Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 13, 2025

Administrator
Franklin Restorative Care Center
900 3rd Street South
Franklin, MN 55333

RE: CCN: 245273
Cycle Start Date: May 1, 2025

Dear Administrator:

On May 15, 2025, we informed you that we may impose enforcement remedies.

On May 28, 2025, the Minnesota Departments of Health and Public Safety completed a recertification survey and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedies listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective August 1, 2025.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective August 1, 2025. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective August 1, 2025.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $13,343, has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by August 1, 2025, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Franklin Restorative Care Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from August 1, 2025. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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

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

DEPARTMENT CONTACT

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

Judy Loecken, Regional Operations Supervisor
St. Cloud B District Office
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: judy.loecken@state.mn.us
Office: (320) 223-7300 Mobile: (320) 241-7797

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

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 November 1, 2025 (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 § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

tamika.brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to tamika.brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 **and Minnesota Statute 144A.10 subd 15**, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
PO Box 64975 | 625 Robert Street North
St. Paul, MN 55164-0975
Office: 651-201-4384
Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245273	A. BUILDING _____ B. WING _____	C 05/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN RESTORATIVE CARE CENTER	900 3RD STREET SOUTH FRANKLIN, MN 55333

(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
E 000	Initial Comments On 5/18/25 to 5/28/25, a survey for compliance with §483.73, Appendix Z, Emergency Preparedness Requirements for Long Term Care Facilities was conducted during a standard recertification survey. The facility was IN compliance. 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. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 5/18/25 to 5/28/25, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with NO deficiencies cited: H52735308C (MN113248) H52734867C (MN105841) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/19/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See 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.

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F 000	Continued From page 1 regulations has been attained.	F 000		
F 552 SS=E	Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5) §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to obtain informed consent, including risks and benefits, for 4 out of 4 residents (R8, R15, R22, R27) reviewed for use of psychotropic medications. Findings include: R8's quarterly minimum data set (MDS) dated 4/19/2025, indicated R8 was admitted 11/3/23, was moderately cognitively impaired, and had the following diagnoses: hypertension (HTN) (high blood pressure), hyperlipidemia (HLD) (high level	F 552	Tag Cited: F552 - Right to be Informed/Make Treatment Decisions Based on interview and document review, the facility failed to obtain informed consent, including risks and benefits, for 4 out of 4 residents (R8, R15, R22, R27) reviewed for use of psychotropic medications. 1. Immediate Actions(s) take for the resident(s) found to have been affected include: Consent for psychotropic medications,	7/11/25

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F 552	Continued From page 2 of fat content in the bloodstream), dementia, and depression. R8's order report summary dated 5/20/25, indicated R8 was currently prescribed mirtazapine (antidepressant) with a start date of 4/23/2025, and Olanzapine (antipsychotic) start date 9/5/2024. R8's Order recap report dated 5/21/25, indicated original start dates for the Mirtazapine was 11/3/2023, and olanzapine was 7/2/2024. Additionally, R8 has a discontinued order for lorazepam (benzodiazepine) start date 7/12/2024 end date 9/5/2024 and paroxetine (antidepressant/anti-panic) original start date 11/3/23 and discontinue date 5/1/24. R8's medical record lacked evidence of informed consents regarding risk and benefits for any of the above listed medications being completed. R15's admission MDS dated 2/10/25, indicated R15 was admitted on 2/4/2025, was moderately cognitively impaired, and had the following diagnoses: anemia (low iron count in the bloodstream), heart failure (failure of the heart to pump blood efficiently), renal insufficiency (kidneys inability to filter blood efficiently), diabetes, HLD, and anxiety. R15's order summary report dated 5/20/25, indicated R15 was currently prescribed alprazolam (benzodiazepine) with a start date of 2/14/2025, and Zoloft (antidepressant) start date 5/13/25. R15's order recap report dated 5/21/25, indicated original start dates for alprazolam was 2/4/25,	F 552	including risks and benefits was signed by resident or residents representative by 6/23/2025 for R8, R15, R22 and R27. 2. Identification of all residents that have the potential to be affected was accomplished by: All residents who take psychotropic medications have the potential to be affected. 3. Actions taken/systems put into place to reduce risk of future occurrences: DON or designee will in-service all Licensed nurses regarding needing consent forms completed for any psychotropic medication the resident is prescribed June 25, 26, & 30, 2025 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The DON/designee will complete 3 random weekly audits of residents receiving psychotropic medication that consents have been signed by resident or residents representative for one (1) month and every 2 weeks thereafter for two (2) additional months. Summary of the audit results will be reported to the QAPI committee until such time consistent substantial compliance has been achieved, as determined by the QAPI committee.	

