Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 31, 2025

Administrator
SHAKOPEE FRIENDSHIP MANOR

1340 THIRD AVENUE WEST
SHAKOPEE, MN 55379

RE: CCN:245445
Cycle Start Date: July 23, 2025

Dear Administrator:

On July 23, 2025, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

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

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC 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:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Stefanie Salberg, Regional Operations Supervisor
Metro C District Office
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: stefanie.salberg@state.mn.us
Office: 651-201-4393 Mobile: 651-279-5602

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

If substantial compliance with the regulations is not verified by October 23, 2025 (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).

In addition, if substantial compliance with the regulations is not verified by January 23, 2026 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245445	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHAKOPEE FRIENDSHIP MANOR	1340 THIRD AVENUE WEST , SHAKOPEE, Minnesota, 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
E0000	Initial Comments On 7/21/25 to 7/23/25, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained.	E0000		07/31/2025
E0026 SS = C	Roles Under a Waiver Declared by Secretary CFR(s): 483.73(b)(8) §403.748(b)(8), §416.54(b)(6), §418.113(b)(6)(C)(iv), §441.184(b)(8), §460.84(b)(9), §482.15(b)(8), §483.73(b)(8), §483.475(b)(8), §485.542(b)(7), §485.625(b)(8), §485.920(b)(7), §494.62(b)(7). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] (8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care	E0026	The facility failed to ensure the Emergency Preparedness Plan (EPP) included a policy and procedure on how to address and identify the facility's role under a waiver declared by the Secretary, in accordance with section 1135 of the Act. The deficient standard has the potential to affect all residents who reside at the facility. Shakopee Friendship Manor (SFM) understands the importance of having a 1135 Waiver policy in place. SFM's plan of correction includes the following: Obtained a 1135 Waiver Policy from the facility owner on July 22, 2025. This policy was added to the EPP on July 31, 2025. The 1135 Waiver Policy and EPP will be reviewed in the department head meeting the week of August 11, 2025. The Assistant Director of Nursing (ADON) and Director of Nursing (DON) will hold a mandatory Plan of Correction (POC) meetings on August 14th and August 15th to discuss the 1135 Waiver Policy and changes made to the EPP. Staff who are unable to attend the meeting will be provided with meeting notes and a copy of the policies in which they will be required to attest that they read and understand the policy before August 22, 2025.	08/22/2025

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 reverse for further 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.

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

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E0026 SS = C	Continued from page 1 site identified by emergency management officials. *[For RNHCIs at §403.748(b):] Policies and procedures. (8) The role of the RNHCI under a waiver declared by the Secretary, in accordance with section 1135 of Act, in the provision of care at an alternative care site identified by emergency management officials. This STANDARD is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure their emergency preparedness plan (EPP) included policies and procedures to address and identify the facility's role under a waiver declared by the Secretary, in accordance with section 1135 of the Act, identified by emergency management officials during an emergency. This had the potential to affect all 52 residents currently residing in the facility. Findings include: The facility's EPP dated 4/9/25, was reviewed. The EPP lacked a policy or procedure for addressing the facility's role under an 1135 waiver declared by the Secretary during an emergency to provide services at an alternate site for their residents. During interview on 7/22/25 at 1:10 p.m., administrator and assistant director of nursing (ADON) verified they developed and oversaw the facility's emergency preparedness program. Both administrator and ADON stated they are unaware of anything pertaining to the procedures or policies relating to an 1135 waiver declaration. Administrator stated she was going to follow up regarding this. During a follow up interview on 7/23/25 at 9:30 a.m., administrator verified the policy regarding a 1135 waiver that was sent via email on 7/22/25 at 1:34 p.m. was not in place prior to the interview yesterday nor prior to start of survey. Administrator stated she had reached out to the owner of the company after the interview and the owner provided a policy regarding an 1135 waiver dated 7/22/25, after survey entrance, and the policy would be added to the emergency preparedness plan now.	E0026	Continued from page 1 To monitor the corrective actions and to ensure the deficient practice will not recur, the facility will review the EPP and subsequent 1135 Waiver Policy annually and update as needed. The deficiency will be corrected by August 22, 2025.	
F0000	INITIAL COMMENTS On 7/21/25 to 7/23/25, a standard recertification survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483,	F0000		07/31/2025

