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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: UEK9

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 **06/07/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

10.THE FACILITY IS CERTIFIED AS:

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

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

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

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Dawn Chiabotti, HFE NE II 07/10/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Certification Specialist 09/01/2017 (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
06/27/2017
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245445 July 10, 2017

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

Dear Mr. Salmela:

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

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

Effective May 18, 2017 the above facility is certified for or recommended 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,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
July 10, 2017

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

RE: Project Number S5445026

Dear Mr. Salmela:

On May 16, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on April 27, 2017. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On June 7, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on June 1, 2017 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on April 27, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 18, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on April 27, 2017, effective May 18, 2017 and therefore remedies outlined in our letter to you dated May 16, 2017, 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.

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: UEK9

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

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(L3) **SHAKOPEE FRIENDSHIP MANOR**
(L4) **1340 THIRD AVENUE WEST**
(L5) **SHAKOPEE, MN** (L6) **55379**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **04/27/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **80** (L18)
13.Total Certified Beds **80** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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1861 (e) (1) or 1861 (j) (1): (L15)

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

17. SURVEYOR SIGNATURE Date :
Dawn Chiabotti, HFE II 05/31/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 5/22/2017 (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:

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2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
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03/01/1987
(L24)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO.
03001 (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
May 16, 2017

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

RE: Project Number S5445026

Dear Mr. Salmela:

On April 27, 2017, 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 a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the electronically delivered CMS-2567, whereby corrections are required.

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

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

> **Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> **Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;**
>
> **Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;**
>
> **Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and**

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

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

DEPARTMENT CONTACT

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

Maria King, RN, APM
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Mankato Plaza
12 Civic Center Plaza, Suite #2105
Mankato, Minnesota 56001-7789
Email: maria.king@state.mn.us
Phone: (507) 344-2716
Fax: (507) 344-2723

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 June 6, 2017, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC 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,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

The state agency may, in lieu of a 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:

- 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 ePoC 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 ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the 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, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved 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.

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by July 27, 2017 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was

issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by October 27, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

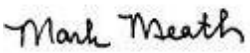
Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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

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

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

Sincerely,



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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245445	A. BUILDING _____ B. WING _____	04/27/2017

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 is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Electronic submission of the POC 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		
F 241 SS=D	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide a dignified dining experience for 2 of 4 residents (R39, R48) seated together at a dining table in the dining room. Findings include: On 4/24/17, at 5:53 p.m. R39 and R48 were sitting at a table in the dining room with two other residents. Each of the four residents had their evening meal plates placed on the table in front of them. Nursing assistant was observed to (NA)-A stand to the right side of R39 and to the left side of R48, with her back to R48. NA-A assisted R39	F 241	All nursing staff assisting residents with feeding are instructed to be sitting while feeding, making eye contact with the residents and also to make conversation with the resident they are feeding. Nursing staff meetings on 05/17/17 and 05/18/17 re-educated all nursing staff on the proper conduct of the nursing staff while feeding. All nursing staff have been instructed to remind staff members of this requirement if the proper procedures are not being followed.	5/18/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/25/2017

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245445	A. BUILDING _____ B. WING _____	04/27/2017

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 241	Continued From page 1 with bites of food and drinks of water while standing, with her left arm along the top backside of the Broda chair R39 was sitting in. At 6:07 p.m. on 4/24/17, NA-A put R39's glass on the table and stepped away from R39 to assist another resident at a different table before returning a few minutes later. Upon return, NA-A proceeded to assist R39 with eating, and drinking. NA-A continued to stand leaning towards R39 as she provided the feeding assistance. NA-A was overheard to state to R39, "Now we are almost done." Throughout these two observations, R48 was observed to sit at the table just looking at her food and at the other residents at the table who were eating. NA-B was also observed to be seated at the table, helping another resident eat. Neither staff had said anything to R48 while at the table assisting other residents. At 6:12 p.m. on 4/24/17, NA-A was heard to encourage R48 to drink her orange juice. This occurred while NA-A was assisting R39, and while NA-A had her back to R48. NA-A looked at the surveyor then and stated, "[R48] never eats her supper." R48 was observed to take a couple of sips of her orange juice. At 6:18 p.m. on 4/24/17, NA-A was observed to put the spoon she was using to feed R39's, down on the table. NA-A walked away to help another resident, then returned a few minutes later to assist R39, while standing with her back to R48. At 6:21 p.m., NA-A who still had her back to R48 said to R48, "Drink up your orange juice." About a minute later, NA-A turned around and stated to R48, "Are you going to drink your juice, it will help	F 241	The Resident Care Coordinator, who spends the majority of her time working out on the floor, will monitor the dining rooms for compliance. The date of completion is May 18, 2017.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245445	A. BUILDING _____ B. WING _____	04/27/2017

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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F 241	Continued From page 2	F 241		

your cough?" NA-A then leaned over R48 and helped her get a drink of orange juice. NA-A was then heard to ask R48 if she wanted to eat, to which R48 replied "no".

R39's quarterly Minimum Data Set (MDS) dated 2/5/17, indicated R39 had short and long term memory problems and was totally dependent on staff for eating.

R48's quarterly MDS dated 4/16/17, indicated R48 had short and long term memory problems and needed supervision of staff for eating including oversight, encouragement or cueing.

On 4/27/17, at 12:41 p.m. the resident care coordinator (RCC) stated she expected staff to sit while assisting residents with meals. The RCC stated staff should sit and be eye level with residents while they ate, and stated, "we just talked about this and held a class for this this last December, even videos talk about it, staff know they should not be standing." The RCC clarified that this was the protocol so staff would be eye level with the residents to "enhance their mealtime." The RCC stated the whole idea was to make the resident feel at home and it would not be normal for a person to stand while eating at home, she further stated staff should turn and face the resident and try to carry on a conversation with the resident while assisting for meals, "that is the way it has to be, there is no excuse." The RCC stated she was surprised another NA had not told NA-A to sit down since all the staff know the expectation.