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F 552	Continued From page 3 original start date for Zoloft was 3/19/25. Additionally, R15 has a discontinued order for duloxetine (antidepressant) start date 2/14/25 end date 3/18/25. R15's medical record lacked evidence of informed consents regarding risk and benefits for any of the above listed medications being completed. R22's significant change MDS, dated 2/21/25, indicated R22 was cognitively intact, and diagnoses included major depressive disorder, generalized anxiety disorder, and hoarding disorder. During the review period, R22 was taking the following "high-risk drug classes": antidepressant, diuretic, opioid, and hypoglycemic. R22's order summary report, dated 5/20/25, indicated R22 was currently prescribed the following psychotropic medications: Trazodone (antidepressant) 50mg by mouth at bedtime with a start date of 2/26/25, Venlafaxine (antidepressant) 37.5 mg by mouth every morning with a start date of 4/11/25, and Venlafaxine (antidepressant) 75 mg by mouth two times a day (BID) with a start date of 8/28/24. R22's record lacked evidence R22 had been informed of the risks and benefits and obtained informed consent for prescribed psychotropic medications. R27's significant change MDS dated 2/20/25, indicated R27 was admitted on 5/3/23, was severely cognitively impaired, and has the following diagnoses: peripheral vascular disease (PVD) (inability of the blood vessels and	F 552		

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F 552	Continued From page 4	F 552		

capillaries in the extremities to constrict enough to send the blood back to the heart), arthritis, Alzheimer's, and anxiety.

R27's order summary report date 5/20/25, indicated R27 was currently prescribed buspirone (psychotropic) with a start date of 11/27/24, and haloperidol (antipsychotic) start date 3/21/25, Lexapro (antidepressant) start date 8/6/24, and olanzapine (antipsychotic) start data 3/21/25.

R27's order recap report dated 5/21/25, indicated original start date for buspirone was 5/25/23, original start date for haloperidol was 12/4/24, original start date for Lexapro was 1/18/23, original start date for olanzapine was 3/14/25. Additionally, R27 has discontinued orders for lorazepam (benzodiazepine) start date 12/15/24 end date 2/19/25, Namenda (psychotropic) start date 3/13/25 end date 3/20/25, risperidone (antipsychotic) start date 8/15/24 end date 8/19/24, and Seroquel (antipsychotic) start date 2/19/25 end date 3/14/25.

R27's medical record lacked evidence of informed consents regarding risk and benefits for any of the above listed medications being completed.

On 5/19/25 at 4:47 p.m., the regional director of nursing (O)-E, stated they do not have any consents for psychotropics, they had not been completed, and whatever was provided for information was all they had.

On 5/28/25 at 1:56 p.m., consulting pharmacist (PharmD) stated the facility was expected to obtain consent for all psychotropic medication, and it was important for residents/resident

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F 552	Continued From page 5 representatives to be informed of the risks and potential side effects prior to initiating the psychotropic. On 5/28/25 at 3:54 p.m., the director of nursing (DON) stated staff were expected to obtain consent after residents/resident representatives were informed of the risk and benefits before a psychotropic medication was administered. The facility's Use of Psychotropic Medications policy, last reviewed 3/5/25, indicated prior to initiating or increasing the psychotropic medication, the resident, family and/or resident representative, must be informed of the benefits, risks, and alternatives for the medication, including any black box warnings for antipsychotic medication, in advance of such an initiation or increase. The resident had the right to accept or decline the initiation or increase of a psychotropic medication. The facility will document the resident or resident representative was informed in advance of the risk and benefits of the purpose are, the treatment alternatives, or other options, and the preferred options to accept or decline in a format that facility deems to use i.e.; consent forms, or narrative notes.	F 552		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure a	F 554	Tag F554 - Resident Self-Administration of Meds-Clinically Appropriate	7/11/25

