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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: RC8M
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 **08/29/2017** (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

X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **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):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Deanna Novak, HFE NEII 07/13/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 11/29/2017 (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
08/08/2017
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN: 24 5229

On August 9, 2017, the Department of Public Safety completed a PCR and found the life safety code deficiencies corrected. However, compliance with the health deficiencies had not been verified at the time of our August 22, 2017 notice, which resulted in the following imposition:

- Mandatory denial of payment for new Medicare and Medicaid Admissions (DPNA), effective September 15, 2017

If DPNA goes into effect, the facility would be subject to a two year loss of NATCEP, beginning September 15, 2017.

On August 29, 2017 a health PCR was completed and all health deficiencies were found corrected as of August 29, 2017.
As a result of the revisit findings, we are recommending to the CMS RO the following action as it relates to the remedy outlined in our letter of August 22, 2017:

- Mandatory denial of payment for new Medicare and Medicaid Admissions (DPNA), effective September 15, 2017, be rescinded.

Since DPNA did not go into effect, the two year loss of NATCEP that was to begin September 15, 2017, would also be rescinded.

Effective August 29, 2017, the facility is certified for 66 skilled nursing facility beds.

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245229

November 29, 2017

Ms. Jennifer Bever, Administrator
Friendship Village of Bloomington
8100 Highwood Drive
Bloomington, MN 55438

Dear Ms. Bever:

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 program.

Effective August 29, 2017 the above facility is certified for:

66 Skilled Nursing Facility Beds

Your facility's Medicare approved area consists of all 66 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 Provider agreement may be subject to non-renewal or termination.

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

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

An equal opportunity employer.

Electronically delivered
November 29, 2017

Ms. Jennifer Bever, Administrator
Friendship Village of Bloomington
8100 Highwood Drive
Bloomington, MN 55438

RE: Project Number S5229027

Dear Ms. Bever:

On August 22, 2017, we informed you that the following enforcement remedy was being imposed:

• Mandatory denial of payment for new Medicare and Medicaid admissions, effective September 15, 2017. (42 CFR 488.417 (b))

Also, we notified you in our letter of August 22, 2017, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from September 15, 2017.

This was based on the deficiencies cited by this Department for a standard survey completed on June 15, 2017, and lack of verification of substantial compliance with the health deficiencies at the time of our August 22, 2017 notice. The most serious health deficiencies in your facility at the time of the standard survey were found 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 August 29, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on June 15, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 30, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on June 15, 2017, as of August 29, 2017.

As a result of the PCR findings, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) Region V Office the following action related to the remedy outlined in our letter of August 22, 2017. The CMS Region V Office concurs and has authorized this Department to notify you of the action:

• Mandatory denial of payment for new Medicare and Medicaid admissions, effective September 15, 2017, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective September 15, 2017, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective September 15, 2017, is to be rescinded.

In our letter of August 22, 2017, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from September 15, 2017, due to denial of payment for new admissions. Since your facility attained substantial compliance on August 29, 2017, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

Electronically delivered

November 29, 2017

Ms. Jennifer Bever, Administrator
Friendship Village of Bloomington
8100 Highwood Drive
Bloomington, MN 55438

Re: Reinspection Results - Project Number S5229027

Dear Ms. Bever:

On August 29, 2017 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on June 15, 2017. At this time these correction orders were found corrected.

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.

Please feel free to call me with any questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: RC8M

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 **06/15/2017** (L34)

7. PROVIDER/SUPPLIER CATEGORY 04 (L7)
01 Hospital, 02 SNF/NF/Dual, 03 SNF/NF/Distinct, 04 SNF, 05 HHA, 06 PRTF, 07 X-Ray, 08 OPT/SP, 09 ESRD, 10 NF, 11 ICF/IID, 12 RHC, 13 PTIP, 14 CORF, 15 ASC, 16 HOSPICE, 22 CLIA

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

FISCAL YEAR ENDING DATE: (L35) **12/31**

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

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

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

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

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

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

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 :
Dawn Chiabotti, HFE II 07/13/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 08/08/2017 (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
08/08/2017
(L33)

DETERMINATION APPROVAL

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
July 3, 2017

Ms. Jennifer Bever, Administrator
Friendship Village Of Bloomington
8100 Highwood Drive
Bloomington, MN 55438

RE: Project Numbers S5229027, H5229023

Dear Ms. Bever:

On June 15, 2017, 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 electronically delivered CMS-2567, whereby corrections are required. In addition, at the time of the June 15, 2017 standard survey the Minnesota Department of Health completed an investigation of complaint number H5229023 that was found to be unsubstantiated.

