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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: QSSK

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 **04/17/2012** (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 IMR	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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Pat Kohls, HFE NE II 04/23/2012 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Shellae Dietrich, Program Specialist 05/04/2012 (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
04/10/2012
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM

CCN# 24-5455

At the time of the standard survey completed March 2, 2012, the facility was not in substantial compliance and the most serious deficiencies were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections are required. The facility was given an opportunity to correct before remedies were imposed.

On April 17, 2012, the Minnesota Department of Health and, on April 12, 2012, the Minnesota Department of Public Safety completed a Post Certification Revisit (PCR) and determined that the facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to the standard survey, completed on March 2, 1012, effective April 17, 2012, therefore, the remedies outlined in our letter dated March 21, 2012, will not be imposed. See attached CMS-2567B forms for the results of the April 17, 2012 and April 12, 2012 revisits.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CCN # 24-5445 May 4, 2012

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 April 17, 2012 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.

Please contact me if you have any questions.

Sincerely,

Shellae Dietrich

Shellae Dietrich, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone #: (651) 201-4106 Fax #: (651) 215-9697
cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

April 23, 2012

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

RE: Project Number S5445021

Dear Mr. Salmela:

On March 21, 2012, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on March 2, 2012. This survey found the most serious deficiencies to beisolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On April 19, 2012, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on April 12, 2012 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 March 2, 2012. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 17, 2012. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on March 2, 2012, effective April 17, 2012 and therefore remedies outlined in our letter to you dated March 21, 2012, 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.

Sincerely,

Gayle Lantto

Gayle Lantto, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3794 Fax: (651) 201-3790

Enclosure

cc: Licensing and Certification File 5445r112.rtf

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	4/17/2012

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 **F0161** Reg. # **483.10(c)(7)** LSC	Correction Completed **04/17/2012**	ID Prefix **F0166** Reg. # **483.10(f)(2)** LSC	Correction Completed **04/17/2012**	ID Prefix **F0274** Reg. # **483.20(b)(2)(ii)** LSC	Correction Completed **04/17/2012**
ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **04/17/2012**	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/sd	04/23/12	03010	04/17/12
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
3/1/2012				

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245445	A. Building **01 - MAIN BUILDING 01** B. Wing	4/12/2012

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 Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # **NFPA 101** LSC K0052	**03/12/2012**	ID Prefix Reg. # **NFPA 101** LSC K0062	**04/10/2012**	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	PS/sd	04/23/12	22373	04/12/12
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:
3/2/2012

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

April 23, 2012

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

Re: Enclosed Reinspection Results - Project Number S5445021

Dear Mr. Salmela:

On April 19, 2012 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on March 1, 2012. At this time these correction orders were found corrected and are listed on the attached Revisit Report Form.

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,

Gayle Lantto

Gayle Lantto, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3794 Fax: (651) 201-3790

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

5445r112lic.rtf

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00820	A. Building B. Wing	4/17/2012

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 State surveyor to show those deficiencies previously reported 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 State Survey Report (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 **20540** Reg. # **MN Rule 4658.0400 Subp.** LSC	Correction Completed **04/17/2012**	ID Prefix **20900** Reg. # **MN Rule 4658.0525 Subp. :** LSC	Correction Completed **04/17/2012**	ID Prefix **21880** Reg. # **MN St. Statute 144.651 Sul** LSC	Correction Completed **04/17/2012**
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	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	GL/sd	04/23/12	03010	04/17/12
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 3/1/2012

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: QSSK

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 **03/02/2012** (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 IMR	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	IMR
	80			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Lisa Hakanson, HPR Dietary Specialist 04/02/2012 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Shellae Dietrich, Program Specialist 04/09/2012 (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
Posted 4/10/2012 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM

CCN# 24-5455

At the time of the standard survey completed March 2, 2012, the facility was not in substantial compliance and the most serious deficiencies were found to be isolated deficiencies that constitute actual harm that is not immediate jeopardy (Level G) whereby corrections are required. The facility has been given an opportunity to correct before remedies are imposed. See attached CMS-2567 for survey results. Post Certification Revisit to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 2780 0001 4939 5196

March 21, 2012

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

RE: Project Number S5445021

Dear Mr. Salmela:

On March 2, 2012, 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 isolated deficiencies that constitute actual harm that is not immediate jeopardy (Level G), 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
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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 April 10, 2012, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by April 10, 2012 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. 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 will be conducted to verify that substantial compliance with the regulations has been attained. The revisit 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 June 1, 2012 (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 September 1, 2012 (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
Division of Compliance Monitoring
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:

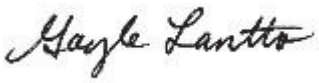
Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,



Gayle Lantto, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3794 Fax: (651) 201-3790

Enclosure

cc: Licensing and Certification File 5445s12.rtf

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 _____	03/01/2012

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 MAR 30 2012 COMPLIANCE MONITORING DIVISION LICENSE AND CERTIFICATION	
F 161 SS=E	483.10(c)(7) SURETY BOND - SECURITY OF PERSONAL FUNDS The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility. POC accepted A Lantto 3/30/12 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure resident's personal monetary funds were protected with a surety bond, having the potential to affect residents with personal funds accounts. Findings include: The facility administrator was interviewed at 3:00 p.m. on 2/28/12. The administrator stated the facility was in the process of switching to a new insurance provider, and could not locate a surety bond at the time of the interview. The administrator was re-interviewed at 11:30	F 161	Not having a surety bond was an oversight. The required surety bond was immediately secured and became effective March 1, 2012. The surety bond has been added to the Company's insurance binder and will automatically renew on an annual basis. The Administrator will verify that the surety bond is included in the renewal each year. The date of completion is March 1, 2012.	03/01/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Bruce D. Salmela — TITLE: ADMINISTRATOR — (X6) DATE: 3/28/2012

