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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 8TTE

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00820

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245445**

2.STATE VENDOR OR MEDICAID NO.
(L2) **487540100**

3. NAME AND ADDRESS OF FACILITY
(L3) **SHAKOPEE FRIENDSHIP MANOR**
(L4) **1340 THIRD AVENUE WEST**
(L5) **SHAKOPEE, MN** (L6) **55379**

4. TYPE OF ACTION: **2** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **02/25/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **80** (L18)

13.Total Certified Beds **80** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	80			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

See Attached Remarks

17. SURVEYOR SIGNATURE — Date :
Sandra Taro, HFE NEII — 03/30/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath
Enforcement Specialist — 04/01/2016 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
_____ 1. Facility is Eligible to Participate
_____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
03/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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

CCN: 24 5445

At the time of the February 25, 2016 standard survey the facility was not in substantial compliance with Federal participation requirements. The most serious deficiencies were widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F). In addition, at the time of the standard survey investigation of complaint numbers H5445019 and H5445020 were conducted and found to be unsubstantiated.

Please refer to the CMS-2567 for both health and life safety code along with the facility's plan of correction. Post Certification Revisit to follow.

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Certified Mail # 7015 0640 0003 5695 3091

March 8, 2016

Mr. Bruce Salmela, Administrator
Shakopee Friendship Manor
1340 Third Avenue West
Shakopee, Minnesota 55379

RE: Project Number S5445025, H5445019 and H5445020

Dear Mr. Salmela:

On February 25, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. In addition, at the time of the February 25, 2016 standard survey the Minnesota Department of Health completed an investigation of complaint number H5445019 and H5445020.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the February 25, 2016 standard survey the Minnesota Department of Health completed an investigation of complaint number H5445019 and H5445020 that was found to be unsubstantiated.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

> Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;
>
> Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

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

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), i.e., the plan of correction should be directed to:

Gayle Lantto, Unit Supervisor
Metro D Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite #220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: gayle.lantto@state.mn.us
Phone: (651) 201-3794 Fax: (651) 215-9697

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by April 5, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by April 5, 2016 the following remedy will be imposed:

- Per instance civil money penalty. (42 CFR 488.430 through 488.444)

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Include signature of provider and date.

If an acceptable PoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable PoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's PoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by May 25, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by August 25, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
444 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012 Fax: (651) 215-0525

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

Enclosure(s)

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245445	A. BUILDING _____ B. WING _____	02/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHAKOPEE FRIENDSHIP MANOR	1340 THIRD AVENUE WEST SHAKOPEE, MN 55379

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A standard recertification survey was conducted on February 22, 23, 24 and 25, 2016. In addition, an investigation of complaint numbers H5445019 and H5445020 were conducted and found to be unsubstantiated.	F 000	RECEIVED MAR 17 2016 BY: email Call light cords for R62, R77, and R88 were repositioned in order for them to be within the residents' reach. The facility's Universal Worker inspected all call light cords verifying that all cords were within the residents' reach. The Maintenance Department inspected all call light cords and replaced all missing or broken clips found. At the scheduled March 16, March 22, and March 24 nursing staff meetings, all nursing staff will be re-educated on being aware of all residents call light cords regarding placement and proper working condition. In addition to the nursing staff monitoring call light cords on a continual basis, the facility's Universal Worker will conduct random audits of the call lights. The Resident Care Coordinator, who spends the majority of her time working out on the floor, will monitor the call light cords for compliance. The date of completion is March 24, 2016.	3/24/16
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure call lights were accessible for 3 of 3 residents (R62, R77, R88) whose call lights were observed out of reach. Findings include:	F 246	POC accepted by MH 3/17/16	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Bruce D. Salmela — TITLE: ADMINISTRATOR — (X6) DATE: 03/17/16