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:

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

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

Remedies - 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:

Maria King, RN, APM
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Mankato Plaza
12 Civic Center Plaza, Suite #2105
Mankato, Minnesota 56001-7789
Email: maria.king@state.mn.us
Phone: (507) 344-2716
Fax: (507) 344-2723

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 25, 2017, 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 25, 2017 the following remedy will be imposed:

- Per instance civil money penalty. (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:

- 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 15, 2017 (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 15, 2017 (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. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety

State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

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

Enclosure

cc: Licensing and Certification File

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 ______	06/15/2017

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 On 6/12/17 to 6/15/17, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. An investigation of complaint [H5229023] was completed. The complaint was unsubstantiated. 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 371 SS=F	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable	F 371		7/30/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 07/11/2017

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 ______ B. WING ______	06/15/2017

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 1 safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure food was served at the proper temperature and equipment was maintained and/or stored appropriately to reduce/eliminate the risk of contamination or food borne illness. This had the potential to affect all 57 residents in the facility who received their meals from the kitchen. Findings include: During an initial tour of the kitchen with the assistant director of culinary services (ADC), and the dietary lead (DL) on 6/12/17, at 11:56 a.m., several sanitation issues were identified: A box of puff pastries was observed to be open and ready for use in the kitchen freezer. The packaging was unlabeled as to when it had been opened. In addition there was an open bag of carrots that had not been dated when opened. The ADC confirmed these products should have been dated when opened, and should have been sealed when placed back in the freezer.	F 371	The statements made in the Plan of Correction do no 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 Federal and State Laws. F371 It is the policy of the Friendship Village to store, prepare, distribute and serve food in accordance with professional standards for food service safety. Regarding dietary assistant-A re-education took place on June 13th, 2017. New cutting boards have been ordered to replace those cutting boards with deep cut marks. Culinary team members will be re-educated on dating and labeling of food items, storage of food items, food	

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	245229	A. BUILDING ______ B. WING ______	06/15/2017

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 2 Ready to use pans were observed stored on racks in the kitchen. Several pans were observed to be stacked wet. Four of six 1/3 size pans were observed to be stacked together while wet. In addition, three of six ½ size pans were observed to be stored wet and stacked on together. The ADC confirmed the pans had been put away wet and stated they should have been dried completely when put away. Three of seven cutting boards were observed to have deep cut marks with dark debris flakes in the grooves. The ADC confirmed this finding and stated the flakes could be residue from the dishwasher. A pie server available for use in the utensil drawer was observed to be soiled with a dark colored debris. The ADC confirmed the pie server was dirty and needed to be rewashed. Uncovered undated dishes of ice cream were observed in the galley freezer on the Linden unit. The ADC verified the dishes of ice cream should have been covered, and dated. The walk-in refrigerator had a large plastic container containing a dark brown liquid that was not covered or labeled. The ADC stated she thought the liquid it was BBQ sauce but was unaware when it had been made, or how long it had been in the refrigerator. On 6/13/17, at 7:40 a.m. the uncovered/undated dishes of ice cream remained available for use in the Linden dining room freezer. Dietary assistant (DA)-A stated she'd been made aware these needed to be covered and dated but had not yet	F 371	temperatures, sanitation of thermometer probe, daily and weekly cleaning schedules, dish washing and drying procedures by June 28th, 2017. To ensure on-going compliance audits of dating and labeling of food items, storage of food items, food temperatures, sanitation of thermometer probe, daily and weekly cleaning schedules, dish washing and drying procedures will be conducted during the 3rd quarter of 2017 and reviewed at upcoming Quality Assurance Performance Improvement (QAPI) committee. Date Certain 7/30/17	

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F 371	Continued From page 3	F 371		

gotten to it since she'd "been busy".

The facility's undated policy Food Storage, indicated frozen foods and refrigerated items should be stored in airtight containers, wrapped in foil or laminated paper, and should be labeled and dated.

