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	07/23/2025

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure a Level II Pre-admission Screening and Resident Review (PASARR) were completed, retained in the medical record, and readily available to ensure continuity of care with mental health needs for 1 of 1 resident (R30) reviewed for PASARR. Findings include:R30's significant change Minimum Data Set (MDS) dated [DATE], indicated R30 had moderate cognitive impairment, did not have delusions, hallucinations or behaviors.R30's Clinical Diagnosis Report printed 7/23/25, indicated R30 was admitted on [DATE] and indicated diagnoses of paranoid schizophrenia (a chronic mental health disorder characterized by significant disturbances in thought, perception, and behavior, primarily marked by paranoid, delusions and hallucinations), cerebral infarction (area of damaged tissue on the brain), muscle weakness, drug induced dyskinesia (uncontrolled, involuntary muscle movement), diabetes, and hypertension.An attached Fax from Senior LinkAge Line, dated 4/5/23, included R30's Preadmission Screening (PAS) which stated Based on the information provided for this nursing home admission, it appears this consumer MEETS Level of Care for purposes of MA payment. The Fax from senior LinkAge Line also included a letter which indicated the Senior LinkAge Line forwarded the PAS to the county/manage care organization for processing. The PAS is not final until the lead agency sends documentation to the nursing facility. R30's entire medical record was reviewed and lacked evidence the facility followed up with the Senior LinkAge Line to find out if further assessment was needed.During interview on 7/22/25 at 11:03 a.m., the administrator stated when a new resident was admitted from a hospital the hospital' social workers sent the PAS screening. The facility usually received the PAS screening upon new residents' admission. In the event a new resident was admitted from home, the facility completed PAS screening. Administrator stated once a PAS screening was received, it was immediately filed on residents' medical record. The administrator reviewed R30's record and verified the medical record lacked documentation of any further assessment done by the Senior LinkAge Line or a letter to confirm R30 did not meet the requirements to be evaluated for a level II screening. Administrator stated she was not aware the facility needed to follow up and obtain a document stating whether a resident needed an OBRA Level II referral.On 7/23/25 at 1:54 p.m., the facility provided a document via e-mail. The document was titled OBRA Level I Criteria Screening for Developmental Disabilities or Mental Illness and was dated 1/11/23. This document indicated R30 had cognitive or behavioral signs that would lead someone to suspect the presence of developmental disabilities or related conditions. This document also indicated R30 had a diagnosis or symptoms of mental illness that significantly interfered with functioning in life activities or caused significant distress the past six months. In addition, the document indicated R30 needed supportive services or interventions due to mental illness to maintain functioning within the past two years, and indicated an OBRA Level II referral was needed.During interview on 7/23/25 at 8:50 a.m., administrator stated she oversaw the PAS screenings and before the interview on 7/22/25 she was not aware a follow up was necessary. Administrator stated the purpose to complete a PASSAR screening was to know the residents' level of care and services needed. A PASARR policy was requested but was not provided.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, intervention, and document review, the facility failed to develop a comprehensive care plan to ensure safety with wandering behaviors for 1 of 1 residents (R9) reviewed who had a history of wandering. Findings include: R9's quarterly Minimum Data Set (MDS) dated [DATE], identified R47 had severe cognitive impairment and was dependent on staff during the lookback period (LBP) to use her manual wheelchair. The MDS indicated R9 had not wandered during the LBP. R9's progress note dated:-3/24/25 at 10:14 p.m., indicated R9 had been wandering trying to find the doctor's office. -4/1/25 at 9:36 p.m., indicated R9 was often wandering down halls and 1:1 and redirection had been effective interventions. -4/2/25 at 3:25 p.m., indicated R9 was wheeling herself into other residents' rooms and attempting to push a wheelchair that was in the hallway. -4/7/25 at 3:01 p.m., indicated R9 was wheeling herself in her wheelchair around the unit and yelling at the laundry lady to come back here. The note indicated staff would continue to redirect the resident. -4/11/25 at 2:48 p.m., indicated R9 was restless and wandering that shift.