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F0000	Continued from page 2 Subpart B, Requirements for Long Term Care Facilities. Your facility was NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F0000		
F0645 SS = D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services,	F0645	The facility failed to ensure a Level II Pre-Admission Screening and Resident Review (PASARR) were completed, retained in the medical record, and readily available to ensure continuity of care with mental health needs for 1 of 1 resident (R30) reviewed for PASARR. Shakopee Friendship Manor (SFM) did not have a current PASARR policy and procedure in place. SFM understands the importance of having a PASARR policy and procedure in place to ensure proper screening and placement of all residents who are admitted to the facility. SFM plan of correction includes the following: Obtained a PASSAR policy from the facility owner on July 22, 2025 and will be immediately implemented by the facility thereafter. This policy will be reviewed at the department head meeting the week of August 11, 2025. The Assistant Director of Nursing (ADON) and Director of Nursing (DON) will hold mandatory Plan of Correction (POC) meetings on August 14th and August 15th to discuss the PASSAR Policy. Staff who are unable to attend the meeting will be provided with meeting notes to include a copy of the policy, and will be required to attest that they read and understand the policy before August 22, 2025. The DON and Administrator audited all current residents residing at the facility to ensure all final letters were in place and any follow-up that was needed occurred. To monitor that the corrective actions and deficient practice will not recur, the DON will complete a monthly audit of all new admissions to ensure the PASSAR has been received and is scanned into the resident's electronic health record (EHR) via Point Click Care (PCC). The DON will meet with the Administrator to ensure the follow-up took place if needed. The deficiency will be corrected by August 22, 2025.	08/22/2025

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F0645 SS = D	Continued from page 3 whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure a Level II Pre-Admission Screening and Resident Review (PASARR) were completed, retained in the medical record, and readily available to ensure continuity of care with mental health needs for 1 of 1 resident (R30) reviewed for PASARR. Findings include:	F0645		

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F0645 SS = D	Continued from page 4 R30's significant change Minimum Data Set (MDS) dated 7/7/25, indicated R30 had moderate cognitive impairment, did not have delusions, hallucinations or behaviors. R30's Clinical Diagnosis Report printed 7/23/25, indicated R30 was admitted on 4/4/23 and indicated diagnoses of paranoid schizophrenia (a chronic mental health disorder characterized by significant disturbances in thought, perception, and behavior, primarily marked by paranoid, delusions and hallucinations), cerebral infarction (area of damaged tissue on the brain), muscle weakness, drug induced dyskinesia (uncontrolled, involuntary muscle movement), diabetes, and hypertension. An attached Fax from Senior LinkAge Line, dated 4/5/23, included R30's Preadmission Screening (PAS) which stated "Based on the information provided for this nursing home admission, it appears this consumer MEETS Level of Care for purposes of MA payment. The Fax from senior LinkAge Line also included a letter which indicated the Senior LinkAge Line forwarded the PAS to the county/manage care organization for processing. The PAS is not final until the lead agency sends documentation to the nursing facility." R30's entire medical record was reviewed and lacked evidence the facility followed up with the Senior LinkAge Line to find out if further assessment was needed. During interview on 7/22/25 at 11:03 a.m., the administrator stated when a new resident was admitted from a hospital the hospital' social workers sent the PAS screening. The facility usually received the PAS screening upon new residents' admission. In the event a new resident was admitted from home, the facility completed PAS screening. Administrator stated once a PAS screening was received, it was immediately filed on residents' medical record. The administrator reviewed R30's record and verified the medical record lacked documentation of any further assessment done by the Senior LinkAge Line or a letter to confirm R30 did not meet the requirements to be evaluated for a level II screening. Administrator stated she was not aware the facility needed to follow up and obtain a document stating whether a resident needed an OBRA Level II referral. On 7/23/25 at 1:54 p.m., the facility provided a document via e-mail. The document was titled OBRA Level I Criteria Screening for Developmental Disabilities or	F0645		