The facility's undated policy Cleaning Schedules, indicated dishes were supposed to be put away dry each morning and night.

ON 6/13/17, at 8:00 a.m. DA-A temped food items and stated the pureed eggs were 126 degrees which wasn't hot enough and needed to microwave them to reheat. DA-A stated the temperature "should be 160-161 degrees". DA-A failed to reheat prior to serving residents. DA-A temped 8 different food items and between each item placed the thermometer under running water for no certain time frame or temperature and dried it on the same paper towel after each wash. DA-A stated she was supposed to use wipes but did not have any available.

During interview on 6/13/17, at 9:16 a.m. dietary lead (DL) stated that assistants are to temp the food prior to serving and a reference to appropriate temperatures was available in the kitchen area. DL stated that she expected staff to utilize a thermometer probe wipe to sanitize the thermometer in between each food item when temping food.

At 3:07 p.m. the assistant director of culinary services (ADC) stated he expected staff to clean the thermometer after each food item with the alcohol thermometer probe wipe.

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F 371	Continued From page 4 The facility's undated policy titled "Food Temperatures" stated "foods will be served at proper temperature to insure food safety". It further directed staff to take the temperature of each pan and reheat or chill the product if they are not appropriate temperatures. Policy indicated that "puree foods should be greater than 150 degrees but preferred of 160-175 degrees". The policy directed staff to re-sanitize the thermometer after each temperature with an alcohol wipe.	F 371		
F 465 SS=C	483.90(i)(5) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON (i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. (5) Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also take into account non-smoking residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the physical environment of the kitchen was not maintained in a sanitary manner. This had the potential to affect any of the 57 residents residing in the facility. Findings include: During an initial tour of the kitchen with the assistant director of culinary services (ADC), and	F 465	F465 It is the policy of Friendship Village to provide a safe, functional, sanitary and comfortable environment for resident, staff and the public. Culinary team members will be re-educated on the following policies, daily and weekly cleaning procedures, schedule of walk-in freezer/refrigerator,	7/30/17

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F 465	Continued From page 5 the dietary lead (DL) on 6/12/17, at 11:56 a.m., several sanitation issues were identified: The floor in the walk-in freezer was soiled with ice cream spillage and frozen carrots. The ADC instructed a dietary staff member to clean the floor right away. The floor in the dry storage area was soiled with a sticky dark matter. At the time of the observation, the ADC stated, "someone must have spilled juice this past weekend and not reported it." The pipes above the cook top were observed to be heavily soiled with dust. The faclity's undated policy Cleaning Schedules, indicated the stove hood and pipes should be kept free of grease and dust at all times due to a high fire hazard risk. The Sanitation of Equipment portion of the policy indicated shelves, sides, and floors of refrigerator should be wiped daily using clean sanitizing solution.	F 465	dry storage area and equipment and equipment areas by June 28th, 2017. To ensure on-going compliance audits will be conducted during the 3rd quarter of 2017 and reviewed at upcoming Quality Assurance Performance Improvement (QAPI) committee. The Director of Culinary, Assistant Director of Culinary and Dietary Manager will be responsible to ensure future compliance. Date Certain 7/30/17	

