureed eggs and pureed sausage back to the kitchen to be reheated. DM further stated, "We want the foods to be brought up to the right temperature."

R42's significant change Minimum Data Set (MDS) dated 4/16/15, indicated R42 had severely impaired cognition and needed supervision for eating. R42's careplan indicated the resident was at moderate nutritional risk related to dementia, Parkinson's disease, and weakness; Mechanical Soft Thin Liquid Diet." R55's quarterly MDS dated 2/24/15, indicated R55's cognition was severely

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00806	A. BUILDING: _____ B. WING _____	06/11/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21025	Continued From page 10 impaired and needed assistance with eating. R55's careplan indicated "[R55] is at moderate nutritional risk r/t dementia, psychosis, depression, hospice pt; Provide Mechanical soft diet." A 2/13/13 Temperature Record - HCC/BC [health care center/board and care] Buffet Units "Objective: To keep accurate record of food temperatures of HCC/BCC buffet line; to provide a quality assurance of hot foods served in the HCC/BCC. Policy: The Temperature Record will be utilized for each meal, documenting a variety of food items served. Procedure: Upon placement of hot foods in the buffet well, the Dietary Aide will record a variety of food temperatures on the specified record. Hot food items should be a minimum of 150 degrees. Items not heated to the minimum need to be returned to the kitchen for reheating, with the Cook responsible being made aware of the situation. Responsibility: Dietary Aides, Cooks." SUGGESTED METHOD FOR CORRECTION: The dietary director or designee, could provide training for all dietary staff staff related to food tempatures. The quality assessment and assurance committee could perform random audits to ensure compliance TIME PERIOD FOR CORRECTION: Seven (7) days.	21025		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data	21390		7/6/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00806	A. BUILDING: _____ B. WING _____	06/11/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21390	Continued From page 11 collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure used a sharp/needle was properly disposed to minimize the risk for infection during blood glucose monitoring for 1 of 1 resident (R68) whose blood glucose monitoring was observed. Findings include: R68's blood glucose testing was observed on 6/8/15 at 5:25 p.m. by a registered nurse (RN)-A. RN-A donned gloves, wiped R68's finger with an	21390	corrected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00806	A. BUILDING: _____ B. WING _____	06/11/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21390	Continued From page 12	21390		

alcohol wipe and then poked the resident's finger. RN-A then threw the used lancet into the trash can that was adjacent to R68. RN-A took a sample of blood from R68 using a glucose test strip, and obtained the reading, detached the test strip from the blood glucose machine and then threw the used glucose test strip in the trash can adjacent to R68.

Immediately after leaving R68's room, RN-A was interviewed regarding the lack of disposing of a used sharp/needle properly. RN-A verified that she threw the used lancet and glucose test strip in a trash can. RN-A stated, "I should have placed the used needles in the sharps container [designed to prevent needle misuse/re-use]. I shouldn't have thrown it in the trash can."

During an interview on 6/8/15, at 5:38 p.m. the director of nursing (DON) explained that the expectations was that all used sharps/needles "must go" in the sharps container. The DON explained that she did not expect the staff would dispose of used sharps in trash cans.

R68's physician orders dated 6/3/15, directed staff to test blood glucose four times per day at 9:00 a.m., 11:30 a.m., 5:30 p.m., and 8:00 p.m.

An undated nursing procedure guide for long-term care titled, "Disposal of Contaminated medical Waste (Used IV Bags, Tubing, Foley bags, Suction Canisters, etc.)" directed staff to engage safety devices on needles, then discard needles into the sharps container.

