Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL371229162M
Compliance #: HL371223004C

Date Concluded: June 2, 2026

Name, Address, and County of Licensee Investigated:
Friendship Village of Bloomington
8130 Highwood Drive
Bloomington, MN, 55438
Hennepin County

Facility Type: Assisted Living Facility with Dementia Care (ALFDC)

Evaluator's Name: Kris Detsch RN, Special Investigator

Finding: Substantiated, facility responsibility

Nature of Investigation:
The Minnesota Department of Health investigated an allegation of maltreatment, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557, and to evaluate compliance with applicable licensing standards for the provider type.

Initial Investigation Allegation(s):
The facility neglected the resident when they failed to provide medications, food, and daily cares of living.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The resident had cellulitis (skin infection), not recognized by staff which resulted in an extended hospital stay. The resident also required blood work to monitor her hemoglobin levels, but the facility failed to transcribe a provider's order to have this completed. Several days later, when the facility did contact the lab company there was a delay in obtaining the blood draw. During this time, the resident had increased weakness and confusion. The resident's hemoglobin was critically low (life-threatening), she hospitalized, and she required an urgent blood transfusion. In addition, the resident returned to the facility newly diagnosed with Covid -19, but the facility failed to complete the required nursing assessment to determine if she required more support and services. The facility staff failed to provide the

resident meals until two days after her return, failed to do monitor the resident's vitals signs daily during an active infection and failed to monitor the resident for any adverse reactions after receiving a blood transfusion. The resident returned to the hospital five days later with low oxygen levels and a fever.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted a social worker. The investigation included review of the resident records, death record, hospital records, facility internal investigation, facility incident reports, personnel files, and related facility policy and procedures. Also, the investigator toured the facility and observed medication administration, treatments, and facility documentation systems.

The resident resided in an assisted living facility. The resident's diagnoses included pancytopenia (blood disorder with dangerously low red blood cells, white blood cells and platelets), anemia (low hemoglobin) and suspected blood cancer.

The resident's service plan included assistance with bathing, hygiene, dressing, continence care, transferring, and escorts. The service plan indicated the resident required medication management three times daily.

The resident's nursing admission assessment indicated she required escort assistance to and from the facility dining room. The resident was independent with all aspects of meal consumption. The assessment indicated the resident required minimal assistance with dressing and grooming. The resident required "minor" assistance with managing her toileting schedule and only required "occasional" help adjusting her clothing. The resident had bladder incontinence and a history of urinary tract infections (UTI), but was generally continent of bowels. The resident walked with a walker but required "occasional" assistance with transferring. The assessment indicated the resident was hard of hearing and required hearing aids and had "very poor" eyesight due to glaucoma. The resident's assessment indicated her skin was intact.

SKIN CONCERNS

The resident's service delivery record indicated the resident received dressing and grooming assistance twice per day, toileting assistance each shift, a weekly bath and vital sign monitoring once per shift. The services delivery records indicated the resident received her scheduled services and received a bath the day prior to the resident going to the hospital with cellulitis. The service delivery record failed to indicate any discoloration of her skin.

Progress notes lacked indication of any skin concerns. Seven days after admission, a progress note indicated the resident's family member asked the nurse to check on the resident because she appeared more confused. The family member also noticed the resident had an inflamed (red/swollen) area on her leg. A facility nurse called the physician, however, did not get a response, so family decided to send the resident into the hospital. The progress notes indicated

the physician sent orders to a different fax within the facility campus. The resident admitted to the hospital for cellulitis, then left the hospital and admitted into the facilities transitional care unit (TCU).

During an interview, a former nurse manager said the staff are supposed to tell the nurse immediately if they notice changes to the resident's skin and the nurse should complete a skin check.

FAILURE TO IMPLEMENT LAB ORDERS

Progress notes indicated the resident re-admitted into the assisted living 18 days later.

Physician records indicated they suspected the resident had blood cancer, but the resident chose to forgo further diagnostic treatment and evaluation. The records indicated the resident required close monitoring of her lab values (hemoglobin). The records indicated the resident required monthly blood draws.