-4/17/25 at 1:51 p.m., indicated R9 was very anxious and wheeling herself around the unit, asking for help leaving. -5/28/25 at 2:58 p.m., indicated R9 continued to wander up and down both the long and short hall, and staff were able to redirect the resident. -5/28/25 at 3:18 p.m., indicated R9 had been wandering and getting into other residents' rooms. R9's Wandering Risk assessment dated [DATE], indicated R9 was disoriented, forgetful/short attention span, independent with mobility with a mobility aide, had Alzheimer's disease, and was taking antipsychotics and antidepressants. The assessment indicated R9 had a known history of wandering and indicated R9 had a high risk for wandering.R9's Wandering Risk Scale dated 4/17/25, indicated R9 was able to follow instructions, could move without assistance while in the wheelchair, and had no history of wandering. The assessment indicated R9 was a low risk for wandering. R9's Wandering Risk assessment dated [DATE], indicated R9 was disoriented, did not understand surroundings or what was being said, and exhibited fear and anxiety. The assessment indicated R9 had Alzheimer's disease and was taking antipsychotics and antidepressants. The assessment indicated R9 had a known history of wandering and indicated R9 had a high risk for wandering.R9's Order Summary Report dated 7/17/25, indicated R9 was a wander risk as well as a fall risk, so red and yellow squares were placed on the outside of the door, and staff were to complete frequent checks on the resident. R9's Follow Up Question Report dated 6/23/25 to 7/22/25, indicated R9 wandered in the hallway on 7/5/25 and 7/21/25 and into other rooms/unsafe areas on 7/6/25, 7/11/25, and 7/21/25.R9's care plan was reviewed and did not include any behavioral interventions for R9 when wandering behaviors were observed. During an observation on 7/21/25 at 1:52 p.m., R9 was observed sitting in a recliner in her room with her eyes open. R9 did not respond or make eye contact to questions. During an interview on 7/22/25 at 1:20 p.m. with licensed practical nurse (LPN)-B and trained medication assistant (TMA)-A, LPN-B stated R9 was able to wheel herself around independently in her wheelchair and did have a history of wandering down the halls and into other resident rooms. LPN-B and TMA-A agreed that they had both attempted redirecting R9 and giving her an activity to do, and that had been a helpful intervention when R9 was wandering. During an interview on 7/23/25 at 9:21 a.m. with the director of nursing (DON) and assistant director of nursing (ADON), a registered nurse (RN), the ADON stated she would expect staff to redirect R9 if she were found wandering. The ADON stated she would expect R9's wandering behaviors to be care planned as soon as the behaviors started, including personalized interventions, so staff could be aware, as they did utilize agency staff. The ADON stated wandering was not a new behavior for R9, and it was kind of her baseline, so she was unsure why this had not made it on the care plan. The facility's Care Planning Policy dated 4/9/25, indicated the facility would develop a comprehensive care plan to reflect each resident's objective goals and include services that would be given to maintain the resident's highest practicable physical, mental, and psychosocial well-being.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure a change with hearing ability was acted upon, fully evaluated and, if needed, treated or referred to the audiologist for 1 of 1 residents (R1) reviewed who complained about worsening hearing. Findings include: R1's annual Minimum Data Set (MDS), dated [DATE], identified R1 had severe cognitive impairment but demonstrated no delusional thinking. Further, the MDS recorded R1 as having, Adequate, hearing with no hearing aid use.On 7/21/25 at 1:43 p.m., R1 was observed seated in a recliner chair while in her room. R1 did not have any hearing aids or audio devices present on her at this time. R1 was interviewed and stated her hearing in the left ear had been getting worse which concerned her. R1 was asked if they'd been seen by the audiologist for this and abruptly laughed stating, I can't afford it. R1 was hard-of-hearing during the interview and would often times turn her head to the left side and respond, Say again[?], to the surveyor's questions. R1 stated she did not wear hearing aids and, again, responded, I can't afford it. R1 stated she thought staff were aware of her hearing concerns but was unsure what, if anything, was being done about it. Further, R1 stated she had her ears checked and flushed (i.e., wax removal) before, however, it was in a clinic setting prior to her admitting to the care center. R1's Nursing Summary(s), dated 10/2024 to 4/2025, were reviewed. These each contained a section labeled, A. Hearing and Hearing Aids, which had two questions to be answered by the evaluator. These identified: On 10/24/24, R1's hearing was recorded as, Adequate, and no hearing devices were used. On 1/13/25, R1's hearing was recorded as, Moderate difficulty, and no hearing devices were used. On 4/14/25, R1's hearing was recorded as, Adequate, and no hearing devices were used.On 7/15/25, R1's hearing was recorded as, Minimal difficulty, and no hearing devices were used. When interviewed on 7/22/25 at 8:56 a.m., nursing assistant (NA)-A stated they had helped R1 multiple times with various cares. NA-A stated R1 was hard-of-hearing and one ear seemed to be worse than the other adding, I'm not sure which ear it is but she is [hard-of-hearing]. NA-A stated R1 had been hard-of-hearing for awhile now and staff would, at times, have to repeat words to her for her to hear them. NA-A stated the believed the nurses were aware of R1's hearing difficulties adding, They take care of it.However, R1's medical record was reviewed and lacked evidence the potential changes in hearing ability (i.e., adequate to moderate/minimal difficulty) had been comprehensively evaluated to determine what, if any, interventions or potential treatment was needed such as irrigation, flushing, or referral to the audiologist, despite the documented changes on the completed nursing summary(s) and direct care staff being aware of R1's hearing difficulty. When interviewed on 7/22/25 at 10:28 a.m., licensed practical nurse (LPN)-A stated they had worked with R1 only a handful of times. LPN-A stated they didn't feel R1 had too much difficult with hearing but added, I