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F 554	Continued From page 6 self-administration of medications assessment was completed, and orders obtained, for all medications kept at bedside for 1 of 1 residents (R24) observed with medications at their bedside. Findings include: R24's quarterly MDS, dated 3/19/25, indicated R24 was cognitively intact, and diagnoses included diabetes, heart failure, and chronic obstructive pulmonary disease (COPD). On 5/20/25 at 7:39 a.m., licensed practical nurse (LPN)-B was observed setting up R24's morning medications but was unable to locate R24's fluticasone-salmeterol (Advair) inhaler in the medication cart. Trained medication assistant (TMA)-A suggested LPN-B look on R24's bedside table to see if the inhaler had been left in R24's room the previous night. On 5/20/25 at 7:59 a.m., when LPN-B entered R24's room to administer his medications, R24's Advair discus was observed on R24's bedside table and was within R24's reach. When LPN-B asked R24 about the Advair discus, R24 stated, "yeah, they never put that away last night". R24's order summary report, dated 5/20/25, indicated an order with a start date of 4/4/24, for Advair 500-50 mcg/act 1 puff inhale orally two times a day related to COPD. R24's self-administration of medications (SAM) assessment dated 3/13/25, indicated R24 was safe to self-administer Bio Freeze and nicotine gum as needed (PRN), and would be left at bedside table for resident to take. However, the SAM assessment did not indicate R24 was	F 554	Based on observation, interview, and document review the facility failed to ensure a self-administration of medications assessment was completed, and orders obtained, for all medications kept at bedside for 1 of 1 residents (R24) observed with medications at their bedside. 1. Immediate action(s) taken for the resident(s) found to have been affected include: R24 has had assessments completed on 6/14/25 for self-administration of biofreeze and nicotine gum. The assessment showed the resident could safety self-administer these medications. Orders state that the resident may self-administer insulin, which resident has not been doing any part of. An order also states that residents may have medications left at their bedside so he can self-administer when ready. Insulin self-administration order and self-administration order of all medications was put on hold on 6/19/25 and the provider messaged for clarification and further orders. Staff will perform self-administration assessments on select medications on 6/20/25 and will update the provider. Staff will discuss with the resident what medications he would like to self-administer to determine what medications self-administration assessments will be done on. Staff communication put on report sheet and left at desk for staff to be aware not to leave any medications in resident room until appropriate assessments and orders are obtained/clarified.	

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F 554	Continued From page 7 determined to safely self-administer Advair. R24's care plan report printed 5/20/25, indicated R24's safety was at risk and there was a potential for abuse due to current medical condition, use of medications, need for assistance with cares and mobility. On 5/28/25 at 3:54 p.m., the director of nursing (DON) confirmed R24's SAM did not indicate it was safe for R24 to keep Advair at bedside to self-administer. DON stated the only medications that were to be left at bedside were those a SAM identified as safe to do so after a nurse evaluation. DON stated she expected staff to store all medication appropriately for the safety of the resident and other residents. The facility's Person-Centered Medication Administration policy, dated 2024, indicated residents had the right to choose the medication goals and preferences, and the facility would determine if the residents' choices presented a risk or safety challenge to the resident or other residents.	F 554	2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected. All residents will be reviewed with nurse managers to determine who wants to self administer medications, appropriate assessments will be conducted, and providers will be informed of those results and appropriate orders obtained if indicated by provider. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: All staff will be in-serviced regarding the facility policy for Resident self-administration of medication 6/25/25, 6/26/25, and 6/30/25. Self administration assessments will be conducted on medications that residents want to self administer quarterly and PRN, and the provider will be updated with those results. Appropriate orders will be given as determined by the provider and facility assessment. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The DON or person delegated will complete 4 random audits per week X1 month and than 4 random audits per month X2 months. Summary of the audit results will be reported to the QAPI committee until such	

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F 554	Continued From page 8	F 554	time consistent substantial compliance has been achieved, as determined by the QAPI committee.	
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least	F 582		7/11/25

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F 582	Continued From page 9 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure the Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN-CMS-10055) was provided to 1 of 3 residents (R143) reviewed for beneficiary notification. Findings include: R143's discharge minimum data set (MDS) dated 3/27/25, indicated R143 was admitted on 1/2/2025 and discharged on 3/27/2025, and their Medicare part A services ended on 2/19/2025. R143's SNFABN-CMS-10055 signed on 2/19/25, informed them services would end on 2/19/2025. However, this notice was given outside of the 48 hours prior to services ending requirement, and was provided the same day as services ending.	F 582	F582 D Failed to ensure SNFABN -CMS-10066 was provided to 1 of 3 residents 1. Resident #143 was informed of payment status as of the residents last covered day on 02/19/2025 and signature of notification was obtained. Resident #143 has been discharged. Resident # 143, as they are their own responsible party, was notified of last covered day on 2/19/2025 and witness verification was documented. 2. The facility has determined that residents with a qualifying hospital stay and Medicare Part A benefit days available have the potential to be affected.	

