Electronically delivered

March 22, 2022

Administrator
Shakopee Friendship Manor
1340 Third Avenue West
Shakopee, MN 55379

RE: CCN: 245445
Cycle Start Date: March 3, 2022

Dear Administrator:

On March 3, 2022, a survey was completed at your facility by the Minnesota Department(s) 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.

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 electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of Payment for new Mediare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective June 3, 2022.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective June 3, 2022. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective June 3, 2022.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is

your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose:

• Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,292; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by June 3, 2022, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Shakopee Friendship Manor will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from June 3, 2022. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.

- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

Pete Cole, RN Unit Supervisor
Metro Team C District Office
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: peter.cole@state.mn.us
Office/Mobile: (651) 249-1724

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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

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

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 September 3, 2022 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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 an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/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 electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing

Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

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 _____	03/03/2022

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 3/1/22 - 3/3/22, a standard licensing survey was conducted completed at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. The following licensing orders were issued: 1855, 0900, 1375, 1675 and 1875.	2 000		

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 _____	03/03/2022

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	Continued From page 1 Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. 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 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 surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE	2 000		

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 _____	03/03/2022

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	Continued From page 2 FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a resident identified at risk for pressure ulcers received the necessary care and treatment to prevent the development of pressure ulcers for 1 of 2 resident (R34) in the sample identified at risk for pressure ulcers. Findings include: R34's quarterly Minimum Data Set (MDS) dated	2 900	Corrected.	4/5/22

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 _____	03/03/2022

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
2 900	Continued From page 3 11/14/21, indicated R34 had an unstageable pressure ulcer (full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar). R34's MDS further had severe cognitive impairment, unable to communicate needs, advanced Parkinson's disease, diabetes, dementia R34's quarterly (MDS) dated 2/13/22, indicated R34 no longer had a pressure ulcer however continued to be at risk for the development of pressure ulcers. R34's Care Area Assessment (CAA) dated 3/3/22, indicated R34 was at risk for developing pressure ulcers. R34's physician order on 10/31/21, indicated heal protectors were to be worn at all times. R34's physician order on 1/17/21, indicated R34's pressure ulcer healed, and to continue wearing heel protectors at all times. R34's treatment administration record (TAR) on 3/3/22, indicated heel protectors to be worn at all times except when dressing or undressing. R34's care plan on 3/3/22, indicated R34 required the use of heel protectors, related to risk for skin impairment complicated by diabetes and advanced Parkinson's disease. During an observation on 3/03/22, 8:50 a.m. R34 was sitting in his wheelchair with dress socks on. R34 did not have his heel protectors on. R34's right heel was resting on top of the foot pedal's heel loop strap. The purpose of a heel strap is to prevent the resident's foot from sliding off the foot	2 900		

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 _____	03/03/2022

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
2 900	Continued From page 4 pedal. During an observation on 3/3/22, 9:00 a.m. R34 was resting in bed. R34's heel protectors were not on. R34's stiff body and bent knees prevented him from lying flat on the bed. Instead, R34's knees remained bent causing his upper and lower legs to be lifted off the bed. As a result of this position, R34's heels were forced directly downward into the mattress while his feet flexed upward. Nursing assistant (NA)-D stated R34's legs tend to be bent at the knees forcing his heels to dig down into the mattress. During an interview on 3/3/22, at 1:14 p.m. medical doctor (MD)-A stated R34 had end stage Parkinson's Disease. MD-A stated R34's previous heal ulcer left the skin thin and weakened. R34 had a high risk for developing another pressure ulcer at the same location. During an interview on 3/3/22, at 1:44 p.m. director of nursing (DON) and registered nurse (RN)-C stated R34's heels are fragile from previous skin breakdown and their expectation was for the nursing staff to follow provider orders to always have his heel protectors on. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, should review all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The director of nursing or designee should conduct measurable audits for a specific amount of time of the delivery of care to residents affected and those who have the	2 900		

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 _____	03/03/2022

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
2 900	Continued From page 5 potential to be affected to ensure appropriate care and services are implemented and reduce the risk for pressure ulcer development. The DON or designee should bring all audit information to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure hand hygiene was performed during personal cares for 8 of 8 residents (R15, R10, R13, R22, R9, R4, R19 and R42) and during a medication pass for 1 of 4 residents (R38) reviewed for medication administration. Findings include: R15's annual MDS dated 1/2/2022, indicated moderate cognitive impairment, chronic pain, heart disease, and depression R10's significant change in status MDS dated 12/21/21, indicated severe cognitive impairment,	21375	Corrected	4/5/22

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 _____	03/03/2022

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
21375	Continued From page 6 Alzheimer's disease, heart disease, depression, and tremors. R13's quarterly Minimum Data Set (MDS) dated 1/2/22, indicated intact cognition, anxiety, muscle weakness, depression, and schizophrenia. R22's significant change in status MDS dated 1/27/21, indicated moderate cognitive impairment, dementia with behavioral disturbance, heart disease, and depression. R9's quarterly MDS dated 12/19/21, indicated severe cognitive impairment, dementia, heart disease, depression, and anxiety. R4's quarterly MDS dated 12/12/21, indicated moderate cognitive impairment, one sided paralysis after a stroke, heart disease, and depression. R19's annual MDS dated 1/23/21, indicated severe cognitive impairment, dementia, one side of the body paralysis, seizure disorder, anxiety, and depression. R42's quarterly MDS dated 1/30/22, indicated heart disease, high blood pressure, dementia with severe cognitive impairment. During an observation on 3/2/22, at 7:59 a.m. in the dining room licensed practical nurse (LPN)-C was seen rubbing her ungloved hands through R15's hair while talking to her. LPN-C went to R10's wheelchair touching the back of the chair. LPN-C rubbed her ungloved hands through her own hair. At no time during the continuous observation did LPN-C use hand sanitizer or wash her hands. LPN-C walked to the dish cart	21375		