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 246	Continued From page 1 R62 was lying in bed on 2/22/16, at 2:14 p.m. The lights were off, the shades were down and the room was dark. A call light was observed behind the resident's mattress, at the top of the bed, out of the resident's reach. A second call light in the room was on the floor toward the head of the bed on the far side away from the doorway. At 3:05 p.m. R62 was again observed lying in bed. Neither call light not been moved. A nursing assistant (NA)-E entered and looked around R62's room, but did not place the resident's call light within her reach. At 3:07 p.m. R62 called out from her bed, "Can I go to the bathroom?" The resident was asked by the surveyor if she knew the location of her call light. She looked around and replied she did not know, and added, "I am just going to go real quick." She proceeded to get out of bed independently and ambulated with an unsteady gait to the toilet. She did not use her walker and and instead steadied herself by holding onto the bed and walls as she made her way to the bathroom. At 4:00 p.m. R62 was ambulating in the hallway outside of her room with a steady gait. Both call lights remained unchanged. The following day, at 3:24 p.m. R62 was in her room. When asked if she knew the location of her call light, she said she did not. When asked if she could reach the call light that was on the floor she shrugged her shoulders and stated, "I don't need anything anyway." R62 was in her room seated in a wheelchair on 2/25/16, at 10:46 a.m. The call lights were in the same position they had been on 2/22/16 and 2/23/16. NA-F said R62's call light should always have been placed within her reach when she was	F 246		

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F 246	Continued From page 2 in the room. He explained that R62's care sheets directed staff to check on the resident every two hours, which included ensuring the call light was placed within her reach. NA-F then verified R62 would have been unable to access either call light--from behind the mattress or to safely reach the call light on the floor. At 10:50 a.m. a registered nurse (RN)-A reported resident call lights were supposed to be within their reach for all residents when they were in their rooms. She also verified neither call light was within R62's reach. She explained the reason the room had two call lights was that it had once been a double room. RN-A stated the expectation was that staff checked that a resident's call light was within their reach prior to leaving the resident's room according to standards of care and the resident's care plan. R62's care plan (target date 5/20/16) noted the resident was at moderate risk for falling, and approaches to minimize the risk for falls included staff placing the call light within R62's reach when she was in the room, to encourage her to utilize the light. The plan also noted R62 needed a working and reachable call light. At 11:02 a.m. RN-A explained she had contacted maintenance to repair R62's call light that was at the head of the bed, as she was unable to remove it from the stuck position on the bed frame. R88 was observed on 2/22/16, at 3:10 p.m. while sitting in his recliner chair with the foot part of the recliner raised. The resident was looking around the room. His call light was clipped on the far left side of R88's bed out of his reach. R88 explained	F 246		

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F 246	Continued From page 3 he was just looking for his call light, as he could not reach his remote control on the far side of the table placed over the bed. R88 said a staff person had just assisted him into the recliner. NA-A walked into R88's room and confirmed R88 consistently used his call light. After telling NA-A R88 was looking for his call light NA-A picked up the call light on the left side of the bed and placed the call light in R88's hand. NA-A said she usually placed the call light on the right side rail within R88's reach but that today she had not helped R88 into his chair, but instead an activities staff had assisted him following an activity. The following day at 1:50 p.m. R88 was observed sitting in his recliner with his feet up. The call light was observed hooked in the middle of R88's bed out of his reach. NA-G walked into R88's room and stated she usually hooked R88's call light onto his recliner. NA-G stated she had not assisted R88 into his chair. NA-G stated R88 used his call light and added "Before lunch I know [R88] had his call light." R88's Minimum Data Set dated 12/25/15, indicated R88's cognition was moderately impaired and R88 required extensive staff assistance with transfers. R77's call light was hanging down on the floor at the head of the bed on 2/22/16, at 2:35 p.m. NA-B walked into R77's room and explained that R77 did require some assistance with activities of daily living and utilized her call light. NA-B stated that R77 used a wheelchair for ambulation and R77 could walk with staff assistance with a walker. NA-B picked up R77's call light off the floor and clipped it to the top of the blanket on R77's bed. Moments later NA-C stated R77	F 246		

