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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: GDXY

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00820

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245445**
2.STATE VENDOR OR MEDICAID NO.
(L2) **487540100**

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

4. TYPE OF ACTION: **7** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **05/22/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A** (L12)

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Gayle Lantto, Unit Supervisor 05/22/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 05/22/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
05/11/2015
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245445

May 22, 2015

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

Dear Mr. Salmela:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective May 7, 2015 the above facility is certified for:

80 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 80 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

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

Sincerely,

Mark Meath

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

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

May 22, 2015

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

RE: Project Number S5445024

Dear Mr. Salmela:

On April 21, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on April 9, 2015. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On May 22, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on May 11, 2015 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on April 9, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 7, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on April 9, 2015, effective May 7, 2015 and therefore remedies outlined in our letter to you dated April 21, 2015, will not be imposed.

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.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

Enclosure

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245445	A. Building B. Wing	5/22/2015

Name of Facility	Street Address, City, State, Zip Code
SHAKOPEE FRIENDSHIP MANOR	1340 THIRD AVENUE WEST SHAKOPEE, MN 55379

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/ or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0167** Reg. # **483.10(g)(1)** LSC	Correction Completed **04/28/2015**	ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **05/07/2015**	ID Prefix **F0356** Reg. # **483.30(e)** LSC	Correction Completed **04/28/2015**
ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **05/07/2015**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GL/mm	05/22/2015	15507	05/22/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
4/9/2015			

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245445	A. Building B. Wing **01 - MAIN BUILDING 01**	5/11/2015

Name of Facility	Street Address, City, State, Zip Code
SHAKOPEE FRIENDSHIP MANOR	1340 THIRD AVENUE WEST SHAKOPEE, MN 55379

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/ or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix	Correction Completed **04/29/2015**	ID Prefix	Correction Completed **05/04/2015**	ID Prefix	Correction Completed **05/04/2015**
Reg. # **NFPA 101**		Reg. # **NFPA 101**		Reg. # **NFPA 101**	
LSC K0018		LSC K0062		LSC K0067	
ID Prefix	Correction Completed **04/28/2015**	ID Prefix	Correction Completed **05/01/2015**	ID Prefix	Correction Completed **04/28/2015**
Reg. # **NFPA 101**		Reg. # **NFPA 101**		Reg. # **NFPA 101**	
LSC K0069		LSC K0074		LSC K0147	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	PS/mm	05/22/2015	25822	05/11/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
4/8/2015			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: GDXY

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00820

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245445**
2.STATE VENDOR OR MEDICAID NO.
(L2) **487540100**

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

4. TYPE OF ACTION: **2** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **04/09/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Jane Teipel, HFE NE II 05/04/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 05/08/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7013 2250 0001 6356 7075

April 21, 2015

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

RE: Project Number S5445024

Dear Mr. Salmela:

On April 9, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

<u>Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not

attained at the time of a revisit;

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

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

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

DEPARTMENT CONTACT

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

Gayle Lantto, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Email: gayle.lantto@state.mn.us
Telephone: (651) 201-3794
Fax: (651) 201-3790

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by May 19, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by May 19, 2015 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

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

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

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

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

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

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

- Include signature of provider and date.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's PoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the PoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by July 9, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by October 9, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

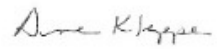
Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Email: pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,



Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697
:

Enclosure

cc: Licensing and Certification File

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

PRINTED: 04/21/2015
FORM APPROVED
OMB NO. 0938-0391

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 _____	04/09/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000	RECEIVED MAY - 1 2015 COMPLIANCE MONITORING DIVISION LICENSE AND CERTIFICATION	
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the most recent surveys results, were posted for residents and the public as required. This had the potential to affect families, staff, visitors and all 65 residents residing at the facility. Findings include:	F 167	POC accepted as is on 5/1/15 Not posting the most recent survey results was an oversight. The facility's information book has been updated to include the most recent survey results. The Administrator and the Staffing Coordinator will be responsible for updating the facility's information book, including replacing the prior survey results with the most recent survey results. The facility's Safety Committee will be responsible for verifying that this is done as required. The date of completion is April 28, 2015	4/28/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Bruce D. Salmela — TITLE: ADMINISTRATOR — (X6) DATE: 4/29/2015