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F0645 SS = D	Continued from page 5 Mental Illness and was dated 1/11/23. This document indicated R30 had cognitive or behavioral signs that would lead someone to suspect the presence of developmental disabilities or related conditions. This document also indicated R30 had a diagnosis or symptoms of mental illness that significantly interfered with functioning in life activities or caused significant distress the past six months. In addition, the document indicated R30 needed supportive services or interventions due to mental illness to maintain functioning within the past two years, and indicated an OBRA Level II referral was needed. During interview on 7/23/25 at 8:50 a.m., administrator stated she oversaw the PAS screenings and before the interview on 7/22/25 she was not aware a follow up was necessary. Administrator stated the purpose to complete a PASSAR screening was to know the residents' level of care and services needed. A PASARR policy was requested but was not provided.	F0645		
F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical	F0656	The facility failed to ensure a Comprehensive Care Clan was developed and maintained for (R9) reviewed with a history of wandering to ensure safety with wandering behaviors. Shakopee Friendship Manor (SFM) understands the importance of developing and maintaining Comprehensive Care Plans for all residents who reside at the facility to ensure appropriate and individualized care is provided. Wandering focus, goal, and interventions were immediately added to (R9) Care Plan. Medical Records (MR) completed a review of all residents in the facility for wandering and added a Task for the Registered Nursing Assistants (NAR) to sign off every shift for interventions used for those that wander. SFM plan of correction includes the following: Update of the following Assessment to ensure each resident is comprehensively evaluated for wandering: Updated the Monthly Summary assessment to include the following question under Wandering: If any of the above indicate wandering has occurred resident should be added to condition charting for one week. In addition, the facility will create a Wander Risk Policy by August 8, 2025 that will discuss procedures to initiate for residents, who through assessment or observation, wander. The policy will be reviewed in the department head meeting the week of August 11, 2025. The Assistant Director of Nursing (ADON) and Director	08/22/2025

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F0656 SS = D	Continued from page 6 record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: Based on observation, intervention, and document review, the facility failed to develop a comprehensive care plan to ensure safety with wandering behaviors for 1 of 1 residents (R9) reviewed who had a history of wandering. Findings include: R9's quarterly Minimum Data Set (MDS) dated 4/20/25, identified R47 had severe cognitive impairment and was dependent on staff during the lookback period (LBP) to use her manual wheelchair. The MDS indicated R9 had not wandered during the LBP. R9's progress note dated: -3/24/25 at 10:14 p.m., indicated R9 had been "wandering" trying to find the doctor's office. -4/1/25 at 9:36 p.m., indicated R9 was "often wandering down halls" and "1:1" and redirection had been effective interventions. -4/2/25 at 3:25 p.m., indicated R9 was wheeling herself into other residents' rooms and attempting to push a wheelchair that was in the hallway. -4/7/25 at 3:01 p.m., indicated R9 was wheeling herself	F0656	Continued from page 6 of Nursing (DON) will hold mandatory Plan of Correction (POC) meetings on August 14th and August 15th to discuss the Wander Risk Policy. Staff who are unable to attend the meeting will be provided with meeting notes with a copy of the policy, and will be required to attest that they read and understand the policy before August 22, 2025. To ensure the corrective actions and deficient practice will not recur, the DON will complete a monthly audit regarding Comprehensive Care Plans to ensure wandering has been addressed if the criteria above is documented in the residents' Electronic Medical Record (EHR) in Point Click Care (PCC). The deficiency will be corrected by August 22, 2025.	

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

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F0656 SS = D	Continued from page 7 in her wheelchair around the unit and yelling at the “laundry lady” to come back here. The note indicated staff would continue to redirect the resident. -4/11/25 at 2:48 p.m., indicated R9 was restless and "wandering" that shift. -4/17/25 at 1:51 p.m., indicated R9 was very anxious and wheeling herself around the unit, asking for help leaving. -5/28/25 at 2:58 p.m., indicated R9 continued to “wander” up and down both the long and short hall, and staff were able to redirect the resident. -5/28/25 at 3:18 p.m., indicated R9 had been “wandering” and getting into other residents’ rooms. R9’s Wandering Risk Assessment dated 4/16/25, indicated R9 was disoriented, “forgetful/short attention span”, independent with mobility with a mobility aide, had Alzheimer’s disease, and was taking antipsychotics and antidepressants. The assessment indicated R9 had a known history of wandering and indicated R9 had a “high risk” for wandering. R9’s Wandering Risk Scale dated 4/17/25, indicated R9 was able to follow instructions, could move without assistance while in the wheelchair, and had no history of wandering. The assessment indicated R9 was a low risk for wandering. R9’s Wandering Risk Assessment dated 7/17/25, indicated R9 was disoriented, did not understand surroundings or what was being said, and exhibited fear and anxiety. The assessment indicated R9 had Alzheimer’s disease and was taking antipsychotics and antidepressants. The assessment indicated R9 had a known history of wandering and indicated R9 had a “high risk” for wandering. R9’s Order Summary Report dated 7/17/25, indicated R9 was a “wander risk” as well as a fall risk, so red and yellow squares were placed on the outside of the door, and staff were to complete “frequent checks” on the resident. R9’s Follow Up Question Report dated 6/23/25 to 7/22/25, indicated R9 wandered in the hallway on 7/5/25 and 7/21/25 and “into other rooms/unsafe areas” on 7/6/25, 7/11/25, and 7/21/25. R9’s care plan was reviewed and did not include any behavioral interventions for R9 when wandering	F0656		