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

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F 161	Continued From page 1 a.m. on 2/29/12. The administrator stated that the facility had obtained a surety bond for the amount of $10,000.00 with West Bend Mutual Insurance Company that would become effective beginning on 3/1/12. The administrator stated he could not locate a surety bond that protected resident's personal funds prior to that date. The facility's resident personal funds account balance was reviewed for the previous quarter. The account balance as of 12/30/11 was $6,196.63.	F 161		
F 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to properly investigate allegations of missing property per facility lost item policy for 2 of 3 residents (R12 and R24). Findings include: The facility failed to ensure grievances were thoroughly investigated and resolved for R12. R12 reported missing candy from her room and the facility did not follow the Lost Items policy to thoroughly investigate and document the missing item.	F 166	All department heads have been educated on the Missing Item Report Policy and Procedure. All staff have been inserviced on the proper policy and procedure for reporting missing items, specifically completing the form in a timely manner. The Resident Care Coordinator will review this policy and form with all staff during the annual mandatory all-day inservice. The Administrator and Social Worker will verify that all missing item reports are filled out properly and resolved per Company policy. The date of completion is March 26, 2012.	03/26/12

#12 candy replaced

#24 pictures found (per SW 3/30/12 SF)

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F 166	Continued From page 2 The quarterly Minimum Data Set (MDS) assessment dated 12/14/11, indicated that R12 had intact cognition with no signs or symptoms of delirium. R12 was interviewed at 3:30 p.m. on 2/27/12. R12 indicated that she had recently reported that a whole box of chocolate covered cherries was missing from her dresser drawer, and half of the candy from another box was missing. The resident stated that the facility was still looking into the issue, and that she had not been reimbursed or provided with a replacement for the missing item. The facility social worker (SW) was interviewed at 9:00 a.m. on 3/1/12. The SW stated that the missing candy was reported to her by the recreational services director on approximately 2/14/12. The SW then went to the resident to get more information on the missing candy. The SW said that her investigation indicated the item may have gone missing during the night shift, and reported this to the director of nursing (DON). The SW stated she did not fill out a Lost Items report for the missing candy. The SW stated she was planning to replace the missing candy but had not gotten to it yet. The DON was interviewed at 2:00 p.m. on 2/28/12. The DON stated that the SW had informed her of the missing items. The DON said that interview and education were completed with her overnight staff at a staff meeting. The DON confirmed she did not complete a missing items report because she felt that candy was not a "solid" item like clothing or jewelry, and that it was therefore not necessary.	F 166		

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F 166	Continued From page 3 The facility's Lost Item policy (undated) was reviewed. The policy indicated that if a resident reported an item missing that it must be reported immediately to the charge nurse. The charge nurses will then look for the item and fill out a missing item report. The report would then be routed to the appropriate departments to ensure all individuals were aware of the missing item. The facility policy directed staff to initiate a missing item alert/report form after notification of a missing item. The form was not completed on R24 after reporting missing items. During observation at 1:45 p.m. on 2/29/12, R24's room had multiple pictures hanging on the walls. At 7:49 p.m. on 2/27/12, a family interview was conducted with family A. Family A reported that R24 was missing two pictures. The family member stated that staff at the facility were notified on 2/21/12, about the missing items and further stated that there had been no follow up from the facility regarding the status of the missing items. The family member reported that the hospice staff informed them of one picture being found with a broken frame, however; the other picture was not recovered and the staff at the facility had not notified the family of the results of the investigation. During an interview with the administrator at 1:20 p.m. on 2/29/12, the lost item policy was reviewed. The administrator verified that the policy directed all staff to complete the missing item report whenever a item was reported missing. Copies of the form were to go to the social worker, director of nursing, and the	F 166		

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F 166	Continued From page 4 administrator. After the form was completed, an investigation would be conducted. At the conclusion of the investigation the social worker would then follow up with the resident and/or family member with the results of the investigation. During interview with director of nursing (DON) at 1:30 p.m. on 2/29/12, the DON reported that she was unaware of any missing items for R24 and verified that she had no documentation of any missing items. During interview with licensed practical nurse (LPN-B) at 1:35 p.m. on 2/28/12, she stated that pictures were reported missing on 2/22/12, by R24's family and further stated that she forgot to fill out the Missing Item Alert/Report Form. LPN-B reported that both pictures that were reported missing by the family, are now in R24's room and further stated that she had not notified the family of the outcome of missing items. LPN-B stated that she would update R24's family of the status of the reported missing items. Review of the facility's Lost Item Policy, undated, instructed staff to report immediately to the charge nurse. The policy indicated that the charge nurse would look for the missing item or assign a nursing assistant to search. The policy added that the charge nurse would fill out a Missing Item Report and the report would be routed to the appropriate departments so that all individuals were aware of the missing item. Although the facility had a system in place to identify and track missing personal belonging the facility failed to implement their system for R12	F 166		

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F 166	Continued From page 5 and R24's missing items.	F 166		
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess 1 of 1 resident (R39) reviewed for dependence of activities of daily living (ADL's) and an indwelling urinary catheter. Findings include: R39 had an indwelling urinary catheter and currently received total assistance with personal care needs and mobility which the facility did not comprehensively assess or evaluate. The significant change Minimum Data Set (MDS) assessment for R39, dated 11/25/11, indicated the resident's active diagnoses included metastatic renal cancer to bone, anemia, altered	F 274	R39's care plan was updated to include the decline in the resident's ADL's. Staff will be re-educated on updating the careplan and the MDS nurse when there are changes in a resident's condition. When changes occur the nursing staff must update the Medical Records nurse and the MDS Coordinator. The Medical Records nurse and MDS Coordinator will communicate to each other of the changes in a resident, so the care sheets and the care plan are both updated at the same time. The MDS Coordinator will verify that all changes in a resident's condition are included on the MDS and care plan. Resident Care Coordinator will be conducting random chart auditing verifying compliance. The date of completion is March 27, 2012.	03/27/12

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F 274	Continued From page 6	F 274		

mental status, hematuria (blood in the urine), benign prostatic hypertrophy without obstruction, and history of disorder of kidney/ureter. The MDS indicated that R39 received assistance from staff for dressing and grooming due to a decline in functional ability. The MDS indicated R39 remained continent of bladder and bowel and was independent with mobility and eating.