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 _____	04/09/2015

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 167	Continued From page 1 On 4/6/15, at 1:12 p.m. surveyors were unable to locate the survey results in the common areas of the facility. On the Wing 1 lounge area a binder titled "Friendship Manor Health Care Center General Resident Data Manual " was found chained to a table. Although the binder contained survey results from 6/3/13, the results of the standard survey conducted 3/13/14, and a focused dementia survey conducted 9/18/14 were unavailable. For the rest of the survey days on 4/7, 4/8, and 4/9/15, the book remained the same. On 4/9/15, at 9:42 a.m. a licensed practical nurse (LPN)-A verified the survey results were not from the current survey. She stated she was unaware the current results were supposed to be posted, and said it would have been the responsibility of the administrator and director of nursing. On 4/9/15, 9:45 a.m. the administrator verified the survey results were not current, and stated he was responsible, but had forgotten. When asked how persons would know where the survey results were kept he responded, "They can ask." On 4/9/15, at 1:40 p.m. medical records staff person reported no policy for posting survey results was available.	F 167		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323		

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	245445	A. BUILDING _____ B. WING _____	04/09/2015

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F 323	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure bed side rails were safely secured to the bed frame to minimize the risk of injury for 1 of 1 resident (R70). Findings include: R70's bed rails were observed in the up position on 4/6/15, at 4:56 p.m. Both rails could easily be moved two to four inches back and forth. On 4/7/15, at 10:13 a.m. the rails were again easily moved and the right rail was bent inward toward the mattress. R70 reported at the time that he had just been assisted out of bed, and he used the side rails "all the time" to aid in bed mobility and transferring. R70's quarterly Minimum Data Set (MDS) dated 1/25/15, revealed the resident was independent with bed mobility and transferring. A fall Care Area Assessment (CAA) dated 5/8/14, indicated R70 had the potential for increased risk of falls, had multiple health concerns and pain. The CAA did not indicate side rails were in use. The care plan for R70 dated 6/9/14, indicated a self-care deficit related to activity intolerance and end stage chronic obstructive pulmonary disease with pain and shortness of breath. The plan noted the use of bilateral half side rails to aid the resident in repositioning and mobility. R70's Side Rail Comprehensive Summary dated 1/19/15, indicated the resident utilized the rails for	F 323	An attempt to fix the side rails on R70's bed proved unsuccessful. On 04/13/15, R70 received a new bed with quarter side rails which he used for bed mobility and transferring. R70's inappropriate bed had been provided to the facility by a Hospice Company. The Hospice Company was informed that a bed with those type of side rails was not allowed in this facility. Staff were reminded to inform the Resident Care Coordinator if this were to happen again. At the scheduled May 7, 2015 nursing staff meetings, all nursing staff will be re-educated on acceptable use of side rails. The Resident Care Coordinator, who spends the majority of her time working out on the floor, will monitor the use of side rails in the facility. The date of completion is May 7, 2015.	5/7/15

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F 323	Continued From page 3 turning side to side and getting out of bed safely. The assessment did not indicate whether the rails had been checked to ensure a secure fit. The maintenance director explained on 4/8/15, at 1:58 p.m. that the nursing assistants (NAs)would have been the first to notice concerns with bed rails, as they were in resident rooms daily. The NAs were supposed to log any concerns at the nursing station. In addition, monthly inspections were conducted by the housekeeping staff. The director then verified R70's bed frames were loosed and explained, "I tighten the clamp that holds the railing to bed frame." The director said R70's bed had been moved in the previous week, and if the rails had been loose at that time, he should have been notified. At 2:09 p.m. the director verified the need for repair of R70's bed rails had not been logged. On 4/9/15, at 11:30 a.m. the director of nursing (DON) explained "If nursing notices equipment that needs repairs they are supposed to put it in the book or call maintenance to fix it." A licensed practical nurse (LPN)-A was present at the time, and reported R70's bed had actually been provided by the hospice agency, who was therefore responsible for proper function of the equipment. The DON stated "We would have maintenance look at it here, but if it was something we were not able to fix, then hospice would be called to replace it." The facility's 4/07, Bed Rails--Intended Purpose and Potential Risks policy directed staff to ensure rails were maintained in good repair to minimize the risk for accidents.	F 323		
F 356	483.30(e) POSTED NURSE STAFFING	F 356		