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F 246	Continued From page 4 would ask for help when she needed it or R77 would come find staff in her wheelchair. The next day at 9:08 a.m. R77's call light was observed hanging on the curtain divider near the wall between the R77's bed and her roommate's bed. The beds were approximately a foot together in distance too close for R77's wheelchair to pass through for R77 to reach her call light. On 2/23/16, at 3:26 p.m. R77's call light was again clipped on the room divider curtain near the wall hanging between R77's bed and her roommate's bed. The beds were approximately 1-2 feet apart too close together for R77's wheelchair to pass through for R77 to reach her call light. R77's 3/26/15, care plan indicated "The resident is Moderate risk for falls r/t [related to] Deconditioning, Psychoactive drug use, Gait/balance problems, Incontinence" and Interventions included "call light is within reach, encourage the resident to use it for assistance as needed." On 2/25/16, at 9:18 a.m. the director of nursing (DON) reported call lights were supposed to be assessable to all residents. The DON stated staff were trained annually regarding safety issues and were expected to follow the residents' care plans. The DON stated she was aware of missing clips in the residents' room and stated the call light clips broke, allowing the call light cord to slip to the floor and not stay fixed onto the residents' beds. The DON stated she had requested maintenance staff look into finding clips that worked better and did not break so easily. On 2/25/16, at 10:07 a.m. the maintenance director stated that he had seen call lights in residents' rooms lying on the floor because the	F 246		

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F 246	Continued From page 5 call light clips that allowed the clips to keep the lights in place were sometimes missing. The maintenance director also stated staff wrote repair orders for non-functioning call lights, but not for broken call light clips. During an interview at 12:25 p.m. the director of nursing (DON) stated she expected call lights to be placed within reach of every resident regardless of whether or not they utilized the call light to summon help. The lights were also expected to be available should a visitor need to call for help for a resident. The DON stated, "Staff should ensure call lights are in place every time they leave a resident's room." The facility's 11/19/13, Call Light Policy indicated, "Objective: To respond to Residents request and needs...Make sure call light is within reach/accessible to Resident before leaving the room."	F 246	Call light cords for R62 and R77 were repositioned in order for them to be within the residents' reach. The facility's Universal Worker inspected all call light cords verifying that all cords were within the residents' reach. The Maintenance Department inspected all call light cords and replaced all missing or broken clips found. Care plans have been reviewed to ensure they agree with each resident's plan of care. The MDS Coordinator will audit each resident's care plan on a continual basis to ensure compliance The date of completion is March 24, 2016.	3/24/16
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure care plans were followed for 2 of 3 residents (R62, R77) whose call lights were reviewed for environmental concerns.	F 282	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.	

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	245445	A. BUILDING _____ B. WING _____	02/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHAKOPEE FRIENDSHIP MANOR	1340 THIRD AVENUE WEST SHAKOPEE, MN 55379

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 6 Findings include: R62's care plan (target date 5/20/16) noted the resident was at moderate risk for falling, and approaches to minimize the risk for falls included staff placing the call light within R62's reach when she was in the room, to encourage her to utilize the light. The plan also noted R62 needed a working and reachable call light. R62 was lying in bed on 2/22/16, at 2:14 p.m. The lights were off, the shades were down and the room was dark. A call light was observed behind the resident's mattress, at the top of the bed, out of the resident's reach. A second call light in the room was on the floor toward the head of the bed on the far side away from the doorway. At 3:05 p.m. R62 was again observed lying in bed. Neither call light not been moved. A nursing assistant (NA)-E entered and looked around R62's room, but did not place the resident's call light within her reach. At 3:07 p.m. R62 called out from her bed, "Can I go to the bathroom?" The resident was asked by the surveyor if she knew the location of her call light. She looked around and replied she did not know, and added, "I am just going to go real quick." She proceeded to get out of bed independently and ambulated with an unsteady gait to the toilet. She did not use her walker and and instead steadied herself by holding onto the bed and walls as she made her way to the bathroom. At 4:00 p.m. R62 was ambulating in the hallway outside of her room with a steady gait. Both call lights remained unchanged. The following day, at 3:24 p.m. R62 was in her room. When asked if she knew the location of her call light, she said she did not. When asked if	F 282	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "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.	