R39 was observed on 2/27/12, at 4:30 p.m. in bed wearing a neck collar device, and received oxygen by nasal cannula. On 2/28/12: at 9:00 a.m. R39 was in bed while the nursing assistant (NA) provided total oral care. R39 was given multiple cues to open his mouth and then was assisted with sips of water via a straw. R39 was then repositioned. R39 did not actively participate during these cares.

At 10:00 a.m. on 2/28/12, the NA provided personal cares to R39. An entire bathing was completed by the NA and R39 did not participate in any part of the cares. The NA was observed to do catheter care and after cares were completed again repositioned R39.

Nurse manager-A (NM-A) was interviewed on 3/1/12 at 10:25 a.m. regarding the lack of a catheter assessment and change in ADL status. NM-A confirmed that a comprehensive catheter assessment had not been completed, the decline in R39's ability to complete personal cares had not been assessed, and current needs had not been identified. Nurse manager-A added that R39 was on hospice and changes were happening quickly due to health decline.

A bladder assessment was last complemented on

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F 274	Continued From page 7 11/25/11. The assessment indicated that R39 "remains independent" and that R39 had exhibited the following changes: 1/23/12, an indwelling urinary catheter placed due to hematuria; 1/28/12, intermittent confusion throughout the day - delusional; restless in bed talking to self; and 2/4/12, required assist of staff with personal cares and transfers. The record lacked documentation of an assessment or evaluation of the justification for the indwelling catheter and the decline in the R39's general status resulting in dependence for ADL's.	F 274	R49 was seen by a wound MD on 3/7/12 and changed the treatment plan. The wound MD does not want any packing done to the wound, only that the wound should be covered with a dressing after normal washing. The NP for R49 seen the resident on 3/8/12 and documented that the wound is not expected to heal. Also, that the goal is to prevent infection and pain.	04/06/12
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure 1 of 1 resident (R49) with a pressure ulcer received care and treatment in accordance with recommendations and treatment orders, resulting in harm to the resident. Findings include: R49 had a stage III pressure ulcer (defined as an	F 314	The two new house NPs were talked to regarding this tag and the necessity of the Registered Dietician's recommendations being addressed in a more timely manner and if the NP's refuses the recommendations, then there must be documentation for their rationale for not following the recommendation. The Dietician will also write "urgent" on the recommendations that need to be addressed sooner than the other recommendations. This will alert the nurses and the NP to address those first. Resident Care Coordinator will keep copies of all the recommendations for tracking follow up on each recommendation. The nursing staff will be educated on documentation and the importance of good skin/prevention of breakdown. The date of completion will be April 6, 2012.	

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F 314	Continued From page 8 observable pressure-related alteration of skin with full thickness tissue loss) on the coccyx and did not receive treatment as ordered for 4 days, resulting in an increase in size of the ulcer. The resident also failed to receive orders for protein powder supplementation to promote wound healing, as recommended by the facility's dietitian. R49 was admitted to the facility on 9/26/11. The resident's admission assessment indicated R49 had intact skin with no areas of breakdown. The resident's quarterly Minimum Data Set assessment dated 1/1/12, indicated that R49 was at risk for pressure ulcers and currently had a stage III pressure ulcer at the time of assessment. The resident was receiving a pressure relieving mattress and wheelchair cushion, was on a repositioning program and receiving nutritional interventions. The resident was coded as occasionally incontinent of bowel and bladder and required extensive assistance in mobility and transferring. Diagnoses noted to contribute to risk for skin breakdown were diabetes mellitus type II and failure to thrive. A Checklist of Skin Risk Factors and Interventions (undated) was completed for R49. The facility rated the resident ' s Braden Score (a sale that measures risk for skin breakdown) as 15, or at mild risk. The resident ' s other risk factors were listed as needs assistance with ADL ' s, low albumin (a measure of serum protein), pain, diabetic, depression and a current stage III pressure ulcer on the coccyx. A Wound Flow Sheet was initiated on 11/13/11	F 314		

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F 314	Continued From page 9 for R49 indicating the resident had developed a stage III pressure ulcer on the coccyx. The ulcer was measured as 1 centimeter (cm) in length by 1 cm in width. The wound was described as 100% slough (necrotic tissue that is light colored, soft and moist) with no undermining or tunneling of the wound. The Resident Wound Log dated 11/14/11 indicated that the resident ' s family, physician and the registered dietitian (RD) were notified of the pressure ulcer on 11/13/11. The log indicated that the resident had complained of butt pain on the morning of 11/13/11 and the ulcer was found during a bath. A repositioning schedule was initiated for every twp hours, but it was noted that the resident preferred to remain on her back. Wound Flow Sheets for R49 were reviewed from 11/21/11 through 2/24/11. The resident's pressure ulcer showed slow improvement from 11/14/11 through 1/31/12, decreasing in size from 0.8 cm by 1 cm on 11/21/11 to 0.2 cm by 0.2 cm on 1/31/12. On 2/8/12, a dietary note indicated that the resident ' s wound continued to improve, but albumin levels drawn on 1/10/12 were low. The dietitian wrote a recommendation for one scoop of protein powder twice daily to be added to the resident's food or fluids to increase protein levels to assist in wound healing. On 2/14/12 the wound was measured at 0.4 cm by 0.2 cm, an increase from the previous measurement, and continued to have no drainage, undermining or tunneling.	F 314		

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F 314	Continued From page 10	F 314		

A dietary note dated 2/17/12 indicated that the resident ' s wound was larger and that the resident had lost weight. Again, one scoop of protein powder twice daily was recommended to aid in wound healing. A review of physician's orders through date 3/2/12 revealed that this order had not been initiated after the recommendation made on 2/8/12.