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F 356 SS=C	Continued From page 4 INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure daily nursing hours were posted as required. This had the potential to affect all 65 residents and the public.	F 356	The Staffing Coordinator has updated the facility's "nurse staffing data" posting to include the facility name as required. The Staffing Coordinator will continue to be responsible for updating and posting the nurse staffing data on a daily basis as required. The Director of Nursing will be responsible for verifying that the daily posting is complete and accurate. The date of completion is April 28, 2015.	4/28/15

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F 356	Continued From page 5 Findings include: An untitled sheet of paper was observed under the activity calendar on a bulletin board on On 4/6/15, at 1:00 p.m. The paper was the posted nursing hours, however, it lacked the required information including the name of the facility, the daily census, and the actual hours worked for licensed and unlicensed nursing staff who provided direct care to residents. The following day at 8:46 a.m. and 4:16 p.m. the posting lacked the name of the facility and was not easily visible. On 4/9/14, at 9:34 a.m. the information posted was dated 4/8/15. On 4/9/15, at 9:34 a.m. the staffing coordinator (SC) explained she was responsible for ensuring the posted hours when she arrived at work at 8:30 a.m. except on the weekends when it was another staff person's responsibility. The SC verified the posting lacked the name of the facility and had not been posted on 4/8/15 and 4/9/15, at the beginning of the shift. The SC reported she was unaware the name of the facility was a requirement on the posting, and planned to check with the administrator regarding the regulation. On 4/9/15, at 9:45 a.m. when informed the daily posting was incomplete and incorrect the administrator stated, "You are right." On 4/9/15, at 1:40 p.m. the medical records staff reported the facility did not have a policy related to posting of nursing hours available.	F 356		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS	F 431		

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F 431	Continued From page 6 The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the medications stored in 2 of 2 medication rooms	F 431	The medication room key was taken away from the non-licensed Medical Records staff person. All nurses and TMA's were educated on not allowing non-licensed staff to go into the medication rooms unless a nurse or TMA stays with the non-licensed staff person while in the medication room. This was done at time of survey. The nurse that left the med cart unlocked and unattended was re-educated on proper med cart protocol. All nurses and TMA's have been reminded that med carts must be locked when walking away from the carts. This was done at time of survey. At the scheduled May 7, 2015 nurses meetings, the nursing staff will be formally re-educated on medication room and med cart protocol. The Resident Care Coordinator, who spends the majority of her time working out on the floor, will monitor the medication rooms and med carts for compliance. The date of completion is May 7, 2015.	5/7/15

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F 431	Continued From page 7 were only accessible to authorized personnel. In addition, the facility failed to lock a medication cart where biologicals and medications were stored, potentially affecting 41 of 65 residents capable of accessing the medications. Findings include: Station B Medication room On 4/6/15, at 6:22 p.m. a nursing assistant (NA)-B asked a registered nurse (RN)-A to open the door to the medication room so she could obtain the residents' snacks. RN-A opened the medication room and then left NA-B unattended inside the medication room. NA-B emerged from the medication room at 6:24 p.m. with a tote full of snacks. On 4/6/15, at 6:31 p.m. RN-A verified she left NA-B unattended in the medication room despite the sign on the door that read, "Only nurses/TMAs" (trained medication aides). RN-A explained that the resident snacks were stored in the locked medication room and the nurses unlocked the room for the NAs to retrieve the snacks every evening. RN-A verified the NAs would have had access to stock medications in the medication room and should not have been left unattended in the medication room. On 4/6/15, at 6:35 p.m. a licensed practical nurse (LPN)-C stated NAs were not supposed to have been in the medication room. LPN-C also indicated if NA-B was in the medication room she would have had access to medications, and the nurse should have supervised the NAs when they retrieved the snacks. On 4/8/15, at 7:21 a.m. the medical records staff	F 431		