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F 282	Continued From page 7 she could reach the call light that was on the floor she shrugged her shoulders and stated, "I don't need anything anyway." R62 was in her room seated in a wheelchair on 2/25/16, at 10:46 a.m. The call lights were in the same position they had been on 2/22/16 and 2/23/16. NA-F said R62's call light should always have been placed within her reach when she was in the room. He explained that R62's care sheets directed staff to check on the resident every two hours, which included ensuring the call light was placed within her reach. NA-F then verified R62 would have been unable to access either call light--from behind the mattress or to safely reach the call light on the floor. On 2/25/16, at 10:50 a.m. a registered nurse (RN)-A reported resident call lights were supposed to be within their reach for all residents when they were in their rooms. She also verified neither call light was within R62's reach. She explained the reason the room had two call lights was that it had once been a double room. RN-A stated the expectation was that staff checked that a resident's call light was within their reach prior to leaving the resident's room according to standards of care and the resident's care plan. At 11:02 a.m. RN-A explained she had contacted maintenance to repair R62's call light that was at the head of the bed, as she was unable to remove it from the stuck position on the bed frame. R77's 3/26/15, care plan indicated "The resident is Moderate risk for falls r/t [related to] Deconditioning, Psychoactive drug use, Gait/balance problems, Incontinence" and	F 282		

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F 282	Continued From page 8 Interventions included "call light is within reach, encourage the resident to use it for assistance as needed." R77's call light was hanging down on the floor at the head of the bed on 2/22/16, at 2:35 p.m. NA-B walked into R77's room and explained that R77 did require some assistance with activities of daily living and utilized her call light. NA-B stated that R77 used a wheelchair for ambulation and R77 could walk with staff assistance with a walker. NA-B picked up R77's call light off the floor and clipped it to the top of the blanket on R77's bed. Moments later NA-C stated R77 would ask for help when she needed it or R77 would come find staff in her wheelchair. The next day at 9:08 a.m. R77's call light was observed hanging on the curtain divider near the wall between the R77's bed and her roommate's bed. The beds were approximately a foot together in distance too close for R77's wheelchair to pass through for R77 to reach her call light. On 2/23/16, at 3:26 p.m. R77's call light was again clipped on the room divider curtain near the wall hanging between R77's bed and her roommate's bed. The beds were approximately 1-2 feet apart too close together for R77's wheelchair to pass through for R77 to reach her call light. On 2/25/16, at 9:18 a.m. the director of nursing (DON) reported call lights were supposed to be assessable to all residents. The DON stated staff were trained annually regarding safety issues and were expected to follow the residents' care plans. The DON stated she was aware of missing clips in the residents' room and stated the call light clips broke, allowing the call light cord to slip to the floor and not stay fixed onto the residents' beds. The DON stated she had requested	F 282		

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F 282	Continued From page 9 maintenance staff look into finding clips that worked better and did not break so easily. On 2/25/16, at 10:07 a.m. the maintenance director stated that he had seen call lights in residents' rooms lying on the floor because the call light clips that allowed the clips to keep the lights in place were sometimes missing. The maintenance director also stated staff wrote repair orders for non-functioning call lights, but not for broken call light clips. During an interview at 12:25 p.m. the director of nursing (DON) stated she expected call lights to be placed within reach of every resident regardless of whether or not they utilized the call light to summon help. The lights were also expected to be available should a visitor need to call for help for a resident. The DON stated, "Staff should ensure call lights are in place every time they leave a resident's room." The facility's 11/19/13, Call Light Policy indicated, "Objective: To respond to Residents request and needs...Make sure call light is within reach/accessible to Resident before leaving the room."	F 282		