On 2/20/12 the wound size was 0.5 cm by 0.5 cm, with a moderate amount of tan drainage. There was tunneling noted at 12 o'clock through 6 o'clock with 0.8 cm depth. The resident complained of tenderness at the time of the assessment. The note indicated the nurse practitioner (NP) was notified and prescribed new treatment orders.

Physician orders dated 2/20/12 for treatment of the pressure ulcer were to irrigate the wound and loosely pack with saline packing into the area twice daily.

On 2/22/12 a nursing progress note indicated R49 complained of severe butt pain related to the open area on the coccyx. The area was described as dark pink with a fluid discharge. The resident complained of severe pain during the dressing change. The resident's certified nurse practitioner (CNP) was notified to obtain an order for pain medication.

Physician orders reviewed for 2/22/12 did not indicate any new orders were placed for pain medication for R49. No changes were made to the treatment for the ulcer.

On 2/24/12 a nursing progress note indicated the

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	245445	A. BUILDING _____ B. WING _____	03/01/2012

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 314	Continued From page 11 CNP observed R49's pressure ulcer. The CNP noted clear yellow drainage and discomfort during the treatment of the area. New treatment orders were written and a referral was placed to a wound clinic. Physician orders dated 2/24/12 indicated the new treatment orders for the pressure ulcer were to irrigate the area with 35 milliliters (ml) of saline, and to monitor for any signs or symptoms of infection. On 2/27/12 R49 was seen by a registered nurse (RN-B) from a specialized wound clinic. RN-B measured the wound opening at 0.3 cm by 0.2 cm. Undermining at 12 o'clock was measured at 1.5 cm and 2 cm at 7 o'clock. RN-B noted creamy drainage from the wound, and that the area was painful to minimal pressure with the exam. The surrounding skin was noted to have a papular rash. RN-B suspected that the wound was larger than it appeared on the surface, and recommended the area be opened by surgeon to further assess it. Orders for a plan of treatment were provided to the facility by RN-B on 2/27/12. This included applying Lidocaine gel to inside of the wound to numb it, fully irrigate with saline, irrigate with dilute Hibicleanse, and rinse again with saline. Roll gauze lightly dampened with saline and tuck into wound to get into undermining and stretch the opening. Apply Nystatin to wound and cover with foam dressing and tape. Change daily. RN-B also recommended a Group 2 mattress for pressure relief, and 3-4 inch foam overlay for additional wheelchair padding.	F 314		

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F 314	Continued From page 12 The Pressure Ulcer and Impaired Skin Integrity Care plan for R49, last updated January 2012, was reviewed. The care plan problem was listed as: at risk for impaired skin integrity due to decreased mobility, occasionally incontinent of bowel and bladder, and refuses meals at times. The goal was listed that the R49 would have no skin breakdown this quarter. Approaches included Braden assessment per protocol and as needed, reposition every two hours, skin audits on bath days, treatments as needed, diabetic foot care at bedtime, air mattress, dressing to skin breakdown per orders and in-house wound nurse to follow. A clinical manager (CM-A) was interviewed on 2/28/12 regarding the resident's current treatment plan. CM-A indicated that she was waiting for a number of supplies to be delivered and would not be completing the wound care clinic's treatment orders from 2/27/12 until supplies arrived. CM-A was interviewed on 2/29/12; the nurse indicated that she was still waiting on supplies to be delivered. CM-A was interviewed at 10:30 a.m. on 3/1/12. CM-A indicated the facility was still waiting on Nystatin powder to be delivered and that she had not yet initiated the wound clinic treatment orders from 2/27/12. CM-A stated that they were still following treatment orders the Nurse Practitioner made on 2/24/12. The CM indicated that they had not notified R49's physician that the treatment orders from 2/27/12 had not yet been initiated and that the physician was likely unaware the previous order was still being used. The CM indicated that the wheelchair cushion	F 314		

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F 314	Continued From page 13	F 314		

recommended by the wound care clinic was due to be delivered later that day.

The facility's certified dietary manager (CDM) was interviewed at 8:15 a.m. on 3/1/12. The CDM was unaware that the dietician had recommended protein powder for R49 in 2 consecutive dietary notes. The CDM indicated that the dietary staff typically fill out a Nutritional Recommendations form and give it to the CDM following each visit. The CDM would then seek out physician orders for the recommendation. The CDM was unable to find a nutritional recommendation form for R49 from 2/8 or 2/17. The CDM confirmed that R49 did not currently have orders for protein powder as recommended. The CDM stated the facility did not have a policy on communication between dietary staff.

The facility ' s consultant registered dietitian (RD) was interviewed at 9:15 a.m. on 3/1/12. The consultant dietician confirmed that a Nutritional Recommendations form would have been completed by the dietitian for any recommendations made for R49, which would have been given to the CDM to obtain physician orders. The RD provided a copy of a Nutritional Recommendations form dated 2/17/12 indicating the dietitian requested R49 start one scoop of protein powder daily.

The resident did not allow observation of the pressure ulcer by survey staff, but the CM-A provided measurements of R49's pressure ulcer at 2:00 p.m. on 3/1/12. Measurements were 0.5 cm by 0.3 cm with tunneling at 7 o'clock a depth of 3 cm and from 12 o'clock to 6 o'clock a depth of 2 cm, indicating the pressure ulcer had

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F 314	Continued From page 14 increased in size and depth since the wound nurse had measured the area on 2/27/12. The facility's Skin Integrity Prevention/Management Policy and Procedure dated 2/11 was reviewed. The policy stated that residents were to be screened for any risk factors for pressure ulcer development, to determine tissue tolerance, and to develop an individualized plan of care for prevention. Evaluation and assessment using the Braden Scale, Tissue Tolerance of each resident for risk would occur on admit, quarterly and as needed with any change. For ulcers that were not improved or show now progression toward healing in two weeks, the physician would be notified for a change in the treatment plan.	F 314		

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	245445	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	03/02/2012

