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	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Friendship Village of Bloomington	8130 Highwood Drive Bloomington, MN 55438

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42584 Based on interview and document review, the facility failed to inform in advance and obtain consent for psychotropic medication use for 1 of 5 residents reviewed for unnecessary medications. Findings include: R22's annual Minimum Data Set (MDS) dated [DATE], indicated R22 had severe cognitive impairment, felt down, depressed or hopeless 2-6 days of the 14 day look back period, required moderate to substantial assistance with most activities of daily living (ADLs) and was taking antipsychotic and antidepressant medication. R22's diagnoses included Alzheimer's, dementia, depression and hallucinations. R22's care plan dated 2/25/25, indicated R22 used antipsychotic and antidepressant medications and was at risk for behaviors related to hallucinations. R22's March, 2025 medication administration record (MAR) indicated: Escitalopram Oxalate Oral Tablet 5 MG (Lexapro). Give 1 tablet by mouth one time a day for anxiety AEB (as evidenced by) reports of anxiety, restless physical movements, repetitive questions about going to work or home, reports of visual hallucinations. R22's physician order indicated Lexapro original start date was 7/4/24. R22's electronic medical record lacked evidence of an informed consent for Lexapro. During interview on 3/27/25 at 10:09 a.m., licensed practical nurse (LPN)-A stated any resident on a psychotropic medication should have been informed of risks and benefits and have a signed informed consent by self or representative. During interview on 3/27/25 at 11:16 a.m., director of nursing (DON) stated expectation R22, or representative should have been provided informed consent for any psychotropic prior to starting the medication and that signed consent should be in the resident chart. During interview on 3/27/25 at 1:54 p.m., consultant pharmacist (CP) stated R22 should have a signed consent for each of the psychotropic medications currently taking. (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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 3/27/25 at 3:21 p.m., SS-A stated unable to locate a consent for Lexapro in R22's chart. Facility policy Antipsychotic Medication Use dated July 2022, indicated, Residents [and/or resident representatives] will be informed of the recommendation, risks, benefits, purpose and potential adverse consequences of antipsychotic medication use.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42584 Based on observation, interview, and document review, the facility failed to ensure activities of daily living (ADLs) were completed, including shaving for 1 of 1 resident (R22) reviewed for grooming. Findings include: R22's annual Minimum Data Set (MDS) dated [DATE], indicated R22 had severe cognitive impairment, required partial to moderate assistance with personal hygiene including shaving, and did not exhibit rejection of care. R22's diagnoses included Alzheimer's, dementia, lack of coordination, and need for assistance with personal cares. R22's care plan dated 2/25/25, indicated R22 had an ADL self-care deficit related to diagnoses and impaired balance. The care plan instructed staff to assist R22 with personal hygiene and cares. R22's Kardex printed 3/25/25, indicated R22 required assistance with cares and instructed staff to keep his routine as consistent as possible. R22's shaving task dated 2/24/25 through 3/24/25 indicated, Resident *MUST* be shaved. A check mark was documented once each day under the Yes column. R22's March 2025, treatment administration record (TAR) indicated, Document if resident was shaved . A check mark and yes or Y was documented twice a day each day in March through day shift on 3/25/25. During observation and interview on 3/24/25 at 1:38 p.m., R22 stated he preferred to be clean shaven and usually shaved every day. R22 had several day's growth of facial hair. During observation on 3/25/25 at 1:05 p.m., R22 was sitting in the dining room eating lunch. R22 was not shaved and had a several day's growth of facial hair. During interview on 3/25/25 at 2:36 p.m., nursing assistant (NA)-A stated NAs were responsible to assist residents with shaving per their preferences. If a resident preferred to shave daily, the NAs would assist the resident as needed. NA-A stated R22 could shave himself but needed assistance with set up and he did like to shave every day. NA-A stated the NAs had a task sheet on their iPad that they would sign off when specific tasks were completed. NA-A stated tasks should not be signed off as completed if not actually done. During interview on 3/25/25 at 2:58 p.m., registered nurse (RN)-A stated NAs were responsible to complete showers and other personal cares such as shaving with the residents, and they should be signing the task off when completed. RN-A confirmed there was a task in R22's TAR for the nurse to sign off to ensure R22 was shaved and could not explain why it was signed off when R22 had not been shaved. RN-A stated occasional residents would refuse some cares and that refusals should be documented as such in the TAR. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 3/25/25 at 3:07 p.m., director of nursing (DON) stated expectation tasks should only be signed off as completed if actually done otherwise refusals or other reasons not completed should be documented. DON further stated expectation R22 would be clean shaven per his preference, but thought there might have been an issue with his shaver. Facility policy Activities of Daily Living (ADLs), Supporting dated March, 2018, indicated residents will be provided with care and services appropriate to maintain their ability to perform ADLs. Those residents who were unable to perform ADLs independently would receive services necessary to maintain good grooming and personal hygiene.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42584 Based on observation, interview, and document review, the facility failed to ensure wounds were accurately assessed and reported appropriately when thought to be deteriorating for 1 of 3 residents reviewed for wound assessment and monitoring. Findings include: R32's quarterly Minimum Data Set (MDS) dated [DATE], indicated R32 had severe cognitive impairment, required substantial/maximal assistance with personal cares and mobility, was always incontinent of bowel and bladder, was at risk for developing pressure ulcers but did not have any at the time of the assessment. The MDS further indicated R32 did not exhibit physical or verbal behaviors towards others and did not reject cares. R32's diagnoses included dementia, type 2 diabetes, congestive heart failure, and kidney disease. R32's care plan revised 12/31/24, indicated R32 had potential for pressure ulcer development related to immobility, incontinence, and diabetes. The care plan instructed staff to monitor/document/report PRN [as needed] any changes in skin status: appearance, color, wound healing, s/sx [signs/symptoms] of infection, wound size [length x width x depth], stage. R32's Kardex printed 3/27/25, indicated, Follow facility policies/protocols for the prevention/treatment of skin breakdown. R32's BRADEN (assessment for predicting skin breakdown risk) dated 2/24/25, indicated R32 was at moderate risk for developing a pressure ulcer. R32's skin check dated 2/26/25, indicated R32 had four skin issues: - bruising on left outer forearm, in-house acquired, wound is new - skin tear on left outer forearm, in-house acquired, wound is new - skin tear on left outer forearm, in-house acquired - abrasion on left gluteal fold, in-house acquired R32's skin check dated 3/5/25, indicated R32 had seven skin issues: -bruising on left outer forearm, stable, in-house acquired, unknown how long wound present - skin tear on left outer forearm, in-house acquired, wound is new - skin tear on left outer forearm, in-house acquired - abrasion on left gluteal fold, in-house acquired (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- skin tear on left outer wrist, in-house acquired, wound is new - scab, in-house acquired, unknown how long wound present, length 1cm, width 1cm - stage 2 pressure ulcer (partial-thickness skin loss involving the epidermis and/or dermis, presents as a shallow open ulcer, blister, or abrasion) on buttocks, increased exudate (fluid that leaks out of blood vessels into surrounding tissue), in-house acquired, unknown how long wound present, wound not measured due to resident being combative. R32's skin check dated 3/12/25, indicated three previous skin tear issues and one scab resolved. The other four skin issues indicated: - stage 2 pressure ulcer-progress deteriorating on buttocks 3.4cm x 3cm x 0.1cm - bruising on left outer forearm - abrasion on left gluteal fold-progress stalled R32's skin check dated 3/19/25, indicated three skin issues: - stage 2 pressure ulcer on buttocks-partial thickness skin loss with exposed dermis (no measurements) - bruising on left outer forearm - abrasion on left gluteal fold R32's March 2025, treatment administration record (TAR) indicated, Left