tend to raise my voice a little louder [when conversing with elderly]. LPN-A stated nobody had reported concerns with R1's hearing to their recall, however, expressed any changes with hearing should be evaluated using a visual inspection to check for wax build-up and then doing treatment, if needed. LPN-A stated if an audiologist referral was needed, then family could be asked and that could be arranged. LPN-A stated this process, including evaluation and treatment, should be recorded in the progress notes.On 7/22/25 at 12:37 p.m., the assistant director of nursing (ADON) was interviewed, and verified they had an opportunity to review R1's medical record. ADON explained all residents were asked upon admission what, if any, ancillary services they wished for which included audiology and R1's family had only consented to podiatry back then. ADON stated the medical records personnel had since visited with R1's family about other services, however, it was not documented. ADON stated they were going to have the nurse working that day (7/22) go check in R1's ears and see if there was any wax build-up which could be addressed. ADON acknowledged the completed 'Nursing Summary(s)' which documented R1's potential hearing difficulties on some of them and expressed if a change was noticed, then staff should let the nurse or management know so it could be acted upon. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ADON stated they were unaware the direct care staff had noticed R1 to be hard-of-hearing, too, and explained audiology was currently not one of the 'prompted' questions being asked at care conferences, either, so it could potentially be added to that and evaluated more often with residents adding, That's another opportunity to improve. ADON verified any changes with hearing should be evaluated and acted upon adding it was important for a resident's quality of life.A facility' policy on hearing evaluations and/or treatment was requested, however, none was received.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure recorded complaints of pain or discomfort were comprehensively assessed and, if needed, interventions developed to ensure adequate comfort for 1 of 2 residents (R12) reviewed for pain management. Findings include: R12's quarterly Minimum Data Set (MDS), dated [DATE], identified R12 had moderate cognitive impairment but demonstrated no delusional thinking. The MDS recorded R12 as consuming scheduled pain medication, but having no as-needed (i.e., PRN) medications or non-pharmacological interventions done for pain. Further, the MDS recorded R12 as, Frequently, having pain with a moderate intensity recorded. On 7/21/25 at 1:57 p.m., R12 was observed seated in her wheelchair while in her room. R12 demonstrated no obvious physical symptoms of pain at this time (i.e., grimacing, moaning), however, when interviewed she expressed having pain in her legs and knees due to a fall which happened awhile ago. R12 explained she was currently working with physical therapy (PT) but it was not doing good to help the pain and she continued to have troubles with walking. R12 described the pain as a sore and expressed aloud, It's terrible. R12 stated the staff were aware of her pain as they just add another pain pill, and another, and another, however, it remained ineffective to adequately control her pain. R12 was asked if she'd ever had ice or heat applied to her knees and abruptly responded, That don't help. R12 stated she had been using some knee patches while working with therapy and those did help some, however, she only used them when working with therapy and expressed maybe wearing those more often would help her pain.R12's care plan, dated 2/18/25, identified R12 was on pain medication and listed a goal which read, [R12] will be free of any discomfort or adverse side effects from pain medication through the review date, along with several interventions to help R12 meet this goal. The interventions included providing pain medication as ordered, allowing her to rest to facilitate relief, completing a pain flow sheet per protocol, using non-medication techniques to help relieve pain and, Review pain medication efficacy. [A]ssess whether pain intensity acceptable to resident, no treatment regimen or change in regimen required; Controlled adequately by therapeutic regimen[,] no treatment regimen or change in regimen required but continue to monitor closely . Therapeutic regimen followed, but pain control ot adequate, changes required. R12's Pain Assessment, dated 2/13/25, identified R12 was evaluated for pain using the MDS questions (i.e., Have you had pain or hurting at any time in the last 5 days?) with R12 being recorded as having no pain or hurting during the last five days.R12's most recent Pain Assessment, dated 5/11/25, identified R12 was again evaluated using the MDS questions but now R12 endorsed having pain or hurting with a recorded frequency of, Frequently. The pain was listed as not having much, if any, effect on R12's sleep but did have interference with her day-to-day activities recorded as, Occasionally. The intensity of the pain was recorded as, 2. Moderate. However, the evaluation lacked any comprehensive assessment of the pain including the pain' characteristics, history of the pain, items which worsened or improved it, or R12's goals for pain management; nor did the evaluation outlined what, if any, changes to R12's pain control regimen (i.e., medication adjustment, non-pharmacological interventions) would be considered or implemented to help reduce the pain. R12's progress note(s), dated 5/21/25 and 6/27/25, respectively, identified