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F 431	Continued From page 8 approached the medication room on Station B. She reached for a key from a ring of keys on her person and selected the key to the medication storage room, opened the door and went into the medication room as the door shut behind her. At 7:23 a.m. the medical records staff came out carrying several sheets of paper in her hands. The medical records staff was then asked if she was a nurse of TMA to which she replied, "No I work in medical records. I have a key to get into the medication rooms...." She explained she obtained papers from a bin stored in the medication room. Wing 3 The medication cart on Station A was unlocked and unattended during continuous observations on 4/7/15, from 1:47 to 2:12 p.m. The cart was located between the dining room and the nursing station approximately four feet from the main entrance door. It would have been obviously unlocked to any persons passing by, as the knob was fully extended outward. Numerous staff, a resident and a visitor passed the unlocked medication cart. Although RN-B said on 4/7/15, at 2:16 p.m., the facility policy was "Every time you turn your back from the cart you are supposed to lock it," but it had instead been left open. RN-B verified numerous types of prescription medications were stored in the cart and and could have been accessed by unauthorized persons. RN-B then locked the cart. On 4/9/15, at 11:20 a.m. the director of nursing (DON) and LPN-C were interviewed. The DON stated, "When they walk away from the cart it should be locked." The DON confirmed the NAs	F 431		

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F 431	Continued From page 9 should not have been left unattended in the medication rooms when obtaining resident snacks. Regarding the medical records staff possessing a key to the medication room, the DON stated "I was not aware she even had the key." LPN-C explained that the previous medical records staff person had been an LPN, but the current staff member was not a licensed staff person. She explained that she would have just picked up the papers she needed and then left the medication room. The facility's Policy And Procedure For Medication Storage dated 4/8/15, indicated "It is the policy of Friendship Manor that all medications will be stored in a secure location. Either in the medication cart or in the locked medication rooms. The staff will be allowed to have access to these locations will be licensed nursing staff/TMA. These staff will have a key to access these areas. If a non nursing staff member needs to be in the medication room for some reason, then the nursing staff may unlock room but must stay in medication room while non nursing staff is in the medication room. Non nursing will not be able to be in the medication room without nurse/TMA supervision."	F 431		

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	245445	A. BUILDING 01 - **MAIN BUILDING 01** B. WING _____	**04/08/2015**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Shakopee Friendship Manor was found not to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) 101 Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or	K 000	Pd ck 5-4-15 RECEIVED MAY 1 2015 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

Exit: 4-9-15 DC: 5-19-15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Bruce D. Salmela	ADMINISTRATOR	4/30/15

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K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Shakopee Friendship Manor is a 1 story building, with no basement. The original building was constructed in 1964 and was determined to be of Type II(111) construction. In 1976 an addition was constructed and was determined to be of Type II(111) construction. Because the original building and the addition meet the construction type allowed for existing buildings, the facility was surveyed as one building. The facility is fully fire sprinkler protected. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors, which is monitored for automatic fire department notification. The facility has a capacity of 80 beds and had a census of 65 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		

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SHAKOPEE FRIENDSHIP MANOR	**1340 THIRD AVENUE WEST SHAKOPEE, MN 55379**

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K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility did not have a corridor door that meets the requirements of NFPA 101 LSC (00) Section 19.3.6.3.2. The deficient practice could affect 15 out of 65 residents. Findings include: On facility tour between 10:30 AM and 2:00 PM on 04/08/2015, it was observed that the kitchen north and south corridor doors did not have latching hardware suitable for keeping the door closed.	K 018	On 04/29/15, new door latches were installed on the kitchen north and south corridor doors. The new door latches are suitable for keeping the door closed as required. The Maintenance Director will be responsible for maintaining that all door latches in the facility meet the required standards. The facility's Safety Committee will continuously monitor the safety of the facility. The date of completion is April 29, 2015.	4/29/15

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	245445	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	04/08/2015

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K 018	Continued From page 3 This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 018	On 04/28/2015, the Maintenance Director ordered six spare sprinkler heads to have in the facility in order for the facility to be in compliance. The Maintenance Director will be responsible for maintaining the appropriate number of spare sprinkler heads within the facility at all times. The facility's Safety Committee will add this requirement to their facility monitoring. The date of completion is May 4, 2015.	5/4/15
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the fire sprinkler system in accordance with the requirements of 2000 NFPA 101, Sections 19.3.4.1 and 9.6, as well as 1998 NFPA 25, section 2-4.1.4. This deficient practice could affect all 65 residents. Findings include: On facility tour between 10:30 AM and 2:00 PM on 04/08/2015, observation revealed that the spare sprinkler head box does not contain 2 of each type of sprinkler head in the facility; This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 062		
K 067 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed	K 067		

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	245445	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	04/08/2015