gluteal fold treatment: Cleanse with wound cleaner, pat dry and cover with Mepilex Border until healed every evening shift. Update provider with any concerns. Start date 2/15/25 (still active) and signed off as being completed every evening shift 3/1/25 through 3/26/25. R32's TAR further indicated left forearm skin tear wound care orders start date 2/4/25 and discontinued date 3/7/25. R32's TAR lacked evidence of any further active or discontinued wound treatment orders. R32's electronic medical record (EMR) lacked evidence of any wound care team weekly rounding notes for any current skin issues. During observation and interview on 3/25/25 at 2:55 at p.m., nursing assistant (NA)-A was overheard requesting a new patch for R32 from a nurse. When interviewed, NA-A stated (R32) had a pressure wound on his backside and the patch was to keep it covered and protected. During observation and interview on 3/27/25 at 9:52 a.m., NA-B and NA-C into R32's room for a brief check and transfer. R32's wet and bm soiled brief removed and personal care completed. An uncovered nickel-sized open area (top layer of skin removed) was observed on R32's left gluteal fold. NA-C stated there should be Mepilex dressing covering the open area and could not explain why it was missing. NA-B stated thinking R32's wound had been open like this for 1-2 weeks. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 3/27/25 at 11:05 a.m., licensed practical nurse (LPN)-A stated R32's wound on his buttock and on the left gluteal fold were actually the same wound and had probably been labeled wrong in documentation. LPN-A stated thinking the wound was from friction-sliding off his wheelchair-and not a pressure ulcer. LPN-A stated could not remember the last time she laid eyes on R32's bottom and was not aware of any open areas. LPN-A stated R32 was not receiving weekly wound rounds and only getting weekly skin checks by the assigned nurse. LPN-A stated expectation for staff to report any changes or new skin areas. LPN-A stated skin status changes could result in new orders for treatment and weekly wound round monitoring for wound pictures and measurements. During interview on 3/27/25 at 11:27 a.m., director of nursing (DON) stated was not aware of any open areas on R32's buttock. DON stated all newly identified skin issues should have been reported to LPN-A. DON stated if a new stage 2 pressure ulcer had been identified and reported, the provider would be updated and new orders for treatment and wound round inclusion would potentially be initiated. DON stated all wounds should be rounded on and tracked for status changes with a goal for the wound to heal or at minimum not to deteriorate. During observation and interview on 3/27/25 at 11:44 a.m., LPN-A, registered nurse (RN)-D and DON entered R32's room to evaluate his wound status. LPN-A stated there was one wound on R32's bottom and it appeared superficial with granulation. LPN-A stated the wound bed and surrounding tissue were blanchable and did not feel it was a stage 2 pressure ulcer. RN-A and DON agreed with LPN-A's assessment. R32 appeared cooperative while wound pictures and measurements were taken. During interview on 3/27/25 at 12:15 p.m., LPN-C stated had just placed new dressing on R32's bottom this morning after NAs reported it missing. LPN-C stated had not worked with R32 in a while and could not identify the type of wound or how long it had been open. During interview on 3/27/25 at 3:32 p.m., nurse practitioner (NP) stated was initially informed of a friction abrasion on R32's bottom and had provided treatment orders. NP stated had not received any notification that the wound had changed or deteriorated or that there were any new pressure ulcers. NP stated had she been notified of any changes; she would have potentially provided new treatment orders and would expect R32 to be included on weekly wound care team rounds. Facility policy Change in a Resident's Condition of Status dated 2/2021, indicated, Our facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status. Facility policy Wound Care dated 4/1/22, indicated the facility would utilize evidence-based clinical practices to provide pressure injury and wound treatments in our skilled nursing and rehabilitation health centers.