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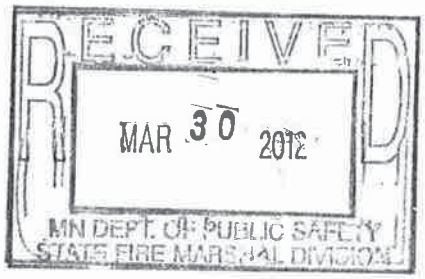
K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR 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 on March 2, 2012. At the time of this survey, Shakopee Friendship Manor was found not 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: Patrick Sheehan, Supervisor Health Care Fire Inspections State Fire Marshal Division 444 Cedar St., Suite 145 ST. Paul, MN 55101-5145 Pat.Sheehan@state.mn.us	K 000	 POC ok PS 4-2-12	

DC: 04/02/2012

EXIT: 03.01.2012

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Bruce D. Dalmela	ADMINISTRATOR	3/28/2012

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

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K 000	Continued From page 1 Facsimile: 651-215-0525 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 was constructed as follows: The original building was constructed in 1964, is one-story in height, has no basement, is fully fire sprinkler protected, and was determined to be of Type II(111) construction; A building addition was constructed in 1976. It is one-story in height, has no basement, is fully fire sprinkler protected and was determined to be of Type II(111) construction. 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 69 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is	K 052		

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K 052	Continued From page 2 installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: NFPA 101 (2000) LIFE SAFETY CODE SURVEY REGULATION - A fire alarm system required for life safety shall be installed, tested, and maintained in accordance with NFPA 70 National Electrical Code (1999 edition) and NFPA 72 National Fire Alarm Code (1999 edition). The system shall have an approved maintenance and testing program complying with the applicable requirements of NFPA 70 (99) and NFPA 72 (99) and NFPA 101 Life Safety Code (2000 edition), Chapter 9, Section 9.6.1.4. This STANDARD is not met as evidenced by: Based upon a review of available documentation provided by facility staff, the facility failed to maintain the building fire alarm system in accordance with NFPA 101 (00) Chapter 9, Section 9.6 and Chapter 19, Section 19.3.4.1. and NFPA 72 (1999 edition) Sections 7-3.2 and 7-5.2.2 and Table 7-3.1. In a fire emergency, this deficient practice could adversely affect 80 of 80 residents, staff and visitors.	K 052	The current annual fire alarm inspection has been updated to include the locations of all the devices and that each one was properly tested. Documentation listing the location of all devices and that each one was properly tested will be required to be included with the annual fire alarm inspection on an ongoing basis. The Resident Care Coordinator will verify that the inventory of the devices is included with the annual inspection by the fire alarm inspection company. The date of completion is March 12, 2012.	03/12/12

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K 052	Continued From page 3 FINDINGS INCLUDE: On 3/2/12 at approximately 1:10 PM, while reviewing the facility's most recent Fire Alarm Inspection and Testing Form dated 11/17/11, it was verified that the form did not include all of the required information for an annual fire alarm system test report. Specifically, in the Alarm Initiating Devices and Circuit Information section, the report identified eight (8) manual fire alarm boxes and twelve (12) heat detectors in the system. However, the Initiating and Supervisory Device Tests and Inspections section of the form did not contain the visual inspection and functional test results for each of the initiating devices on the fire alarm system. This finding was confirmed with the facility administrator.	K 052		
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: NFPA 101 (2000) LIFE SAFETY CODE SURVEY REGULATION - Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically, and are in conformance with NFPA 101 (2000 edition), Chapter 19, Sections 19.3.5 and 19.7.6, and Chapter 9, Section 9.7	K 062	The fire alarm company has been contracted to relocate the sprinkler heads that are obstructed by the wall cabinet. The Resident Care Coordinator will conduct periodic tours of the facility, and correcting any violations found. The date of completion is April 10, 2012.	04/10/12

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K 062	Continued From page 4 and NFPA 13 (1999 edition) and NFPA 25 (1998 edition). This STANDARD is not met, as evidenced by the following: Based upon observation, the facility had a sidewall spray sprinkler installed closer than four (4) feet from a fixed obstruction. In a fire emergency, this deficient practice could adversely affect all staff working in the facility's kitchen. FINDINGS INCLUDE: On 3/2/12 at 2:20 PM, while surveying in the facility's Kitchen, observation revealed a sidewall spray sprinkler installed within six (6) inches of a wall cabinet. This arrangement created an obstruction to the full development of the sprinkler spray pattern, and was not in accordance with NFPA 13 (99), Chapter 5, Section 5-7.5.1.2. This finding was verified with the facility administrator at the time of discovery.	K 062		

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 2780 0001 4939 5196

March 21, 2012

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5445021

Dear Mr. Salmela:

The above facility was surveyed on February 27, 2012 through March 1, 2012 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

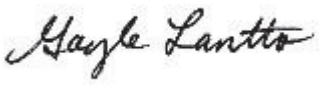
When all orders are corrected, the order form should be signed and returned to this office at Minnesota Department of Health, P.O. Box 64900, St. Paul, Minnesota 55164-0900. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

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,



Gayle Lantto, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3794 Fax: (651) 201-3790

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

5445s12lic.rtf

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 _____	03/01/2012

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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 On February 27- March 1, 2012 surveyors of this Department's staff, visited the above provider and the following correction orders are issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance Monitoring, Licensing and	2 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	

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2 000	Continued From page 1 Certification Programs; 85 East Seventh Place, Suite 220; P.O. Box 64900, St. Paul, Minnesota 55164-0900.	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
2 540	MN Rule 4658.0400 Subp. 1 & 2 Comprehensive Resident Assessment Subpart 1. Assessment. A nursing home must conduct a comprehensive assessment of each resident's needs, which describes the resident's capability to perform daily life functions and significant impairments in functional capacity. A nursing assessment conducted according to Minnesota Statutes, section 148.171, subdivision 15, may be used as part of the comprehensive resident assessment. The results of the	2 540		