SUGGESTED METHOD FOR CORRECTION: The director of nursing and pharmacist could review and revise policies and procedures for infection control practices. Staff could be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00806	A. BUILDING: _____ B. WING _____	06/11/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21390	Continued From page 13 educated as necessary. The director of nursing could conduct random audits to ensure compliance with state and federal regulations, and the results brought to the quality committee for review. TIME PERIOD FOR CORRECTION: Seven (7).	21390		
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate	21530		7/20/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00806	A. BUILDING: _____ B. WING _____	06/11/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21530	Continued From page 14 justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee. This MN Requirement is not met as evidenced by: Based on interview and document review, the consultant pharmacist (CP) failed to ensure facility staff was adequately monitoring and a rationale was provided for the continued use of antipsychotic medication for 1 of 5 residents (R76) reviewed for unnecessary medication. Findings include: R76's physician orders dated 6/1/15, indicated R76 was prescribed the antipsychotic medication Seroquel 25 milligrams (mg) by mouth one time a day at 2:00 p.m., 37.5 mg twice daily at 8:00 a.m. and 8:00 p.m. and 12.5 mg once daily as needed. The order included direction to staff to monitor the resident's orthostatic blood pressures monthly. In addition, R76 was prescribed other medications known to potentially contribute to orthostatic hypotension and/or falls including Sinemet for Parkinson's disease, and Trazodone 50 mg (antidepressant commonly used to promote sleep). R76's fall incidents revealed the resident experienced eight falls in six months from 12/14 to 6/15, and in three cases sustained an injury. R76's electronic treatment administration record (ETAR) indicated the resident's orthostatic blood	21530	corrected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00806	A. BUILDING: _____ B. WING _____	06/11/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21530	Continued From page 15 pressures were to be measured on the 20th day of each month, however, there was no evidence the orthostatic blood pressures had ever been taken. During an interview on 6/11/15, at 8:24 a.m. a registered nurse (RN)-B verified there was no evidence in the resident's record this had been completed by nursing staff. The director of nursing then reported at 12:17 p.m. the director of nursing (DON) no orthostatic blood pressures had been completed. In addition, target behaviors had not been identified for the use of antipsychotic medication. R76's EMAR dated 6/15, indicated staff was to monitor for "anxiety/agitation/paranoid statements," there was a lack of direction provided for staff as to what specific symptoms staff was to record if observed. (For example, it did not specify if agitation was evidenced by pacing, pounding her fist, cursing, etc.) During an interview on 6/11/15, at 8:24 a.m. RN-B explained that before R76 received antipsychotic medication, nursing staff should have indicated whether the resident was exhibiting behaviors warranting the medication use. If so, those behaviors should have been documented in a progress note. RN-B confirmed the information was not individualized and specific. The DON verified on 6/11/15, at 12:17 p.m. that the information was lacking in R76's record. During an interview on 6/10/15, at 3:00 p.m. with the facility's CP, he reported the resident's orthostatic blood pressures should have been measured related to the antipsychotic medication use. A follow-up interview was conducted with the CP the next day, at which time the CP verified	21530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00806	A. BUILDING: _____ B. WING _____	06/11/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21530	Continued From page 16 he reviewed R76's medication regime. The CP said in 5/15, it was noted the resident's orthostatic blood pressures were not taken because the resident was unable to stand. The CP did not recall whether the lack of monitoring was noted on other monthly visits. The facility's 1/29/03, Psychoactive Medications policy read, "This facility supports the cooperative efforts of physicians, pharmacist, nursing staff and professionals to establish specific goals and objectives for review of the use of psychoactive medication. Consistent monitoring should be done to assess the risk/benefit relationship of psychoactive drug therapy." SUGGESTED METHOD FOR CORRECTION: The director of nursing and consulting pharmacist could review and revise policies and procedures for proper monitoring of medication usage. Staff could be educated as necessary. The director of nursing could monitor medications on a regular basis to ensure compliance with state rules. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21530		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General 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.	21535		7/20/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00806	A. BUILDING: _____ B. WING _____	06/11/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21535	Continued From page 17 In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure adequate monitoring and rationale for continued use for antipsychotic medication for 1 of 5 residents (R76) reviewed for unnecessary medication use. Findings include: Medications known to contribute to orthostatic hypotension and/or falls were prescribed for R76 including order changes dated 5/18/15, to increase Seroquel 25 mg (milligrams) bid (twice a day) and 37.5 mg at HS (hour of sleep) for hallucinations, Sinemet for Parkinson's disease, and Trazodone 50 mg (antidepressant commonly 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. R76's fall incidents revealed the resident experienced eight falls in six months from 12/14 to 6/15, and in three cases sustained an injury.	21535	corrected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00806	A. BUILDING: _____ B. WING _____	06/11/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21535	Continued From page 18	21535		

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."

R76's electronic treatment administration record (ETAR) indicated the resident's orthostatic blood pressures were to be measured on the 20th day of each month, however, there was no evidence the orthostatic blood pressures had ever been taken.

During an interview on 6/11/15, at 8:24 a.m. a registered nurse (RN)-B verified there was no evidence in the resident's record this had been completed by nursing staff. The director of nursing then reported at 12:17 p.m. the director of nursing (DON) no orthostatic blood pressures had been completed from 3/1/15 to 6/11/15. The explanation for the missing data was that the facility had a new computerized system, and in the past they would have been alerted to the problem. Although the start date for the medication and monitoring was ordered on 11/20/14, it had not been completed.