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49617 Based on observation, interview and document review, the facility failed to ensure hand hygiene was performed for 1 of 3 residents (R24) observed during personal cares and 1 of 1 residents (R24) observed during wound cares. Furthermore, the facility failed to ensure enhanced barrier precautions (EBP) were followed for 1 of 1 residents (R24) observed for EBP. Findings include: R24's quarterly Minimum Data Set, dated dated [DATE], indicated he had intact cognition and required partial to moderate assistance with personal hygiene. The MDS reported diagnoses of kidney failure, high blood pressure, depression and chronic pain. The MDS also reported his use of an indwelling urinary catheter and identified he had one venous ulcer. R24's care plan identified his catheter use and need for EBP. The care plan also indicated he had an activities of daily living (ADL) self-care performance deficit related to his left leg amputation and limited mobility. The care plan directed staff to provide extensive assistance with personal hygiene. Furthermore, the care plan reported a venous/stasis ulcer to his left shin and identified a goal to be free from signs and/or symptoms of infection. R24's treatment administration record (TAR) dated 3/27/25, indicated the following wound care order: - wound on right lower leg, cleanse with wound cleanser. Leave on bed 1 - 5 min. [sic, minutes] Apply skin prep to peri wound skin. Allow to dry completely (not tacky). Then apply thin layer, Xeroform over open leg wound. Only apply on wound bed. Cover with ABD Pad. Hold in place with Kerlix. Apply a white wound sock over Kerlix before applying low stretch wrap to his foot to help with edema two times a day. Hand Hygiene and Personal Cares (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation on 3/26/25 at 11:35 a.m., R24 was lying in bed and nursing assistant (NA)-D and NA-E were performing personal cares with gowns and gloves on. NA-E set up a basin with water and washcloths at the bedside. The NAs helped R24 remove his hospital gown over his head and then pulled down his incontinence brief. NA-E used one hand to secure the catheter tubing while using the other hand to wash his peri-area. NA-E used a new corner of a folded washcloth to wipe his groin and then each thigh/inner leg. Next, NA-E used a new washcloth to wipe down each of R24's legs, starting at his hip level and wiping down. NA-E did not change gloves or perform hand hygiene. NA-D assisted him onto his left, and he grabbed the grab bar with his hands and pulled himself over. R24 had a tan-colored foam dressing covering his coccyx and the bottom portion of the dressing was not intact. Continuing with the same gloves, NA-E used a new washcloth to wipe his back, then cleansed his buttocks. NA-E rolled the briefs and linen under his body and using the same gloved hands, applied cream to his bottom and around the foam dressing. Next, R24 was assisted to turn over the pile of rolled briefs and linen onto his other side and NA-D pulled the linen and briefs through so he could lay flat on his back again. NA-D fastened the tabs on the brief and NA-E doffed the gloves before donning new gloves without performing hand hygiene. Together, the NAs helped guide his arms into his t-shirt and pulled it over his head and pulled it down in the back. The NAs assist him onto his back per his comfort and NA-E gave him a washcloth for him to wash his hands. Per interview on 3/26/25 at 11:52 a.m., NA-E stated to prevent the spread of infection, staff should perform hand hygiene before entering a resident's room, during resident cares, and with any glove change. NA-E also stated staff should wear appropriate personal protective equipment (PPE). NA-E verified staff should wash in a clean to dirty manner or change gloves between dirty and clean during personal hygiene cares. NA-E confirmed a missed opportunity for hand hygiene during cares when going from dirty to clean and not changing gloves. Hand Hygiene, EBP and Wound Care (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation of wound care on 3/27/25 at 10:32 a.m., registered nurse (RN)-C knocked and entered R24's room without a gown or gloves on and asked him if wound cares could be performed. He was agreeable and RN-C donned clean gloves but not a gown. RN-C placed an absorbent pad underneath his right leg and began removing the tape and wrapped gauze from his wound. R24 asked RN-C if he could have pain medication and RN-C offered to bring him his medication before starting the dressing change. He stated he would prefer to have his pain medication first. RN-C finished removing the wrapped gauze, leaving the padded dressing to cover his leg wound, doffed the gloves the doorway and exited the room. At 10:41 a. m., RN-C knocked and entered the room with a paper medication cup. RN-C assessed his pain and gave him the cup before going to the bathroom and