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F 582	Continued From page 10 On 5/19/25 at 2:41 p.m., the office manager (OM) stated they were responsible for completing the Medicare SNFABN-0CMS-10055 forms, and they were expected to provide them to the resident 48 hours prior to the end of services. OM stated they were typically informed by therapies or the MDS nurse when someone's services were ending. OM confirmed R143 was given their SNFABN-CMS-10055 outside of the required 48 hours prior to end of services. OM stated the SNFABN-CMS-10055 were important to provide to the resident so they were aware they will need to cover the cost of services at that time. On 5/22/25 at 10:054 a.m., the administrator stated their expectation was for the staff member responsible to complete and provide the notices to the resident and to follow the guidelines of their policy related to the time frame. The administrator stated it was important to provide these notices because it was part of the Medicare process. The facility policy dated 2024, indicated to ensure the resident or representative has enough time to make a decision whether or not to receive the services in question and assume financial responsibility, the notice shall be provided at least two days before the end of a Medicare part A stay or when all of Part B therapies are ending.	F 582	An audit will be conducted on current residents who were admitted in the past six months, and corrective actions will be completed on 6/23/2025. 3. The Administrator educated the following personnel on the facility's Advance Beneficiary Notices policy: Business Office Manager, Social Service Director, MDS Coordinator, Director of Nursing, and RN Manager. Policy will be followed and notices will be issued in a timely matter to residents/Resident representatives. Copies of the relevant forms were placed in a binder in the Business office. These actions were completed on 6/17/2025. 4. The Social Service Director, or designee will conduct a random audit of five (5) residents weekly for four (4) consecutive weeks to verify that notices were issues timely and appropriately. This Plan of correction will be monitored at the monthly Quality Assurance Meeting until such time consistent substantial compliance has been met.	
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.	F 584		7/11/25

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F 584	Continued From page 11 The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and document review, the facility failed to ensure resident living areas were free from unwanted noise for 3 of 4	F 584	F584: Failed to ensure resident living areas were free from unwanted noise Based on observations, interviews and	

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F 584	Continued From page 12 residents (R3, R14, R22) reviewed for uncomfortable sound levels. This had the potential to affect residents in surrounding rooms, visitors and facility staff. Findings include: R3's annual Minimum Data Set (MDS), dated 3/17/25, indicated R3 was cognitively intact, and diagnoses included schizophrenia, anxiety disorder, major depressive disorder, bipolar disorder, and delusional disorders. R14's significant change MDS, dated 3/7/25, indicated R14 was cognitively intact, and diagnoses included major depressive disorder, mood affective disorder, and diabetes. R22's quarterly MDS, dated 5/24/25, indicated R22 was cognitively intact, and diagnoses included chronic tension-type headache, major depressive disorder, and anxiety disorder. On 5/20/25 at 7:39 a.m., during a medication administration observation, a continuous, loud, high-pitched, obstructive noise was heard repeatedly for long lengths of time in the hallway outside the residents' rooms. Trained medication aide (TMA)-A stated the noise was from the call light system that was located at the nurses' station. The nurses' station was in the center of the building, between the 3 resident hallways, and adjacent to the resident common area. It was noted that the noise could be heard down the length of the resident hallways. The call light system was activated for long periods of time, frequently, throughout the survey period. A sample of activation time lengths were	F 584	document review, the facility failed to ensure resident living areas were free from unwanted noise for 3 of 4 residents (R3, R14, R22) reviewed for uncomfortable sound levels. This had the potential to affect residents in surrounding rooms, visitors and facility staff. 1 . It was noted that the call light system that is located in the Nurses station adjacent to the common area in the middle of all 3 resident halls, was loud and may caused a disturbance to the residents. The volume to the system was immediately turned down on 05/29/2025. 2. The facility has determined that all residents in the vicinity of the call light system, located in the Nurses station, has potential to be affected. 3. All staff will be in-serviced on the facility's policy for Resident Environmental Quality on June 25, 26 and 30, 2025. 4. The Environmental Service Director or designee will conduct a weekly audit for one (1) month on noise levels in the common area to ensure alarm sounds are at an acceptable level. The administrator will review the audits to ensure a safe, clean, comfortable, and homelike environment is being presented to the residents. Audits will also be reviewed by Risk Management and by the Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the	

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F 584	Continued From page 13 as follows: On 5/20/25 at 10:39 a.m., the noise from the call light sounded non-stop for 24 minutes. On 5/20/25 at 1:21 p.m., the noise from the call light sounded non-stop for 20 minutes. On 5/21/25 at 11:48 a.m., the noise from the call light sounded non-stop for 34 minutes. On 5/21/25 at 3:10 p.m., the noise from the call light sounded non-stop for 19 minutes. On 5/22/25 at 2:29 p.m., the noise from the call light sounded non-stop for 9 minutes. On 5/22/25 at 3:02 p.m., the noise from the call light sounded non-stop for 19 minutes. On 5/27/25 at 2:32 p.m., the noise from the call light sounded non-stop for 8 minutes. On 5/28/25 at 8:35 a.m., the noise from the call light sounded non-stop for 13 minutes. On 5/28/25 at 2:46 p.m., the noise from the call light sounded non-stop for 18 minutes. On 5/20/25 at 10:32 a.m., R22 stated the call light alarms "go off a lot" for long periods of time until a staff person turns them off. The noise was "irritating". R3 and R14 agreed with R22's statement. R14 stated the call light noise occurred "even at night" and the loud noises affected sleep. On 5/22/25 at 1:31 p.m., registered nurse (RN)-A and licensed practical nurse (LPN)-C stated they have been frustrated because it was hard to work with the noise from the call light system and they found it "incredibly hard to focus" on what they were doing. RN-A stated residents have complained about the noise and have yelled, "shut that [expletive] thing up". RN-A stated the frequent noise has caused more severe negative resident behaviors, and it has been a concern the	F 584	committee. Results will be shared with resident Council for comment and suggestions.	