Physician order records indicated a nurse practitioner (NP) faxed orders to the facility to obtain a hemoglobin lab draw for the resident "today."

Progress notes indicated the day after the NP ordered the lab, the facility failed to complete the resident's required blood draw and lacked explanation why this did not occur. Progress notes indicated the facility notified the NP, who then told them they could delay the blood draw for three days. During this time, progress notes indicated the resident had increased weakness and required extensive assistance with mobility. Progress notes indicated a family member called the resident's provider about the resident's declining health status. The NP ordered a hemoglobin lab draw for the following day.

The facility failed to complete the lab order.

Four days later, the NP wrote another order for the facility to compete a "STAT" (immediate) lab draw. The order indicated the NP required the blood draw as soon as the lab staff was at the facility. The facility obtained the lab draw the following day. The resident's hemoglobin lab draw occurred five days after the NP's initial order.

The resident's medication administration record (MAR) lacked indication the nurse transcribed the initial lab draw for "today." The MAR indicated the facility erroneously transcribed the lab order every day and evening one day before the lab draw occurred. The MAR also then contained an accurately written order on the day the lab draw occurred.

Progress notes indicated the resident's hemoglobin result was critically low, and the resident required an urgent blood transfusion.

During an interview, a former nurse manager said the facility used a company who went to the facility weekly to complete blood draws. The manager said the facility also had other health centers within their campus, so the company could have come to the assisted living area on all other days as well. The manager said the company was “short staffed” and they missed blood draws.

FAILURE TO ASSESS AND MONITOR

Progress notes indicated the resident returned to the facility the following morning after she received the blood transfusion. The resident tested positive for Covid 19 while at the hospital. Upon her return, the facility kept her in her room for Covid precautions. The notes indicated the resident’s family asked the facility to assist the resident with feeding herself. The notes indicated the facility told the family they do not provide feeding assistance. Family assisted the resident with eating.

The licensee failed to update her service delivery records to reflect the need to have staff members bring her meals. Meal service to her room stated two days after her quarantine began.

Resident records indicated the facility failed to complete a nursing assessment to determine what services the resident required to address her changing health status and/or service requirements after she returned to the facility after her blood transfusion and newly diagnosed Covid 19 infection. There was no change to her monthly vital monitoring and the resident’s vitals were not monitored for five days after her return. Additionally, there was a lack of indication the resident was monitored for an adverse reaction after receiving a blood transfusion.

Progress notes lacked further documentation of the resident’s capabilities until five days later when the notes indicated the resident was “not doing good.” The notes indicated the resident vomited continuously and was lethargic (weak/tired). The notes indicated the resident had a fever, low oxygen levels, and difficulty breathing. Emergency responders took the resident to the hospital.

The service plan report inaccurately indicated the resident was independent in all aspects of her meal consumption. The report inaccurately indicated the resident required only minimal assistance with activity of daily living cares.

During investigative interviews, family members said the facility did not provide meals to the resident consistently. Family members said the resident did not receive services as required by her initial service plan such as timely medication management, skin checks, and toileting.

During an interview, a former nurse manager said the facility completed change of condition nursing assessments after a resident stayed overnight in the hospital, but not necessarily if a resident had Covid 19. The nurse manager said completion of a nursing assessment depended

upon how sick a resident was. The former nurse manager said if staff members told the nurses the resident required increased assistance, then the nurse would complete a nursing assessment.

In conclusion, the Minnesota Department of Health determined neglect was substantiated.

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.
“Substantiated” means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
“Neglect” means neglect by a caregiver or self-neglect.
(a) "Caregiver neglect" means the failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:
(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
(2) which is not the result of an accident or therapeutic conduct.

Vulnerable Adult interviewed: No. Deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility investigated family concerns and re-educated staff members.

Action taken by the Minnesota Department of Health:
The responsible party will be notified of their right to appeal the maltreatment finding.

