Electronically delivered
August 3, 2020

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

RE: CCN: 245229
Cycle Start Date: June 17, 2020

Dear Administrator:

On July 31, 2020, the Minnesota Department(s) of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

Electronically delivered
July 8, 2020

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

RE: CCN: 245229
Cycle Start Date: June 17, 2020

Dear Administrator:

On June 17, 2020, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Sarah Grebenc, Unit Supervisor
Metro D Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: sarah.grebenc@state.mn.us
Phone: (651) 201-3792
Fax: (651) 215-9697

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by September 17, 2020 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by December 17, 2020 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
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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 _____	06/17/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A COVID-19 Focused Infection Control survey was conducted 6/16/20 through 6/17/20, at your facility by the Minnesota Department of Health to determine compliance with Emergency Preparedness regulations §483.73(b)(6). The facility was in full compliance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS A COVID-19 Focused Infection Control survey was conducted on 6/16/20 through 6/17/20, at your facility by the Minnesota Department of Health to determine compliance with §483.80 Infection Control. The facility was determined not to be in compliance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Upon receipt of an acceptable electronic POC, a revisit of your facility will be conducted to validate substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an	F 880		7/22/20

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

Electronically Signed | 07/15/2020

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F 880	Continued From page 1	F 880		

infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and

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F 880	Continued From page 2 (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 1 rooms was appropriately disinfected to mitigate transmission of COVID-19, and failed to ensure staff donned (put on) appropriate personal protection equipment (PPE) for 1 of 1 residents (R1) in a quarantined room in accordance with Centers for Disease Control (CDC) and Centers for Medicare and Medicaid (CMS) guidance for COVID-19. Findings include: On 6/16/20, at 9:48 a.m., observation and	F 880	The statements in the Plan of Correction do not constitute admission of agreement by the Provider of the truth of the facts alleged or the conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of the Federal and State Laws. F-880-D It is the policy and procedure of Friendship Village for team members to appropriately “don” and “doff” Personal	

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F 880	Continued From page 3 interview of custodial worker (C)-A identified he was in the hallway outside room 3 and prepared to clean the vacated room for a new admission to arrive at 1:30 p.m. The room was a double occupancy room with two beds. The bed near the window had no bed linens, and the bed by the door had bed linens. There were two divider curtains that hung from the ceiling. C-A identified the room was vacated recently by a hospice resident who was on quarantine status. C-A sprayed a dry, clean rag with a spray cleaner and wiped the horizontal surfaces of the built in cabinets. C-A sprayed the rag and wiped surfaces of the head board, foot board, and grab bars with PERdiem. The surfaces were not left wet. C-A lowered himself onto the floor to clean the bed frame. When C-A wiped the bed frame, C-A sprayed the frame with the cleaner. When C-A wiped the frame, C-A crawled on his hands and knees, and drug the the rag across the floor with his hand. C-A continued with the same rag and sprayed the rag with cleaner, and continued to wipe the exterior and interior bedside table surfaces. C-A misted the room divider curtains with PERdiem and then End Block aerosol spray. The curtains were dry to touch. C-A identified the curtains were not visibly soiled and were not required to be changed unless they were visibly soiled. C-A misted the walls with PERdiem. C-A moved the undressed bed from the window side of the room to the door side of the room and the dressed bed next to the window. C-A identified the bed on the door side was not used by the previous resident. C-A misted the bedding with PERdiem and plugged the bed cord into the wall outlet by the window. With the same rag,	F 880	Protective Equipment (PPE) for resident's in a quarantined room in accordance with the Center for Disease Control (CDC) and Center for Medicare and Medicaid (CMS) guidance for COVID-19. In reference to NA-A he resigned on 6/27/2020. Team members required to enter a quarantine room will be reeducated on COVID-19 infection control practices and "don" and "doff" PPE. To ensure ongoing compliance random audits will be conducted by the Infection Control Preventionist or designee to ensure that team members are donning and doffing the appropriate PPE to enter a quarantine room. Audits will be conducted weekly x 4 weeks, then monthly x 3 months and then random audits will be conducted quarterly x 3 quarters. Audits will be presented quarterly to QAPI. The Director of Nursing is responsible for ongoing compliance. It is the policy of Friendship Village to appropriately clean and disinfect quarantine rooms to mitigate transmission of COVID-19. In reference to C-A – this team member was reeducated on 6/17/2020 on appropriate procedures and product for	