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2 540	Continued From page 2 comprehensive resident assessment must be used to develop, review, and revise the resident's comprehensive plan of care as defined in part 4658.0405. Subp. 2. Information gathered. The comprehensive resident assessment must include at least the following information: A. medically defined conditions and prior medical history; B. medical status measurement; C. physical and mental functional status; D. sensory and physical impairments; E. nutritional status and requirements; F. special treatments or procedures; G. mental and psychosocial status; H. discharge potential; I. dental condition; J. activities potential; K. rehabilitation potential; L. cognitive status; M. drug therapy; and N. resident preferences. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess 1 of 1 resident (R39) reviewed for dependence of activities of daily living (ADL's) and an indwelling urinary catheter. Findings include: R39 had an indwelling urinary catheter and currently received total assistance with personal care needs and mobility which the facility did not comprehensively assess or evaluate. The significant change Minimum Data Set (MDS) assessment for R39, dated 11/25/11, indicated the resident's active diagnoses included	2 540		

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2 540	Continued From page 3 metastatic renal cancer to bone, anemia, altered mental status, hematuria (blood in the urine), benign prostatic hypertrophy without obstruction, and history of disorder of kidney/ureter. The MDS indicated that R39 received assistance from staff for dressing and grooming due to a decline in functional ability. The MDS indicated R39 remained continent of bladder and bowel and was independent with mobility and eating. R39 was observed on 2/27/12, at 4:30 p.m. in bed wearing a neck collar device, and received oxygen by nasal cannula. On 2/28/12: at 9:00 a.m. R39 was in bed while the nursing assistant (NA) provided total oral care. R39 was given multiple cues to open his mouth and then was assisted with sips of water via a straw. R39 was then repositioned. R39 did not actively participate during these cares. At 10:00 a.m. on 2/28/12, the NA provided personal cares to R39. An entire bathing was completed by the NA and R39 did not participate in any part of the cares. The NA was observed to do catheter care and after cares were completed again repositioned R39. Nurse manager-A (NM-A) was interviewed on 3/1/12 at 10:25 a.m. regarding the lack of a catheter assessment and change in ADL status. NM-A confirmed that a comprehensive catheter assessment had not been completed, the decline in R39's ability to complete personal cares had not been assessed, and current needs had not been identified. Nurse manager-A added that R39 was on hospice and changes were happening quickly due to health decline. A bladder assessment was last complemented on 11/25/11. The assessment indicated that R39	2 540		

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2 540	Continued From page 4 "remains independent" and that R39 had exhibited the following changes: 1/23/12, an indwelling urinary catheter placed due to hematuria; 1/28/12, intermittent confusion throughout the day - delusional; restless in bed talking to self; and 2/4/12, required assist of staff with personal cares and transfers. The record lacked documentation of an assessment or evaluation of the justification for the indwelling catheter and the decline in the R39's general status resulting in dependence for ADL's. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could review the comprehensive assessments for residents who have indwelling catheters, and those who have a diagnosis of urinary incontinence to determine if the assessment were complete and accurate. Staff could be educated to assure signifiant change assessments are correctly completed. TIME PERIOD FOR CORRECTION: Thirty (30) days.	2 540		
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	2 900		

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2 900	Continued From page 5 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 1 of 1 resident (R49) with a pressure ulcer received care and treatment in accordance with recommendations and treatment orders, resulting in harm to the resident. Findings include: R49 had a stage III pressure ulcer (defined as an observable pressure-related alteration of skin with full thickness tissue loss) on the coccyx and did not receive treatment as ordered for 4 days, resulting in an increase in size of the ulcer. The resident also failed to receive orders for protein powder supplementation to promote wound healing, as recommended by the facility's dietitian. R49 was admitted to the facility on 9/26/11. The resident's admission assessment indicated R49 had intact skin with no areas of breakdown. The resident's quarterly Minimum Data Set assessment dated 1/1/12, indicated that R49 was at risk for pressure ulcers and currently had a stage III pressure ulcer at the time of assessment. The resident was receiving a pressure relieving mattress and wheelchair cushion, was on a repositioning program and receiving nutritional interventions. The resident was coded as occasionally incontinent of bowel and bladder and required extensive assistance in	2 900		

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2 900	Continued From page 6 mobility and transferring. Diagnoses noted to contribute to risk for skin breakdown were diabetes mellitus type II and failure to thrive. A Checklist of Skin Risk Factors and Interventions (undated) was completed for R49. The facility rated the resident ' s Braden Score (a sale that measures risk for skin breakdown) as 15, or at mild risk. The resident ' s other risk factors were listed as needs assistance with ADL ' s, low albumin (a measure of serum protein), pain, diabetic, depression and a current stage III pressure ulcer on the coccyx. A Wound Flow Sheet was initiated on 11/13/11 for R49 indicating the resident had developed a stage III pressure ulcer on the coccyx. The ulcer was measured as 1 centimeter (cm) in length by 1 cm in width. The wound was described as 100% slough (necrotic tissue that is light colored, soft and moist) with no undermining or tunneling of the wound. The Resident Wound Log dated 11/14/11 indicated that the resident ' s family, physician and the registered dietitian (RD) were notified of the pressure ulcer on 11/13/11. The log indicated that the resident had complained of butt pain on the morning of 11/13/11 and the ulcer was found during a bath. A repositioning schedule was initiated for every twp hours, but it was noted that the resident preferred to remain on her back. Wound Flow Sheets for R49 were reviewed from 11/21/11 through 2/24/11. The resident's pressure ulcer showed slow improvement from 11/14/11 through 1/31/12, decreasing in size from 0.8 cm by 1 cm on 11/21/11 to 0.2 cm by 0.2 cm on 1/31/12.	2 900		

