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	05/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shakopee Friendship Manor	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)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure a mechanical lift was used in accordance with manufacturer's guidelines and Federal law to complete a safe transfer for 1 of 3 residents (R1) reviewed who used mechanical lifts. Two nursing assistant (NA) staff members, one of which was not [AGE] years of age, attempted to transfer R1 using the lift, but did not properly secure the sling to the device prior to lifting R1 up. This resulted in R1 falling onto the floor and sustaining multiple injuries including a fractured shoulder and head laceration. These findings constituted an immediate jeopardy (IJ) situation for R1. The IJ began on 5/3/26 when the two NA staff members failed to fully connect the lift sling to the device, nor did they double check the sling attachment prior to initiating the transfer of R1. R1 was raised from the bed with only three of the four attachment points placed which caused R1 to fall from the sling onto the floor and sustain serious physical injuries. The administrator and director of nursing (DON) were notified of the IJ on 5/8/26 at 9:46 a.m. The facility took appropriate corrective actions prior to the onsite survey so the IJ was removed on 5/4/26, and these findings are issued at past non-compliance.Findings include: The EZ Way Classic Lift Operator's Instructions, revised 3/2026, identified directions for the lift devices used by the care center. This included a section labeled, Safety Notes, which directed multiple items including, For safe operation . operators should watch the training video, read through this manual, complete the competency checklist, and practice on fellow staff members before using with patients. The section also listed, As always, patient lifts should only be operated by trained personnel, and a full patient assessment should be conducted to determine the appropriate accessory [sling] size and type prior to use. The manual listed step-by-step instructions for how to transfer a patient from their bed to a chair/wheelchair. This included attaching the sling loops nearest the patient's shoulders to the hanger bar hooks of the lift nearest each shoulder, crossing the sling leg straps and attaching to the opposite side of the hanger using the loops and, Make a final check of all four loop attachment points to ensure each loop is sufficiently attached to the respective hook of the hanger bars.A submitted Facility Reported Incident (FRI), dated 5/3/26, identified R1 was being transferred using a mechanical lift shortly before 7:00 a.m. from her bed to wheelchair by two NA staff members. One of the NA staff came into the hallway and retrieved the nurse who entered the room to find R1 with her head and shoulders were out of the sling and being held by the second aide. R1 was lowered completely to the floor and found to have a skin tear which was three centimeters (cm) long. R1 had pain in her right arm when moved and a portable x-ray order was obtained. On 5/7/26 at 10:03 a.m., a tour was completed of the campus which identified three mechanical EZ-Way lifts (Model L500PN) in the hallways for use. There were no slings present with the machines and each of them demonstrated no obvious defects when pushed, pulled, or inspected. At 10:18 a.m., NA-A was interviewed and stated they used the mechanical lifts regularly during their shift to help transfer residents. NA-A explained use of the device while demonstrating it with the machine. This included each resident having their own personal sling, placing the sling underneath them and crossing the leg straps, securing it to the metallic hanger bar using the colored loops adding once the loops are attached, the users needed to (continued on next page)

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	double-check them to ensure they were secured. NA-A stated only someone 18 or older was able to use the device and someone less than [AGE] years old could only assist with a transfer such as adjusting the person's position or helping move the wheelchair underneath the patient during a transfer. NA-A stated the schedule sheets identified who was and was not [AGE] years old and felt staff knew to check that if questions. NA-A stated they had received education on use of the mechanical lifts when they started at the care center along with additional education in the past few days as someone had fallen from the lift. NA-A stated they only knew minimal details of the incident but had been told R1 fell onto the floor due to one of the sling loops not being hooked right. On 5/7/26 11:22 a.m., R1's family member (FM)-A and FM-B were interviewed. FM-A explained they received a telephone call on 5/3/26 in the early morning saying R1 had fallen and sustained a head laceration and possible broken arm. FM-A and FM-B then arrived at the care center a short while later and R1 did not want to go to the hospital for further care which they honored. FM-A stated a portable x-ray was ordered after the fall as R1 was very much complaining of significant pain in her arm after the fall. FM-A stated they had installed a camera in R1's room prior to the fall and had the entire event of the fall on recorded clips. They had presented these to the care center leadership on 5/4/26, when they saw on the clips the fall was human error with use of the lift device. FM-A stated the care center leadership was shocked when they saw the footage on 5/4/26. FM-A stated the two NA helping R1 on the clips didn't secure the sling straps or double check them at any point prior to lifting R1 up from the bed. FM-A stated the fall directly resulted in R1 having a fractured shoulder and head laceration along with some worsened bruises on her arms which had not been there prior. After the fall, R1 then had a very rapid change of status and actively declined until she passed away on 5/5/26. FM-A and FM-B both reiterated they knew the facility had acted on this incident and were re-training the staff members on using the mechanical lifts since it happened. R1's quarterly