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F 584	Continued From page 14	F 584		

entire time RN-A has worked at the facility. RN-A and LPN-C stated they had reported the concern about the noise level's effect on residents, but were told "nothing can be done".

On 5/28/25 at 3:54 p.m., the director of nursing (DON) stated an environment that was not calm could contribute to challenging resident behaviors and had identified loud noises as a trigger for residents. DON stated concern the frequent call light noise throughout the day and night in common areas and rooms negatively affected resident quality of life. DON acknowledged the constant distraction from the loud noise could negatively affect staff performance and their ability to concentrate. DON stated a call light system was required for safety, but a quieter sounding alarm would be better for the residents.

On 5/28/25 at 5:31 p.m., the administrator stated background noise could be difficult for residents with dementia to sort out, too much noise could be overstimulating, and it was important to maintain a calm environment. The facility's call light system is old, and the board, located at the nursing station, rings until the call is answered and shut off.

The facility's General Information document, undated, provided with the facility's admission packet, indicated "quiet hours" were from 10:00 p.m. to 6:00 a.m., and to be considerate of the rights of other residents, including noise control.

The facility's Resident Rights policy, dated 2024, indicated the resident has a right to a safe, clean, comfortable and homelike environment.

The facility's Resident Environmental Quality

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F 584	Continued From page 15 policy, dated 2024, indicated the facility would be designed, constructed, equipped, and maintained to provide a safe, functional, sanitary and comfortable environment for residents, staff and the public.	F 584		
F 605 SS=D	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2), 483.45(c)(3)(d)(e) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any . . . chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-. . . §483.12(a)(2) Ensure that the resident is free from . . . chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. . . . . §483.45(c)(3) A psychotropic drug is any drug that	F 605		7/11/25

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F 605	Continued From page 16 affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. §483.45(d) Unnecessary drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. §483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these	F 605		

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F 605	Continued From page 17 drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure ordered as needed (PRN) antipsychotic medications were limited to a 14-day time period and clinical rational indicated continuation past the 14-day time period. Additionally, the facility failed to ensure a gradual dose reduction (GDR) or appropriate indication for use for medications was documented for 2 of 4 residents (R15, and R27) reviewed for unnecessary medications. Findings include: R15's admission MDS dated 2/10/25, indicated R15 was admitted on 2/4/2025, was moderately	F 605	Tag 0605 - 483.10(e)(1), 483.12(a)(2), 483.45(c)(3)(d)(e) Right to be Free from Chemical Restraints Based on interview and document review the facility failed to ensure ordered as needed (PRN) antipsychotic medications were limited to a 14-day time period and clinical rational indicated continuation past the 14-day time period. Additionally, the facility failed to ensure a gradual dose reduction (GDR) or appropriate indication for use for medications was documented for 2 of 4 residents (R15, and R27) reviewed for unnecessary medications.	