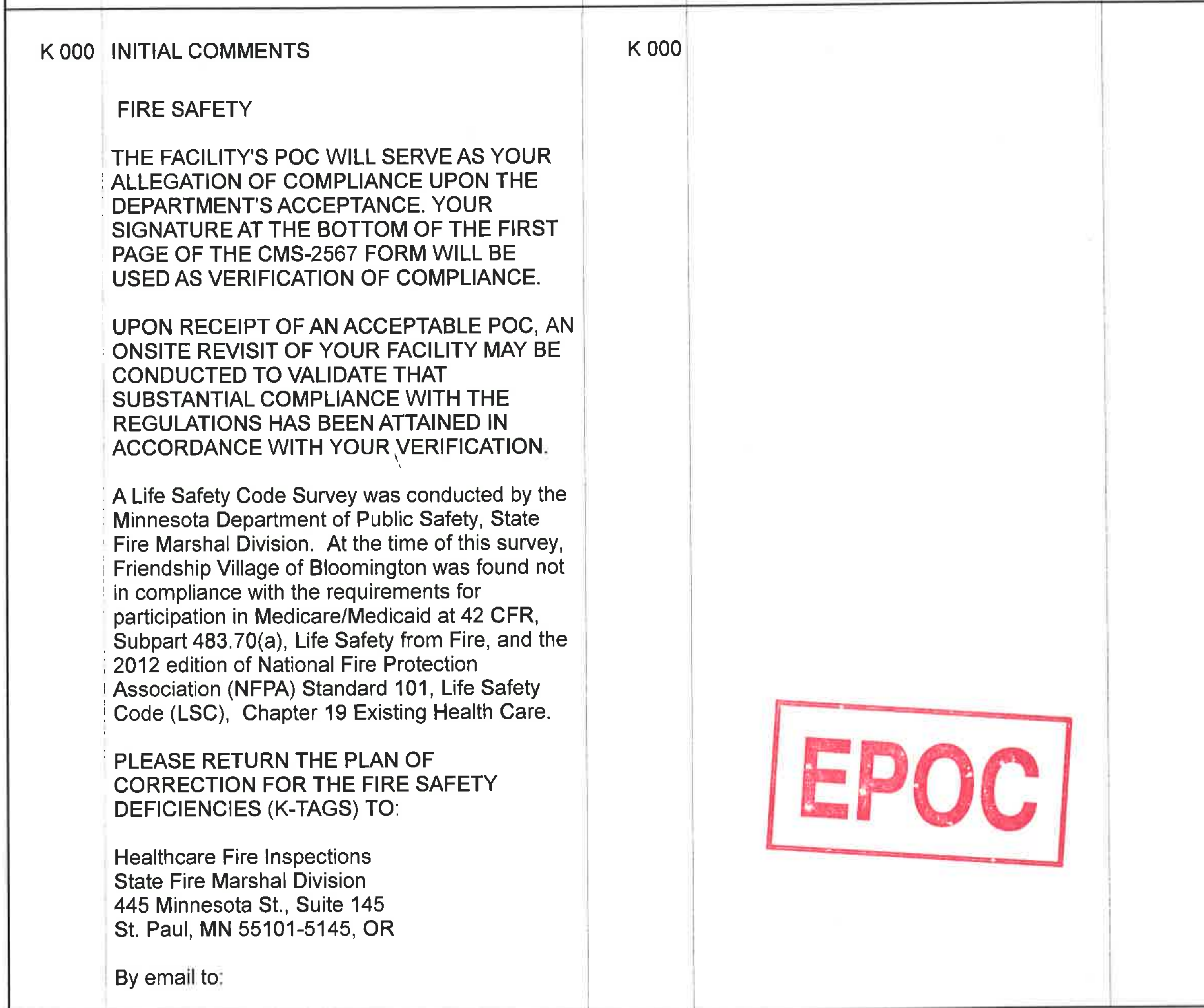
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

F5229026

PRINTED: 07/14/2017
FORM APPROVED
OMB NO. 0938-0391

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 ______	**06/14/2017**

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



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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, State Fire Marshal Division. At the time of this survey, Friendship Village of Bloomington was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 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		07/11/2017

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.

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K 000	Continued From page 1 Marian.Whitney@state.mn.us and Angela.Kappenman@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 1-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. 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 57 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is **NOT MET** as evidenced by:	K 000		
K 211 SS=E	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges,	K 211		7/28/17

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

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K 211	Continued From page 2 exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This **STANDARD** is not met as evidenced by: Based on observation and interview, the Facility failed to be in accordance with Chapter 7, which states, all means of egress is to be continuously maintained free of all obstructions to full use in case of emergency. This deficient practice could affect 57of the 57 residents. Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 FINDINGS INCLUDE: On facility tour between 10:00 AM and 2:00 PM on 06/14/2017, observation revealed the exit from the Family Dining Room was observed impeded by a table being placed directly in front of the exit door. This deficient practice was verified by the Facility Maintenance Director.	K 211	The statements made in the Plan of Correction do no 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 Federal and State Laws. K211: It is the policy of Friendship Village to maintain clear means of egress. The table that was blocking the exit door was immediately moved to ensure clear egress. Janitors will be re-educated on maintaining a clear means of egress by July 28th, 2017. To ensure on-going compliance, audits will be conducted during the 3rd Quarter of 2017 and reported to the Quality Assurance Performance Improvement (QAPI) committee. The Maintenance Director will be responsible for ensuring future compliance.	