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F 880	Continued From page 4 C-A entered the bathroom, sprayed the rag and wiped the toilet, hand sanitizer and paper towel dispensers, and the sink. C-A opened the cabinet in the bathroom and wiped a wash basin, and emesis basin and the cabinet handles. C-A was unsure if the basins were used, and wiped them down to be sure they were cleaned before use. C-A finished the room and misted the End Block disinfectant spray throughout the room. The surfaces were observed to be dry. Interview on 6/16/20, at 11:35 a.m. with C-A identified he used PERdiem, a peroxide-based general cleaner, and End Block to clean the room. Both cleaners killed all germs instantly, and no dry time was needed. PERdiem was effective against COVID-19 because it was peroxide based. End Block also killed germs immediately, and no wet contact time was needed. Use of both cleaners ensured surfaces were properly disinfected. Observation of the PERdiem and End Block manufacturer labels with C-A identified the labels had not included wet contact time or environmental protection agency (EPA) registration numbers on the labels. Additionally, the labels made no mention they killed COVID-19 viruses. C-A identified he had worked in housekeeping for 28 years and started work at the facility last September. He was not trained on how to terminally clean rooms because he was told at orientation, he knew what he was doing. He had not received any additional training about how to clean vacated rooms. He volunteered to clean the COVID-19 rooms because additional staff were needed to keep up with the demand for housekeeping duties. Interview on 6/16/20, at 3:50 p.m., with the administrator identified the PERdiem cleaner was	F 880	cleaning and disinfecting a quarantined room including; removing and changing linens and privacy curtain, approved disinfectant and wet time of approved disinfectant. The environmental service team members were reeducated on 7/9/2020 on appropriate procedures and product for cleaning and disinfecting a quarantined room including; removing and changing linens and privacy curtain, approved disinfectant and wet time of approved disinfectant. To ensure on-going compliance random audits will be conducted by Environmental Services Lead or designee of cleaning and disinfecting quarantined rooms. Audits will be conducted weekly x 4 weeks and then random audits monthly for six months. Audits will be presented quarterly to QAPI. The Director of Community Services is Responsible for ongoing compliance. Date Certain 7/22/2020	

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F 880	Continued From page 5	F 880		

a general purpose cleaner. Both PERdiem and End Block were not on the EPA approved list for disinfection against COVID-19. The Administrator identified she had trained all staff on housekeeping responsibilities during the initial staff training of COVID-19 requirements. The training included terminal cleaning, disinfectant products and wet contact times. She expected staff to remove privacy curtains and bed linens during a terminal room clean, and expected staff to replace cleaning rags when soiled or in contact with the floor. Surfaces were expected to be sprayed directly onto surfaces and left wet for the amount of time directed by the manufacturer.

Interview on 6/17/20, at 1:30 p.m., with the environmental director identified C-A was trained to clean COVID-19 rooms on 5/30/20. Staff were expected to clean rooms according to facility policies and procedures. Privacy curtains were not changed during a terminal cleaning unless they were visibly soiled. Nursing was responsible to remove supplies and bed linens before housekeeping entered the room. Unused bedding was not changed unless it was visibly soiled. She was unaware C-A was not using EPA approved cleaners until she returned to work on 6/17/20. The environmental director verified PERdiem was only used for general cleaning, and was not a disinfectant used to complete terminal room cleaning.

Review of the 2019, Infection Prevention and Control Manual Environmental Services/Housekeeping/Laundry identified when a resident moved out, the room was to be stripped, including the cubicle curtain. The bed frame, mattress bedside stand (inside and out), over bed table, chairs, lights, walls, bathroom,

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F 880	Continued From page 6	F 880		

and closets were to be cleaned daily with an EPA approved hospital-grade disinfectant-detergent solution.

Review of the 3/10/20, Environmental Cleaning and Disinfecting Special Focus on COVID-19 training PowerPoint identified staff were to ensure cleaning and disinfecting procedures were followed consistently and correctly and wet contact times for cleaners and disinfectants were adhered to. Staff were to ensure cleaning products not registered with the EPA had label claims for effectiveness against human coronavirus and were used according to label instructions. A terminal clean of a room included stripping the room, including privacy curtains.

PPE USE

Observation on 6/17/20, at 9:50 a.m., identified nursing assistant (NA)-A wore eye protection on the top of his head. NA-A walked throughout the common area and resident hallways while residents were present.

Observation on 6/17/20, at 11:42 a.m., NA-A entered R1's room without donning (putting on a gown, gloves). NA-A's eye protection was on the top of his head. R1 was on quarantine. A PPE cart was at the doorway entrance. Signage posted identified staff were to use droplet precautions in the room. NA-A spoke to R1 and stood next to R1's wheelchair. NA-A did not wear PPE. NA-A exited R1's room without performing hand hygiene.

Interview on 6/17/20, at 11:55 a.m., with NA-A identified R1 was on quarantine and had no symptoms of COVID-19. R1 fell frequently and

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F 880	Continued From page 7 required staff to check on him. NA-A went into the room to check on R1. NA-A identified if R1 would have needed anything, he would have went out to gown and glove before NA-A would assist R1 with cares. R1 was fine, and had not required any assistance, and no contact was make with R1. NA-A identified staff were to don gowns and gloves in addition to the eye protection and masks. He would have double masked because the room was a quarantine room. Staff were to wear N95 masks in all quarantine and COVID-positive resident rooms. The surgical mask was worn over the N95 for mask conservation. Interview on 6/17/20, at 12:30 p.m., with the director of nursing (DON) identified staff were expected to wear the appropriate PPE any time staff entered quarantined resident rooms. R1 was on droplet precautions due to COVID-19 quarantine practices. Droplet precautions included donning gowns, gloves, and wearing eye protections according to CDC and CMS guidance.	F 880		