The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:

https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

You may also call 651-201-4200 to receive a copy via mail or email

cc:
The Office of Ombudsman for Long Term Care

The Office of Ombudsman for Mental Health and Developmental Disabilities
Hennepin County Attorney
Bloomington City Attorney
Bloomington Police Department
Minnesota Board of Nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37122	A. BUILDING: _____ B. WING _____	C 04/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP VILLAGE BLOOMINGTON	8130 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
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: HL371223004C/HL371229162M On April 29, 2026, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 70 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for HL371223004C/HL371229162M, tag identification 1620, 2360.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is 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. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
01620 SS=G	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring	01620		

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01620	Continued From page 1 (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in	01620		

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01620	Continued From page 2 the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to assess the medical and service needs after illness for one of one resident (R1) with record reviewed. R1's health declined, and she required urgent hospitalization for a blood transfusion. R1 returned to the licensee with a covid infection. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1 admitted to the licensee for diagnoses including pancytopenia (blood disorder with dangerously low levels of red blood cells, white blood cells and platelets) and anemia (low hemoglobinth). R1's service plan report dated August 3, 2025, indicated R1 required minimal assistance for dressing and undressing, but "may" need	01620		

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01620	Continued From page 3 occasional hands-on assistance. The report indicated R1 groomed herself adequately with minimal staff supervision. R1 required "minor" toileting assistance, but could manage her own toileting schedule. R1 required occasional help managing incontinent products. R1 required "occasional" one person assist with transfers. R1 required escort services to all meals in the dining room, but was independent with all aspects of the meal. Former director of nursing (DON)-F and R1's family member signed this report on admission August 4, 2025. R1's service plan (addendum) dated August 4, 2025, included assistance for bathing, grooming, dressing, continence, transferring, and escorts. The frequency for these services was, "Per Schedule". The service plan indicated R1 received medication management/administration three times a day. Admission nursing assessment dated August 4, 2025, indicated R1's medical history included cellulitis (infections), and urinary tract infections (UTI's). The assessment indicated R1 was incontinent of bladder, but continent of bowel. R1 required minor assistance with toileting. R1 fed herself and ate her meals in the licensee's dining room. R1 required escort services to get to and from the dining room. R1 required minimal assistance with dressing, grooming, and hygiene. The assessment indicated R1 used a walker for mobility and occasional help from staff to transfer. The assessment indicated R1's skin was intact. Progress notes dated August 11, 2025, indicated a family member requested a nurse to check on R1 because she appeared confused and had an inflamed (red, swollen) area on her left lower leg. Progress notes indicated R1 went to the hospital	01620		

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01620	Continued From page 4 via emergency services (911). Physician visit records dated August 28, 2025, indicated R1 received treatment for cellulitis (infection) while at the hospital, but then left the hospital and went into a transitional care unit (TCU). The records indicated R1's medical history included multiple hospitalizations for cellulitis, and anemia (low red blood cells). The records indicated physicians suspected R1 had myelodysplastic syndrome (blood cancer), but R1 chose to forgo further diagnostic testing to confirm the diagnosis. The records indicated R1 required monthly lab draws (CBC) and blood transfusions if R1's hemoglobin (HGB) was below seven. Progress notes dated August 29, 2025, indicated R1 returned to the licensee post hospital and TCU stay. Nursing assessment dated August 29, 2025, indicated R1 required services from physical and occupational therapy (PT/OT). The assessment indicated R1 walked short distances with her walker but required a wheelchair for longer distances. The assessment indicated the licensee would continue to escort R1 to all meals. The assessment indicated R1 was hard of hearing and had "very poor" eyesight from glaucoma. Physician visit records dated September 10, 2025, indicated family noticed R1 had increased confusion and irritability. The records indicated a nurse practitioner (NP) told the licensee to obtain a urine sample from R1 to test for an infection. The records indicated the NP increased the dosage of R1's medication used to treat depression and pain.	01620		