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K 211	Continued From page 3	K 211	Date certain 7/28/17	
K 324 SS=F	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This STANDARD is not met as evidenced by: Based on documentation review and interview the Facility did not ensure that the cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations. This deficient practice could effect 57 of the 57 residents.	K 324	K324: To ensure ongoing compliance, the kitchen fire suppression inspection has been added to the preventive maintenance software system calendar as of July 7th, 2017. In addition, the current vendor was contacted on June 14th, 2017	7/28/17

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K 324	Continued From page 4 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2. FINDINGS INCLUDE: On facility tour between 10:00 AM and 2:00 PM on 06/14/2017, during documentation review, it was revealed that documentation could not be located to show that the kitchen fire suppression system was inspected was not inspected within the required time frame. The dates of inspection were 05/19/2016 and 02/22/2017 which is not within the 6 month inspection requirement. This deficient practice was verified by the Facility Maintenance Director.	K 324	and re-educated of the required timeframe of contracted service. The required kitchen fire suppression inspection will be performed in the required time frame by a qualified vendor, monitored by the Maintenance Director and reported to the Quality Assurance Performance Improvement (QAPI) committee for the 4th Quarter of 2017. The Maintenance Director will be responsible for ensuring future compliance. Date certain 7/28/17	
K 521 SS=F	NFPA 101 HVAC	K 521		7/28/17

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K 521	Continued From page 5 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This STANDARD is not met as evidenced by: Based on documentation review and interview, the Facility failed to ensure that the fire/smoke dampers were maintained according to 9.2 and in accordance with the manufacturer's specifications. The deficient practice could affect 57 out of 57 residents. HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 FINDINGS INCLUDE: On facility tour between 10:00 AM and 2:00 PM on 06/14/2017, documentation could not be provided that indicated the fire/smoke damper test had occurred within the past 4 years. This deficient practice was verified by the Facility Maintenance Director.	K 521	K521: Service for the fire dampers has been scheduled and will be completed by July 28th, 2017. To ensure ongoing compliance, the testing of fire dampers on HVAC systems has been added to the preventive maintenance software system calendar as of July 7th, 2017. The required fire dampers on HVAC systems will be performed in the required time frame by a qualified vendor, monitored by the Maintenance Director and reported to the Quality Assurance Performance Improvement (QAPI) committee for the 3th Quarter of 2017. The Maintenance Director will be responsible for ensuring future compliance. Date certain 7/28/17	

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
July 3, 2017

Ms. Jennifer Bever, Administrator
Friendship Village Of Bloomington
8100 Highwood Drive
Bloomington, MN 55438

Re: Enclosed State Boarding Care Home Licensing Orders - Project Numbers S5229027, H5229023

Dear Ms. Bever:

The above facility survey was completed on June 15, 2017 for the purpose of assessing compliance with Minnesota Department of Health Boarding Care Home Rules and to investigate complaint number H5229023 that was found to be unsubstantiated. 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 electronically delivered Minnesota Department of Health order form. 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 contact Maria King, RN, APM at (507) 344-2716 or maria.king@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 with any questions related to this letter.

Sincerely,

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

Enclosure(s)

cc: Licensing and Certification File

Minnesota Department of Health

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 ________	06/15/2017

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	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 12th, 13th, 14th and 15th, 2017 surveyors of this Department's staff, visited the above provider and the following correction order is issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota

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3 000	Continued From page 1 Department of 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		
3 601	MN St. Statute 144.56 Subp. 2c Tuberculosis Prevention And Control	3 601		7/30/17

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3 601	Continued From page 2	3 601		

(a) A boarding care home must establish and 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 administer TST (Tuberculosis skin tests) in an appropritate time frame, and failed to properly document the interpretation of the TST for 3 of 3 residents hired since the last survey (R4, R9, R10) in accordance with currently accepted standards.

corrected

Findings include:

The Friendship Village of Bloomington current Resident Information Sheet verified R4 was

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3 601	Continued From page 3	3 601		

admitted to the facility on 1/10/17. The Tuberculosis (TB) Test History Sheet indicated R4 received a first-step TST on 1/11/17which was read on 1/13/17. the results were negative and showed 0.00 mm (milimeter) induration. The second-step TST was given on 1/25/17. Although the results stated negative 0.00 mm induration, a "Date Read" was not documented.