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F0656 SS = D	Continued from page 8 behaviors were observed. During an observation on 7/21/25 at 1:52 p.m., R9 was observed sitting in a recliner in her room with her eyes open. R9 did not respond or make eye contact to questions. During an interview on 7/22/25 at 1:20 p.m. with licensed practical nurse (LPN)-B and trained medication assistant (TMA)-A, LPN-B stated R9 was able to wheel herself around independently in her wheelchair and did have a history of wandering down the halls and into other resident rooms. LPN-B and TMA-A agreed that they had both attempted redirecting R9 and giving her an activity to do, and that had been a helpful intervention when R9 was wandering. During an interview on 7/23/25 at 9:21 a.m. with the director of nursing (DON) and assistant director of nursing (ADON), a registered nurse (RN), the ADON stated she would expect staff to redirect R9 if she were found wandering. The ADON stated she would expect R9's wandering behaviors to be care planned as soon as the behaviors started, including personalized interventions, so staff could be aware, as they did utilize agency staff. The ADON stated wandering was not a new behavior for R9, and it was "kind of her baseline," so she was unsure why this had not made it on the care plan. The facility's Care Planning Policy dated 4/9/25, indicated the facility would develop a comprehensive care plan to reflect each resident's objective goals and include services that would be given to maintain the resident's highest practicable physical, mental, and psychosocial well-being.	F0656		
F0685 SS = D	Treatment/Devices to Maintain Hearing/Vision CFR(s): 483.25(a)(1)(2) §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the	F0685	The facility failed to ensure a change with hearing ability was acted upon, fully evaluated, and if needed, treated or referred to the audiologist for (R1) reviewed who complained about worsening hearing. Shakopee Friendship Manor (SFM) understands the importance of developing a process to comprehensively evaluate and determine interventions or potential treatment needed for all residents who may have a change in hearing to promote quality of life. SFM plan of correction includes the following: Create an Assistive Device Evaluation and Management Policy by August 8, 2025. In the policy, the following interventions will be added and implemented: 1). All residents will receive Biannual (i.e., every 6	08/22/2025

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F0685 SS = D	Continued from page 9 treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a change with hearing ability was acted upon, fully evaluated and, if needed, treated or referred to the audiologist for 1 of 1 residents (R1) reviewed who complained about worsening hearing. Findings include: R1's annual Minimum Data Set (MDS), dated 4/20/25, identified R1 had severe cognitive impairment but demonstrated no delusional thinking. Further, the MDS recorded R1 as having, "Adequate," hearing with no hearing aid use. On 7/21/25 at 1:43 p.m., R1 was observed seated in a recliner chair while in her room. R1 did not have any hearing aids or audio devices present on her at this time. R1 was interviewed and stated her hearing in the left ear had been getting worse which concerned her. R1 was asked if they'd been seen by the audiologist for this and abruptly laughed stating, "I can't afford it." R1 was hard-of-hearing during the interview and would often times turn her head to the left side and respond, "Say again[?]," to the surveyor's questions. R1 stated she did not wear hearing aids and, again, responded, "I can't afford it." R1 stated she thought staff were aware of her hearing concerns but was unsure what, if anything, was being done about it. Further, R1 stated she had her ears checked and flushed (i.e., wax removal) before, however, it was in a clinic setting prior to her admitting to the care center. R1's Nursing Summary(s), dated 10/2024 to 4/2025, were reviewed. These each contained a section labeled, "A. Hearing and Hearing Aids," which had two questions to be answered by the evaluator. These identified: On 10/24/24, R1's hearing was recorded as, "Adequate," and no hearing devices were used. On 1/13/25, R1's hearing was recorded as, "Moderate difficulty," and no hearing devices were used. On 4/14/25, R1's hearing was recorded as, "Adequate," and no hearing devices were used.	F0685	Continued from page 9 months) ear checks for wax and start Standing House Orders (SHO) Treatment as needed to rule out excessive ear wax. 2). Update the Nursing Summary Assessment to include comprehensive questions regarding hearing loss and need for treatment and/or referral. 3) Edit the Care Conference template to include questions regarding ancillary services such as hearing, therefore any changes in residents' hearing can be addressed throughout their stay at the facility. Above interventions will be completed by August 8, 2025. The policy will be reviewed in the department head meeting the week of August 11, 2025. The Assistant Director of Nursing (ADON) and Director of Nursing (DON) will hold mandatory Plan of Correction (POC) meetings on August 14th and August 15th to discuss the Assisted Device Evaluation and Management Policy. Staff who are unable to attend the meeting will be provided with meeting notes including a copy of the policy, and will be required to attest that they read and understand the policy on or before August 22, 2025. To ensure the corrective actions and deficient practice will not recur, Medical Records will complete a monthly audit of all residents in the current assessment period for any changes in hearing based on current Nursing Summary Assessment answers, Care Conference notes or staff observation. A follow-up with the resident or resident's representative will occur if needed for possible referral by Medical Records. The deficiency will be corrected by August 22, 2025.	