Minimum Data Set (MDS), dated [DATE], identified R1 had severe cognitive impairment and several medical conditions Alzheimer's Disease and age-related physical debility. R1 was recorded as being dependent on staff for chair/bed-to-chair transfers. R1's care plan, dated 5/5/26, identified all R1's identified actual or potential problems and interventions to address them. The care plan identified R1 was at risk for falls and injury due to her cognitive impairment and incontinence and listed a goal which read, [R1] will be free of falls through the review date. The plan listed interventions to help R1 meet that goal including camera placement in her room and, Weekly observation of safety with transfers completed by Nurse/TMA [trained medication aide]. The plan continued and identified R1 had an activities of daily living (ADL) self-care deficit and needed extensive assistance with bed mobility, bathing and transfers. The plan outlined, TRANSFERS: Total assist of 2 staff with the use of Hoyer Lift. This had a start date of 8/6/24 and last revision on 11/4/25.R1's Treatment Administration Record (TAR), dated 4/2026, identified R1's nursing and medical treatments along with spaces to record their administration. This included a treatment labeled, Observe Transfer on Bathday [sic] . every day shift every 2 weeks on Sun for monitoring. This was last completed on 4/26/26 and no issues were identified. R1's progress note, dated 5/3/26 at 7:38 a.m., identified R1 had fallen out of the mechanical lift and two NA were present at the time of fall. The nurse assessed R1 and identified a head laceration on the right side of her head and pain in the right arm and elbow. R1 was recorded as grimacing and stating ouch ouch with arm movement. R1 was assisted back into bed and family updated. R1 refused to go to the hospital. R1's progress note, dated 5/3/26, identified R1's shirt was removed after the fall, and she was found to have bruises on her right elbow which were light blue in color and tender to touch. R1 had another bruise on her upper arm which was tender to touch, swollen and was firm when palpated. An ordered x-ray was pending at this time. R1's Radiology Report, dated 5/4/26, identified right shoulder and right elbow x-ray were completed. The report identified, [Shoulder] Results: Fracture of the surgical neck. No dislocation of the head . Conclusion: Acute appearing fracture of the surgical neck as noted. On 5/7/26 at 12:21 p.m., the video clips provided to the care center by FM-A and FM-B were watched with the director of nursing (DON) and assistant (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	director of nursing (ADON) present. A total of six clips were attached, and each was dated 5/3/26 with a corresponding timestamp. The camera was pointed down from R1's head-of-bed and NA-D was on the left side with NA-E on the right side. A tan-colored sling was positioned underneath R1 and NA-E attached both the upper and lower points on the right side. NA-D attached the upper loop to the hanger on the left side, however, did not attach the lower (leg) point. The clips continue and the following were observed: 6:46:56 - NA-E walked around the bed to the side with the lift controls present. NA-D stood in the middle of the room moving a commode and NA-E then moved R1's wheelchair into the middle of the room. NA-D and NA-E are heard conversing aloud while R1 waited in the attached sling with her hands crossed. 6:47:19 - NA-E stood at the controls of the mechanical lift and used it to raise R1 up from the bed. Neither NA-D nor NA-E were seen to double-check the attachment points to ensure the sling was correctly attached as the left lower hanger attachment point did not have a sling loop secured on it as the device was raised up with R1 inside. NA-E turned away from watching R1 as R1 was raised and conversed with NA-D who was back in the middle of the room doing other tasks. Neither of them had a physical hand on R1 as she was raised from the bed. The metallic hanger on the mechanical lift was seen to immediately turn from parallel to perpendicular to the bed as R1 was lifted. 6:47:41 - R1 was raised up from the bed and NA-E pulled R1 off the bed surface by pulling the mechanical lift away from the bed and into the middle of the room. NA-D came to the bedside at 6:47:48 and physically grabbed R1's feet as R1 was being lifted away from the bed. R1 was then seen in the air and immediately fell out of the sling onto the floor on her right side and an audible gasp was heard. The final clip ended at 6:47:53. DON and ADON verified the footage as observed and was provided by FM-A and FM-B to them on 5/4/26. The DON and ADON both acknowledged the loop was not secured to the lift hanger prior to transferring R1, and that staff did not at any observed point double-check the loops prior to lifting R1 in the device. DON stated the two staff members involved were immediately removed from the schedule when they learned of these clips. Further, DON stated NA-E was not [AGE] years old yet and should not have been operating the lift in the manner they were at the time of the incident. When interviewed on 5/7/26 at 12:35 p.m., NA-D verified they were present and helping with the transfer of R1 on 5/3/26 when she fell from the lift. NA-D stated they had been educated on using the mechanical lifts prior to the incident involving R1 but had missed securing the loop to the hanger when R1 was transferred. NA-D stated they had noticed the wheelchair needed to be moved to complete the transfer and just got distracted and forgot to attach it. NA-D then assumed NA-E had noticed it and attached it prior to lifting R1 up in the machine. NA-D verified they never re-checked the loops to ensure they were secured prior to the transfer and expressed, I should have. NA-D reiterated they believed NA-E would have caught and attached the last loop to the hanger adding, I assumed she [R1] was good to go. NA-D stated there was poor communication between them and NA-E which they attributed to causing the fall for R1. NA-D explained they should have also been the one operating the lift machine as they were over [AGE] years old and NA-E was not, however, at the