The facility's undated policy Serving Food and Assisting a Resident to Eat, indicated: "...Residents who cannot feed themselves will be

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F 241	Continued From page 3 fed with attention to safety, comfort and dignity... Staff feeding resident will be eye level with the resident while assisting with eating ... Residents requiring assistance or to be fed as needed with attention to safety, comfort and dignity..."	F 241		
F 242 SS=D	483.10(f)(1)-(3) SELF-DETERMINATION - RIGHT TO MAKE CHOICES (f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. (f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. (f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to honor a resident's preference for bathing frequency for 2 of 3 residents (R44, R23) reviewed for choices. Findings include: R44 stated during interview on 4/24/17 at 4:35 p.m., that she would like to have more than one bath/shower a week. However, she stated she was only allowed to have one, and that "is the way it is here".	F 242	At the nursing staff meetings held on 05/17/17 and 05/18/17 all nursing staff were reminded to follow up on all concerns addressed by the residents. The facility currently provides more than once a week showers to residents and also several residents get up later in the mornings per their request. Once particular preferences are known the facility will try to accommodate the residents if appropriate.	5/18/17

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F 242	Continued From page 4 R44's minimum data set (MDS) dated 8/10/16, Section F indicated: "it is very important to this resident to have bathing choices". R44's therapeutic recreation assessment dated 8/10/16, also noted it was important for the resident to have choices about bathing. The individual care plan dated 2/4/17, indicated "the resident [R44] prefers a weekly shower". On 4/25/17, at 12:21 p.m. the social services (SS) staff was interviewed. The SS described the facility's process for collecting resident data: "Typically, we will ask the resident [for preferences] on admission and collect a social history. Determine what the pattern was at home, if they like to sleep in, get up early and confirm this with the resident. Then we care plan for this". When asked if this was reviewed with the resident after this time, SS stated, "Basically, we do not unless there are other issues". When asked if they document any follow up with the resident, SS stated that they "do not, unless there are concerns or a specific problem. Typically, the facility will provide one bath or shower per week and a sponge bath in the a.m. and p.m. R44 has not ever brought up wanting another bath weekly" to herself (SS) or at her care conference. Review of the R44's record failed to include any documented evidence that the resident or her family had been invited, or attended, her January or March 2017 care conferences. On 4/25/17, at 12:59 p.m. the director of nursing (DON) stated she was unaware R44 wanted more than one bath a week. The DON verified R44 was able to make her own decisions, and stated R44 would be able to let staff know whether she wanted another baths.	F 242	The Care Conference team has created a questionnaire that will document who has been invited to the resident's care conference and any requests made by the resident or family members at the care conference. The MDS Coordinator and Social Worker will gather and monitor the care conference attendance and any requests made at care conferences to ensure residents' choices are being addressed. The date of completion is May 18, 2017.	

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F 242	Continued From page 5 An activity note, dated 2/15/17, indicated: "resident continues to be very pleasant and cooperative..." An activity note from 11/23/16, included: "Resident continues to participate in independent and group activities of choice daily..." R23 stated on 4/24/17, at 3:09 p.m.she did not get to choose what time to get up in the morning. R23 stated staff got her up at 7:00 a.m. but stated she would like to lay in bed longer and get up closer to 8:00 a.m. On 4/26/17, at 12:25 p.m. R23 stated staff had gotten her up at 6:30 a.m. On 4/27/17 at 9:04 a.m., NA-E stated R23 required staff assistance getting in and out of the bed with the EZ stand (a mechanical lift) and required help with repositioning. R23's quarterly MDS dated 1/29/17, indicated R23's cognition was moderately impaired, and verified R23 required extensive assist with transfers, dressing, personal hygiene and had no behaviors of rejection of care. R23's 2/15/17, care conference (cc) progress note indicated that although R23 had some cognitive deficits, she did make simple daily care decisions, communicated her needs to staff, knew her care givers, and required extensive assist with all cares.	F 242		

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F 242	Continued From page 6 R23's most recent CAA (care area assessment) dated 5/12/16, indicated R23 required extensive staff assistance with all cares and mobility. The CAA also indicated R23 was usually able to communicate needs and make simple daily decisions. R23's April 2017 careplan indicated R23 had an ADL (activities of daily living) self-care performance deficit and needed extensive assist with dressing and daily hygiene. R23's therapeutic recreation assessment dated 4/26/17, indicated it was very important for R23 to make choices.	F 242		
F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care.	F 280		5/18/17

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F 280	Continued From page 7 (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident.	F 280		

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F 280	Continued From page 8 (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to include 2 of 3 residents (R64 and R23) reviewed for choices, in their patient care planning process. Findings include: On 4/26/17, at 11:08 a.m. R64 denied going to his care conference meetings After R64 was told what a care conference involved he stated, "I have never heard about anything like that". During a telephone conversation on 4/26/17 at 11:33 a.m., R64's nephew and guardian (FM-A) stated although he regularly attended the care conferences via telephone, his (R64) uncle did not attend. On 4/26/17 at 11:46 a.m., the director of nursing	F 280	The Care Conference team has created a communication form that will inform all residents of their upcoming care conference. This form will document whether the resident attended the care conference, or whether they declined to attend and their reason for not attending. This form will also document any concerns brought up by the resident or family members, and how any concerns will be addressed. The MDS Coordinator and Social Worker will gather and monitor the care conference attendance forms and any requests made at care conferences to ensure residents' choices are being addressed.	

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F 280	Continued From page 9 (DON) explained the normal procedure for care conference meetings included inviting the residents and their families, and having those present sign the care conference attendance sheet. The DON said when a resident or family declined or did not attend, staff would document the reason on the attendance sheet. The DON confirmed there had been two care conferences held for R64 since admission, one on 1/18/17 and the other 4/19/17. The DON verified R64 had not attended either. The DON could not confirm whether R64 had been invited because R64's records did not contain documentation confirming such or any notes as to whether he had declined. The DON further stated she expected all residents to be invited to their care conferences and said their should be documentation as to whether or not they attended. The DON further stated she expected residents to be invited and encouraged to attend even if a family or representative was present. The Initial Care Conference Attendance Sheet dated 1/18/17, was reviewed and lacked documentation as to whether R64 was in attendance at the care conference. A Significant Change Care Conference Attendance Sheet dated 4/19/17, lacked documentation as to whether R64 had been invited or was in attendance. R23 was interviewed on 4/24/17, at 3:16 p.m.. She said she did not feel staff included her in decisions about her plan of care. R23 stated she did not get invited to her care conferences but would like to be. On 4/26/17, at 12:52 p.m. the Minimum Data Set care coordinator (CC) stated she made up the	F 280	The date of completion is May 18, 2017.	