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F 605	Continued From page 18 cognitively impaired, and had the following diagnoses: anemia (low iron count in the bloodstream), heart failure (failure of the heart to pump blood efficiently), renal insufficiency (kidneys inability to filter blood efficiently), diabetes, HLD, and anxiety. R15's order summary report dated 5/20/25, indicated R15 was currently prescribed alprazolam (benzodiazepine) 0.5 mg (milligrams)-give two tablets by mouth every 6 hours PRN, with a start date of 2/14/2025. R15's medical record lacks any evidence of clinical indication or rational to continue past the required 14-day time frame. R15's monthly pharmacy reconciliation for March 2025, indicated the pharmacist requested the clinical rational for surpassing the 14-day time frame. R15's medical record lacked any evidence of a rationale, or any evidence the facility responded to the pharmacist request. R27's significant change MDS dated 2/20/25, indicated R27 was admitted on 5/3/23, was severely cognitively impaired, and had the following diagnoses: peripheral vascular disease (PVD) (inability of the blood vessels and capillaries in the extremities to constrict enough to send the blood back to the heart), arthritis, Alzheimer's, and anxiety. R27's order summary report date 5/20/25, indicated R27 was currently prescribed the following medications: 1. Haloperidol (antipsychotic) inject 0.25 ml intramuscularly (IM) every 24 hours PRN, with a start date 3/21/25. 2. Lexapro (antidepressant) give 10 mg my	F 605	1. Immediate action(s) taken for the resident(s) found to have been affected include: The medication regimen for R1, R15, R27 was reviewed by the physician. The Alprazolam prescribed prn for anxiety was discontinued for R15 on 6/19/2025. Pharmacy recommendations were reviewed for June and recommendations followed up on 6/19/25. Haloperidol IM PRN, Morphine 5mg every 1 hour, and Zyprexa 10mg every 4 hours PRN for R27 has been discontinued. DON spoke with Hospice on resident R27 and requests for a possible GDR were requested for scheduled Zyprexa and Lexapro. Diagnosis for use for Zyprexa was requested, and Lexapro was given a diagnosis of Anxiety for use. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected. A review of all prn medication orders and indications for use, will be completed on 6/27/25. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: All Licensed Nursing staff will be inserviced regarding the facility policy for Use of Psychotropic Medication. The regulation regarding unnecessary drugs/unnecessary psychotropic meds will be reviewed with staff at our mandatory meetings on 6/25, 6/26, and 6/30/25. DON and ADON (or delegated staff	

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F 605	Continued From page 19 mouth daily with a start date of 8/6/24. 3. Olanzapine (antipsychotic) give 10 mg three times daily (TID) and every 4 hours PRN with a start date of 3/21/25. 4. Morphine (analgesic) give 5 mg by mouth every 4 hours PRN with the indication of dementia. R27's medical record lacks any evidence of clinical indication or rational to continue past the 14-day time frame for both Haloperidol and/or Olanzapine. Furthermore, R27's medical record lacked any evidence of a GRD being completed or attempted for Lexapro. R27's monthly pharmacy reconciliation for January 2025, indicated the pharmacist requested the clinical rational for Haloperidol surpassing the 14 days, for a second time. R27's medical record lacked any evidence of the facility responded to the pharmacist request. R27's monthly pharmacy reconciliation for April 2025, indicated the pharmacist requested the clinical rationale for Olanzapine, a third request for the rationale for Haloperidol, and requested a GDR for Lexapro. R27's medical record lacked any evidence of the rationale, the GDR, or if the facility responded to the pharmacist requests. R27's monthly pharmacy reconciliation for May 2025, indicated the pharmacist had send a fourth request for haloperidol clinical rationale, and a second request for Olanzapine clinical rational. R27's medical record lacked any evidence the facility responded to the pharmacist request. On 5/28/25 at 1:56 p.m., the consulting pharmacist (O)-D stated their expectation was if	F 605	member) reviewed all medication orders for identification of PRN medications and if the diagnosis is appropriate for use. A form will be created for staff to put all PRN psychotropic and opioid medication orders in DONs box for DON (or delegated staff member) to address the renewal of 14 day orders, if appropriate diagnosis is present, if side effects are being monitored, and if target behaviors are listed for PRN medications. DON (or delegated staff member) will review all psychoactive medications and behaviors each month and notify the MD if a GDR is needed at that time. DON (or delegated staff member) will review pharmacy consults each month, follow up on recommendations, and update the doctor as directed by the pharmacist. 4. How the corrective action(s) will be monitored to ensure the practice will not reoccur: The Director of Nursing Services (DNS), or designee, will complete random weekly audits for six (6) consecutive weeks of new prn medication orders to ensure that appropriate indications for use of any prn psychotropic medication are clearly documented in the medical record. Audit records will be reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee.	

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F 605	Continued From page 20 the psychotropic medication needed to be continued, the provider should have provided a clinical rational explaining why and a duration. The pharmacist confirmed both R15 and R27's medical records lacked any clinical rational to support the continuance of their above listed medications. The pharmacist stated their expectation for a GDR was to be completed within 6 months after starting the medication and then yearly. The pharmacist stated the importance of completing GDR's, as the side effects of these meds can be harmful and it was important to keep them on the lowest effective dose. The Pharmacist reviewed the indication of R27's morphine order, and confirmed dementia was not an acceptable indication for this medication. Lastly, the pharmacist confirmed they had attempted to address all of the above issues in R15 and R27's monthly pharmacy reviews, however they had not received any response from the facility. On 5/28/25 at 3:54 p.m., the director of nursing (DON) confirmed R15 and R27 did not have documented clinical rational to continue use of PRN medications beyond 14 days. The DON stated their expectation was the clinical rational be documented in the residents medical records. The DON confirmed no GDR had been attempted for R27's Lexapro, and the DON expected one to have been completed within 6 months of starting the mediation, and then yearly, GDR's were important to keep the resident on the lowest possible does as some of these medications have a black box warning. The DON confirmed the indication for R27's morphine of dementia was not appropriate and should have been more personalized. Lastly, the DON confirmed they were unsure who was responsible for completing	F 605		