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	245445	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/23/2016**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Shakopee Friendship Manor was found not to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) 101 Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or	K 000	**APPROVED** **By Tom Linhoff at 1:43 pm, Mar 30, 2016** RECEIVED MAR 21 2016 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Bruce D. Dalmela	ADMINISTRATOR	03/18/16

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Shakopee Friendship Manor is a 1 story building, with no basement. The original building was constructed in 1964 and was determined to be of Type II(111) construction. In 1976 an addition was constructed and was determined to be of Type II(111) construction. Because the original building and the addition meet the construction type allowed for existing buildings, the facility was surveyed as one building. The facility is fully fire sprinkler protected. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors, which is monitored for automatic fire department notification. The facility has a capacity of 80 beds and had a census of 64 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		

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K 018 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3 This STANDARD is not met as evidenced by: Based on the observation and staff interview, the facility had several corridor doors that did not meet the requirements of NFPA 101 LSC (00) Section 19.3.6.3, they did not fit tight in the frame or latch. This deficient practice could affect the safety of approximately 40 of 80 residents and an undetermined number of staff and visitors, if smoke from a fire were allowed to enter the exit access corridors making it untenable. Findings include: On the facility tour between 0900 and 1330 on 2/24/2016 observations revealed that the following room doors did not positively latch: Room 409, 438, 440, and 305A	K 018	The doors to rooms 409, 438, 440, and 305A have all been adjusted so they positively latch. The Maintenance Department were capable of making the necessary adjustments. The Maintenance Department has added checking door latches to their periodic checklist of routine building maintenance. The Maintenance Supervisor will randomly test door latching on a monthly basis to verify compliance. The date of completion is March 17, 2016.	03/17/16

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K 018	Continued From page 3 The deficient practice was observed by the Facility Manager.	K 018		
K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the smoke barrier walls in all three wings in accordance with the following requirements of 2000 NFPA 101, Section 19.3.7.3, and 8.3.4.1. The deficient practice could affect 33 residents. Findings include: On the facility tour between 0900 and 1230 on 2/17/2016 observations revealed that smoke barriers in all wings had penetrations at the smoke barrier doors above the ceiling tiles around wires, conduits, and ducts in the following locations: a. Smoke barrier from wing 1 to the central dining area. b. Smoke barrier from wing 2 to the central dining area. c. Smoke barrier from wing 3 to the central dining area. The deficient practice was observed by the Facility Manager.	K 025	Smoke barrier walls on Wing 1, Wing 2 and Wing 3 have all been inspected and all penetrations found have been filled with 3M Fire Barrier Sealant. The Maintenance Department will monitor all work done by outside vendors within the building to ensure that penetrations made in the barrier walls are filled with fire barrier sealant. The Maintenance Supervisor will randomly inspect the barrier walls to verify compliance. The date of completion is March 17, 2016.	03/17/16

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K 027 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1o-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 This STANDARD is not met as evidenced by: Based on observations and interview, the facility has failed to maintain smoke/fire barrier doors in accordance with LSC 19.3.7.5. This deficient practice could affect all patients. Findings include: On facility tour between 09:00 AM and 1330 on 02/24/2016, observation revealed: 1. Doors from Wing 1 to the Nurse's station has a 1/2 inch gap 2. Doors from Nurse's station to Wing 2, Nurses Station to Wing 3, Wing 4 to the long hall, Wing 4 to the short hall sets of doors had gaps over an 1/8". This deficient practice was verified by the Facility Manager.	K 027	The appropriate fire rated astrogals has been ordered through Greystone Construction to repair the fire doors on Wing 1, Wing 2, Wing 3, and the two doors on Wing 4. The astrogals will eliminate the gap of the smoke barrier doors. The Maintenance Department will attach the astrogals upon receiving it from Greystone Construction. The Maintenance Supervisor will randomly inspect the barrier doors to verify compliance. The date of completion is March 25, 2016.	03/25/16
K 062 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25,	K 062		