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 _____	03/03/2022

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
21375	Continued From page 7	21375		

and got a clean coffee cup. LPN-C poured coffee into the cup and brought the cup to R13's room. LPN-C went to R13's room, set the cup on his tray table and walked out of the room back to the dining area. LPN-C went meal tray cart and opened it. Without using hand sanitizer, washing her hands or applying gloves LPN-C grabbed R22's meal tray. LPN-C placed the meal tray on a table and removed the lid off the glasses, cut the french toast into smaller sizes, opened the syrup package and poured the syrup on to the french toast. LPN-C then picked up the meal tray and delivered it to R22's table. LPN-C went to the meal cart and grabbed R9's meal tray. LPN-C removed the lid off the glasses, cut R9's food into smaller bite sizes and brought R9's tray to her table. Without using hand sanitizer, washing her hands or applying gloves LPN-C took another tray for R4. LPN-C applied peanut butter and jelly to R4's toast, she peeled the banana and placed it on the tray. LPN-C then picked up R4's tray and placed it back on to the food cart. She then got R22 a drinking straw. After LPN-C removed the straw's wrapper she touched the straw with her bare hands before placing it into R4's glass. LPN-C then pulled down the condiment basket from the top of the meal cart. LPN-C then searched through the salt and pepper packets to find salt. When she got a packet of salt, an additional packet fell onto the floor. LPN-C bent over to pick up the packet off the floor and placed it back into the condiment container. LPN-C did not use hand sanitizer or wash her hands before entering or after leaving R4's room. LPN-C then placed R4's meal tray on his tray table. LPN-C grabbed a washcloth from R4's tray table, walked to the bathroom and rinsed the washcloth off. She then exited the bathroom and gave R4 the washcloth to wash his hands. LPN-C then exited R4's room, walked back to the dining room and

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 _____	03/03/2022

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
21375	Continued From page 8	21375		

without cleaning her hands or applying gloves she sat next to R9 to encourage her to eat. LPN-C proceeded to pick up R9's fork and placed a piece of french toast onto the fork. LPN-C then handed the fork back to R9. LPN-C walked into the kitchen area, got a bucket from under the sink and several washcloths from the cabinet. LPN-C then filled the bucket with water and soap. LPN-C then placed the washcloths into the bucket. LPN-C did not apply soap directly to her hands during this process and did not use appropriate hand washing technique at that time. LPN-C then sat down next to R19 and started to set up his meal tray. LPN-C provided total feeding assistance to R19. During the entire observation LPN-C was not observed hand sanitizing or washing her ungloved hands.

During observation on 3/2/22, 12:37 p.m. LPN-C used a washcloth to wipe R19's face. She then placed the washcloth in the laundry bin. LPN-C identified a wet area on the floor and grabbed a dry washcloth placed it on the floor and used the bottom of her shoe to wipe up the spill. LPN-C picked up the dirty washcloth and started to walk back to the laundry bin when she stopped to talk to R10. LPN-C took R10's walker and moved it to the other side of the table and then stood for a few minutes talking to R10. LPN-C still had the dirty washcloth from wiping up the floor in the palm of her hand, and when she grabbed R10's walker the washcloth became in contact with R10's walker handle. LPN-C proceeded to get another resident's clothing protector. Without washing her hands or using hand sanitizer LPN-C went R42 who was coughing and adjusted R42's mask over her nose. Once R42 stopped coughing, LPN-C went back to the bucket to get another washcloth. LPN-C then proceeded to wash R22's hands and walked R22 back to her

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 _____	03/03/2022

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
21375	Continued From page 9 room. During an interview on 3/2/22, at 1:13 p.m. LPN-C stated she did not wash her hands while serving breakfast and lunch. She stated facility protocol indicated staff must wash their hands before and after each encounter with a resident. During interview on 3/3/22, at 1:44 p.m. director of nursing (DON) and registered nurse (RN)-C stated their expectation was for all employees to wash or sanitize their hands before and after each resident encounter. R38's admission MDS dated 2/18/22, indicated R38 had mild cognitive deficits and was diagnosed with blindness in the right eye, heart failure, and glaucoma. During an observation and interview on 3/3/22, at 8:43 a.m. licensed practical nurse (LPN)-B entered R38's room with a small medicine cup containing 12 oral medications. LPN-B did not perform hand hygiene or use hand sanitizer prior to entering R38's room. LPN-B proceeded to pour a couple of pills into R38's hand, then picked up R38's large water jug and, holding the straw approximately 1.5 inches from the top with ungloved hands, assisted R38 to drink from it. R38 then requested the remaining pills be administered in yogurt. LPN-B left R38's room and returned to her medication cart without performing hand hygiene and proceeded to open the cup of yogurt on her cart and spoon some into R38's medication cup. LPN-B left the remainder of the yogurt on her medication cart and returned to R38's room. Without performing hand hygiene, LPN-B spooned a several medications out of the medication cup with yogurt and administered	21375		

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 _____	03/03/2022

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
21375	Continued From page 10 them to R38. LPN-B again took R38's water jug, and holding the straw approximately 1.5 inches from the top held it in R38's mouth while she drank from it. After R38 finished swallowing all her pills, LPN-B left R38's room and returned to the medication cart without performing hand hygiene. LPN-B stated the policy was to wash their hands after every third resident that they assisted and to use hand sanitizer if their hands or gloves were visibly soiled. LPN-B stated she should have used hand sanitizer after assisting R38 to take her medications and touching her straw multiple times. Suggested Method of Correction The DON (Director of Nursing) or designee could review/revise facility policies related to hand hygiene and educate staff. Then the DON or designee could educate staff and perform audits to ensure the policies are being followed. Time Period for Correction: Twenty-one (21) days.	21375		
21675	MN Rule 4658.1410 Linen Nursing home staff must handle, store, process, and transport linens so as to prevent the spread of infection according to the infection control program and policies as required by part 4658.0800. These laundering policies must comply with the manufacturer's instructions for the laundering equipment and products and include a wash formula addressing the time, temperature, water hardness, bleach, and final pH.	21675		4/5/22