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K 067	Continued From page 4 in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, that the facility's general ventilating and air conditioning system (HVAC) was not maintained in accordance with the LSC, Section 19.5.2.1 and NFPA 90A, Section 3-4.7. A noncompliant HVAC system could affect all 65 residents. Findings include: On facility tour between 10:30 AM and 2:00 PM on 04/08/2015, documentation review for fire/smoke damper testing revealed, there was no documentation that the fire/smoke dampers have been tested with-in the last 4 years. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 067	Not having the fire/smoke damper testing done timely was an oversight. The facility's contracted fire alarm testing company has been scheduled to perform the fire/smoke damper testing on May 4, 2015. The facility is in the process of contracting with a new company to perform all fire alarm testing and monitoring. The facility's expectations of the new fire alarm testing and monitoring company will be to adhere to all timing deadlines. The Maintenance Director will be responsible for scheduling all fire alarm testing and monitoring keeping the facility in compliance. The facility's Safety Committee will monitor the accuracy of the fire alarm testing verifying that the facility is in compliance. The date of completion is May 4, 2015.	5/4/15
K 069 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility's kitchen cooking hood fire extinguishing system was not maintained in	K 069		

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K 069	Continued From page 5 accordance with 2000 NFPA 101 - 9.2.3 and 1998 NFPA 96 section 8.2. This deficient practice could affect all 65 residents. Findings include: On facility tour between 10:30 AM and 2:00 PM on 04/08/2015, the review of the kitchen hood system inspection documentation for the past 12 months revealed that the kitchen hood was not inspected every 6 months. The documented inspections were done on 06/09/14 and 01/14/15. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 069	The kitchen hood testing was scheduled with a contracted fire alarm testing company, however, the testing was not done timely. The facility is in the process of contracting with a new company to perform all fire alarm testing and monitoring. The facility's expectations of the new fire alarm testing and monitoring company will be to adhere to all timing deadlines. The Maintenance Director will be responsible for scheduling all fire alarm testing and monitoring keeping the facility in compliance. The facility's Safety Committee will monitor the accuracy of the fire alarm testing verifying that the facility is in compliance. The date of completion is April 28, 2015.	4/28/15
K 074 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701. Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 19.7.5.1, NFPA 13 Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3) , 10.3.4. 19.7.5.3	K 074		

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	245445	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/08/2015**

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K 074	Continued From page 6 This STANDARD is not met as evidenced by: Based on observation and staff interview, that the facility did not maintained the draperies/curtains for flame resistant in accordance with the LSC, Sections 10.3.1, 19.7.5.1 and NFPA 701. A noncompliant flame resistant material could affect 2 out of 65 residents. Findings include: On facility tour between 10:30 AM and 2:00 PM on 04/08/2015, observation revealed, that in the beauty shop there were shear draperies on windows and curtains covering the closet. No documentation could be provided for flame spread rating when asked. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 074	ForceField FireGuard flame retardant for fabrics and upholstery will be applied to the curtains and shear draperies in the beauty shop on May 1, 2015. The FireGuard product has been tested and proven effective, in accordance with the testing procedures of the National Fire Protection Association (Test Method NFPA 701) and meets the requirements of California State Fire Marshall Test 1237.1 The Maintenance Director will be responsible for maintaining that all draperies and curtains in the facility meet the required standards. The facility's Safety Committee will continuously monitor the safety of the facility. The date of completion is May 1, 2015.	5/1/15
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain electrical supply in accordance with the requirements of 2000 NFPA 101 - 19.5.1, 9.1.2, 1999 NFPA 70 and 2007	K 147		

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K 147	Continued From page 7 MSFC. The deficient practice could affect 15 out of 65 residents. Findings include: On facility tour between 10:30 AM and 2:00 PM on 04/08/2015, observation revealed, that the following was found: 1. The following locations have circuit breaker panels that are blocked: a. Main Entrance - free standing grandfather clock directly in front of panel b. Emergency generator room - nights stand blocking panel 2. Water fall is plugged into extension cord These deficient practices were confirmed by the Facility Maintenance Director at the time of discovery. *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 147	The circuit breaker panels have been made free of obstacles. The grandfather clock has been moved and the night stand in the generator room has been removed. An electrical outlet has been installed behind the waterfall display and the extension cord was removed. The Maintenance Director will be responsible for keeping the circuit breaker panels free of obstacles, and that no extension cords are used in the facility. The facility's Safety Committee will continuously monitor the safety of the facility. The date of completion is April 28, 2015.	4/29/15