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F0685 SS = D	Continued from page 10 On 7/15/25, R1's hearing was recorded as, "Minimal difficulty," and no hearing devices were used. When interviewed on 7/22/25 at 8:56 a.m., nursing assistant (NA)-A stated they had helped R1 multiple times with various cares. NA-A stated R1 was hard-of-hearing and one ear seemed to be worse than the other adding, "I'm not sure which ear it is but she is [hard-of-hearing]." NA-A stated R1 had been hard-of-hearing for "awhile" now and staff would, at times, have to repeat words to her for her to hear them. NA-A stated the believed the nurses were aware of R1's hearing difficulties adding, "They take care of it." However, R1's medical record was reviewed and lacked evidence the potential changes in hearing ability (i.e., adequate to moderate/minimal difficulty) had been comprehensively evaluated to determine what, if any, interventions or potential treatment was needed such as irrigation, flushing, or referral to the audiologist, despite the documented changes on the completed nursing summary(s) and direct care staff being aware of R1's hearing difficulty. When interviewed on 7/22/25 at 10:28 a.m., licensed practical nurse (LPN)-A stated they had worked with R1 only a handful of times. LPN-A stated they didn't feel R1 had too much difficult with hearing but added, "I tend to raise my voice a little louder [when conversing with elderly]." LPN-A stated nobody had reported concerns with R1's hearing to their recall, however, expressed any changes with hearing should be evaluated using a visual inspection to check for wax build-up and then doing treatment, if needed. LPN-A stated if an audiologist referral was needed, then family could be asked and that could be arranged. LPN-A stated this process, including evaluation and treatment, should be recorded in the progress notes. On 7/22/25 at 12:37 p.m., the assistant director of nursing (ADON) was interviewed, and verified they had an opportunity to review R1's medical record. ADON explained all residents were asked upon admission what, if any, ancillary services they wished for which included audiology and R1's family had only consented to podiatry back then. ADON stated the medical records personnel had since visited with R1's family about other services, however, it was not documented. ADON stated they were going to have the nurse working that day (7/22) go check in R1's ears and see if there was any wax build-up which could be addressed. ADON acknowledged the completed 'Nursing Summary(s)' which documented R1's potential hearing difficulties on some	F0685		

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F0685 SS = D	Continued from page 11 of them and expressed if a change was noticed, then staff should let the nurse or management know so it could be acted upon. ADON stated they were unaware the direct care staff had noticed R1 to be hard-of-hearing, too, and explained audiology was currently not one of the 'prompted' questions being asked at care conferences, either, so it could potentially be added to that and evaluated more often with residents adding, "That's another opportunity to improve." ADON verified any changes with hearing should be evaluated and acted upon adding it was important for a resident's "quality of life." A facility' policy on hearing evaluations and/or treatment was requested, however, none was received.	F0685		
F0697 SS = D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure recorded complaints of pain or discomfort were comprehensively assessed and, if needed, interventions developed to ensure adequate comfort for 1 of 2 residents (R12) reviewed for pain management. Findings include: R12's quarterly Minimum Data Set (MDS), dated 5/11/25, identified R12 had moderate cognitive impairment but demonstrated no delusional thinking. The MDS recorded R12 as consuming scheduled pain medication, but having no as-needed (i.e., PRN) medications or non-pharmacological interventions done for pain. Further, the MDS recorded R12 as, "Frequently," having pain with a moderate intensity recorded. On 7/21/25 at 1:57 p.m., R12 was observed seated in her wheelchair while in her room. R12 demonstrated no obvious physical symptoms of pain at this time (i.e., grimacing, moaning), however, when interviewed she expressed having pain in her legs and knees due to a fall which happened "awhile ago." R12 explained she was	F0697	The facility failed to ensure recorded complaints of pain and discomfort were comprehensively assessed and interventions developed to ensure adequate comfort of 1 of 2 residents (R12). Shakopee Friendship Manor (SFM) understands the importance of comprehensively assessing all residents for pain management to promote comfort and attain or maintain the highest level of well being for each resident. SFM plan of correction includes the following: 1) Update the Care Conference template to include a review of current effectiveness of pain regimen and what goals they have for pain management. 2) The Pain Assessment will be modified by August 8, 2025 to include comprehensive questions about the residents current pain regimen, interventions used, if they improved or exacerbated the pain, any pain characteristics and history of pain and goals for pain management. 3) SFM's current policy titled Pain Management Policy will be updated by August 8, 2025 to reflect changes made to the Care Conference template and the Pain Assessment to ensure guidance on the new procedures for pain management are clearly documented. The policy will be reviewed in the department head meeting the week of August 11, 2025. The Assistant Director of Nursing (ADON) and Director of Nursing (DON) will hold mandatory Plan of Correction (POC) meetings on August 14th and August 15th to discuss the changes made to the Pain Management Policy and the Care Conference template. Staff who are unable to attend the meeting will be provided with meeting	08/22/2025