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 _____	03/03/2022

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
21675	Continued From page 11 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure ventilation in the laundry room prevented cross-contamination of clean linens from fans blowing from the soiled linen processing area to the clean linen area. This had the potential to affect all residents residing in the facility. Findings include: During observation on 3/03/22, at 1:06 p.m. there were two fans attached to the walls turned on and blowing air from the dirty laundry processing area into the clean laundry area. When interviewed on 3/3/22, at 1:06 p.m. laundry aide (LA)-A stated the fans were placed because it was hot in the laundry area, and they had been in the same place for a long time. When interviewed on 3/3/22, at 1:12 p.m. maintenance worker (MW)-A stated the fans were placed to get air to the dryer side of the laundry room, but that he could see that the fans could blow dirty pathogens in to the clean area. When interviewed on 3/3/22, at 1:24 p.m. the director of nursing (DON) stated the fans placed where they were could cause cross contamination. A policy about laundry ventilation was requested; the DON stated she did not have a policy for that, but would have the fans moved. , SUGGESTED METHOD OF CORRECTION: The director of environmental services could review and revise the policies and procedures	21675	Corrected	

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 _____	03/03/2022

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
21675	Continued From page 12 related to ventilation and linen handling. He/she or designee could provide education to all involved staff. The facility could develop a monitoring system to ensure ongoing compliance and report the findings to the Qualify Assurance Committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21675		
21855	MN St. Statute 144.651 Subd. 15 Patients & Residents of HC Fac.Bill of Rights Subd. 15. Treatment privacy. Patients and residents shall have the right to respectfulness and privacy as it relates to their medical and personal care program. Case discussion, consultation, examination, and treatment are confidential and shall be conducted discreetly. Privacy shall be respected during toileting, bathing, and other activities of personal hygiene, except as needed for patient or resident safety or assistance. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain personal privacy when video monitoring in resident rooms was within view for all staff and visitors for 2 of 2 residents (R27 and R11) observed to have electronic video monitoring (EVM) in their room. Additionally, the facility failed to obtain proper written consent from the families for 2 of 2 residents (R27, R11) reviewed for EVM. Findings include:	21855	Corrected	4/5/22

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 _____	03/03/2022

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
21855	Continued From page 13 The Minnesota Department of Health (MDH) website guidance updated 10/22/21, indicated as part of the Elder Care and Vulnerable Adult Protection Act of 2019, the electronic monitoring law was one of a series of protections for elderly and vulnerable Minnesotans that took effect 1/1/20. Before an electronic monitoring device was placed, a resident or resident's representative must give written consent and if they had a roommate, get written consent from the roommate or the roommate's representative. Consent forms and further instructions regarding options for conditions and restrictions were provided on the MDH website. R27's Prospective Payment Systems (PPS) 5-day minimum data set (MDS) assessment dated 2/2/22, indicated R27 had moderate cognitive impairment and required extensive assistance of two people to assist with toileting, and extensive assistance of one person for walking in his room and transfers. R27's face sheet dated 3/3/22, indicated diagnoses of unsteadiness on feet, dementia, and muscle weakness. R27's providers orders dated 1/24/22, indicated EVM for risk for falls. R27's care plan dated 1/24/22, indicated a risk for falls related to medications, weakness, impaired balance, and because R27 did not always ask for assistance. Interventions to prevent falls included a video monitor placed in the room. The care plan indicated, "family is aware." There was no consent for video monitoring in the records.	21855		

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 _____	03/03/2022

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
21855	Continued From page 14 During observation on 3/2/22, R27 was observed sleeping on the video monitor that was located on the nursing station desk. The monitor was in view for anyone who entered the building or who came from the dining room to the living area of the facility. During observation 3/2/22, from 9:02 a.m. until 11:49 a.m. eight visitors came to nurses station to sign in for visitation who had opportunity to view the monitor. During that time, staff was observed looking at the monitor a 10:02 a.m. and 10:19 a.m. but not ongoing. When interviewed on 3/2/22, at 9:12 a.m. licensed practical nurse (LPN)-A stated seven residents were viewable on the monitor at that nurses station. LPN-A indicated the facility had consent from the families to use EVM, but there was no form to document the consent. LPN-A stated the camera in the room was turned when providing personal cares. When interviewed on 3/02/22, at 10:19 a.m. registered nurse (RN)-B stated the consent for EVM would be found in a progress note. There was no consent documented in R27's progress notes. R11's quarterly MDS dated 12/26/21, indicated R11 had severe cognitive impairment and diagnoses which included stroke and non-Alzheimer's dementia. The MDS indicated R11 required extensive assistance with bed mobility, transfers, walking and toileting. R11's Order Summary Report dated 4/23/21, indicated EVM for risk for falls. R11's care plan dated 9/25/20, indicated R11 was	21855		

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 _____	03/03/2022

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
21855	Continued From page 15	21855		

at risk for falls related to history of falls, cognitive impairment, impaired mobility and balance and frequent attempts to self transfer. The interventions included video monitor set up in room and "family is aware".

During observations on 3/1/22, at 1:45 p.m. R11 was laying in bed with her eyes closed and her call light within reach. R11 made no effort or attempt to self transfer out of bed. A video camera located on R11's television stand was pointed toward R11 while she was laying in bed. The video was observed to live stream R11 sleeping on a standard size computer monitor screen at the nurses station and there was no one at the nurses station at this time, however people intermittantly walked by the monitor. The monitor remained on and did not shut off or go to sleep due to inactivity. The monitor was easily viewable from the front desk nurses station where visitors and staff signed in and completed their COVID-19 screening before entering the resident care areas.

During an interview on 3/1/22, at 2:53 p.m. family member (FM)-A stated the facility felt EVM was necessary due to R11's fall risk and asked FM-A if she agreed to it. FM-A stated she agreed however had not signed a written consent. FM-A stated she did not know if the EVM was a saved recording or if it was live streamed. FM-A stated she would expect the EVM to be private and only viewed when necessary.