R12 had a care conference held where R12's pain medications were reviewed. However, on 6/27/25, a note recorded R12 as sitting on the bedside in the morning and, . complaining of knee pain and noted to be short tempered. R12 was provided her scheduled pain medications and had no further complaints recorded. R12's POC (Point of Care) Response History, dated 7/22/25, identified a look-back period of 21 days with recorded nursing assistant (NA) data asking, Resident complained of pain? This recorded the staff marking R12 as having complained of pain on 7/13/25, 7/15/25, 7/18/25, and 7/19/25.R12's Medication Administration Record (MAR), dated 7/2025, identified R12's current medications along with spacing to record their respective administration. The MAR outlined R12 had orders including:- (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Muscle Rub Cream 10-15% applied once daily which was ; - Tramadol (a narcotic) 25 milligrams (mg) twice a day with a, Pain Level, recorded for each administration. These levels ranged from 0 to 3 (i.e., mild) on the scale; - Tylenol 1000 mg three times daily with a, Pain Level, recorded for each administration. These levels ranged from 0 to 3 on the scale. R12's Treatment Administration Record (TAR), dated 7/2025, identified R12's current treatments along with spacing to record their respective administration. The TAR outlined ta treatment for non-pharmacological pain interventions (i.e., massage, warm pack, cold pack) along with a number to represent which intervention was done and spacing to record which was used and if it improved the pain. This identified only a single non-pharmacological intervention of, Cold Pack, as being done on 7/8/25 with the pain being recorded as improved. The TAR lacked any other recorded non-pharmacological interventions being done despite R12 having documented pain on 7/13/25, 7/15/25, 7/18/25, and 7/19/25, per the POC Response charting.When interviewed on 7/22/25 at 8:52 a.m., NA-A stated they had worked with R12 in helping with her with transfers, and expressed needed extensive assistance for many activities of daily living (ADLs). NA-A stated R12 used to complain of knee pain but they had not heard her voice complaints for awhile. NA-A stated the nurses did a muscle rub on R12 and reiterated they had not heard complaints of pain from R12 for awhile adding, Me, personally [hadn't heard any]. R12's medical record was reviewed and lacked evidence R12's pain had been comprehensively evaluated to determine what, if any, additional interventions were needed to ensure comfort for R12 despite a potential change in her reported pain (i.e., Pain Assessments) and direct care staff charting R12 as having pain. The record lacked a comprehensive assessment of the pain including the pain' characteristics, history of the pain, items which worsened or improved it, or R12's goals for pain management. When interviewed on 7/22/25 at 10:26 a.m., licensed practical nurse (LPN)-A stated they had not worked closely with R12 but were aware of her care needs. LPN-A stated they had not heard R12 complain of pain themselves but explained the Pain Assessment(s) were the only documented evaluation of pain the nurses' completed to their knowledge. LPN-A stated if a resident started complaining of pain, the staff could repeat the evaluation or place a progress note with their evaluation and implement condition monitoring on the resident. LPN-A verified the POC Response History documentation was charted by the NA staff and verified R12 had recorded pain on several dates in July 2025. LPN-A stated there was no documented comprehensive assessment in the medical record per se but expressed complaints of pain should be evaluated adding it was more a verbal process than documented process. On 7/22/25 at 12:25 p.m., the assistant director of nursing (ADON) and director of nursing (DON) were interviewed. ADON verified they had been able to review R12's medical record, and explained the 'Pain Assessment(s)' were done on admission and with the MDS' cycle thereafter. ADON stated pain was tracked and monitored using the 'Pain Level' on the MAR and TAR, too, explaining R12 had dementia and was occasionally confused or forgetful so staff could also use the Pain AD scale then (uses physical signs to equate pain levels). ADON stated the charted pain for R12 was mild in nature but expressed the assessments needed more detail and evaluation recorded adding, I would agree with your [surveyor] point. ADON added, There is room for improvement. ADON verified the only comprehensive evaluation documented within the medical record for pain was via the annual MDS if a Care Area Assessment (CAA) triggered for the person. ADON stated it was important to ensure complaints of pain were evaluated to provide good quality of life. A facility' provided Pain Management Policy and Procedure, dated 4/2025, identified a pain level of 1 to 3 was considered, Mild Pain, and listed a procedure which included each resident having an initial pain interview completed and having that reassessed on readmission, annually, quarterly and with a significant change in condition. The policy outlined, Resident experiencing pain should be treated with non-pharmacological and pharmacological methods to help relieve pain and re-evaluate for effectiveness of interventions used. The policy outlined a section on how to evaluate and record pain for severely cognitively impaired residents, which included a progress note and review of interventions, however, the policy did not outline how or what would be included in an assessment for non-severely impaired residents.