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care conference schedule and gave a list to social services (SS) and to the receptionist. The CC stated care conferences were held on Wednesdays and Thursdays, and that the receptionist types up the list and invites the families. The CC stated SS or therapeutic recreation (TR) staff invited the residents, but it was not consistent which did this, and sometimes the residents were not invited to care conferences. The CC stated the residents who the facility knew had intact cognition were probably invited and that perhaps a closer look was needed to revamp their process.

At 2:36 p.m. on 4/26/17, family member (FM)-A stated she thought her mother [R23] should be invited to care conferences and thought R23 would understand more then FM-A did. FM-A stated her mother gets frustrated and had stated that nobody in the facility tells her anything. She stated again she thought it would be good if her mother was invited to her care conferences, even if she only understood parts of it, and stated she (FM-A) thought it would help with her mother [R23] maintain independence without feeling loss of control.

R23's quarterly Minimum Data Set (MDS) dated 1/29/17, indicated R23's cognition was moderately impaired with no rejection of cares. R23's admission MDS dated 5/11/16, indicated it was very important to have family or close friend involved in discussion about resident care.

R23's CAA (care area assessment) dated 5/11/16, indicated R23 needed extensive staff assistance with all cares and mobility and had some cognitive deficit. The same CAA indicated R23 was usually able to communicate most

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needs and make simple daily decisions.

Care conference progress notes dated 2/15/17, indicated R23's daughter had been called, but was not present. The note did not indicate whether or not R23 had been invited, or present at the care conference.

Review of additional care conference notes revealed the last care conference R23 had been present at was 8/18/16.

On 4/27/17 at 11:48 a.m., during an interview with the social services (SS) director, she stated residents are invited to quarterly and annual care conferences. However, the SS director said there was not one specific person responsible for this task. "We just make sure it gets done". One of us, either the MDS coordinator, TR or SS who attend the conference will invite the resident. Sometimes, we ask the nurse to see if the resident wants to attend. We post an invitation with the date and time of the conference in every resident room and the notice gets sent to the resident's family. The SS director stated she thought the receptionist would be responsible for sending the invitations.
The SS staff and the surveyor then reviewed three resident rooms for residents who had upcoming patient care conferences scheduled for the week of 5/3/17. R62 and R40s rooms were reviewed however, there were no invitations in either of the rooms. The third resident she was a new resident, and there was an invitation noted.

On 4/27/17 at 1:39 p.m., the receptionist was interviewed about her role in care conference invitation. The receptionest stated she only sends invitations to new residents in the room,

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F 280	Continued From page 12 otherwise sends an invite to the residents' responsible parties for the current residents. She verified she did not invite current residents to their patient care conferences. The facility policy Care Plans Comprehensive dated Revised 8/06, indicated: " ... The resident has the right to refuse to participate in the development of his/her care plan... When such refusals are made, appropriate documentation will be entered into the resident's clinical records in accordance with established policies." A policy provided by the facility, Goals and Objectives, Care Plan, dated as revised 8/06 indicated, "...The resident has the right to refuse to participate in establishing care plan goals and objectives. When such refusals are made, appropriate documentation will be entered into the resident's clinical records in accordance with established policies." The facility policy Care Planning -- Interdisciplinary Team dated as revised 8/06 indicated, "... Every effort will be made to schedule care plan meetings/care conferences at the best time of the day for the resident and family..."	F 280		

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F 280	Continued From page 13 The facility policy Resident/Family participation -Assessment /care Conference Policy, dated 11/1/16, included: "the Resident and his/her family, and/or legal representative (sponsor), are invited to attend and participate in the Resident's assessment and care planning conference...The Social Services Director or designee is responsible the Resident's family and maintaining records for such notices...the following information will be documented from care conference: input from family members when they are not able to attend, input from residents when he/she is not able to attend, refusal of participation, if applicable and the reason, and date and signature of the individual making the contact."	F 280		
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on obseration, interview and document review, the facility failed to follow the plan of care for 2 of 3 residents (R64, R9) reviewed for ADLs (activities of daily living). Findings include: R64 was interviewed on 4/24/17 at 3:57 p.m. R64's fingernails were observed to be long and	F 282	All nursing staff were re-educated at their meetings on 05/17/17 and 05/18/17 regarding personal hygiene and the importance of documenting if the resident refuses shaving and nail care. If the resident is showing behaviors then the staff should re-approach later until the task is completed. Behaviors of refusal of cares will be documented. Behaviors that	5/18/17

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F 282	Continued From page 14 dirty. On 4/25/17 at 10:04 a.m., R64 was again observed to have long fingernails with dirty underneath the nails of several fingers. On 4/26/17 at 9:58 a.m., licensed practical nurse (LPN-B) explained during interview that podiatry cuts R64's toenails but staff nurses are responsible for his fingernail care. R64 was interviewed on 4/26/17, at 10:57 a.m. R64 stated during this interview that he did not get his nails clipped "very often". He further stated that nobody has offered to clip his nails recently. He then pointed to his ring, middle and pointer finger on his right hand and stated his nails were "dirty too." R64 stated, "I would like my nails cut at least every 2 weeks but nobody has done it or even asked." He stated his bath day was on Sundays. R64's care plan revised 1/12/17 included: BATH DAY: clean under finger nails. Nurse to trim finger nails and podiatrist does toe nails. Diabetic. The Shakopee Friendship Manor Daily Assignment Sheet for nursing assistants dated 4/25/17, identified R64's bath day as "Sun (Sunday) PM (evening)". During interview the director of nursing (DON) on 4/26/17, at 11:52 a.m. she stated she'd spoken to the responsible nurse per telephone. The DON stated, the nurse had confirmed she'd not provided nail care for R64 on Sunday evening (R64's bathday) 4/23/17, because she'd been "extremely busy and did not get to it." The DON stated the nurse had acknowledged she did not	F 282	are ongoing will be care planned. Also, a "New Task" was implemented in Point Click Care on April 27, 2017 which will monitor completion of nail care assignments. The Resident Care Coordinator will monitor the residents to ensure that their hygiene needs are being met and also the RCC will monitor the care plans for behaviors so they too are properly addressed. The RCC will also review the task section of Point Click Care to ensure compliance. The date of completion is May 18, 2017.	

