



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
September 8, 2026

Administrator
FRIENDSHIP VILLAGE OF BLOOMINGTON
8130 HIGHWOOD DRIVE
BLOOMINGTON, MN 55438

RE: CCN: 245229
Cycle Start Date: September 2, 2026

Dear Administrator:

On September 2, 2026, the Minnesota Department 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.

A handwritten signature in black ink, appearing to read 'M. Poepping', with a stylized, cursive script.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us



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September 8, 2026

Administrator
FRIENDSHIP VILLAGE OF BLOOMINGTON
8130 HIGHWOOD DRIVE
BLOOMINGTON, MN 55438

Re: Reinspection Results
Event ID: 2CFB51-H2

Dear Administrator:

On September 2, 2026 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on July 29, 2026. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'M. Poepping', with a stylized, cursive script.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
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Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 3, 2026

Administrator
FRIENDSHIP VILLAGE OF BLOOMINGTON
8130 HIGHWOOD DRIVE
BLOOMINGTON, MN 55438

RE: CCN:245229
Cycle Start Date: July 29, 2026

Dear Administrator:

On July 29, 2026, a survey was completed at your facility by the Minnesota Department of Health 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" and/or an "E" tag), i.e., the plan of correction should be directed to:

Lisa Krebs, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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 October 29, 2026 (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 January 29, 2027 (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)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Feel free to contact me if you have questions.

Sincerely,



Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
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August 3, 2026

Administrator

FRIENDSHIP VILLAGE OF BLOOMINGTON

8130 HIGHWOOD DRIVE

BLOOMINGTON, MN 55438

Re: State Nursing Home Licensing Orders

Event ID: 2CFB51-H1

Dear Administrator:

The above facility survey was completed on July 29, 2026 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules 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 https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. 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 immediately contact:

Lisa Krebs, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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 feel free to call me with any questions.



Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245229		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/29/2026	
NAME OF PROVIDER OR SUPPLIER FRIENDSHIP VILLAGE OF BLOOMINGTON				STREET ADDRESS, CITY, STATE, ZIP CODE 8130 HIGHWOOD DRIVE , BLOOMINGTON, Minnesota, 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
F0000	INITIAL COMMENTS On 7/28/26 through 7/29/26, a standard abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed: H52293502C (3108649) with citation issued at F689. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.			F0000			08/11/2026
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to assess a resident's supervision needs, evaluate interventions, and revise the care plan following a significant incident for 1 of 3 residents (R1) reviewed for supervision and accidents. Findings include: R1's admission record dated 2/23/24, indicated R1's diagnoses included Alzheimer's disease with			F0689	Facility timely submits this response and plan of correction pursuant to federal and state law requirements. This response and plan of correction are not admissions or an agreement that a deficiency exists or that the statement of deficiency was correctly cited or factually based, and it is also not to be construed as an admission against interest of the facility, the administrator or any employees, agents or other individuals who participated in the drafting or who may be discussed or otherwise identified in the same. 1. Corrective Action for Resident Affected Resident R1 was immediately reassessed by the interdisciplinary team regarding wandering behaviors, supervision needs, and risk of entering other residents' rooms. A root cause analysis was completed related to the 7/22/26 incident. R1's care plan was revised to include individualized supervision and redirection interventions, including enhanced monitoring, engagement activities, and		08/21/2026