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F0697 SS = D	Continued from page 12 currently working with physical therapy (PT) but it was "not doing good" to help the pain and she continued to have troubles with walking. R12 described the pain as "a sore" and expressed aloud, "It's terrible." R12 stated the staff were aware of her pain as they just add "another pain pill, and another, and another," however, it remained ineffective to adequately control her pain. R12 was asked if she'd ever had ice or heat applied to her knees and abruptly responded, "That don't help." R12 stated she had been using some "knee patches" while working with therapy and those did help some, however, she only used them when working with therapy and expressed maybe wearing those more often would help her pain. R12's care plan, dated 2/18/25, identified R12 was on pain medication and listed a goal which read, "[R12] will be free of any discomfort or adverse side effects from pain medication through the review date," along with several interventions to help R12 meet this goal. The interventions included providing pain medication as ordered, allowing her to rest to facilitate relief, completing a pain flow sheet per protocol, using non-medication techniques to help relieve pain and, "Review pain medication efficacy. [A]ssess whether pain intensity acceptable to resident, no treatment regimen or change in regimen required; Controlled adequately by therapeutic regimen[,] no treatment regimen or change in regimen required but continue to monitor closely ... Therapeutic regimen followed, but pain control ot adequate, changes required." R12's Pain Assessment, dated 2/13/25, identified R12 was evaluated for pain using the MDS questions (i.e., "Have you had pain or hurting at any time in the last 5 days?") with R12 being recorded as having no pain or hurting during the last five days. R12's most recent Pain Assessment, dated 5/11/25, identified R12 was again evaluated using the MDS questions but now R12 endorsed having pain or hurting with a recorded frequency of, "Frequently." The pain was listed as not having much, if any, effect on R12's sleep but did have interference with her day-to-day activities recorded as, "Occasionally." The intensity of the pain was recorded as, "2. Moderate." However, the evaluation lacked any comprehensive assessment of the pain including the pain' characteristics, history of the pain, items which worsened or improved it, or R12's goals for pain management; nor did the evaluation outlined what, if any, changes to R12's pain control regimen (i.e., medication adjustment, non-pharmacological interventions) would be considered or implemented to help reduce the pain.	F0697	Continued from page 12 notes including a copy of the policy, and will be required to attest that they read and understand the policy before August 22, 2025. To ensure the corrective action and deficient practice will not recur, the ADON or DON will complete a monthly audit for all residents in the current assessment period to ensure pain is being comprehensively assessed based on current Pain Assessment answers, Care Conference notes, and review of residents' medical records. The deficiency will be corrected by August 22, 2025.	