On 6/14/17, at 10:10 a.m., medical records (MR) verified the lack of a date on the second TST interpretation, "We do not have a date for the reading. We are in the process of 're-doing' her mantoux. We are getting orders now."

R9's immunization record indicated R9 had received a second step TST on 4/3/17, however there were no documented results of the TST.

R10's immunization record indicated R10 had received a TST on 1/16/16. The documented reading was not dated, the results did not include documentation of the millimeters of induration, instead only indicated "Negative".

On 6/14/17, at 10:00 a.m. the medical records (MR) staff verified the above information.

The policy provided by the facility dated 5/26/15, indicated, "Responsibility for the TB infection control program is assigned to the Director of Nursing. The Director of Nursing is given the authority to implement and enforce TB infection control policies and procedures... tests will be administered, read and interpreted in accordance with current guidelines..."

SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or her designee could develop systems to ensure TB screenings are

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3 601	Continued From page 4 completed according to the Center for Disease Control recommendations. The DON or her designee could educate all appropriate staff on these systems. The DON or her designee could develop monitoring systems tto ensure ongoing complianc TIME PERIOD FOR CORRECTION: Twenty One (21) days	3 601		

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
July 3, 2017

Ms. Jennifer Bever, Administrator
Friendship Village Of Bloomington
8100 Highwood Drive
Bloomington, MN 55438

Re: Enclosed State Nursing Home Licensing Orders - Project Numbers S5229027, H5229023

Dear Ms. Bever:

The above facility was surveyed on June 12, 2017 through June 15, 2017 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes and to investigate complaint number H5229023 that was found to be unsubstantiated. 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 or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 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 and/or statute 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 order 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 Minnesota Department of Health State Form and are being delivered 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 or rule after the statement, "This MN Requirement 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 contact Maria King, RN, APM at (507) 344-2716 or maria.king@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.

Please feel free to call me with any questions.

Sincerely,

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

cc: Licensing and Certification File

Minnesota Department of Health

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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: 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	2 000		

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

Electronically Signed | | 07/11/17

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2 000	Continued From page 1	2 000		

Department of Health orders being submitted to you electronically. 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.

On dates 6/12, 6/13, 6/14 and 6/15/17, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.

An investigation of complaints [H5229023] were completed. The complaint was unsubstantiated.

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 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,

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2 000	Continued From page 2 "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.	2 000		
2 302	MN State Statute 144.6503 Alzheimer's disease or related disorder train ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING: MN St. Statute 144.6503 (a) If a nursing facility serves persons with Alzheimer's disease or related disorders, whether in a segregated or general unit, the facility's direct care staff and their supervisors must be trained in dementia care. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and related disorders; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; and (4) communication skills. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. (d) The facility shall document compliance with this section.	2 302		7/28/17

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2 302	Continued From page 3	2 302		

This MN Requirement is not met as evidenced by:
Based on interview and document review, the facility failed to ensure consumers were provided information regarding dementia training as required which had the potential to affect any of the residents and/or their representatives.

corrected

Findings include:

During a review of the facility's Alzheimer training program, there was no evidence consumers (residents and their representatives) were provided a description of the facility's Alzheimer training program, categories of employees trained, frequency of training and the basic topics covered.

On 6/14/17, a request was made of facility administration for evidence that consumers were informed regarding the facility's Alzheimer training program. No information was provided.

During an interview on 6/15/17, at 9:15 a.m. the administrator stated that although the facility completed annual Alzheimer's training for employees, they did not have documentation of their Alzheimer's training to provide for consumers. The administrator also verified no such information had been posted in the facility nor provided in resident admission package informaiton.

SUGGESTED METHOD OF CORRECTION: The DON or designee could add information regarding Alzheimer's staff training to the resident admission packet or post within the facility for consumer information.