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K 062	Continued From page 5 9.7.5 This STANDARD is not met as evidenced by: Based on observation and interview, the complete automatic fire sprinkler system is not being maintained in accordance with NFPA 25(99) Section 9.2.7. This deficient practice could effect all patients. Findings include: On facility tour between 09:00 AM and 1:30 PM on 02/24/2016, observation revealed that the sprinkler head in the dishwasher room was corroded and the deflector was painted. This deficient practice was verified by the Facility Manager.	K 062	Summit Company has been contracted to replace all the sprinkler heads in the kitchen (8), which will include the sprinkler head in the dishroom. Summit is scheduled to complete this work on March 21, 2016. The Maintenance Department will include checking the sprinkler heads throughout the facility on a routine basis. The Maintenance Supervisor will randomly inspect sprinkler heads to verify compliance. The date of completion is March 21, 2016.	03/21/16
K 064 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers shall be installed, inspected, and maintained in all health care occupancies in accordance with 9.7.4.1, NFPA 10. 18.3.5.6, 19.3.5.6 This STANDARD is not met as evidenced by: Based on observation and staff interview, it was determined that the facility failed to maintain portable fire extinguisher in accordance with NFPA 101-2000 edition, Section 9.7.4.1 and NFPA 10. This deficient practice could affect 40 out of 80 residents. Findings include: On facility tour between 0900 and 1330 on 02/24/2016, observation revealed that the fire extinguisher located in the kitchen was being blocked by a cart with trays on it.	K 064	The fire extinguisher being blocked by a cart was an oversight. The fire extinguisher has been relocated to an area that is free of obstructions. The Maintenance Supervisor will monitor all fire extinguishers in the facility making sure they are free of obstructions. The date of completion is March 17, 2016.	03/17/16

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K 064	Continued From page 6 This deficient practice was confirmed by the Facility Manager.	K 064		
K 075 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Soiled linen or trash collection receptacles do not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space does not exceed .5 gal/sq ft (20.4 L/sq m). A capacity of 32 gal (121 L) is not exceeded within any 64 sq ft (5.9-sq m) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) are located in a room protected as a hazardous area when not attended. 19.7.5.5 This STANDARD is not met as evidenced by: Based on observations and staff interview, the facility has failed to store large trash and linen carts in properly protected rooms in accordance with the NFPA 101 "The Life Safety Code" 2000 edition (LSC) section 19.7.5.5. This deficient practice could affect the safety of all residents, staff and visitors if smoke or fire from one of these carts rendered the corridors untenable. Findings include: On the facility tour between 0900 and 1330 on 2/24/2016 it was found that the facility was storing multiple 50 gallon bins for soiled linen containers which are greater than the maximum 32 gallons that are allowed to be stored in spaces that are greater than 64 square feet (in area) and areas that are open to the corridors and not in the required hazardous storage areas. This deficient practices was confirmed by the	K 075	All 50 gallon soiled linen containers have been replaced with 32 gallon bins. The Maintenance Supervisor will be responsible for maintaining appropriate soiled linen bins. The date of completion is March 17, 2016.	03/17/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245445	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/23/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHAKOPEE FRIENDSHIP MANOR	**1340 THIRD AVENUE WEST** **SHAKOPEE, MN 55379**

(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
K 075	Continued From page 7 Facility Manager.	K 075		
K 144 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) This STANDARD is not met as evidenced by: Based on review of records and interview, the facility failed to maintain the emergency generator in accordance with the requirements of NFPA 110 - 1999 edition and NFPA 99 - 1999 edition, section 3-4.1.1.2. This deficient practice could affect the safety of all patients, staff and visitors. Findings include: On facility tour between 9:00 AM and 1:30 PM on 02/24/2016, based on review of available documentation it was revealed that there was no documentation for the minimum 5 minute cool down period when testing generator. This deficient practice was verified by the Facility Manager.	K 144	Onan Cummins has been contracted to install a transfer switch to the generator which will allow the required 5 minute cool down period to be conducted. This transfer switch will be installed by March 25, 2016. The Maintenance Department will conduct the mandatory five minute cool down when testing the generator. The Maintenance Supervisor will monitor the generator testing log sheet verifying compliance. The date of completion is March 25, 2016.	03/25/16