time that was just something I really wasn't thinking about. After the fall, the nurse responded to the situation and took over the care. The DON then arrived onsite and directed NA-D and NA-E to not work with the lifts for the remainder of the shift. The following day (5/4/26), the management then started to re-train staff, including them, on the machines and how to use them safely. NA-D stated the DON made them watch the footage of the fall provided by family and reiterated miscommunication had caused the incident in their opinion. NA-D stated they had not worked again since 5/3/26 but felt confident and safe to use the mechanical lifts moving forward. When interviewed on 5/7/26 at 12:57 p.m., NA-E verified they were present and helping with the transfer on 5/3/26 when R1 fell onto the floor. NA-E stated NA-D had called them into the room to help transfer R1 and the attached their side of the sling loops to the metallic hanger. NA-E then raised R1 up from the bed and next thing I knew R1 fell onto the floor. NA-E stated they had seen the video footage of the incident and verified the one loop on the left side was not attached, nor did they double-check the loops prior to lifting R1 up from the bed surface. NA-E stated that from the (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	video footage, it also seemed like themself and NA-D were talking and not really paying attention to the transfer which was something they should not have been doing. NA-E then stated they sometimes forget to double-check the loops as being secure before lifting patients and then abruptly stopped and said aloud, I [actually] never double check 'em. NA-E stated they would usually not double-check them as they had just attached them, so they knew they'd be attached. NA-E verified they were under [AGE] years of age and use of the machine like they were doing on 5/3/26 was not something we're supposed to do. When asked why they were using the machine and not the other NA present, NA-E responded, I really have no reason why. NA-E stated someone should have double-checked the loops and had physical contact with R1 the entire time she was being raised up in hindsight. The following day (5/4/26), NA-E stated they were re-educated on slings and the lifts but had not worked again since this incident happened. NA-E stated they had no formal education in the lift machines prior to the incident but rather just a quick discussion about them from another staff member on the floor. NA-E stated they felt the fall happened as we weren't paying enough attention. On 5/7/26 at 1:39 p.m., DON and ADON were interviewed. They explained the NA staff were trained on mechanical lifts through the new employee orientation (NEO) process and staff were not allowed to physically use or run the machines until they turned 18-years-old. They provided the education for NA-D that showed training had been completed prior to the incident on 5/3/26, however, did not have any documentation to provide for NA-E as they weren't supposed to be using the machine like that at all. ADON stated they use the TAR intervention with the nurse or TMA watching a transfer as their audit system to ensure safe transfers and staff should be aware of who is and isn't 18 by the blue dot on the schedules. DON verified the fall on 5/3/26 is what caused the shoulder fracture, head laceration, and the bruising as recorded in the record. DON stated the cause of the fall was solely due to human error. When the fall happened, the DON came onsite to start investigating it. They reported it to the State agency (SA) and directed NA-D and NA-E to no longer use the lifts for the remainder of the shift. The following day (5/4/26), the family then presented the video clips of the incident and the footage was unsettling. DON added, I watched it multiple times to make sure I saw what I saw. They both acknowledged the loop not being secured or double-checked, and NA-D and NA-E seemingly not paying attention to R1 as she was being raised. DON said the situation was frustrating. DON explained they had nurses' meetings scheduled for 5/4/26 prior to the incident happening, so they just shifted the agenda to the lifts and started re-education then. The re-education included repeating the checklist of use to ensure competency and reiterating to staff members that persons less than 18 cannot use the devices other than minimal assistance. They were also going to include this incident as part of their ongoing QAPI (Quality Assurance) review. The facility Mechanical Lift Policy (HOYER), dated 4/2025, identified two staff were always required when using the machine and sling size was determined by the weight of the resident. A procedure was listed which included informing the resident of the transfer, checking for a clear pathway from start to finish, checking slings for wear-and-tear, positioning the sling and . lift Resident just enough off the bed/wheelchair and double check positioning of sling straps before moving Resident off the bed/wheelchair to new surface. However, the policy did not provide any language or direction on age-of-use with the device or what a 16- or [AGE] year-old person could assist with and still comply with Federal law. A United States (US) Department of Labor Field Assistance Bulletin No. 2011-3, dated 7/2011, identified the Department's position on use of power-driven patient lifts/hoists under the Child Labor Provisions of the Fair Labor Standards Act. The bulletin identified the position that use of the devices was not allowed, however, the Department . will not charge a child labor violation when a 16- or [AGE] year-old employee assists [underlined] a trained adult employee . The bulletin listed several items which the below age user may assist with including attaching the slings and operating the controls with directions reading, You may only assist [underline] in the 'hands on' activities discussed above and may not engage in them by yourself, adding further, Remember, until you are 18-years-old, you may not operate any floor-based vertical powered patient/resident lift devices . by yourself. The IJ (continued on next page)

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