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F0697 SS = D	Continued from page 13 R12's progress note(s), dated 5/21/25 and 6/27/25, respectively, identified R12 had a care conference held where R12's pain medications were reviewed. However, on 6/27/25, a note recorded R12 as sitting on the bedside in the morning and, " ... complaining of knee pain and noted to be short tempered." R12 was provided her scheduled pain medications and had no further complaints recorded. R12's POC (Point of Care) Response History, dated 7/22/25, identified a look-back period of 21 days with recorded nursing assistant (NA) data asking, "Resident complained of pain?" This recorded the staff marking R12 as having complained of pain on 7/13/25, 7/15/25, 7/18/25, and 7/19/25. R12's Medication Administration Record (MAR), dated 7/2025, identified R12's current medications along with spacing to record their respective administration. The MAR outlined R12 had orders including: - Muscle Rub Cream 10-15% applied once daily which was ; - Tramadol (a narcotic) 25 milligrams (mg) twice a day with a, "Pain Level," recorded for each administration. These levels ranged from 0 to 3 (i.e., mild) on the scale; - Tylenol 1000 mg three times daily with a, "Pain Level, " recorded for each administration. These levels ranged from 0 to 3 on the scale. R12's Treatment Administration Record (TAR), dated 7/2025, identified R12's current treatments along with spacing to record their respective administration. The TAR outlined ta treatment for non-pharmacological pain interventions (i.e., massage, warm pack, cold pack) along with a number to represent which intervention was done and spacing to record which was used and if it improved the pain. This identified only a single non-pharmacological intervention of, "Cold Pack," as being done on 7/8/25 with the pain being recorded as improved. The TAR lacked any other recorded non-pharmacological interventions being done despite R12 having documented pain on 7/13/25, 7/15/25, 7/18/25, and 7/19/25, per the POC Response charting. When interviewed on 7/22/25 at 8:52 a.m., NA-A stated they had worked with R12 in helping with her with transfers, and expressed needed "extensive" assistance for many activities of daily living (ADLs). NA-A stated R12 "used to" complain of knee pain but they had not heard her voice complaints for awhile. NA-A stated the nurses did a muscle rub on R12 and reiterated they had	F0697		

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F0697 SS = D	Continued from page 14 not heard complaints of pain from R12 for awhile adding, "Me, personally [hadn't heard any]." R12's medical record was reviewed and lacked evidence R12's pain had been comprehensively evaluated to determine what, if any, additional interventions were needed to ensure comfort for R12 despite a potential change in her reported pain (i.e., Pain Assessments) and direct care staff charting R12 as having pain. The record lacked a comprehensive assessment of the pain including the pain' characteristics, history of the pain, items which worsened or improved it, or R12's goals for pain management. When interviewed on 7/22/25 at 10:26 a.m., licensed practical nurse (LPN)-A stated they had not worked closely with R12 but were aware of her care needs. LPN-A stated they had not heard R12 complain of pain themselves but explained the Pain Assessment(s) were the only documented evaluation of pain the nurses' completed to their knowledge. LPN-A stated if a resident started complaining of pain, the staff could repeat the evaluation or place a progress note with their evaluation and implement condition monitoring on the resident. LPN-A verified the POC Response History documentation was charted by the NA staff and verified R12 had recorded pain on several dates in July 2025. LPN-A stated there was no documented comprehensive assessment in the medical record "per se" but expressed complaints of pain should be evaluated adding it was more a verbal process than documented process. On 7/22/25 at 12:25 p.m., the assistant director of nursing (ADON) and director of nursing (DON) were interviewed. ADON verified they had been able to review R12's medical record, and explained the 'Pain Assessment(s)' were done on admission and with the MDS' cycle thereafter. ADON stated pain was tracked and monitored using the 'Pain Level' on the MAR and TAR, too, explaining R12 had dementia and was "occasionally confused or forgetful" so staff could also use the Pain AD scale then (uses physical signs to equate pain levels). ADON stated the charted pain for R12 was mild in nature but expressed the assessments needed more detail and evaluation recorded adding, "I would agree with your [surveyor] point." ADON added, "There is room for improvement." ADON verified the only comprehensive evaluation documented within the medical record for pain was via the annual MDS if a Care Area Assessment (CAA) triggered for the person. ADON stated it was important to ensure complaints of pain were evaluated to provide good "quality of life." A facility' provided Pain Management Policy and	F0697		

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F0697 SS = D	Continued from page 15 Procedure, dated 4/2025, identified a pain level of 1 to 3 was considered, "Mild Pain," and listed a procedure which included each resident having an initial pain interview completed and having that reassessed on readmission, annually, quarterly and with a significant change in condition. The policy outlined, "Resident experiencing pain should be treated with non-pharmacological and pharmacological methods to help relieve pain and re-evaluate for effectiveness of interventions used." The policy outlined a section on how to evaluate and record pain for severely cognitively impaired residents, which included a progress note and review of interventions, however, the policy did not outline how or what would be included in an assessment for non-severely impaired residents.	F0697		

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K0000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 07/23/2025. At the time of this survey, SHAKOPEE FRIENDSHIP MANOR was found NOT in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: If PARTICIPATING IN THE E-POC PROCESS, a paper copy of the plan of correction is not required. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR	K0000		07/31/2025

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 reverse for further 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.