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2 900	Continued From page 7 On 2/8/12, a dietary note indicated that the resident ' s wound continued to improve, but albumin levels drawn on 1/10/12 were low. The dietitian wrote a recommendation for one scoop of protein powder twice daily to be added to the resident's food or fluids to increase protein levels to assist in wound healing. On 2/14/12 the wound was measured at 0.4 cm by 0.2 cm, an increase from the previous measurement, and continued to have no drainage, undermining or tunneling. A dietary note dated 2/17/12 indicated that the resident ' s wound was larger and that the resident had lost weight. Again, one scoop of protein powder twice daily was recommended to aid in wound healing. A review of physician's orders through date 3/2/12 revealed that this order had not been initiated after the recommendation made on 2/8/12. On 2/20/12 the wound size was 0.5 cm by 0.5 cm, with a moderate amount of tan drainage. There was tunneling noted at 12 o'clock through 6 o'clock with 0.8 cm depth. The resident complained of tenderness at the time of the assessment. The note indicated the nurse practitioner (NP) was notified and prescribed new treatment orders. Physician orders dated 2/20/12 for treatment of the pressure ulcer were to irrigate the wound and loosely pack with saline packing into the area twice daily. On 2/22/12 a nursing progress note indicated R49 complained of severe butt pain related to the open area on the coccyx. The area was described as dark pink with a fluid discharge.	2 900		

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2 900	Continued From page 8 The resident complained of severe pain during the dressing change. The resident's certified nurse practitioner (CNP) was notified to obtain an order for pain medication. Physician orders reviewed for 2/22/12 did not indicate any new orders were placed for pain medication for R49. No changes were made to the treatment for the ulcer. On 2/24/12 a nursing progress note indicated the CNP observed R49's pressure ulcer. The CNP noted clear yellow drainage and discomfort during the treatment of the area. New treatment orders were written and a referral was placed to a wound clinic. Physician orders dated 2/24/12 indicated the new treatment orders for the pressure ulcer were to irrigate the area with 35 milliliters (ml) of saline, and to monitor for any signs or symptoms of infection. On 2/27/12 R49 was seen by a registered nurse (RN-B) from a specialized wound clinic. RN-B measured the wound opening at 0.3 cm by 0.2 cm. Undermining at 12 o'clock was measured at 1.5 cm and 2 cm at 7 o'clock. RN-B noted creamy drainage from the wound, and that the area was painful to minimal pressure with the exam. The surrounding skin was noted to have a papular rash. RN-B suspected that the wound was larger than it appeared on the surface, and recommended the area be opened by surgeon to further assess it. Orders for a plan of treatment were provided to the facility by RN-B on 2/27/12. This included applying Lidocaine gel to inside of the wound to numb it, fully irrigate with saline, irrigate with	2 900		

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2 900	Continued From page 9 dilute Hibicleanse, and rinse again with saline. Roll gauze lightly dampened with saline and tuck into wound to get into undermining and stretch the opening. Apply Nystatin to wound and cover with foam dressing and tape. Change daily. RN-B also recommended a Group 2 mattress for pressure relief, and 3-4 inch foam overlay for additional wheelchair padding. The Pressure Ulcer and Impaired Skin Integrity Care plan for R49, last updated January 2012, was reviewed. The care plan problem was listed as: at risk for impaired skin integrity due to decreased mobility, occasionally incontinent of bowel and bladder, and refuses meals at times. The goal was listed that the R49 would have no skin breakdown this quarter. Approaches included Braden assessment per protocol and as needed, reposition every two hours, skin audits on bath days, treatments as needed, diabetic foot care at bedtime, air mattress, dressing to skin breakdown per orders and in-house wound nurse to follow. A clinical manager (CM-A) was interviewed on 2/28/12 regarding the resident's current treatment plan. CM-A indicated that she was waiting for a number of supplies to be delivered and would not be completing the wound care clinic's treatment orders from 2/27/12 until supplies arrived. CM-A was interviewed on 2/29/12; the nurse indicated that she was still waiting on supplies to be delivered. CM-A was interviewed at 10:30 a.m. on 3/1/12. CM-A indicated the facility was still waiting on Nystatin powder to be delivered and that she had not yet initiated the wound clinic treatment orders from 2/27/12. CM-A stated that they were still	2 900		

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2 900	Continued From page 10 following treatment orders the Nurse Practitioner made on 2/24/12. The CM indicated that they had not notified R49's physician that the treatment orders from 2/27/12 had not yet been initiated and that the physician was likely unaware the previous order was still being used. The CM indicated that the wheelchair cushion recommended by the wound care clinic was due to be delivered later that day. The facility's certified dietary manager (CDM) was interviewed at 8:15 a.m. on 3/1/12. The CDM was unaware that the dietician had recommended protein powder for R49 in 2 consecutive dietary notes. The CDM indicated that the dietary staff typically fill out a Nutritional Recommendations form and give it to the CDM following each visit. The CDM would then seek out physician orders for the recommendation. The CDM was unable to find a nutritional recommendation form for R49 from 2/8 or 2/17. The CDM confirmed that R49 did not currently have orders for protein powder as recommended. The CDM stated the facility did not have a policy on communication between dietary staff. The facility ' s consultant registered dietitian (RD) was interviewed at 9:15 a.m. on 3/1/12. The consultant dietician confirmed that a Nutritional Recommendations form would have been completed by the dietitian for any recommendations made for R49, which would have been given to the CDM to obtain physician orders. The RD provided a copy of a Nutritional Recommendations form dated 2/17/12 indicating the dietitian requested R49 start one scoop of protein powder daily. The resident did not allow observation of the pressure ulcer by survey staff, but the CM-A	2 900		

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2 900	Continued From page 11 provided measurements of R49's pressure ulcer at 2:00 p.m. on 3/1/12. Measurements were 0.5 cm by 0.3 cm with tunneling at 7 o'clock a depth of 3 cm and from 12 o'clock to 6 o'clock a depth of 2 cm, indicating the pressure ulcer had increased in size and depth since the wound nurse had measured the area on 2/27/12. The facility's Skin Integrity Prevention/Management Policy and Procedure dated 2/11 was reviewed. The policy stated that residents were to be screened for any risk factors for pressure ulcer development, to determine tissue tolerance, and to develop an individualized plan of care for prevention. Evaluation and assessment using the Braden Scale, Tissue Tolerance of each resident for risk would occur on admit, quarterly and as needed with any change. For ulcers that were not improved or show now progression toward healing in two weeks, the physician would be notified for a change in the treatment plan. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) could review and revise existing policies and procedures as necessary to ensure residents receive care and services to promote healing of pressure ulcers. The DON could inservice all appropriate personnel and establish a monitoring system to ensure compliance. TIME PERIOD FOR CORRECTION: Thirty (30) days.	2 900		
21880	MN St. Statute 144.651 Subd. 20 Patients & Residents of HC Fac.Bill of Rights Subd. 20. Grievances. Patients and residents shall be encouraged and assisted, throughout	21880		