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 reverse for further 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245229		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/29/2026	
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F0689 SS = D	Continued from page 1 late onset, dementia, psychotic disturbance and mood disturbance, generalized weakness, altered mental status, and hallucinations. R1's quarterly Minimum Data Set (MDS) dated 7/03/26, indicated R1 had severe cognitive impairment and required substantial/maximal assistance for toileting, transfers, and ambulation. R1's activities of daily living (ADLs) care plan dated 3/08/24, identified R1 as being at risk for wandering due to disorientation to places. The care plan directed staff to identify patterns of wandering, anticipate and meet the residents' needs, reorientation and supervise R1 as needed. R1's updated ADLs care plan, dated 4/13/26, indicated R1 was known to wander into other residents' rooms. The care plan instructed staff to redirect R1 by offering alternative activities as needed. R1's point of care (POC) records were reviewed for the period of July 15, 2026, through July 22, 2026. The review showed staff completed a scheduled task directing them to provide R1 with a stack of washcloths to fold when R1 was restless or wandering as a means of redirection. R1's point of care (POC) behavior monitoring and intervention task records from 7/15/26 through 7/22/26 reviewed showed staff documented the task as completed and checks "No behavior observed" during the monitoring period. R1's progress note dated 7/14/26 at 12:13 p.m., indicated R1 tended to be most engaged during baking groups and singing groups. The note further indicated R1 was disoriented and wandered often throughout the day. R1's progress note dated 7/22/26 at 8:59 p.m., documented R1 was found sitting naked on the bed of female resident R2 after R2's son alerted staff. The note further indicated R2 was awake, fully clothed, and covered with blanket up to her chest. Review of R1's medical record from April through July 2026 did not identify a comprehensive assessment of R1's wandering behavior to determine the level of supervision needed to prevent R1 from wandering into other residents' rooms, identify behavior patterns, evaluate the effectiveness of existing interventions, or revise interventions following the incident in which R1 was found naked in R2's room.			F0689	Continued from page 1 documentation requirements. Current staff were educated regarding R1's current care plan interventions and supervision expectations. 2. Identification of Other Residents at Risk An audit of residents with diagnoses of dementia, wandering behaviors, exit-seeking behaviors, or a history of entering other residents' rooms was completed. Care plans were reviewed to ensure appropriate interventions were in place for residents identified as "at risk." 3. Systemic Changes The facility revised its process for post-incident reviews involving wandering and supervision concerns. Any significant wandering incident will require: A comprehensive assessment. Root cause analysis. Review and revision of interventions and care plans. Documentation of effectiveness of interventions. Licensed nurses and nursing assistants were educated on resident supervision requirements, wandering interventions, care plan compliance, and reporting responsibilities. The Director of Nursing or Designee will review all wandering-related incidents to ensure interventions are implemented and evaluated for effectiveness. 4. Monitoring		08/21/2026

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F0689 SS = D	Continued from page 2 R2’s physician regulatory visit note dated 7/9/26 identified R2 diagnoses included history of subdural hematoma with decline leading to hospice enrollment, acute confusion change, restlessness and agitation. R2’s quarterly Minimum Data Set (MDS) dated 7/7/26, indicated R2 had severe cognitive impairment and required substantial/maximal assistance for toileting and transfers. During an interview on 7/28/26 at 3:26 p.m., a family member (FM)-A stated during a visit with his mother, R2 on 7/22/26, he observed R1 sitting naked on the edge of R2’s bed. FM-A stated he was shocked by what he observed and immediately went to the nursing station to report the incident to the nursing staff. At the nursing station five staff members were sitting there at the time he made the report. FM-A stated R2 had severe cognitive impairment. When he asked R2 about the incident, she responded “what this man is doing in her room”. FM-A reported he did not believe R2 experienced distress, fear or emotional trauma due to the incident. FM-A explained his primary concern was what interventions the facility was going to implement to increase R1’s supervision in order to prevent reoccurrence. FM-A denied any sexual behavior occurred between R1 and R2. FM-A confirmed the facility informed him they would increase monitoring of R1 by conducting checks every 30 minutes and documenting the increased supervision; however, FM-A expressed concern regarding whether the increased monitoring would be consistently implemented. During an interview on 7/28/26 at 4:47 p.m., nursing assistant (NA)-A stated he was working the evening shift on 7/22/26 when R1 was found naked sitting on R2’s bed. NA-A explained R1 frequently wandered into other residents’ rooms to use their bathrooms. NA-A stated he was at the nursing station when R2’s son found R1 naked sitting in R2’s bed and reported the incident to staff. NA-A stated he did not know how long R1 had been in R2’s room and could not recall when R1 had last been observed. NA-A explained staff were expected to keep R1 within sight at all times. NA-A confirmed he did not receive any education or retraining following the incident. During an interview on 7/28/26 at 4:25 p.m., licensed practical nurse (LPN)-A stated she was working the evening shift on 7/22/26 when R1 was found sitting naked in R2’s bed at approximately			F0689	Continued from page 2 The Director of Nursing or Designee will audit residents with wandering behaviors weekly for four weeks, then monthly for two months to verify: Assessments are completed. Care plans are updated. Interventions are implemented consistently. Required supervision is provided and documented. Audit findings will be reported to the Quality Assurance and Performance Improvement (QAPI) Committee monthly for three months, and corrective action will be taken as indicated.		08/21/2026