During continuous observation on 3/2/22, from 7:55 a.m. to 8:55 a.m. six visitors came to the front desk nurse's station to sign in and complete their COVID-19 screening and had an opportunity to view R11 on the monitor. At 7:57 a.m. the monitor showed an unidentified nursing assistant

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 _____	03/03/2022

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
21855	Continued From page 16 transfer R11 from her wheelchair to her recliner. At 8:04 a.m. RN-B entered R11's room and administered oral medications. LPN-A looked at the monitor at 8:09 a.m. but not ongoing. During intermittent observations on 3/2/22, between 10:55 a.m. and 12:01 p.m. there was live, continuous video feed from R11's room which broadcast on the monitor at the front desk nurses station. R11 was visible on the monitor. R11 was observed to be transferred into her wheelchair by nursing assistant (NA)-A, have a face mask put on, and be pushed in her wheelchair out of the room. R11 was observed to later enter her room alone by using her feet to self propel in her wheelchair. R11 removed her face mask and self propelled around in her room for a few minutes, organized some items in her dresser and then left. R11 made no attempts to self transfer. During an interview on 3/2/22, at 12:07 p.m. NA-A stated they were supposed to turn the video camera away when cares were being provided to allow for privacy because the monitors were always on. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) or designee could review and revise policies for maintaining confidentiality and privacy during electronic video monitoring of residents. All staff could be educated as necessary to the importance of maintaining privacy. The DON or designee, could perform observational audits to ensure no unnecessary staff, residents or visitors are able to view residents who are on electronic video monitoring. The DON or designee could take that information to QAPI to determine the	21855		

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 _____	03/03/2022

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
21855	Continued From page 17 need for further monitoring or compliance. TIME PERIOD FOR CORRECTION: (21) days.	21855		

Electronically delivered
March 22, 2022

Administrator
Shakopee Friendship Manor
1340 Third Avenue West
Shakopee, MN 55379

Re: State Nursing Home Licensing Orders
Event ID: 91Q311

Dear Administrator:

The above facility was surveyed on March 1, 2022 through March 3, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the

"Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Pete Cole, RN Unit Supervisor
Metro Team C District Office
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: peter.cole@state.mn.us
Office/Mobile: (651) 249-1724

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.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program

Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

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 _____	03/03/2022

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 On 3/1/22 through 3/3/22, a standard recertification survey was conducted at your facility. Your facility was found to be not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken),	F 583		4/5/22

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

Electronically Signed | 03/31/2022

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
	245445	A. BUILDING _____ B. WING _____	03/03/2022

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 583	Continued From page 1 written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain personal privacy when video monitoring in resident rooms was within view for all staff and visitors for 2 of 2 residents (R27 and R11) observed to have electronic video monitoring (EVM) in their room. Additionally, the facility failed to obtain proper written consent from the families for 2 of 2 residents (R27, R11) reviewed for EVM. Findings include: The Minnesota Department of Health (MDH) website guidance updated 10/22/21, indicated as part of the Elder Care and Vulnerable Adult Protection Act of 2019, the electronic monitoring law was one of a series of protections for elderly and vulnerable Minnesotans that took effect 1/1/20. Before an electronic monitoring device	F 583	Electronic Video Monitoring (EVM) of R27 and R11 was a facility-initiated fall-prevention intervention. Facility discussion included members of the QAPI team determined that EVM that was facility-initiated for R27, R11, and other facility residents posed a greater risk of infringing on residents' privacy and confidentiality which outweighed the potential benefit of using EVM as a fall prevention measure. Each resident's representative who had facility-initiated EVM devices (including R11 and R27) placed in their room received a notification letter either via email or mail indicating that Friendship Manor Health Care Center (FMHCC) would be discontinuing facility-initiated EVM as a fall-prevention intervention and this was documented by	

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 _____	03/03/2022

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 583	Continued From page 2 was placed, a resident or resident's representative must give written consent and if they had a roommate, get written consent from the roommate or the roommate's representative. Consent forms and further instructions regarding options for conditions and restrictions were provided on the MDH website. R27's Prospective Payment Systems (PPS) 5-day minimum data set (MDS) assessment dated 2/2/22, indicated R27 had moderate cognitive impairment and required extensive assistance of two people to assist with toileting, and extensive assistance of one person for walking in his room and transfers. R27's face sheet dated 3/3/22, indicated diagnoses of unsteadiness on feet, dementia, and muscle weakness. R27's providers orders dated 1/24/22, indicated EVM for risk for falls. R27's care plan dated 1/24/22, indicated a risk for falls related to medications, weakness, impaired balance, and because R27 did not always ask for assistance. Interventions to prevent falls included a video monitor placed in the room. The care plan indicated, "family is aware." There was no consent for video monitoring in the records. During observation on 3/2/22, R27 was observed sleeping on the video monitor that was located on the nursing station desk. The monitor was in view for anyone who entered the building or who came from the dining room to the living area of the facility.	F 583	Social Services in each individual resident chart. After resident representatives received notice of discontinuation, the Director of Nursing (DON) and Assistant Director of Nursing (ADON) removed all EVM devices currently in place and documented in each individual resident's chart (including R11 and R27). The devices are not stored in a container in the Nursing Office. Ongoing observation of R27, R11, and other residents who had EVM in their rooms continues through use of frequent visual checks by nursing staff which is signed-off in the Treatment Administration Record (TAR). The ADON reviewed and updated FMHCC's Electronic Video Monitoring policy to guide future use of EVM at the facility utilizing MN Statue 144.6502 and Minnesota Department of Health (MDH) for guidance which includes obtaining proper notification and consent forms. The EVM policy will be discussed during the admission process by Social Services going forward. The DON and ADON will ensure that any future EVM used at FMHCC follows the necessary privacy concerns and includes proper notification and consent received from the resident, the resident representative, the roommate, or the roommate's representative as applicable. The Director of Nursing will monitor EVM and that the facility's EVM policy is followed.	