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document or report the incident to on-coming staff. The DON stated she expects residents to be cared for as per the facility's protocol which indicates residents' nails should be clipped every week, and stated, "If a staff is unable to complete the task I would expect it to be carried forward to the next shift". The DON further explained there was no system in place to ensure this would happen however, the facility is looking into establishing one.

R9 was observed to have long unshaven facial hair while seated in the dining room at 4:28 p.m. on 4/24/17. During the observation, there were other residents and staff present.

On 4/25/17 at 12:20 p.m., R9 was observed sitting in his room, and was noted to have long unshaven facial hair.

On 4/26/17, at 12:18 p.m. R9 was observed sitting in his room again, and had still not been assisted with shaving.

During interview with nursing assistant (NA)-F at 2:26 p.m. on 4/26/17, NA-F stated NAs shave R9 without any resistance from R9. NA-F said R9 could only use one of his hands so usually received staff assistance during morning cares. NA-F further stated NAs documented on point of care when they had provided personal hygiene care, and verified shaving would be included in personal hygiene.

On 4/27/17 at 9:00 a.m., R9 was observed sitting in his room. Although he still had facial hair, the hair appeared somewhat shorter than the days prior. At that time, R9 stated he had attempted to shave himself.

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	245445	A. BUILDING _____ B. WING _____	04/27/2017

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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F 282	Continued From page 16 On 4/27/17, at 1:55 p.m. NA-D stated R9 only had use of one hand and that R9 attempts to shave himself but that staff will finish up the shaving. R9 stated he had not assisted R9 with shaving that morning because the night shift NAs had gotten R9 up. NA-D stated R9 had an electric shaver and whoever gets him up was supposed to help him shave. NA-D stated shaving was a daily thing. However, verified he had not offered R9 assistance with shaving that day. R9's Care Area Assessment (CAA) dated 1/8/17, indicated R9 needed extensive assistance with personal care due to only having one hand to use. R9's April 2017 careplan indicated R9 needed staff assistance with personal hygiene and grooming. R9's NAR daily assignment sheet indicated "ADL's- 1 ASSIST". R9's quarterly Minimum Data Set (MDS) dated 4/2/17, indicated R9 required extensive assist with personal hygiene.	F 282		
F 312 SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide grooming	F 312	All nursing staff were re-educated at their meetings on 05/17/17 and 05/18/17	5/18/17

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F 312	Continued From page 17 assistance for 2 of 3 residents (R9 and R64) reviewed who were dependent on staff to meet their activities of daily living (ADLs) needs. Findings include: R64 was interviewed on 4/24/17 at 3:57 p.m. R64's fingernails were observed to be long and dirty. On 4/25/17 at 10:04 a.m., R64 was again observed to have long fingernails with dirty underneath the nails of several fingers. On 4/26/17 at 9:58 a.m., licensed practical nurse (LPN-B) explained during interview that podiatry cuts R64's toenails but staff nurses are responsible for his fingernail care. R64 was interviewed on 4/26/17, at 10:57 a.m. R64 stated during this interview that he did not get his nails clipped "very often". He further stated that nobody has offered to clip his nails recently. He then pointed to his ring, middle and pointer finger on his right hand and stated his nails were "dirty too." R64 stated, "I would like my nails cut at least every 2 weeks but nobody has done it or even asked." He stated his bath day was on Sundays. During interview the director of nursing (DON) on 4/26/17, at 11:52 a.m. she stated she'd spoken to the responsible nurse per telephone. The DON stated, the nurse had confirmed she'd not provided nail care for R64 on Sunday evening (R64's bathday) 4/23/17, because she'd been "extremely busy and did not get to it." The DON stated the nurse had acknowledged she did not document or report the incident to on-coming	F 312	regarding personal hygiene and the importance of documenting if the resident refuses shaving and nail care. If the resident is showing behaviors then the staff should re-approach later until the task is completed. Behaviors of refusal of cares will be documented. Behaviors that are ongoing will be care planned. Also, a "New Task" was implemented in Point Click Care on April 27, 2017 which will monitor completion of nail care assignments. The Resident Care Coordinator will monitor the residents to ensure that their hygiene needs are being met and also the RCC will monitor the care plans for behaviors so they too are properly addressed. The RCC will also review the task section of Point Click Care to ensure compliance. The date of completion is May 18, 2017.	

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F 312	Continued From page 18	F 312		

staff. The DON stated she expects residents to be cared for as per the facility's protocol which indicates residents' nails should be clipped every week, and stated, "If a staff is unable to complete the task I would expect it to be carried forward to the next shift". The DON further explained there was no system in place to ensure this would happen however, the facility is looking into establishing one.

R64's care plan revised 1/12/17 included: BATH DAY: clean under finger nails. Nurse to trim finger nails and podiatrist does toe nails. Diabetic.

The Shakopee Friendship Manor Daily Assignment Sheet for nursing assistants dated 4/25/17, identified R64's bath day as "Sun (Sunday) PM (evening)".

R9 was observed to have long unshaven facial hair while seated in the dining room at 4:28 p.m. on 4/24/17. During the observation, there were other residents and staff present.

On 4/25/17 at 12:20 p.m., R9 was observed sitting in his room, and was noted to have long unshaven facial hair.

On 4/26/17, at 12:18 p.m. R9 was observed sitting in his room again, and had still not been assisted with shaving.

On 4/27/17 at 9:00 a.m., R9 was observed sitting in his room. Although he still had facial hair, the hair appeared somewhat shorter than the days

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F 312	Continued From page 19 prior. At that time, R9 stated he had attempted to shave himself. R9's Care Area Assessment (CAA) dated 1/8/17, April 2017 care plan, 4/2/17 quarterly minimum data set assessment, and NA daily assignment sheet all indicated R9 needed extensive assistance with personal care due to only having one hand to use. During interview with nursing assistant (NA)-F at 2:26 p.m. on 4/26/17, NA-F stated NAs shave R9 without any resistance from R9. NA-F said R9 could only use one of his hands so usually received staff assistance during morning cares. NA-F further stated NAs documented on point of care when they had provided personal hygiene care, and verified shaving would be included in personal hygiene. On 4/27/17, at 1:55 p.m. NA-D stated R9 only had use of one hand and that R9 attempts to shave himself but that staff will finish up the shaving. R9 stated he had not assisted R9 with shaving that morning because the night shift NAs had gotten R9 up. NA-D stated R9 had an electric shaver and whoever gets him up was supposed to help him shave. NA-D stated shaving was a daily thing. However, verified he had not offered R9 assistance with shaving that day.	F 312		
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and	F 323		6/2/17