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21880	Continued From page 12 their stay in a facility or their course of treatment, to understand and exercise their rights as patients, residents, and citizens. Patients and residents may voice grievances and recommend changes in policies and services to facility staff and others of their choice, free from restraint, interference, coercion, discrimination, or reprisal, including threat of discharge. Notice of the grievance procedure of the facility or program, as well as addresses and telephone numbers for the Office of Health Facility Complaints and the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12) shall be posted in a conspicuous place. Every acute care inpatient facility, every residential program as defined in section 253C.01, every nonacute care facility, and every facility employing more than two people that provides outpatient mental health services shall have a written internal grievance procedure that, at a minimum, sets forth the process to be followed; specifies time limits, including time limits for facility response; provides for the patient or resident to have the assistance of an advocate; requires a written response to written grievances; and provides for a timely decision by an impartial decision maker if the grievance is not otherwise resolved. Compliance by hospitals, residential programs as defined in section 253C.01 which are hospital-based primary treatment programs, and outpatient surgery centers with section 144.691 and compliance by health maintenance organizations with section 62D.11 is deemed to be compliance with the requirement for a written internal grievance procedure.	21880		

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21880	Continued From page 13 This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to properly investigate allegations of missing property per facility lost item policy for 2 of 3 residents (R12 and R24). Findings include: Findings include: The facility failed to ensure grievances were thoroughly investigated and resolved for R12. R12 reported missing candy from her room and the facility did not follow the Lost Items policy to thoroughly investigate and document the missing item. The quarterly Minimum Data Set (MDS) assessment dated 12/14/11, indicated that R12 had intact cognition with no signs or symptoms of delirium. R12 was interviewed at 3:30 p.m. on 2/27/12. R12 indicated that she had recently reported that a whole box of chocolate covered cherries was missing from her dresser drawer, and half of the candy from another box was missing. The resident stated that the facility was still looking into the issue, and that she had not been reimbursed or provided with a replacement for the missing item. The facility social worker (SW) was interviewed at 9:00 a.m. on 3/1/12. The SW stated that the missing candy was reported to her by the recreational services director on approximately 2/14/12. The SW then went to the resident to get more information on the missing candy. The SW	21880		

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21880	Continued From page 14 said that her investigation indicated the item may have gone missing during the night shift, and reported this to the director of nursing (DON). The SW stated she did not fill out a Lost Items report for the missing candy. The SW stated she was planning to replace the missing candy but had not gotten to it yet. The DON was interviewed at 2:00 p.m. on 2/28/12. The DON stated that the SW had informed her of the missing items. The DON said that interview and education were completed with her overnight staff at a staff meeting. The DON confirmed she did not complete a missing items report because she felt that candy was not a "solid" item like clothing or jewelry, and that it was therefore not necessary. The facility's Lost Item policy (undated) was reviewed. The policy indicated that if a resident reported an item missing that it must be reported immediately to the charge nurse. The charge nurses will then look for the item and fill out a missing item report. The report would then be routed to the appropriate departments to ensure all individuals were aware of the missing item The facility policy directed staff to initiate a missing item alert/report form after notification of a missing item. The form was not completed on R24 after reporting missing items. During observation at 1:45 p.m. on 2/29/12, R24's room had multiple pictures hanging on the walls. At 7:49 p.m. on 2/27/12, a family interview was conducted with family A. Family A reported that R24 was missing two pictures. The family member stated that staff at the facility were notified on 2/21/12, about the missing items and further stated that there had been no follow up	21880		

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21880	Continued From page 15 from the facility regarding the status of the missing items. The family member reported that the hospice staff informed them of one picture being found with a broken frame, however; the other picture was not recovered and the staff at the facility had not notified the family of the results of the investigation. During an interview with the administrator at 1:20 p.m. on 2/29/12, the lost item policy was reviewed. The administrator verified that the policy directed all staff to complete the missing item report whenever a item was reported missing. Copies of the form were to go to the social worker, director of nursing, and the administrator. After the form was completed, an investigation would be conducted. At the conclusion of the investigation the social worker would then follow up with the resident and/or family member with the results of the investigation. During interview with director of nursing (DON) at 1:30 p.m. on 2/29/12, the DON reported that she was unaware of any missing items for R24 and verified that she had no documentation of any missing items. During interview with licensed practical nurse (LPN-B) at 1:35 p.m. on 2/28/12, she stated that pictures were reported missing on 2/22/12, by R24's family and further stated that she forgot to fill out the Missing Item Alert/Report Form. LPN-B reported that both pictures that were reported missing by the family, are now in R24's room and further stated that she had not notified the family of the outcome of missing items. LPN-B stated that she would update R24's family of the status of the reported missing items.	21880		

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 _____	03/01/2012

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

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21880	Continued From page 16 Review of the facility's Lost Item Policy, undated, instructed staff to report immediately to the charge nurse. The policy indicated that the charge nurse would look for the missing item or assign a nursing assistant to search. The policy added that the charge nurse would fill out a Missing Item Report and the report would be routed to the appropriate departments so that all individuals were aware of the missing item. Although the facility had a system in place to identify and track missing personal belonging the facility failed to implement their system for R12 and R24's missing items. SUGGESTED METHOD FOR CORRECTION: The administrator and social worker could review the policies and procedures regarding addressing the concerns brought forth regarding missing items to ensure that the issues brought forth are addressed, investigated and resolved in a timely manner. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21880		