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 _____	03/03/2022

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 583	Continued From page 3 During observation 3/2/22, from 9:02 a.m. until 11:49 a.m. eight visitors came to nurses station to sign in for visitation who had opportunity to view the monitor. During that time, staff was observed looking at the monitor a 10:02 a.m. and 10:19 a.m. but not ongoing. When interviewed on 3/2/22, at 9:12 a.m. licensed practical nurse (LPN)-A stated seven residents were viewable on the monitor at that nurses station. LPN-A indicated the facility had consent from the families to use EVM, but there was no form to document the consent. LPN-A stated the camera in the room was turned when providing personal cares. When interviewed on 3/02/22, at 10:19 a.m. registered nurse (RN)-B stated the consent for EVM would be found in a progress note. There was no consent documented in R27's progress notes. R11's quarterly MDS dated 12/26/21, indicated R11 had severe cognitive impairment and diagnoses which included stroke and non-Alzheimer's dementia. The MDS indicated R11 required extensive assistance with bed mobility, transfers, walking and toileting. R11's Order Summary Report dated 4/23/21, indicated EVM for risk for falls. R11's care plan dated 9/25/20, indicated R11 was at risk for falls related to history of falls, cognitive impairment, impaired mobility and balance and frequent attempts to self transfer. The interventions included video monitor set up in room and "family is aware".	F 583		

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 _____	03/03/2022

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 583	Continued From page 4 During observations on 3/1/22, at 1:45 p.m. R11 was laying in bed with her eyes closed and her call light within reach. R11 made no effort or attempt to self transfer out of bed. A video camera located on R11's television stand was pointed toward R11 while she was laying in bed. The video was observed to live stream R11 sleeping on a standard size computer monitor screen at the nurses station and there was no one at the nurses station at this time, however people intermittantly walked by the monitor. The monitor remained on and did not shut off or go to sleep due to inactivity. The monitor was easily viewable from the front desk nurses station where visitors and staff signed in and completed their COVID-19 screening before entering the resident care areas. During an interview on 3/1/22, at 2:53 p.m. family member (FM)-A stated the facility felt EVM was necessary due to R11's fall risk and asked FM-A if she agreed to it. FM-A stated she agreed however had not signed a written consent. FM-A stated she did not know if the EVM was a saved recording or if it was live streamed. FM-A stated she would expect the EVM to be private and only viewed when necessary. During continuous observation on 3/2/22, from 7:55 a.m. to 8:55 a.m. six visitors came to the front desk nurse's station to sign in and complete their COVID-19 screening and had an opportunity to view R11 on the monitor. At 7:57 a.m. the monitor showed an unidentified nursing assistant transfer R11 from her wheelchair to her recliner. At 8:04 a.m. RN-B entered R11's room and administered oral medications. LPN-A looked at the monitor at 8:09 a.m. but not ongoing.	F 583		

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 _____	03/03/2022

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 583	Continued From page 5 During intermittent observations on 3/2/22, between 10:55 a.m. and 12:01 p.m. there was live, continuous video feed from R11's room which broadcast on the monitor at the front desk nurses station. R11 was visible on the monitor. R11 was observed to be transferred into her wheelchair by nursing assistant (NA)-A, have a face mask put on, and be pushed in her wheelchair out of the room. R11 was observed to later enter her room alone by using her feet to self propel in her wheelchair. R11 removed her face mask and self propelled around in her room for a few minutes, organized some items in her dresser and then left. R11 made no attempts to self transfer. During an interview on 3/2/22, at 12:07 p.m. NA-A stated they were supposed to turn the video camera away when cares were being provided to allow for privacy because the monitors were always on. During an interview on 3/2/22, at 12:11 p.m. LPN-A stated they were supposed to turn the video camera away when cares were provided to allow for privacy. LPN-A stated the monitor at the front desk nurses station was always on showing EVM on a live stream, it did not turn of when not in use or during periods of inactivity. LPN-A agreed the monitor could be viewed clearly from the front desk during visitor sign in and COVID-19 screening station. During an interview on 3/2/22, at 12:14 p.m. RN-B stated the EVM was in place due to R11's risk of falls. RN-B stated they could probably turn the monitor away when not in use so it was not in view to anyone that came in or walked by,	F 583		

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 _____	03/03/2022

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 583	Continued From page 6 however that had not been addressed yet. During an interview on 3/2/22, at 12:23 p.m. social services (SS)-A stated when residents were admitted she completed a written video consent with the family or representative which she believed covered EVM. Orders were then placed to review the need for ongoing monitoring and EVM was put in the care plan. SS-A reviewed the video consent which indicated a media consent for "publicizing or explaining Friendship Manor and its activities". SS-A stated she was not aware the consent did not cover EVM until at this time. SS-A stated they always got verbal consent from the family to initiate EVM. During an interview on 3/2/22, at 12:26 p.m. RN-C stated the facility did not have a specific consent form for EVM. RN-C agreed the monitor was not private at the front desk nurses station. RN-C stated during cares the camera was supposed to be turned away to allow for privacy and there was no purpose to have it on while no one was at the nurses station. During an interview on 3/3/22, at 11:00 a.m. the director of nursing (DON) stated she would expect resident privacy to be maintained and the proper consent to be obtained for EVM. The DON stated they put a couple pieces of paper over the monitor today so it was not visible all the time. Additionally, when nurses were at the desk they were instructed to angle the monitor so it was not visible to all visitors entering the facility. The Notice of Privacy Practices dated 6/8/20, indicated the facility was required to maintain the privacy of health information.	F 583		

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 _____	03/03/2022

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 583	Continued From page 7 The facility Photo-Video Release Approval spreadsheet dated 2/4/22, did not include permission for EVM. The Electronic Video Monitoring Policy dated 4/20/21, indicated EVM equipment would be placed in areas that did not enable public viewing while in use.	F 583		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to follow orders for TED hose (compression stockings) to legs for 1 of 1 resident (R40) reviewed for edema. Findings include: R40's admission Minimum Data Set (MDS) dated 2/21/21, indicated R40 had moderate cognitive impairment and required extensive assist of one staff for bed mobility and dressing. R40's diagnoses included high blood pressure, edema (swelling caused due to excess fluid accumulation in the body tissues) and muscle weakness.	F 684	TED Stockings were applied to R40 immediately and all nursing staff providing care for R40 were informed of R40's current order for TED Stockings. The NAR care sheets, care plan, and Kardex were updated to match R40's current order in Treatment Administration Record (TAR) to include R40's use of TED Stockings on in AM and off at HS. All nursing staff (i.e., Registered Nurses (RN), Licensed Practical Nurse (LPN), Trained Medication Aide (TMA), Nursing Assistants (NAR), and Temporary Nurse Aides (TNA) received education on edema management including what	4/5/22

