

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  245445	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/22/2025
NAME OF PROVIDER OR SUPPLIER  Shakopee Friendship Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  1340 Third Avenue West Shakopee, MN 55379	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER  
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  245445	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/22/2025
NAME OF PROVIDER OR SUPPLIER  Shakopee Friendship Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  1340 Third Avenue West Shakopee, MN 55379	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and document review, the facility failed to ensure signs of a potential gastrointestinal (GI) bleed were acted upon or evaluated timely and, if needed, referred for care or treatment to reduce the risk of complication for 1 of 1 residents (R1) reviewed who was hospitalized with GI complications. Findings include: R1's Entry Minimum Data Set (MDS), dated [DATE], identified R1 admitted to the care center on 9/15/25 from the acute care hospital. R1's initial Medicare/5-Day MDS remained, In Progress, at the time of survey. R1's Interagency Transfer Form, dated 9/10/25, was completed by the admitting hospital and outlined R1 as having a past medical history significant for colon cancer and chronic kidney disease (CKD). The report outlined R1 admitted to the hospital on [DATE] after a mechanical fall with a resulted odontoid fracture (i.e., a form of cervical fracture). R1's medical history was detailed which included a history of right hemicolectomy (a surgical procedure that involves removing the right side of the colon) in June 2025; however, the completed report lacked any evidence R1 had a current or active GI bleed which was being treated or monitored while he had been hospitalized. R1's progress note, dated 9/15/25, identified R1 admitted to the care center via a transport service. R1's vital signs were listed as being within normal limits and he rated his pain at three (out of ten). R1 had no skin issues present aside from a scab on his head. The note concluded with, . no other area of concern noted at this time. R1's corresponding Admission/re-admission Summary - V6, dated 9/15/25, identified an evaluation completed by the care center' staff which detailed a brief review of systems. The evaluation included a section labeled, A4. Elimination, which outlined R1 as having urinary and bowel incontinence, having a last bowel movement on 9/15/25, and having hypoactive bowel sounds in all four quadrants. The completed summary lacked any concern or indication of R1 having an active or monitored GI bleed. R1's POC (Point of Care) Response History, dated 9/22/25, outlined a task labeled, B&amp;B - Bowel and Bladder Elimination, and recorded responses from the staff members for the previous 14 day period. This recorded R1 as having a large bowel movement (BM) on 9/16/25 at 4:30 p.m., and another large bowel movement on 9/17/25 at 12:00 p.m. The report continued and identified both of these BM(s) were, Formed/Normal, in consistency. However, R1's progress note, dated 9/17/25 at 12:19 p.m., identified R1 was being transferred to the hospital [due to prior complaints of head pain after a fall]. The note outlined, EMTS [sic] just came in to pick up resident . staff stood resident up to move to gurney [and] a large amount of very bloody black stool come [sic] down his leg . [EMT] stated it smells like a GI bleed . placed on the gurney and left the building to ED . The note was authored by licensed practical nurse (LPN)-A. When interviewed on 9/22/25 at 10:06 a.m., nursing assistant (NA)-A explained they had worked with R1 during his few days at the care center and recalled him as often saying he feels dizzy with ambulation. NA-A stated R1 needed help with dressing and most cares. NA-A explained they were assisting R1 with ambulation on 9/17/25 when he, again, reported being dizzy and was lowered to the floor. NA-A stated they did not recall ever helping R1 after a BM, however, then expressed everyone was complaining about the smell in the room. NA-A explained they had noticed a foul odor in R1's wash room the morning of 9/17/25 before the breakfast meal (i. e., approx. 7:30 a.m.) which NA-A described as the same smell as happened when R1 evacuated his bowels with the EMT present later in the day. NA-A stated they had not always noticed that odor but felt it was because R1 had just used the bathroom. NA-A stated they did not report this odor to the nurse as someone from a previous overnight shift had told them R1's room sometimes smells, so they assumed it had been addressed. NA-A stated they didn't recall ever seeing any active bleeding from R1, however, verified the odor they noticed in the early morning hours on 9/17/25 was the same one they smelled later in the afternoon when R1 was transferred to the hospital adding, It's not a normal smell. NA-A expressed further the odor was, Not a [typical] poop smell. When interviewed on 9/22/25 at 11:04 a.m., LPN-A verified they were assigned care for R1 on 9/17/25 and helped transfer him to the hospital. LPN-A explained R1 had been lowered to the ground earlier on 9/17/25, and he had complained of severe head or neck pain afterward which was the reason for the hospital transfer. LPN-A recalled that day and expressed R1 had gotten up for the day per usual and had said he was fine. Then while being prepared for the hospital transfer, the NA staff called her back into the room as they had noticed a large amount of blood in R1's incontinence product. LPN-A stated this happened between the time EMS was contacted and when they arrived. LPN-A stated R1 was visibly uncomfortable at this time. The EMS then arrived and R1 was assisted to stand to transfer to their stretcher and at that time R1 became incontinent of bowel and it had just flooded down his pants leg</p>		