

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

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(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, MN 55438	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE], 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. 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 [DATE], 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 (continued on next page)		

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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 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 (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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.		