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 _____	03/03/2022

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 684	Continued From page 8 R40's Order Summary Report dated 2/19/22, indicated knee high TED hose on in the morning (AM) and off in the evening (PM) for edema. R40's care plan dated 2/24/22, indicated R40 had a self-care deficit related to pain in right knee and weakness. R40 required extensive assistance with dressing. The care plan lacked direction for TED hose. R40's nursing assistant (NA) care card, undated, indicated R40 required one assist with activities of daily living (ADLs). The NA care card lacked direction to apply TED hose. During observation on 3/1/22, at 3:53 p.m. R40 was sitting in her room chair. R40 removed her sock to show pitting edema (swelling caused due to excess fluid accumulation in the body tissues) in both ankles and feet. R40 had on gray ankle socks and did not have TED hose on as ordered. R40 stated her TED hose were not put on today by nursing staff but she did not know why. R40 stated her TED hose were normally kept in her dresser top drawer. One pair of TED hose were observed folded in the top drawer. During observation on 3/2/22, at 9:18 a.m. R40 was sitting in her room chair. R40 removed her sock to show pitting edema in both ankles and feet. R40 had on similar gray ankle socks as the previous day and did not have TED hose on, as ordered. R40 stated it was too difficult to put TED hose on herself and her feet hurt some days due to the swelling. R40 stated she had not had them put on for a few days now and her physician told her to wear them to help push fluid from her legs up to her heart. R40 stated, "I should probably have them on today."	F 684	edema is, how it is treated, prevented, and managed at FMHCC, and what each employee's role in edema management at FMHCC through Power Point, Policy review, and Quiz during in-service. The Assistant Director of Nursing (ADON) reviewed and updated the current facility policy Compression Stockings to include use of all compression therapy used at FMHCC (i.e., TED Stockings, Ace Wraps, or Tubigrips) now titled Compression Therapy which outlines specific steps in obtaining and transcribing orders for compression therapy at the facility. The ADON also created the Application of Compression Therapy policy to guide nursing staff on the wear and care of the specific types of compression therapy used (i.e., application, removal, and care). Both policies (i.e., Compression Therapy Policy and Application of Compression Therapy) discussed and an attestation received by all nursing staff during the in-service conducted by the ADON. The MDS Coordinator and Medical Records Nurse reviewed all resident's charts for the use of compression therapy to ensure the residents who are receiving compression therapy have the correct treatment/service listed in the TAR, NAR Care Sheets, Kardex, and Care plan (i.e., Each individual resident who has compression therapy has the same order in the TAR, NAR Care Sheets, Kardex, and Care Plan). Thereafter, chart review and audits will occur upon admission/readmission and quarterly to	

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 _____	03/03/2022

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 684	Continued From page 9 During an interview on 3/2/22, at 1:51 p.m. NA-C stated she had not put R40's TED stockings on her for a couple days because she was not sure where they were. During an observation on 3/3/22, at 9:51 a.m. R40 was sitting in her room chair. R40 removed her sock to show pitting edema in both ankles and feet. R40 had on loose gripper socks, no shoes and no TED hose on as ordered. R40 stated her other socks did not fit today so the NA's put on gripper socks. During an interview 3/3/22, at 9:57 a.m. licensed practical nurse (LPN)-B checked the medical record and stated R40 had an order for TED hose. LPN-B stated the NA's were responsible to put them on the residents during morning cares. LPN-B went into R40's room and removed her gripper socks. LPN-B stated R40 had pitting edema in both feet, ankles and lower legs, and indentations from the socks. LPN-B stated the TED hose were not placed and should have been. LPN-B brought NA-D into R40's room. NA-D removed a pair of TED hose from R40's top drawer and put them on R40's lower legs. During interview on 3/3/22, at 11:00 a.m. director of nursing (DON) stated she would expect edema management to be completed as ordered and TED'S applied as ordered. Compression Stocking Policy dated 3/3/22, indicated compression therapy (i.e. TED stockings) would be utilized when determined to be medically necessary by licensed nursing staff and the medical provider. The order would be added to NA care cards and care plan. NA would	F 684	assure residents who utilize compression therapy are receiving the necessary treatment/services to reduce, prevent, and manage edema. The MDS Coordinator will monitor that the care plans are being followed regarding cares on a routine basis. This will include random inspections throughout the facility. The Director of Nursing will monitor that the care plans are being followed on a periodic basis.	

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 _____	03/03/2022

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 684	Continued From page 10 assist residents with application of compression stockings per provider order and licensed staff would ensure they were applied.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a resident identified at risk for pressure ulcers received the necessary care and treatment to prevent the development of pressure ulcers for 1 of 2 resident (R34) in the sample identified at risk for pressure ulcers. Findings include: R34's quarterly Minimum Data Set (MDS) dated 11/14/21, indicated R34 had an unstageable pressure ulcer (full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar). R34's MDS further had	F 686	Heel protectors were applied to R34 immediately, and all staff providing care for R34 were reminded to follow R34's care plan which required that heel protectors be applied when R34 is sitting in the wheelchair and while in bed. All nursing assistants were re-educated to follow each resident's care plan. All nurses were re-educated that they are responsible for ensuring that the nursing assistants follow the resident's care plan, especially that heel protectors are applied when ordered, during the in-service. The MDS Coordinator and Medical	4/5/22

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 _____	03/03/2022

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 686	Continued From page 11 severe cognitive impairment, unable to communicate needs, advanced Parkinson's disease, diabetes, dementia R34's quarterly (MDS) dated 2/13/22, indicated R34 no longer had a pressure ulcer however continued to be at risk for the development of pressure ulcers. R34's Care Area Assessment (CAA) dated 3/3/22, indicated R34 was at risk for developing pressure ulcers. R34's physician order on 10/31/21, indicated heal protectors were to be worn at all times. R34's physician order on 1/17/21, indicated R34's pressure ulcer healed, and to continue wearing heel protectors at all times. R34's treatment administration record (TAR) on 3/3/22, indicated heel protectors to be worn at all times except when dressing or undressing. R34's care plan on 3/3/22, indicated R34 required the use of heel protectors, related to risk for skin impairment complicated by diabetes and advanced Parkinson's disease. During an observation on 3/03/22, 8:50 a.m. R34 was sitting in his wheelchair with dress socks on. R34 did not have his heel protectors on. R34's right heel was resting on top of the foot pedal's heel loop strap. The purpose of a heel strap is to prevent the resident's foot from sliding off the foot pedal. During an observation on 3/3/22, 9:00 a.m. R34 was resting in bed. R34's heel protectors were	F 686	Record Nurse reviewed all residents at risk for pressure ulcers facility wide to assure residents are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. Thereafter, review and audits will occur upon admission/readmission and quarterly to assure residents at risk for pressure ulcers receive the necessary treatment/services for prevention and to promote healing of pressure ulcers. The MDS Coordinator will monitor that the care plans are being followed regarding cares on a routine basis. This will include random inspections throughout the facility. The Director of Nursing will monitor that the care plans are being followed on a periodic basis.	