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Certified Mail # 7015 0640 0003 5695 3091

March 8, 2016

Mr. Bruce Salmela, Administrator
Shakopee Friendship Manor
1340 Third Avenue West
Shakopee, Minnesota 55379

Re: Enclosed State Nursing Home Licensing Orders - Project Numbers S5445025, H5445025 and H5445020

Dear Mr. Salmela:

The above facility was surveyed on February 22, 2016 through February 25, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint numbers H5445019 and H5445020. that were found to be unsubstantiated. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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 deficiency within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). 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 after the

statement, "This Rule 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.

When all orders are corrected, the order form should be signed and returned to this office at:

Gayle Lantto, Unit Supervisor
Metro D Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite #220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: gayle.lantto@state.mn.us
Phone: (651) 201-3794 Fax: (651) 215-9697

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 Gayle Lantto at the phone number or email listed above.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

Enclosure(s)

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00820	A. BUILDING: _____ B. WING _____	02/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHAKOPEE FRIENDSHIP MANOR	1340 THIRD AVENUE WEST SHAKOPEE, MN 55379

(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
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 2/22/16 through 2/25/16, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance Monitoring, Licensing and	2 000	RECEIVED MAR 17 2016 BY: email 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.	

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Bruce D. Talmela	ADMINISTRATOR	03/17/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00820	A. BUILDING: _____ B. WING _____	02/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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2 000	Continued From page 1 Certification Program, P.O. Box 64900, Saint Paul, MN 55164-0900. Complaint investigations of H5445019 and H5445020 were also completed at the time of the license survey and both were found to be unsubstantiated	2 000	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 which are in violation of the state statute after the statement, "This Rule 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.	
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure care plans were followed for 2 of 3 residents (R62, R77) whose call lights were reviewed for environmental	2 565		

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	00820	A. BUILDING: _____ B. WING _____	02/25/2016

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SHAKOPEE FRIENDSHIP MANOR	1340 THIRD AVENUE WEST SHAKOPEE, MN 55379

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2 565	Continued From page 2 concerns. Findings include: R62's care plan (target date 5/20/16) noted the resident was at moderate risk for falling, and approaches to minimize the risk for falls included staff placing the call light within R62's reach when she was in the room, to encourage her to utilize the light. The plan also noted R62 needed a working and reachable call light. R62 was lying in bed on 2/22/16, at 2:14 p.m. The lights were off, the shades were down and the room was dark. A call light was observed behind the resident's mattress, at the top of the bed, out of the resident's reach. A second call light in the room was on the floor toward the head of the bed on the far side away from the doorway. At 3:05 p.m. R62 was again observed lying in bed. Neither call light not been moved. A nursing assistant (NA)-E entered and looked around R62's room, but did not place the resident's call light within her reach. At 3:07 p.m. R62 called out from her bed, "Can I go to the bathroom?" The resident was asked by the surveyor if she knew the location of her call light. She looked around and replied she did not know, and added, "I am just going to go real quick." She proceeded to get out of bed independently and ambulated with an unsteady gait to the toilet. She did not use her walker and and instead steadied herself by holding onto the bed and walls as she made her way to the bathroom. At 4:00 p.m. R62 was ambulating in the hallway outside of her room with a steady gait. Both call lights remained unchanged. The following day, at 3:24 p.m. R62 was in her room. When asked if she knew the location of	2 565		

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SHAKOPEE FRIENDSHIP MANOR	1340 THIRD AVENUE WEST SHAKOPEE, MN 55379

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2 565	Continued From page 3	2 565		

her call light, she said she did not. When asked if she could reach the call light that was on the floor she shrugged her shoulders and stated, "I don't need anything anyway."