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F0689 SS = D	Continued from page 3 5:30 p.m. LPN-A stated this was not the first time R1 had been found in another resident's room. LPN-A stated she recalled a previous incident in which R1 was found lying in another female resident's bed. LPN-A explained nursing staff were expected to reorient R1, provide supervision and keep him engaged in activities in the common area. LPN-A confirmed she did not receive any education or retraining following the incident. During an interview on 7/28/26 at 2:31 p.m., a registered nurse (RN)-A who served as the charge nurse, stated she was informed by LPN-A that R1 had been found sitting naked in R2's bed after the incident was reported by R2's son. RN-A stated she came over to the room to apologize to R2 and her son and removed R1 from the room. RN-A explained R1 had severe cognitive impairment and a history of wandering into other residents' rooms. RN-A stated nursing staff were required to know R1's whereabouts at all times and keep him engaged in the common area. RN-A reported she did not provide staff with any education following the incident regarding R1's wandering behavior or the corresponding interventions needed to ensure R1's safety. RN-A stated she was not sure who updated R1's care plan following the incident. RN-A explained she did not know how long R1 had been in R2's room while unclothed. RN-A confirmed she did not receive any education or retraining related to the incident. During an interview on 7/29/26 at 12:57 p.m., the director of nursing (DON) stated R1 had a history of wandering into other resident's rooms, and the facility had been trying to work with R1's family to determine what interventions might work better for R1. The DON stated she did not know whether each wandering incident had been reviewed to identify the root cause or whether corresponding interventions had been developed to prevent recurrence. The DON stated she expected staff to reorient and supervise R1, ensure he was engaged in activities during each shift. The DON stated she expected staff to complete a comprehensive assessment to determine the root cause of wandering behaviors. The DON stated she did not know how long R1 had been naked in R2' bed. The DON confirmed the facility did not complete a root cause analysis following the incident and did not provide staff education regarding appropriate supervision. The DON stated she could not find any documentation about whether or not the facility had evaluated the effectiveness of interventions implemented for R1. The Facility Safety and Supervision of Residents			F0689			08/21/2026

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F0689 SS = D	Continued from page 4 Policy dated 10/13/25 indicated resident supervision is a core component of the systems approach to safety. The type and frequency of resident supervision is determined by the individual resident's assessed needs. The policy directed the facility to implement interventions to reduce accident risk by: Communicating specific interventions to all relevant team members; Providing training as necessary; Monitoring the effectiveness of interventions which include evaluating the effectiveness of interventions, modifying or replacing interventions as needed. Ensuring that interventions are implemented correctly and consistently.			F0689			08/21/2026

Minnesota Department of Health

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20000	Initial Comments *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 7/28/26 through 7/29/26, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. The following complaint was reviewed: H52293502C (3108649) with licensing orders issued at 20830. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and			20000			08/11/2026