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 _____	03/03/2022

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 686	Continued From page 12 not on. R34's stiff body and bent knees prevented him from lying flat on the bed. Instead, R34's knees remained bent causing his upper and lower legs to be lifted off the bed. As a result of this position, R34's heels were forced directly downward into the mattress while his feet flexed upward. Nursing assistant (NA)-D stated R34's legs tend to be bent at the knees forcing his heels to dig down into the mattress. During an interview on 3/3/22, at 1:14 p.m. medical doctor (MD)-A stated R34 had end stage Parkinson's Disease. MD-A stated R34's previous heal ulcer left the skin thin and weakened. R34 had a high risk for developing another pressure ulcer at the same location. During an interview on 3/3/22, at 1:44 p.m. director of nursing (DON) and registered nurse (RN)-C stated R34's heels are fragile from previous skin breakdown and their expectation was for the nursing staff to follow provider orders to always have his heel protectors on.	F 686		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at	F 880		4/5/22

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 _____	03/03/2022

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 880	Continued From page 13 a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.	F 880		

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 _____	03/03/2022

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 880	Continued From page 14 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure hand hygiene was performed during personal cares for 8 of 8 residents (R15, R10, R13, R22, R9, R4, R19 and R42) and during a medication pass for 1 of 4 residents (R38) reviewed for medication administration. Further the facility failed to ensure ventilation in the laundry room prevented cross-contamination of clean linens from fans blowing from the soiled linen processing area to the clean linen area. Findings include: R15's annual MDS dated 1/2/2022, indicated moderate cognitive impairment, chronic pain, heart disease, and depression R10's significant change in status MDS dated 12/21/21, indicated severe cognitive impairment, Alzheimer's disease, heart disease, depression, and tremors. R13's quarterly Minimum Data Set (MDS) dated	F 880	Friendship Manor Health Care Center (FMHCC) failed to ensure hand hygiene was performed during personal cares of R15, R10, R13, R22, R9, R4, R19, and R42 and a medication pass for R38 and failed to ensure ventilation in the laundry room preventing cross-contamination of clean linens from fans blowing from soiled linen processing area to the clean linen area. FMHCC understands that the deficient practices above have the potential of affecting all resident's facility-wide. The maintenance department immediately relocated the erroneously placed fans to the clean linen side only to prevent cross-contamination. All staff were verbally informed immediately of hand hygiene noncompliance and more alcohol-based hand rub (ABHR) was placed on Station B dining room tables. A root cause analysis (RCA) was initiated	

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 _____	03/03/2022

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 880	Continued From page 15 1/2/22, indicated intact cognition, anxiety, muscle weakness, depression, and schizophrenia. R22's significant change in status MDS dated 1/27/21, indicated moderate cognitive impairment, dementia with behavioral disturbance, heart disease, and depression. R9's quarterly MDS dated 12/19/21, indicated severe cognitive impairment, dementia, heart disease, depression, and anxiety. R4's quarterly MDS dated 12/12/21, indicated moderate cognitive impairment, one sided paralysis after a stroke, heart disease, and depression. R19's annual MDS dated 1/23/21, indicated severe cognitive impairment, dementia, one side of the body paralysis, seizure disorder, anxiety, and depression. R42's quarterly MDS dated 1/30/22, indicated heart disease, high blood pressure, dementia with severe cognitive impairment. During an observation on 3/2/22, at 7:59 a.m. in the dining room licensed practical nurse (LPN)-C was seen rubbing her ungloved hands through R15's hair while talking to her. LPN-C went to R10's wheelchair touching the back of the chair. LPN-C rubbed her ungloved hands through her own hair. At no time during the continuous observation did LPN-C use hand sanitizer or wash her hands. LPN-C walked to the dish cart and got a clean coffee cup. LPN-C poured coffee into the cup and brought the cup to R13's room. LPN-C went to R13's room, set the cup on his	F 880	by the Assistant Director of Nursing (ADON) to identify the problems which resulted in the deficient practice(s). The RCA was discussed with members of the QAPI team including the Medical Director, Administrator, and Director of Nursing (DON) (refer to attached RCA(1). As a result of the RCA, an intervention FMHCC will implement is increasing the amount of ABHR conveniently located throughout the facility to increase hand hygiene compliance of staff (refer to attached (2) RCA Addendum). The ADON reviewed and updated current FMHCC policies on hand hygiene. Thereafter, the ADON developed education (refer to (3B) POC PowerPoint 2022) which incorporated the importance of hand hygiene, hand hygiene videos utilized from the Minnesota Department of Health (MDH) website on how to properly wash hands with soap and water and properly complete (ABHR, a hand hygiene quiz, and competency skills check off of ABHR and Hand Washing with Soap and water for all FMHCC employees to complete (refer to (4) sign-in sheets, (5) POC in-service education, and (5A)Education Addendum). Employees who missed the mandatory in-services dates of March 28, 2022 through April 1, 2022 are highlighted in yellow and are expected to complete this education with the ADON before their next shift. Starting Friday March 25, 2022 through April 1, 2022 the DON and ADON completed hand hygiene audits on all	