R62 was in her room seated in a wheelchair on 2/25/16, at 10:46 a.m. The call lights were in the same position they had been on 2/22/16 and 2/23/16. NA-F said R62's call light should always have been placed within her reach when she was in the room. He explained that R62's care sheets directed staff to check on the resident every two hours, which included ensuring the call light was placed within her reach. NA-F then verified R62 would have been unable to access either call light--from behind the mattress or to safely reach the call light on the floor.

On 2/25/16, at 10:50 a.m. a registered nurse (RN)-A reported resident call lights were supposed to be within their reach for all residents when they were in their rooms. She also verified neither call light was within R62's reach. She explained the reason the room had two call lights was that it had once been a double room. RN-A stated the expectation was that staff checked that a resident's call light was within their reach prior to leaving the resident's room according to standards of care and the resident's care plan.

At 11:02 a.m. RN-A explained she had contacted maintenance to repair R62's call light that was at the head of the bed, as she was unable to remove it from the stuck position on the bed frame.

R77's 3/26/15, care plan indicated "The resident is Moderate risk for falls r/t [related to] Deconditioning, Psychoactive drug use, Gait/balance problems, Incontinence" and

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SHAKOPEE FRIENDSHIP MANOR	1340 THIRD AVENUE WEST SHAKOPEE, MN 55379

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2 565	Continued From page 4 Interventions included "call light is within reach, encourage the resident to use it for assistance as needed." R77's call light was hanging down on the floor at the head of the bed on 2/22/16, at 2:35 p.m. NA-B walked into R77's room and explained that R77 did require some assistance with activities of daily living and utilized her call light. NA-B stated that R77 used a wheelchair for ambulation and R77 could walk with staff assistance with a walker. NA-B picked up R77's call light off the floor and clipped it to the top of the blanket on R77's bed. Moments later NA-C stated R77 would ask for help when she needed it or R77 would come find staff in her wheelchair. The next day at 9:08 a.m. R77's call light was observed hanging on the curtain divider near the wall between the R77's bed and her roommate's bed. The beds were approximately a foot together in distance too close for R77's wheelchair to pass through for R77 to reach her call light. On 2/23/16, at 3:26 p.m. R77's call light was again clipped on the room divider curtain near the wall hanging between R77's bed and her roommate's bed. The beds were approximately 1-2 feet apart too close together for R77's wheelchair to pass through for R77 to reach her call light. On 2/25/16, at 9:18 a.m. the director of nursing (DON) reported call lights were supposed to be assessable to all residents. The DON stated staff were trained annually regarding safety issues and were expected to follow the residents' care plans. The DON stated she was aware of missing clips in the residents' room and stated the call light clips broke, allowing the call light cord to slip to the floor and not stay fixed onto the residents' beds. The DON stated she had requested maintenance staff look into finding clips that	2 565		

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2 565	Continued From page 5 worked better and did not break so easily. On 2/25/16, at 10:07 a.m. the maintenance director stated that he had seen call lights in residents' rooms lying on the floor because the call light clips that allowed the clips to keep the lights in place were sometimes missing. The maintenance director also stated staff wrote repair orders for non-functioning call lights, but not for broken call light clips. During an interview at 12:25 p.m. the director of nursing (DON) stated she expected call lights to be placed within reach of every resident regardless of whether or not they utilized the call light to summon help. The lights were also expected to be available should a visitor need to call for help for a resident. The DON stated, "Staff should ensure call lights are in place every time they leave a resident's room." The facility's 11/19/13, Call Light Policy indicated, "Objective: To respond to Residents request and needs...Make sure call light is within reach/accessible to Resident before leaving the room." SUGGESTED METHOD OF CORRECTION: Staff could be re-educated regarding placement of residents' call lights. Maintenance staff could ensure clips are in working order, and staff trained to report failures. Audits could be conducted to ensure call lights are accessible to the residents and the results could be brought to the quality committee for review. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	2 565		