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F 323	Continued From page 20 (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure side rails were properly secured to the bedframe for 3 of 5 residents (R76, R9, R14) reviewed for accidents. Findings include: R76's bilateral one-quarter side rails were observed in the up position on 4/24/17, at 4:22 p.m. The side rail on the door side of the bed was tested, and moved back and forth approximately 2-3 inches from the bed. The side rail on the window side was loose and moved back and forth approximately 1-2 inches. During the observation, nursing assistant (NA)-H stated R76 required assistance of two staff and use of the side rails for bed mobility.	F 323	The side rail assessment form has been revised so that the assessment will not be able to be locked (finalized) in the Point Click Care system until all areas (questions) are completed by the assessing nurse. Side rail assessments will be reviewed during each resident's quarterly care conference. The nursing assistants and nurses will monitor the necessity for side rails on an ongoing basis. All nursing staff were re-educated on 05/17/17 and 05/18/17 at their nursing meetings regarding the revised assessments and to report loose side rails in the maintenance books so they can re	

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F 323	Continued From page 21 On 4/26/17, at 8:17 a.m. while R76 was out of the room, the bilateral side rails on the bed were observed in the up position. Again, the side rail on the door side of the bed remained loose and moved back and forth 2-3 inches, and the rail on the window side moved 1-2 inches back and forth. R76's Admission Minimum Data Set (MDS) dated 2/14/17, indicated R76's cognition was severely impaired and R76 needed extensive staff assistance with bed mobility and transfers. R76's careplan dated 2/7/17, indicated R76 had an Activities of Daily Living self performance deficit related to muscle weakness and Alzheimer's disease and needed extensive staff assistance with bed mobility and transfers. R76's care plan dated 2/23/17, indicated R76's 1/4 rails bilateral needed to be up at all times. R76's same careplan indicated R76 was cognitively impaired due to Dementia, impaired decision making, and long and short term memory loss. R76's same careplan also indicated R76 was high risk for falls and had a history of falls. R76's side rail assessment dated 2/8/17, indicated R76 was unaware of safety needs with cognitive or mental status changes. The same assessment indicated R76 had a history of rolling out of bed and a fear of rolling out of bed and indicated the side rails were to assist R76 with bed mobility and transfers. R9's one quarter side rails on the bed were in the upright position on 4/24/17, at 4:27 p.m. The side rail on the door side of the bed was loose and moved back and forth 2-3 inches, and window	F 323	repaired or replaced as deemed necessary. A thorough assessment of all side rails in the facility has been completed. All side rails attached to a bed that are not being used have been removed. All side rails that are deemed inappropriate are being replaced with either an appropriate side rail or a repositioning bar. The Universal Worker will continue to monitor the side rails on a monthly basis. Side rails found to be inappropriate will be brought to the attention of the Maintenance Department so they can be repaired or replaced. The Resident Care Coordinator and the Maintenance Department will conduct random audits to verify compliance. The date of completion is June 2, 2017.	

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side rail moved 1-2 inches back and forth. At that time, NA-G stated R9 used the side rails with staff assistance for bed mobility and transfers.

On 4/26/17, at 8:14 a.m. R9's side rail on the window side of the bed was observed in the down position, and the side rail on the door side was in the up position, was loose, and moveable 2-3 inches back and forth.

On 4/27/17, at 2:02 p.m. NA-D stated R9 needed staff assistance with transfers, stated R9 could stand and when sitting on the bed R9 would grab the door side rail to stand up. At that time, NA-D stated sometimes R9's level of assistance by staff varied from extensive to limited.

R9's quarterly MDS dated 4/2/17, indicated R9 was cognitively impaired and needed extensive assist with transfers and bed mobility.

R9's side rail assessment dated 3/29/17, indicated side rails were recommended for R9. The assessment further indicated R9 was unaware of safety needs.

R9's careplan dated 1/18/15, indicated R9 needed extensive staff assistance with transfers and indicated, "SIDE RAIL: 1/4 left-side rail up to aid with bed mobility.

R14's one quarter side rails on bed were observed to be in the upright position on 4/24/17, at 4:14 p.m. The side rail on the door side of the bed was loose and moved back and forth 2-3 inches, and the side rail on the window side was loose and moved back and forth 1-2 inches. R14 who was present during the observation,

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acknowledged requiring the side rails to assist with turning in bed.

On 4/26/17 at 8:13 a.m., R14's side rails were observed again, Both of the quarter side rails were observed in the upright position, and were loose. The rail on the door side moved 3-4 inches back and forth, and the rail on the window side, 2-3 inches.

R14's quarterly MDS dated 2/26/17, indicated R14's cognition was intact and R14 needed extensive staff assistance with bed mobility and transfers. R14's Care Area Assessment dated 8/31/16, indicated R14 had physical limitations and needed staff assistance with transferring and bed mobility.

R14's side rail assessment dated 2/22/17, indicated R14 had had cognitive or mental status changes and needed side rails assistance for bed mobility and for support with transfers.

On 4/27/17, at 10:59 a.m., licensed practical nurse (LPN)-F stated she had completed side rail assessments and when she did so she would visualize and physically check side rails for secureness, including determination of how well they fit the bed. LPN-F said if a side rail had greater than 1/2 inch flexibility, it would need to be tightened. LPN-F stated a little give was necessary for the rail to go up and down. LPN-F stated if the side rail moved back and forth more than one-half inch she would document the issue in the maintenance book so maintenance could fix it. LPN-F verified there had been no documentation documented in the maintenance book at the nurses' station requesting R76's, R9's, R14's side rails, or any other side rails, to