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2 302	Continued From page 4 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 302		
21095	MN Rule 4658.0650 Subp. 4 Food Supplies; Storage of Nonperishable food Subp. 4. Storage of nonperishable food. Containers of nonperishable food must be stored a minimum of six inches above the floor in a manner that protects the food from splash and other contamination, and that permits easy cleaning of the storage area. Containers may be stored on equipment such as dollies, racks, or pallets, provided the equipment is easily movable and constructed to allow for easy cleaning. Nonperishable food and containers of nonperishable food must not be stored under exposed or unprotected sewer lines or similar sources of potential contamination. The storage of nonperishable food in toilet rooms or vestibules is prohibited. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure food was served at the proper temperature and equipment was maintained and/or stored appropriately to reduce/eliminate the risk of contamination or food borne illness. This had the potential to affect all 57 residents in the facility who received their meals from the kitchen. Findings include: During an initial tour of the kitchen with the assistant director of culinary services (ADC), and the dietary lead (DL) on 6/12/17, at 11:56 a.m.,	21095	corrected	7/30/17

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21095	Continued From page 5	21095		

several sanitation issues were identified:

A box of puff pastries was observed to be open and ready for use in the kitchen freezer. The packaging was unlabeled as to when it had been opened. In addition there was an open bag of carrots that had not been dated when opened. The ADC confirmed these products should have been dated when opened, and should have been sealed when placed back in the freezer.

Ready to use pans were observed stored on racks in the kitchen. Several pans were observed to be stacked wet. Four of six 1/3 size pans were observed to be stacked together while wet. In addition, three of six ½ size pans were observed to be stored wet and stacked on together. The ADC confirmed the pans had been put away wet and stated they should have been dried completely when put away.

Three of seven cutting boards were observed to have deep cut marks with dark debris flakes in the grooves. The ADC confirmed this finding and stated the flakes could be residue from the dishwasher.

A pie server available for use in the utensil drawer was observed to be soiled with a dark colored debris. The ADC confirmed the pie server was dirty and needed to be rewashed.

Uncovered undated dishes of ice cream were observed in the galley freezer on the Linden unit. The ADC verified the dishes of ice cream should have been covered, and dated.

The walk-in refrigerator had a large plastic container containing a dark brown liquid that was not covered or labeled. The ADC stated she

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21095	Continued From page 6	21095		

thought the liquid it was BBQ sauce but was unaware when it had been made, or how long it had been in the refrigerator.

On 6/13/17, at 7:40 a.m. the uncovered/undated dishes of ice cream remained available for use in the Linden dining room freezer. Dietary assistant (DA)-A stated she'd been made aware these needed to be covered and dated but had not yet gotten to it since she'd "been busy".

The facility's undated policy Food Storage, indicated frozen foods and refrigerated items should be stored in airtight containers, wrapped in foil or laminated paper, and should be labeled and dated.

The facility's undated policy Cleaning Schedules, indicated dishes were supposed to be put away dry each morning and night.

On 6/13/17, at 8:00 a.m. DA-A temped food items and stated the pureed eggs were 126 degrees which wasn't hot enough and needed to microwave them to reheat. DA-A stated the temperature "should be 160-161 degrees". DA-A failed to reheat prior to serving residents. DA-A temped 8 different food items and between each item placed the thermometer under running water for no certain time frame or temperature and dried it on the same paper towel after each wash. DA-A stated she was supposed to use wipes but did not have any available.

During interview on 6/13/17, at 9:16 a.m. dietary lead (DL) stated that assistants are to temp the food prior to serving and a reference to appropriate temperatures was available in the kitchen area. DL stated that she expected staff to utilize a thermometer probe wipe to sanitize the

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21095	Continued From page 7	21095		

thermometer in between each food item when temping food.

At 3:07 p.m. the assistant director of culinary services (ADC) stated he expected staff to clean the thermometer after each food item with the alcohol thermometer probe wipe.

The facility's undated policy titled "Food Temperatures" stated "foods will be served at proper temperature to insure food safety". It further directed staff to take the temperature of each pan and reheat or chill the product if they are not appropriate temperatures. Policy indicated that "puree foods should be greater than 150 degrees but preferred of 160-175 degrees". The policy directed staff to re-sanitize the thermometer after each temperature with an alcohol wipe.

SUGGESTED METHOD OF CORRECTION: The dietary director could review and revise food storage policies and procedures. They could provide education to appropriate staff and develop a monitoring system to ensure compliance.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days.