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01620	Continued From page 5 Progress notes dated September 11, 2025, indicated R1 did not have a urinary tract infection (UTI). Progress notes dated September 11, 2025, indicated R1 called staff for assistance two to three times per hour during the evening. R1 requested assistance getting up from the toilet. The progress notes indicated R1 was able to perform all cares independently when cued by staff. Progress notes dated September 12, 2025, indicated R1 did not sleep all night and sat on the toilet "constantly" calling out. Physician order form dated September 18, 2025, indicated R1 required a blood draw, CBC and basic metabolic panel (BMP) "today." The NP electronically signed the order on September 18, 2025, at 12:19 p.m. and faxed the order to the licensee on September 18, 2025, at 12:19 p.m. Progress note dated September 19, 2025, contained limited information, but indicated R1's blood draw had not been completed. Progress notes dated September 21, 2025, indicated R1 had increased weakness and required extensive assistance from staff to transfer. R1 required staff to place a gait belt (belt around the abdomen so staff could hold her), and grab bars. R1 had difficulty moving/lifting her legs. The notes indicated a family member was concerned about R1's history of having a low HGB. Physician's order form dated September 22, 2025, indicated R1 required a "STAT" (immediate) blood draw (CBC and BMP). The NP	01620		

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01620	Continued From page 6 electronically signed the order on September 22, 2025, at 4:13 p.m. and faxed it to the facility on September 22, 2025, at 4:13 p.m. Lab report dated September 23, 2025, indicated R1's HGB was 7.4, and her platelets (clot blood to prevent bleeding) were critically low at 49 (normal 150-450). Physician's order form dated September 23, 2025, at 3:47 p.m., indicated R1's HGB dropped from 8.4 to 7.4 in one month and she required a blood transfusion in the emergency room (ER). Progress notes dated September 23, 2025, indicated R1's family took her to the ER for a blood transfusion. Progress notes dated September 24, 2025, indicated R1 returned to the licensee. R1's family member told the licensee staff R1 had covid 19 infection. The progress notes indicated the licensee's staff placed R1 in quarantine (isolation precautions) and obtained required protective equipment. R1 had acute (sudden) pain with movement. The licensee called a physician and told them about R1's acute pain and recent blood transfusion. The progress notes indicated the physician did not make any further medication or treatment changes. There were no further progress notes until September 29, 2025. R1's record lacked an assessment post ER with blood transfusion and positive infection. Service delivery record dated September 1, 2025, through September 30, 2025, indicated the licensee did not provide R1 meals upon her return on September 24, 2025, while she remained in her room due to quarantine	01620		

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01620	Continued From page 7 precautions. The licensee scheduled toileting assistance to begin September 24, 2025, but all other services remained unchanged. The records indicated the licensee failed to deliver meals to R1 when she was in quarantine until the following dates: Breakfast: September 26, 2025. Lunch: September 26, 2025. Lunch: September 27, 2025. Supper: September 27, 2025. The facility failed to do daily vital sign monitoring while R1 had an active infection and received a blood transfusion until September 29, 2025. The facility failed to do monitoring for an allergic reaction post blood transfusion. Progress notes dated September 29, 2025, indicated R1 was ill, "not doing good." R1 had continuous vomiting, and was lethargic (tired). R1 had an elevated body temperature of 101.4 (normal temp 97-99). R1's oxygen saturations were 86% (normal result 92%). R1 required urgent hospitalization. On May 4, 2025, at 9:16 a.m., the surveyor sent administrator (A)-G an email to clarify R1's nursing assessment. A-G responded at 9:36 a.m., there were no other assessments other nursing assessments competed for R1 in September 2025. On May 7, 2025, at 10:00 a.m., DON-F said the licensee did not complete change of condition assessments due to acute illness, but did complete them if a resident went into the hospital overnight. DON-F said if unlicensed staff told the nurses a resident required increased assistance, then the nurse would complete a change of condition assessment. When asked if the	01620		

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01620	Continued From page 8 licensee would compete a change of condition assessment if a resident had covid 19, DON-F said it would depend on how sick the resident was. The licensee's policy titled, Initial and On-Going Nursing Assessments of Residents, dated April 13, 2023, indicated the licensee would complete a comprehensive nursing assessment if a resident had a change in condition. Time Period for Correction: Seven (7) days	01620		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident(s) reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		