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F 323	Continued From page 24 be tightened. At 1:04 p.m. the resident care coordinator (RCC) stated a universal worker (UW) went around weekly and checked all side rails. The RCC said if the side rails were 4 inches or more loose the UW was to notify maintenance because loose rails could cause the resident to be unstable. RCC stated she had a new form she was going to use for which residents were capable of using side rails and also identified loose side rails. RCC stated R76 might possibly grab the side rail when trying to get up. On 4/27/17, at 1:26 p.m. the UW stated she checked all side rails in the facility weekly and if any side rail moved back and forth at all she would write down "loose" on her audit sheet, make three copies and give one to maintenance, one to the RCC and keep one for herself. The UW did not know what follow up was completed after she gave the audit sheets to maintenance and RCC. The UW stated she usually found some loose side rails every week. The RCC sitting nearby stated, "Loose is loose" and stated she needed to talk to maintenance. The RCC stated the nurses completed side rail assessments and were to physically touch them and try to shake them when completing the side rail assessment. The RCC also stated she had told the NAs at the December 2016 staff meeting, to check the side rails for looseness every shift. In addition, the RCC reported the nurse practitioner had told them that if a resident had severe impairment in cognition, the resident should not have side rails on the bed. The RCC said if side rails could not be tightened up, or if they were not fixable, the side rails would have to be removed from the bed.	F 323		

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F 323	Continued From page 25 The facility's 2/15/13 policy, Bed Safety Bed Rails, included "... Bed Rail Safety Guidelines ... 5. Latches securing bed rails should be stable so that the bed rails will not falls when shaken..."	F 323		
F 334 SS=E	483.80(d)(1)(2) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS (d) Influenza and pneumococcal immunizations (1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza	F 334		4/28/17

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F 334	Continued From page 26 immunization due to medical contraindications or refusal. (2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure their systems for vaccination administration were implemented in order to ensure pneumococcal vaccinations were	F 334	The facility's system in place for monitoring influenza and pneumococcal immunizations lacked timely follow-up on omissions for the pneumococcal. Medical	

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F 334	Continued From page 27 provided in accordance with current standards for 6 of 9 residents (R36, R18, R42, R26, R64, R16) reviewed for pneumococcal vaccine administration. Findings include: The Center for Disease Control (CDC) recommendations indicate all Adults 65 years of age or older who have not previously received PCV13 (Pneumococcal conjugate vaccine), and who have previously received one or more doses of pneumococcal polysaccharide vaccine 23 (PPSV23), should receive a dose of PCV13. The recommendations indicate the dose of PCV13 should be administered at least one year after the most recent PPSV23 dose. R36 was admitted to the facility on 2/22/16. R36's date of birth (DOB) was 11/99/44. R36's immunization record revealed Pneumovax 23 vaccination had been received 9/13/11. R36's record did not indicate whether a Prevnar 13 vaccine had been offered or addressed with the resident or family. R18 was admitted to the facility on 1/21/16. R18's DOB was 1/31/32. R18's immunization record revealed Pneumovax 23 had been received 12/04/01. R18's record did not indicate Prevnar 13 had been offered or addressed with the resident or family. R42 was admitted to the facility on 2/22/17. R42's DOB was 10/29/22. R42's immunization record revealed Pneumovax 23 had been received 10/2/12. R42's record did not indicate whether a Prevnar 13 had been addressed with a resident or family representative.	F 334	Records has added monthly checking of immunizations to their end of the month tasks to correct this shortfall. This was implemented on April 26, 2017. The Infection Control Coordinator will monitor this new system on a quarterly basis ensuring compliance. The date of completion is April 28, 2017.	

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R26 was admitted to the facility on 3/28/17. R26's DOB was 7/26/35. R26's immunization record revealed Pneumovax 23 had been received 9/24/12. R26's record did not indicate whether a Prevnar 13 had been addressed with resident or family representative.

R64 was admitted to the facility on 1/4/17. R64's DOB was 1/15/38. R64's immunization record revealed Pneumovax 23 had been received 1/15/03. R64's record did not indicate whether a Prevnar 13 had been addressed with the resident or family.

R16 was admitted to the facility on 7/19/16. R16's DOB was 6/22/26. R16's immunization record revealed Pneumovax 23 had been received 1/20/03. R16's record did not indicate whether a Prevnar 13 had been addressed with the resident or family.

On 4/25/17, at 1:12 p.m. licensed practical nurse (LPN)-G stated she checked residents' immunization records upon admission to determine whether a resident needed any immunizations. LPN-G stated she tracked the residents' immunizations and every September or October when getting ready for influenza vaccinations she would review all the residents' pneumococcal records for Pneumovax 23 as Pneumovax 23 could be given to the residents every 5 years and now with Prevnar 13 could be given no closer than a year apart. LPN-G stated she would also determine at admission whether the resident should have a pneumococcal vaccination. LPN-G stated she thought R36 had refused the Prevnar 13 vaccination but could not find any documentation.

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On 4/26/17, at 8:55 a.m. LPN-G reported that R36 had been treated for pneumonia 11/2/16, and again 12/30/16. LPN-G stated R36 had not needed hospitalization and was "back to baseline." LPN-G also stated R36 and R16 had been offered Prevnar 13 vaccinations in the spring of 2016, but she had received no response from either R36 or R16's families. LPN-G stated she had reviewed R36's record and R16's record again last October 2016 for the Prevnar 13 however, had not followed up with their families. Further, LPN-G stated it had been last Spring 2016 when Prevnar 13 was first discussed at the facility's Quality Committee. LPN-G stated she had now created a system for follow up and instead of a paper cheat sheet would link to dashboard on the computer to help her monitor this. LPN-G stated R42 was due for a Prevnar 13 and she had received verbal consent from the daughter and would order the Prevnar 13 and could have it given today. LPN-G stated, "It only takes a day to get it [Prevnar 13]." LPN-G verified R26 had not had the Prevnar 13 and that she had called and left a message for R26's family representative. LPN-G stated she did not know why R64 had not had the Prevnar 13 but stated she had received verbal consent from the family representative to give R64 the Prevnar 13 as it was more important to give Prevnar 13 first. LPN-G stated she would now have a better system and review residents' immunization records monthly, "so if one slips through I will see it."

On 4/26/17, at 10:00 a.m. LPN-G stated she had spoken with the resident care coordinator (RCC) who had stated she had discussed the pneumococcal vaccination issue with the medical

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director (MD), and that he wanted Prevnar 13 to be given first to the residents instead of the Pneumococcal 23. LPN-G stated she had not previously known that and had been giving Pneumococcal 23 first to admitting residents per the facility's standing orders. LPN-G stated she had not known the MD wanted Prevnar 13 given first when reviewing the residents' immunization records last October, nor since admitting residents. LPN-G stated she had reviewed all residents admitted since October 2016, to see whether they had been offered or received the Prevnar 13. LPN-G verified the facility's standing orders dated 10/27/15, indicated give the Prevnar 13 first before the Pneumococcal 23 to be given a year later.