Office of Primary Care and Health Systems Management

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/29/2026	
NAME OF PROVIDER OR SUPPLIER FRIENDSHIP VILLAGE OF BLOOMINGTON				STREET ADDRESS, CITY, STATE, ZIP CODE 8130 HIGHWOOD DRIVE , BLOOMINGTON, Minnesota, 55438			
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20000	Continued from page 1 therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.		20000			08/11/2026	
20830	Adequate and Proper Nursing Care; General CFR(s): MN Rule 4658.0520 Subp. 1 Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to assess a resident's supervision needs, evaluate interventions, and revise the care plan following a significant incident for 1 of 3 residents (R1) reviewed for supervision and accidents. Findings include: R1's admission record dated 2/23/24, indicated R1's diagnoses included Alzheimer's disease with late onset, dementia, psychotic disturbance and mood disturbance, generalized weakness, altered mental status, and hallucinations. R1's quarterly Minimum Data Set (MDS) dated 7/03/26, indicated R1 had severe cognitive impairment and required substantial/maximal assistance for toileting, transfers, and ambulation. R1's activities of daily living (ADLs) care plan dated 3/08/24, identified R1 as being at risk for wandering due to disorientation to places. The care plan directed staff to identify patterns of wandering, anticipate and meet the residents' needs, reorientation and supervise R1 as needed. R1's updated ADLs care plan, dated 4/13/26, indicated R1 was known to wander into other residents' rooms. The care plan instructed staff to redirect R1 by offering alternative activities as needed. R1's point of care (POC) records were reviewed for the period of July 15, 2026, through July 22, 2026.		20830	Facility timely submits this response and plan of correction pursuant to federal and state law requirements. This response and plan of correction are not admissions or an agreement that a deficiency exists or that the statement of deficiency was correctly cited or factually based, and it is also not to be construed as an admission against interest of the facility, the administrator, or any employees, agents, or other individuals who participated in the drafting or who may be discussed or otherwise identified in the same. 1. Corrective Action for Resident Affected Resident R1 was immediately reassessed by the interdisciplinary team regarding wandering behaviors, supervision needs, and risk of entering other residents' rooms. A root cause analysis was completed related to the 7/22/26 incident. R1's care plan was revised to include individualized supervision and redirection interventions, including enhanced monitoring, engagement activities, and documentation requirements. Staff were educated regarding R1's current care plan interventions and supervision expectations. 2. Identification of Other Residents at Risk An audit of residents with diagnoses of dementia, wandering behaviors, exit-seeking behaviors, or a history of entering other residents' rooms was completed. Care plans were reviewed to ensure appropriate interventions were in place for residents identified as "at risk." 3. Systemic Changes		08/21/2026	

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20830	Continued from page 2 The review showed staff completed a scheduled task directing them to provide R1 with a stack of washcloths to fold when R1 was restless or wandering as a means of redirection. R1's point of care (POC) behavior monitoring and intervention task records from 7/15/26 through 7/22/26 reviewed showed staff documented the task as completed and checks "No behavior observed" during the monitoring period. R1's progress note dated 7/14/26 at 12:13 p.m., indicated R1 tended to be most engaged during baking groups and singing groups. The note further indicated R1 was disoriented and wandered often throughout the day. R1's progress note dated 7/22/26 at 8:59 p.m., documented R1 was found sitting naked on the bed of female resident R2 after R2's son alerted staff. The note further indicated R2 was awake, fully clothed, and covered with blanket up to her chest. Review of R1's medical record from April through July 2026 did not identify a comprehensive assessment of R1's wandering behavior to determine the level of supervision needed to prevent R1 from wandering into other residents' rooms, identify behavior patterns, evaluate the effectiveness of existing interventions, or revise interventions following the incident in which R1 was found naked in R2's room. R2's physician regulatory visit note dated 7/9/26 identified R2 diagnoses included history of subdural hematoma with decline leading to hospice enrollment, acute confusion change, restlessness and agitation. R2's quarterly Minimum Data Set (MDS) dated 7/7/26, indicated R2 had severe cognitive impairment and required substantial/maximal assistance for toileting and transfers. During an interview on 7/28/26 at 3:26 p.m., a family member (FM)-A stated during a visit with his mother, R2 on 7/22/26, he observed R1 sitting naked on the edge of R2's bed. FM-A stated he was shocked by what he observed and immediately went to the nursing station to report the incident to the nursing staff. At the nursing station five staff members were sitting there at the time he made the report. FM-A stated R2 had severe cognitive impairment. When he asked R2 about the incident, she responded "what this man is doing in her		20830	Continued from page 2 The facility revised its process for post-incident reviews involving wandering and supervision concerns. Any significant wandering incident will require: A comprehensive assessment. Root cause analysis. Review and revision of interventions and care plans. Documentation of effectiveness of interventions. Licensed nurses and nursing assistants were educated on resident supervision requirements, wandering interventions, care plan compliance, and reporting responsibilities. The Director of Nursing or Designee will review all wandering-related incidents to ensure interventions are implemented and evaluated for effectiveness. 4. Monitoring The Director of Nursing or Designee will audit residents with wandering behaviors weekly for four weeks, then monthly for two months to verify: Assessments are completed. Care plans are updated. Interventions are implemented consistently. Required supervision is provided and documented. Audit findings will be reported to the Quality Assurance and Performance Improvement (QAPI) Committee monthly for three months, and corrective		08/21/2026	