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 _____	03/03/2022

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 880	Continued From page 16 tray table and walked out of the room back to the dining area. LPN-C went meal tray cart and opened it. Without using hand sanitizer, washing her hands or applying gloves LPN-C grabbed R22's meal tray. LPN-C placed the meal tray on a table and removed the lid off the glasses, cut the french toast into smaller sizes, opened the syrup package and poured the syrup on to the french toast. LPN-C then picked up the meal tray and delivered it to R22's table. LPN-C went to the meal cart and grabbed R9's meal tray. LPN-C removed the lid off the glasses, cut R9's food into smaller bite sizes and brought R9's tray to her table. Without using hand sanitizer, washing her hands or applying gloves LPN-C took another tray for R4. LPN-C applied peanut butter and jelly to R4's toast, she peeled the banana and placed it on the tray. LPN-C then picked up R4's tray and placed it back on to the food cart. She then got R22 a drinking straw. After LPN-C removed the straw's wrapper she touched the straw with her bare hands before placing it into R4's glass. LPN-C then pulled down the condiment basket from the top of the meal cart. LPN-C then searched through the salt and pepper packets to find salt. When she got a packet of salt, an additional packet fell onto the floor. LPN-C bent over to pick up the packet off the floor and placed it back into the condiment container. LPN-C did not use hand sanitizer or wash her hands before entering or after leaving R4's room. LPN-C then placed R4's meal tray on his tray table. LPN-C grabbed a washcloth from R4's tray table, walked to the bathroom and rinsed the washcloth off. She then exited the bathroom and gave R4 the washcloth to wash his hands. LPN-C then exited R4's room, walked back to the dining room and without cleaning her hands or applying gloves she sat next to R9 to encourage her to eat. LPN-C	F 880	shifts, every day during this time period. 100% compliance was met on March 31 and April 1 (refer to (6) Hand Hygiene Audits). Therefore, the DON and ADON will complete hand hygiene audits on a bi-monthly basis and audits will continue until 100% compliance is met. The results of all the hand hygiene audits will be discussed in the next QAPI meeting. The Director of Nursing will conduct random hand hygiene audits on a continuing basis. Infection prevention including hand hygiene will be discussed at future Quality Assurance meetings.	

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 _____	03/03/2022

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 880	Continued From page 17 proceeded to pick up R9's fork and placed a piece of french toast onto the fork. LPN-C then handed the fork back to R9. LPN-C walked into the kitchen area, got a bucket from under the sink and several washcloths from the cabinet. LPN-C then filled the bucket with water and soap. LPN-C then placed the washcloths into the bucket. LPN-C did not apply soap directly to her hands during this process and did not use appropriate hand washing technique at that time. LPN-C then sat down next to R19 and started to set up his meal tray. LPN-C provided total feeding assistance to R19. During the entire observation LPN-C was not observed hand sanitizing or washing her ungloved hands. During observation on 3/2/22, 12:37 p.m. LPN-C used a washcloth to wipe R19's face. She then placed the washcloth in the laundry bin. LPN-C identified a wet area on the floor and grabbed a dry washcloth placed it on the floor and used the bottom of her shoe to wipe up the spill. LPN-C picked up the dirty washcloth and started to walk back to the laundry bin when she stopped to talk to R10. LPN-C took R10's walker and moved it to the other side of the table and then stood for a few minutes talking to R10. LPN-C still had the dirty washcloth from wiping up the floor in the palm of her hand, and when she grabbed R10's walker the washcloth became in contact with R10's walker handle. LPN-C proceeded to get another resident's clothing protector. Without washing her hands or using hand sanitizer LPN-C went R42 who was coughing and adjusted R42's mask over her nose. Once R42 stopped coughing, LPN-C went back to the bucket to get another washcloth. LPN-C then proceeded to wash R22's hands and walked R22 back to her room.	F 880		

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 _____	03/03/2022

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 880	Continued From page 18 During an interview on 3/2/22, at 1:13 p.m. LPN-C stated she did not wash her hands while serving breakfast and lunch. She stated facility protocol indicated staff must wash their hands before and after each encounter with a resident. During interview on 3/3/22, at 1:44 p.m. director of nursing (DON) and registered nurse (RN)-C stated their expectation was for all employees to wash or sanitize their hands before and after each resident encounter. R38's admission MDS dated 2/18/22, indicated R38 had mild cognitive deficits and was diagnosed with blindness in the right eye, heart failure, and glaucoma. During an observation and interview on 3/3/22, at 8:43 a.m. licensed practical nurse (LPN)-B entered R38's room with a small medicine cup containing 12 oral medications. LPN-B did not perform hand hygiene or use hand sanitizer prior to entering R38's room. LPN-B proceeded to pour a couple of pills into R38's hand, then picked up R38's large water jug and, holding the straw approximately 1.5 inches from the top with ungloved hands, assisted R38 to drink from it. R38 then requested the remaining pills be administered in yogurt. LPN-B left R38's room and returned to her medication cart without performing hand hygiene and proceeded to open the cup of yogurt on her cart and spoon some into R38's medication cup. LPN-B left the remainder of the yogurt on her medication cart and returned to R38's room. Without performing hand hygiene, LPN-B spooned a several medications out of the medication cup with yogurt and administered	F 880		

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 _____	03/03/2022

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 880	Continued From page 19 them to R38. LPN-B again took R38's water jug, and holding the straw approximately 1.5 inches from the top held it in R38's mouth while she drank from it. After R38 finished swallowing all her pills, LPN-B left R38's room and returned to the medication cart without performing hand hygiene. LPN-B stated the policy was to wash their hands after every third resident that they assisted and to use hand sanitizer if their hands or gloves were visibly soiled. LPN-B stated she should have used hand sanitizer after assisting R38 to take her medications and touching her straw multiple times. During observation on 3/03/22, at 1:06 p.m. there were two fans attached to the walls turned on and blowing air from the dirty laundry processing area into the clean laundry area. When interviewed on 3/3/22, at 1:06 p.m. laundry	F 880		

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 _____	03/03/2022

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 880	Continued From page 20 aide (LA)-A stated the fans were placed because it was hot in the laundry area, and they had been in the same place for a "long time". When interviewed on 3/3/22, at 1:12 p.m. maintenance worker (MW)-A stated the fans were placed to get air to the dryer side of the laundry room, but that he could see that the fans could direct air from the dirty laundry area to the clean laundry area. When interviewed on 3/3/22, at 1:24 p.m. the director of nursing (DON) stated the fans were placed where they were could cause cross contamination in the laundry area. A policy about laundry ventilation was requested; DON stated the facility did not have a policy for, but would have the fans moved.	F 880		