On 4/27/17 at 9:09 a.m., physician-A stated it was recommended by studies that if a resident needed both the Pneumococcal 23 and the Prevnar 13, to give the Prevnar 13 first and the Pneumococcal 23 later. Physician-A stated if a resident had already received the Pneumococcal 23 it would help the resident to receive the Prevnar 13 pneumococcal vaccination as well.

On 4/27/17, at 9:25 a.m. LPN-G stated R36 had received the Prevnar 13 vaccination "last evening," and that R26, R42 and R64's Prevnar 13 doses would be given today as consents had been received.

The facility's 2/8/16 policy, "POLICY STATEMENT: All residents will be offered the Pneumococcal Vaccine (PPSV3 and PCV13) to aid in preventing infections [e.g. pneumonia]... 4. Administration of the pneumococcal vaccination or revaccinations will be made in accordance with current Centers for Disease Control and

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F 334	Continued From page 31 Prevention (CDC) recommendations at the time of the vaccination..." A review of the facility's 10/26/15 Standing Orders, indicated, "...Under these standing orders, all Residents will be offered the Pneumococcal Vaccination to aid in preventing infections... 1. Identify adults in need of vaccination with pneumococcal conjugate vaccine (PCV13) ... 2. Identify adults in need of vaccination with pneumococcal polysaccharide vaccine (PPSV23) ... 3. Identify adults in need of an additional dose of PPSV23 if 5 or more years have elapsed since the previous dose of PPSV23 ... 7. Document each patient's vaccine administration information ..."	F 334		
F 431 SS=E	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and	F 431		5/27/17

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F 431	Continued From page 32 disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure eye drops bottles in 3 of 4 medication carts (Short Hall, Wing 3, and Wing 2), affecting 8 residents (R61, R18, R79, R32, R75, R44, R15, R29), were appropriately labeled as to when opened to verify	F 431	The nursing staff were re-educated at their nurses meeting on May 18, 2017. All nurses were required to watch a video on eye drop administration and documentation protocol. All eye drop medications will be checked for current	

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F 431	Continued From page 33 whether the medications could still be used. Findings Include: On 4/24/17, at 11:46 a.m. the Short Hall medication cart was reviewed with licensed practical nurse (LPN)-A. R61's Timolol Ophthalmic Solution bottle had a label with a hand written open date of 8/9/16, and Latanoprost eye drop bottle did not have an open date written on the opened bottle. R18's Visine eye drops had an open date hand written on the label of 12/7/16. On 4/24/17, at 11:56 a.m. during an interview with registered nurse (RN)-A she stated the open date for R61's Timolol was 8/9/16, and there was approximately 15 percent of the liquid eye medication remaining in the bottle. RN-A verified R61's Latanoprost eye drops did not have an open date on the bottle, but there was about one half of the medicated eye solution remaining. She also confirmed the open date written on R18's Visine eye drop bottle was 12/7/16, and there was about one half of the solution remaining in the bottle. On 4/24/17, at 1:11 p.m. the Wing 3 med cart was reviewed with RN-A who stated R79's Azelastine eye drop bottle had an open date of 11/17/16, and had one half of the solution remaining in the bottle. R32's Timolol, open and in use, did not have an open date indicated on the eye drop bottle, and R75's Latanoprost eye drop bottle had a label with the month and year it was opened but not the day of the month. At that time, RN-A stated the facility's protocol for eye drops was to document the open date on label when eye drops were opened including the month, day and year	F 431	date opened and expiration dates every week by the day nurse. Each medication cart will have a tracking sheet for the nurses to sign after checking the dates. This form was implemented on May 27, 2017. The Resident Care Coordinator will monitor by performing random audits, and the pharmacy will audit medications per protocol when doing onsite visits. The date of completion is May 27, 2017.	

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written. RN-A further explained staff were to check the Medication open date and expiration dates to know when eye drops should no longer be used.

On 4/24/17, at 1:19 p.m. During a medication cart review on Wing 2, LPN-C stated R44's Artificial Tears had an open date written on the vial of 1/30/15, with ten percent of the solution remaining, R15's Systane drops had an open date written on a label on the bottle but it was illegible, and R29's Artificial Tears also had an illegible open date written on the bottle. LPN-C further stated the same bottles had labels which she could not read so she could not determine whether they were acceptable to use. LPN-C further stated the staff member administering eye medications should be able to read the resident's name, open date and the expiration date for eye drops and then compare that to the facility's protocol 'Medication To Date When Opened' sheet in the medication room to ensure they are not expired or past their use date.

On 4/24/17, at 2:56 p.m. RN-A stated during interview that she had called the pharmacist and confirmed R61's Timolol was expired so she'd discarded it. RN-A stated the pharmacist had confirmed the Latanoprost eye drops for R61 were good for 42 days after opening, but since there was no visible date on the vial, she'd discarded them. RN-A also confirmed R18's Visine did not have an open date indicated on the vial so she'd discarded it.

On 4/26/17, at 10:47 a.m. during an interview with the Staff Coordinator (SC), she indicated that after review of the medication carts, she'd determined they contained outdated eye drops

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F 431	Continued From page 35 and other eye drop bottles not labeled properly with open dates. The SC further stated medication administration staff are supposed to use labels and a black marker to write the open dates on eye drop bottles, and confirmed this had not been done consistently. She stated staff are supposed to be looking at the labels and expiration dates before administering eye drops, and stated the facility was currently implementing a retraining program for all staff who administer medications, because although there was a system in place to label eye drops properly, staff were not following the protocols. On 4/2617 at 10:55 a.m. the director of nursing (DON) stated the pharmacy audits the medication carts monthly and the staff should have put the date opened labels on the eye drop bottles. She further stated the night nurse had been checking the medication carts once monthly and now will check them weekly. She also verified medication administration staff should always be checking the expiration date before giving any medications.	F 431		
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment	F 441		5/18/17

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conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2);

(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:

(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;

(ii) When and to whom possible incidents of communicable disease or infections should be reported;

(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;

(iv) When and how isolation should be used for a resident; including but not limited to:

(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.