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

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K0000	Continued from page 1 By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. SHAKOPEE FRIENDSHIP MANOR is a 1 story building with no basement. The building was constructed at (2) different times. The original building was constructed in 1964 and was determined to be of Type II (111) construction. In 1976 an addition was constructed and was determined to be of Type II (222) construction. Because the original building and addition meet the construction type allowed for existing buildings, the facility was surveyed as one building as allowed in the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. The facility is fully protected throughout by an automatic sprinkler system and has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, that is monitored for automatic fire department notification.	K0000		

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K0000	Continued from page 2 The facility has a capacity of 65 beds and had a census of 51 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K0000		
K0345 SS = D	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This STANDARD is NOT MET as evidenced by: Based on review of available documentation and staff interview, the facility failed to conduct fire alarm system testing and maintenance per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.4.1, 9.6.1.3, and NFPA 72 (2010 edition), National Fire Alarm and Signaling Code, section 14.4.5.3, 14.4.5.3.2. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 07/23/2025 between 10:00 AM and 1:00 PM, it was revealed by review of available documentation that most current fire alarm sensitivity documentation of record was completed in 2023. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0345	On 7/23/25, based on observation and an interview, the facility failed to provide documentation of the 2024 fire alarm sensitivity test (most current was in 2023). In the afternoon on 7/23/25, the Maintenance Director reached out to Summit Fire. Summit Fire stated that they typically do two consecutive years and if both years pass then they skip the following year (this was why 2024 was not completed). The Maintenance Director stated that going forward the facility would like the fire alarm sensitivity test done annually. The Maintenance Director scheduled Summit Fire to come out 9/9/25 to perform a current fire alarm sensitivity test. To prevent future deficiencies in this area, the Maintenance Director scheduled Summit Fire to come out annually to perform the fire alarm sensitivity test. The Maintenance Director will provide the statement of completion and file it in the fire book. In order to monitor and ensure that this deficiency is corrected and will not recur, the Maintenance Director scheduled Summit Fire to come out annually to perform fire alarm sensitivity tests beginning 9/9/25. The Maintenance Director will be responsible for the corrective actions and monitoring to ensure the facility remains in compliance. This deficiency was corrected on 7/23/25 when the Maintenance Director spoke with Summit Fire and scheduled an upcoming fire alarm sensitivity test at the soonest date possible. The next fire alarm sensitivity test is scheduled for 9/9/25.	07/23/2025
K0923 SS = F	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet	K0923	On 7/23/25, it was revealed that the Med Gas (O2) storage room, which stores liquid oxygen tanks and used for trans-fill, had an exhaust fan that was not operating. On 7/24/25, the Maintenance Director ordered a new exhaust fan from Grainger and on 7/25/25 the exhaust fan was delivered. On 7/28/25, the Maintenance Director installed the exhaust fan and the exhaust fan	07/28/2025

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K0923 SS = F	Continued from page 3 Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited-combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain proper medical gas (O2) storage ventilation per NFPA 99 (2012 edition), Health Care Facilities Code, sections 9.3.7, 9.3.7.1, 9.3.7.4, and NFPA 55 (2010 edition), section 6.15. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 07/23/2025 between 10:00 AM and 1:00 PM, it was	K0923	Continued from page 3 is currently operable. To prevent future deficiencies in this area, the Maintenance Director will complete monthly audits and regularly check the Med Gas (O2) storage room to ensure that the exhaust fan is in good working condition. In order to monitor and ensure that this deficiency is corrected and will not recur, the Maintenance Director will schedule monthly audits to ensure the exhaust fan is operable. In addition, nurses that frequently go into the Med Gas (O2) storage room, will take note of the exhaust fan and inform the Maintenance Director if it is ever out of service. The Maintenance Director will be responsible for the corrective actions and monitoring to ensure the facility remains in compliance. This deficiency was corrected on 7/28/25 when the Maintenance Director installed the new exhaust fan in the Med Gas (O2) storage room.	

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K0923 SS = F	Continued from page 4 revealed by observation that the Med Gas (O2) Storage Room, storing liquid oxygen tanks and used for trans-fill, had an exhaust fan that was not operational. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0923		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
September 17, 2025

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

RE: CCN: 245445

Cycle Start Date: July 23, 2025

Dear Administrator:

On July 23, 2025, the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us