performing hand washing. RN-C donned clean gloves but did not don a gown. At his bedside, RN-C sprayed wound cleanser over the padded dressing to remove it, then removed the yellowed-colored petroleum dressing from the wound beds. RN-C asked R24 how he was feeling and, with the same gloved hands, began to spray the wound with the wound cleanser before patting it dry with clean, dry gauze. RN-C repeated the spray and patting dry with gauze three times. Next, RN-C doffed the gloves, performed handwashing at the bathroom sink, and donned clean gloves. RN-C then applied liquid from a blue bottle labeled Vashe to a clean gauze and dabbed it onto each wound bed on R24's right shin. With gloved hands, RN-C walked over to his dresser and opened the top drawer, then closed the drawer and came back to his bedside and began applying more of the Vashe to the gauze, then dabbing it onto his wound beds. RN-C explained the Vashe had to dry for 5 minutes before it could be covered with the padded dressing. R24 asked for a drink of water, and RN-C assisted him lifting his water pitcher to his mouth with the same gloved hands. RN-C conversed with him about the TV program he was watching and doffed the gloves, did not perform hand hygiene and donned new gloves. RN-C cut new pieces of the petroleum gauze and laid them overtop the wound beds on his right shin. Next, RN-C applied the padded dressing, then wrapped his right lower leg with the rolled gauze. As RN-C was about to tear a piece of tape off the roll, the petroleum gauze fell on to the floor and with gloved hands, RN-C picked up the dressing from the floor and threw it away in the garbage. Without changing gloves, RN-C tore two pieces of tape from the roll and applied them to the wrapped gauze on R24's leg. RN-C then doffed gloves and performed hand washing at the sink. Per interview on 3/27/25 at 10:59 a.m. with RN-C, hand hygiene should be performed before starting resident cares, between glove changes, if gloves are soiled, and when finished with cares. RN-C verified R24 was on EBP and stated staff were expected to wear gown and gloves when performing wound care and catheter care. RN-C stated it was important to perform hand hygiene and follow EBP to prevent the spread of infection and for resident safety. RN-C stated I should have worn a gown during wound cares. RN-C indicated changing gloves during wound care but acknowledged missed hand hygiene opportunities. Per interview at 3/27/25 at 1:09 p.m. with RN-D, a nurse lead, and the infection preventionist (IP), staff were expected to perform hand hygiene, or foam in and out, when going in and out of resident rooms and when changing gloves. RN-D and IP expected staff to perform peri-cares in a clean-to-dirty manner or, if gloves become dirty or soiled, to change gloves and perform hand hygiene. RN-D and IP stated PPE for EBP should be worn during wound care and expected staff to perform hand hygiene after going from a dirty dressing or area to a clean dressing or area and with glove changes. Per interview on 3/27/25 at 3:19 p.m. with licensed practical nurse (LPN)-A, staff were expected to perform hand hygiene during personal cares and wound cares in addition to wearing appropriate PPE for a resident on EBP. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Per facility policy titled Handwashing/Hand Hygiene revised 8/19, the facility considered hand hygiene the primary means to prevent the spread of infection and directed staff to perform handwashing when hands were visibly soiled and after contact with a resident with infectious diarrhea. The policy directed staff to use an alcohol-based hand rub (ABHR) or soap and water before and after direct contact with residents, before performing any non-surgical invasive procedures, before and after handling an invasive device (for example, urinary catheters), before handling clean or soiled dressings or gauze pads, before moving from a contaminated body site to a clean body site during reside care, after contact with a resident's intact skin, after contact with blood or bodily fluids, after contact with objects (medical equipment) in the immediate vicinity of the resident, after removing gloves, before and after entering isolation precaution settings, and remove and disposing of PPE. Per facility policy titled Enhanced Barrier Precautions revised 4/5/24, EBP would be implemented for residents with chronic wounds, including pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers. The policy indicated all team members would wear appropriate PPE (gown and gloves) for high-contact resident care, including wound care.