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F 605	Continued From page 21 the monthly pharmacy reviews for the facility. The previous DON had left unexpectedly, and the current DON stated they assumed the pharmacy reviews had been sent to the previous DON and now they were unsure who was completing them,. The DON stated the importance of responding and following up on pharmacy's recommendations to ensure safe medication usage and ensuring the residents were getting their appropriate mediations for the right reasons. The facility policy Use of Psychotropic medications last reviewed 3/5/25, indicated PRN orders for psychotropic medications, excluding antipsychotics, shall be limited to no more than 14 days unless the physician believe it appropriate to extend beyond 14 days. The medical record should include documentation from the physician for the rationale for the extended time period and indicate a specific duration. Residents who use psychotropic medication shall receive gradual dose reductions, unless clinically contraindicated, in an effort to discontinue these drugs. Lastly, the residents medical record shall include documentation of the rationale for chosen treatment options.	F 605		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(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	F 657		7/11/25

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F 657	Continued From page 22 resident. (C) A nurse aide with responsibility for the resident. (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 record review and interviews the facility failed to update the care plan for 1 of 2 residents (R31) reviewed for pressure ulcer interventions. Findings include: R31's significant change minimum data set (MDS) dated 4/7/25, indicated R31 was cognitively intact and had the following diagnoses: osteoporosis (deterioration of bone structure), thyroid disorder, malnutrition, and depression. R5's care plan last reviewed 4/21/25, indicated R31 has the potential for nutrition/hydration problems and an intervention listed was Arginaid Oral packet (Nutritional Supplements) give one packet by mouth two times daily to aid with	F 657	Tag F657 - Care Plan Timing and Revision Based on record review and interviews the facility failed to update the care plan for 1 of 2 residents (R31) reviewed for pressure ulcer interventions. 1. Immediate action(s) taken for the resident(s) found to have been affected include: On 6-18-2025 the MDS coordinator updated the care plan for Resident R31 & R5. 2. Identification of other residents having the potential to be affected was accomplished by: All residents of the facility have the potential to be affected by this practice.	

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F 657	Continued From page 23 wound healing. R5's physician orders accessed 5/27/25, indicated following order: Arginaid Oral Packet (Nutritional Supplements) give 1 packet by mouth two times daily was stated on 2/14/2024 and discontinued on 8/26/2024. On 5/27/25 at 1:48 p.m., the licensed practical nurse (LPN)-A stated the charge nurse on duty was responsible for updating the care plans when necessary. LPN-A stated there was no set schedule of when to complete the updates but they typically happened the same day or as soon as possible after. On 5/28/25 at 3:54 p.m., the director of nursing (DON) stated their expectation was the care plans should be updated at least quarterly and with all changes of condition. The DON confirmed they would have expected R31's care plan to have been updated prior to present day as the order was discontinued in August of 24'. The DON stated the importance of updating care plans to provide consistent and current care for the residents. The facility policy was requested and not provided.	F 657	3. Actions taken/systems put into place to reduce the risk of future occurrence include: The facilitys Interdisciplinary Team and licensed nurses will attended an in-service presented by the Clinical Nurse consultant on 6-30-2025. 4. How the corrective action(s) will be monitored to ensure the practice will not reoccur: ADON or designee will review care plans 5 days per week for (2) weeks for those residents experiencing a change in status to ensure new or modified interventions have been addressed and documented regarding the residents care. The Director of Nursing Services or designee will review a random sample of care plans one (1) time per week for one (1) month and every other week for one (1) month to assure the review and revision of care plans. Results will be reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee.	
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in	F 684		7/11/25