In addition, target behaviors had not been identified for the use of antipsychotic medication. R76's EMAR dated 6/15, indicated staff was to monitor for "anxiety/agitation/paranoid statements," there was a lack of direction provided for staff as to what specific symptoms staff was to record if observed. (For example, it did not specify if agitation was evidenced by pacing, pounding her fist, cursing, etc.)
During an interview on 6/11/15, at 8:24 a.m. RN-B

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00806	A. BUILDING: _____ B. WING _____	06/11/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21535	Continued From page 19 explained that before R76 received her antipsychotic medication nursing staff had to indicated if R76 was exhibiting any signs of anxiety/agitation/paranoid statements and if so, should have documented those behaviors in a progress note. RN-B confirmed the information was not individualized and specific. The DON stated on 6/11/15, at 12:17 p.m. there were no indications for targeted behaviors identified. The facility's 1/29/03, Psychoactive Medications policy read, "This facility supports the cooperative efforts of physicians, pharmacist, nursing staff and professionals to establish specific goals and objectives for review of the use of psychoactive medication. Consistent monitoring should be done to assess the risk/benefit relationship of psychoactive drug therapy." SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or desigee could work with the medical director and consultant pharmacist to ensure medications were reviewed for appropriate interventions and monitoring. The DON could ensure the staff were educated on the importance of monitoring for unnecessary medications.The DON or designee could randomly audit resident records to ensure adequate monitoring and documentation was in place. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21535		

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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.

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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00806	A. BUILDING: _____ B. WING _____	06/11/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
3 000	INITIAL COMMENTS *****ATTENTION****** BOARDING CARE HOME LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On June 8th, 9th, 10th and 11th, 2015 surveyors of this Department's staff, visited the above provider and the following correction orders are issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of	3 000	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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00806	A. BUILDING: _____ B. WING _____	06/11/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
3 000	Continued From page 1 Health; Licensing and Certification Program; P.O. Box 64900, St. Paul, Minnesota 55164-0900. BOARDING CARE HOME LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.	3 000	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 which 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.	
3 601	MN St. Statute 144.56 Subp. 2c Tuberculosis Prevention And Control (a) A boarding care home must establish and	3 601		7/20/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00806	A. BUILDING: _____ B. WING _____	06/11/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
3 601	Continued From page 2 maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of The guidelines. (b) Written compliance with this subdivision must be maintained by the boarding care home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 7 employees (E)-5 reviewed for required annual immunizations was screened for tuberculosis (TB). Findings include: E-5's tuberculin skin test (TST or Mantoux) results dated 2/17/14, were reviewed. It was noted the facility had failed to document the result of TST for E-5 in millimeters (mm) of induration as required. The results were circled as "negative" in the interpretation of the skin test.	3 601	corrected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00806	A. BUILDING: _____ B. WING _____	06/11/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
3 601	Continued From page 3 A facility 4/1/13, Mantoux Skin Testing policy directed, "The diameter of the indurated area should be measured across the forearm...All reactions should be recorded in millimeters of induration, even those classified as negative. If no induration is found, '0 mm' should be recorded." On 6/11/15, at 11:23 a.m. the assistant director of nursing said she had not realized the mm was not recorded, and stated, "I would expect to see the results of a Mantoux recorded as 'negative/0 millimeters.' There should have been a number in millimeters."	3 601		
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. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure staff properly cleaned hands to minimize the risk of infectious	3 945	corrected	7/20/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00806	A. BUILDING: _____ B. WING _____	06/11/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
3 945	Continued From page 4 transmission for 2 of 12 residents (R7, R10) whose personal cares were observed. Findings include: R7 was assisted into the bathroom on 6/10/15, at 11:00 a.m. by a nursing assistant (NA)-F. NA-F donned gloves and removed R7's incontinent pad, placed the pad in the bathroom garbage can and proceeded to put on a new pad. The NA reported the incontinent pad contained a small amount of stool. While wearing the same gloves, NA-F had the resident stand up from the toilet and provided peri-care with disposable wipes, adjusted incontinent pad and clothing then removed the gloves. Without performing hand washing, NA-F donned a new pair of gloves, and assisted R7 with shaving utilizing an electric razor. NA-F then removed gloves, and again without hand washing, donned a new pair of gloves, and assisted R7 to put on his shirt. R10 was assisted to use the toilet on 6/10/15, at 7:45 a.m. by NA-F. R10 sat down on the toilet independently while NA-F donned gloves. After using the toilet R10 stood from the toilet, NA-F provided peri-care using disposable wipes, adjusted incontinent pad, and clothing. NA-F then removed gloves and donned a new pair without washing hands and walked resident to her bed to assist with changing out of pajamas. NA-F went to closet and removed clothing, went to armoire and took out bra and socks. After assisting R10 with dressing NA-F changed gloves but did not wash her hands, but instead walked back into the bathroom with R10, turned on the sink, put toothpaste on the toothbrush and handed brush to R10 to brush teeth and assisted her to complete the task. NA-F then combed R10's hair. NA-F then removed gloves and washed hands.	3 945		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00806	A. BUILDING: _____ B. WING _____	06/11/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
3 945	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 fluids...Gloves will be changed between client contacts. When gloves are removed, thorough hand washing is required. Gloves DO NOT take the place of hand washing."	3 945		
31930	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: Based on observation and interview the facility,	31930	corrected	7/1/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00806	A. BUILDING: _____ B. WING _____	06/11/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
31930	Continued From page 6 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 there...I'm not sure why it's not."	31930		