(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and

(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.

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F 441	Continued From page 37 (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement procedures to prevent the potential spread of infection related to the cleansing of multi-use blood glucose monitoring machines. This had the potential to affect 2 of 2 residents (R44 and R46) reviewed who had blood glucose checks observed. Findings include: On 4/24/17 at 4:54 p.m., licenced practical nurse (LPN) B was observed to conduct a blood glucose test for R44. During the observation, LPN-B stated she needed to clean the machine and proceeded to wipe the machine with a disinfectant wipe called a Caviwipe. LPN-B wiped the machine and threw the cloth away stating, "that's about a minute" however, LPN-B had not actually timed the cleansing to ensure a minute had passed. LPN-B also verified the machine needed to be wiped with the disinfectant wipe for one minute to adequately disinfect it. On 4/24/17 at 4:58 p.m., LPN-B proceeded to go to R26's room to conduct a blood glucose check	F 441	The nursing staff were re-educated at their nurses meeting on May 18, 2017. Proper protocol for infection control on disinfecting the glucometer is for a full minute per facility policy. This policy has been in effect and this was considered an isolated incident. The Resident Care Coordinator will conduct random audits to ensure compliance. The date of completion is May 18, 2017.	

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with the same machine. Prior to using the machine, LPN-B wiped the machine with the disinfectant wipe for approximately 10 seconds.

During an interview on 4/25/17 at 3:19 p.m., the director of nursing (DON) and resident care manager stated the expectation for disinfection of the multi-use glucometer was to wipe the machine for one full minute per the directions on the Caviwipe container for disinfection. The resident care manager also stated that was how staff have been trained. The resident care manager stated they had moved away from use of a 2 minute product. Special instructions identified on the Caviwipe product indicated, "for cleaing and decontamination against HIV-1, HBV, and HCB (all blood borne pathogens) on surfaces or objects soiled with blood or body fluids". The directions for use state to " thouroghly wet surface with a caviwipe 1 towellet, Repeated use of the proced may be required to ensure that the surce remainds visibly wet for 1 minute.

The facility "Disinfecting Glucometer Policy" Under "Procedure for disinfecting the Glucometer between each resident" indicated "Step 2. a. [Disinfectant] the glucometer by wiping the entire meter with disinfectant wipe for 1 minute".

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	245445	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/26/2017**

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K 000	INITIAL COMMENTS	K 000		

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 WILL BE USED AS VERIFICATION OF COMPLIANCE.

UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.

A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, Shakopee Friendship Manor was found not 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) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care.

PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES
(K-TAGS) TO:

Health Care Fire Inspections
State Fire Marshal Division
445 Minnesota St., Suite 145
St Paul, MN 55101-5145, or

By email to:
Marian.Whitney@state.mn.us and

EPOC

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/24/2017

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245445	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/26/2017**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Shakopee Friendship Manor is a 1 story building, with no basement. The original building was constructed in 1964 and was determined to be of Type II(111) construction. In 1976 an addition was constructed and was determined to be of Type II(111) construction. Because the original building and the addition meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is protected by a full fire sprinkler system. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 80 beds and had a census of 62 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 291 SS=D	NFPA 101 Emergency Lighting	K 291		4/28/17

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K 291	Continued From page 2 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This STANDARD is not met as evidenced by: Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 Findings Include: On facility tour between 09:00 AM and 01:00 PM on 4/26/2017, based on observation and interview revealed that the following include: The emergency back-up light unit did not work when tested in the generator room. This deficient practice could affect the safety of all the residents, staff and visitors within the smoke compartment. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 291	The battery for the back-up lighting in the generator room was replaced and the emergency lighting is working properly. The Maintenance Department verifies that the emergency lighting is functioning during their routine testing. Added to their routine testing will be to replace the battery in the emergency lighting on an annual basis. The maintenance Supervisor will verify that the back-up lighting in the generator room is routinely tested and that the battery is replaced on an annual basis. The date of completion is April 28, 2017.	
K 321 SS=D	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure 2012 EXISTING Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4-hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates	K 321		4/28/17

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	245445	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/26/2017**

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K 321	Continued From page 3 that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This STANDARD is not met as evidenced by: Hazardous Areas - Enclosure 2012 EXISTING Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4-hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1 Area Automatic Sprinkler Separation N/A	K 321	The ceiling panel was installed in room 200, no additional openings were noted. All staff have been reminded to record maintenance concerns in the maintenance books found on each nursing station. The Maintenance Supervisor will monitor the general upkeep of the facility. The date of completion is April 28, 2017.	

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K 321	Continued From page 4 a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) Findings Include: On facility tour between 09:00 AM and 01:00 PM on 4/26/2017, based on observation and interview revealed that the following include: An opening in the ceiling for room 200 was found. This deficient practice could affect the safety of all the residents, staff and visitors within the smoke compartment. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 321		
K 351 SS=D	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for	K 351		4/28/17

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K 351	Continued From page 5 sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This STANDARD is not met as evidenced by: Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) Findings Include: On facility tour between 09:00 AM and 01:00 PM on 4/26/2017, based on observation and interview revealed that the following include: The fire sprinkler protection in the load area does not cover the lined storage cabinet with inclosed ceiling.	K 351	The top covering of the linen cabinet was removed allowing the sprinkler system to fully cover the loading area room. The Maintenance Supervisor will monitor the general upkeep of the facility. The date of completion is April 28, 2017.	

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K 351	Continued From page 6 This deficient practice could affect the safety of all the residents, staff and visitors within the facility. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 351		
K 374 SS=D	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This STANDARD is not met as evidenced by: Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal	K 374	The doors between wings 3 and 4 have been adjusted so they close properly. The Maintenance Department was capable of making the necessary adjustments. The Maintenance Department will periodically check the doors throughout the facility verifying that they close properly. The Maintenance Supervisor will randomly test door closings on a monthly	4/28/17

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K 374	Continued From page 7 doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 Findings Include: On facility tour between 09:00 AM and 01:00 PM on 4/26/2017, based on observation and interview revealed that the following include: The smoke compartment doors do not close tight when tested between wings 3&4 This deficient practice could affect the safety of all the residents, staff and visitors within the smoke compartments. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 374	basis to verify compliance. The date of completion is April 28, 2017.	