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20830	Continued from page 3 room". FM-A reported he did not believe R2 experienced distress, fear or emotional trauma due to the incident. FM-A explained his primary concern was what interventions the facility was going to implement to increase R1's supervision in order to prevent reoccurrence. FM-A denied any sexual behavior occurred between R1 and R2. FM-A confirmed the facility informed him they would increase monitoring of R1 by conducting checks every 30 minutes and documenting the increased supervision; however, FM-A expressed concern regarding whether the increased monitoring would be consistently implemented. During an interview on 7/28/26 at 4:47 p.m., nursing assistant (NA)-A stated he was working the evening shift on 7/22/26 when R1 was found naked sitting on R2's bed. NA-A explained R1 frequently wandered into other residents' rooms to use their bathrooms. NA-A stated he was at the nursing station when R2's son found R1 naked sitting in R2's bed and reported the incident to staff. NA-A stated he did not know how long R1 had been in R2's room and could not recall when R1 had last been observed. NA-A explained staff were expected to keep R1 within sight at all times. NA-A confirmed he did not receive any education or retraining following the incident. During an interview on 7/28/26 at 4:25 p.m., licensed practical nurse (LPN)-A stated she was working the evening shift on 7/22/26 when R1 was found sitting naked in R2's bed at approximately 5:30 p.m. LPN-A stated this was not the first time R1 had been found in another resident's room. LPN-A stated she recalled a previous incident in which R1 was found lying in another female resident's bed. LPN-A explained nursing staff were expected to reorient R1, provide supervision and keep him engaged in activities in the common area. LPN-A confirmed she did not receive any education or retraining following the incident. During an interview on 7/28/26 at 2:31 p.m., a registered nurse (RN)-A who served as the charge nurse, stated she was informed by LPN-A that R1 had been found sitting naked in R2's bed after the incident was reported by R2's son. RN-A stated she came over to the room to apologize to R2 and her son and removed R1 from the room. RN-A explained R1 had severe cognitive impairment and a history of wandering into other residents' rooms. RN-A stated nursing staff were required to know R1's whereabouts at all times and keep him engaged in the common area. RN-A reported she did not provide staff with any education following the			20830	Continued from page 3 action will be taken as indicated.		08/21/2026

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20830	Continued from page 4 incident regarding R1's wandering behavior or the corresponding interventions needed to ensure R1's safety. RN-A stated she was not sure who updated R1's care plan following the incident. RN-A explained she did not know how long R1 had been in R2's room while unclothed. RN-A confirmed she did not receive any education or retraining related to the incident. During an interview on 7/29/26 at 12:57 p.m., the director of nursing (DON) stated R1 had a history of wandering into other resident's rooms, and the facility had been trying to work with R1's family to determine what interventions might work better for R1. The DON stated she did not know whether each wandering incident had been reviewed to identify the root cause or whether corresponding interventions had been developed to prevent recurrence. The DON stated she expected staff to reorient and supervise R1, ensure he was engaged in activities during each shift. The DON stated she expected staff to complete a comprehensive assessment to determine the root cause of wandering behaviors. The DON stated she did not know how long R1 had been naked in R2' bed. The DON confirmed the facility did not complete a root cause analysis following the incident and did not provide staff education regarding appropriate supervision. The DON stated she could not find any documentation about whether or not the facility had evaluated the effectiveness of interventions implemented for R1. The Facility Safety and Supervision of Residents Policy dated 10/13/25 indicated resident supervision is a core component of the systems approach to safety. The type and frequency of resident supervision is determined by the individual resident's assessed needs. The policy directed the facility to implement interventions to reduce accident risk by: Communicating specific interventions to all relevant team members; Providing training as necessary; Monitoring the effectiveness of interventions which include evaluating the effectiveness of interventions, modifying or replacing interventions as needed. Ensuring that interventions are implemented correctly and consistently. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review/revise policies and procedures related to			20830			08/21/2026

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20830	Continued from page 5 accidents and resident supervision to ensure proper assessment and interventions are being implemented. The DON or designee could re-educate staff on this policies and procedures, and audit periodically to ensure the needs of resident(s) are maintained. The DON or designee could perform measurable audits and report the findings of those audits to the Quality Assessment and Performance Improvement (QAPI) committee to ensure compliance and determine the need for further improvement. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.			20830			08/21/2026