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F 684	Continued From page 24 accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to accurately implement physician orders for 1 of 1 resident (R5) reviewed for weekly weight monitoring. Findings include: R5's annual minimum data set (MDS) dated 2/23/25, indicated R5 was cognitively intact, and had the following diagnoses: neurogenic bladder, paraplegia (has lost use of some of their limbs), malnutrition, and depression. R5's physician order list accessed 5/22/25, indicated a physician order which started on 12/27/23 indicated weekly weights and vitals on bath day as an active order. R5's care plan last reviewed 3/14/25, indicated R5 was at risk for potential nutrition/hydration problems, and to monitor weights per MD order and/or facility policy. R5's electronic medical administration record (eMAR) and treatment administration record (TAR) were reviewed from December 2024 through May 2025, and the last documented weight for R5 was on 12/25/24. On 5/27/25 at 1:48 p.m., licensed practical nurse (LPN)-A stated the nurse on duty was responsible for collecting weights which need to be completed, or when appropriate delegating the task to a certified nursing assistant (CNA). LPN-A	F 684	Tag Cited: F684 Quality of Care Based on record review and interview the facility failed to accurately implement physician orders for 1 of 1 resident (R5) reviewed for weekly weight monitoring. 1. Immediate Actions(s) take for the resident(s) found to have been affected include: R5s weight was obtained 6/23/25. 2. Identification of all residents that have the potential to be affected was accomplished by: All residents have the potential to be affected. 3. Actions taken/systems put into place to reduce risk of future occurrences: DON or designee will in-service all clinical staff regarding obtaining residents weight per physicians orders on June 25, 26, & 30, 2025. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The DON/designee will complete 3 random weekly audits of residents's weights for one (1) month and every 2 weeks thereafter for two (2) additional months. Summary of the audit results will be reported to the QAPI committee until such time consistent substantial compliance has been achieved, as determined by the	

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F 684	Continued From page 25 stated the weights to be completed, show up in the MAR and TAR, or they will receive and email from the dietician or dietary requesting one. LPN-A confirmed there were no further weights charted since December 2024 and was unsure why they were not completed. LPN-A further noted the R5 was agreeable to taking their weight and stated it would not be charted in any other locations. On 5/28/25 at 3:54 p.m., the Director of nursing (DON) stated they expected weights to be collected based on each resident's specific physician orders or at a minimum monthly, until deemed not necessary. The DON confirmed the no weights had been charted or completed since December 2024 for R5. The DON stated it was important to follow physician orders because it was the facility's responsibility to complete, was in the nurse's scope of practice to complete or explain why it was not completed and was part of the care plan. The facility policy Weight Monitoring dated 2023, indicated the facility will ensure all residents maintain acceptable parameters of nutritional status, such as usual body weight or desirable body weight range.	F 684	QAPI committee.	
F 727 SS=F	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 1919(b)(4)(C);1919(b)(4)(C)(i);1819(b)(4)(C);1819(b)(4)(C)(i);483.35(c)(1)-(3) Social Security Act §1919 [42 U.S.C. 1396r] §1919(b)(4)(C) Required nursing care; facility waivers.- §1919(b)(4)(C)(i) General requirements.-With respect to nursing facility services provided on or after October 1, 1990, a nursing facility-	F 727		7/11/25

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F 727	Continued From page 26 (II) except as provided in clause (ii), must use the services of a registered professional nurse for at least 8 consecutive hours a day, 7 days a week. Social Security Act §1819 [42 U.S.C. 1395i-3] §1819(b)(4)(C) REQUIRED NURSING CARE.- §1819(b)(4)(C)(i) IN GENERAL.-Except as provided in clause (ii), a skilled nursing facility … must use the services of a registered professional nurse at least 8 consecutive hours a day, 7 days a week. §483.35(c)(3) Except when waived under paragraph (f) or (g) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(c)(4) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: I'm not sure if this is correct, I used other surveyors tags as guidiance, and their tag from last year. Let me know if you want me to change anything. Based on interview and document review the facility failed to ensure a registered nurse (RN) was scheduled for at least 8 consecutive hours a day, seven days a week. This had the potential to affect at 35 residents who reside in the facility. Findings include: The Facility's PBJ Staffing report 1705D dated quarter 1 2025 October 1st-Decemeber 31st,	F 727	F727 RN 8 hrs/7 days/ WK, Full Time Based on interview and document review the facility failed to ensure a registered nurse (RN) was scheduled for at least 8 consecutive hours a day, seven days a week. This had the potential to affect at 35 residents who reside in the facility. 1. Immediate action taken for all residents of Franklin Restorative Care Center facility to ensure a registered nurse (RN) is scheduled for at least 8 consecutive hours a day, seven days per week. For those times that facility is unable to schedule a RN or scheduled RN is unable to work on site 8 hours that day, a RN	

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F 727	Continued From page 27 indicated the facility had triggered the following staffing concerns: 1. One star staffing rating. 2. Excessively low weekend staffing. 3. No RN hours. Review of the facility's license staff schedule for May 10th, 2025, and May 24th, 2025, confirmed they was no consecutive eight hours of RN coverage in the facility. The Daily Timecards Log dated 5/6/25 -5/10/25, listed punch in and outs times for licensed employees from 5/6/25 -5/10/25, and 5/23/25-5/26/25. These logs confirmed there was no RN coverage on 5/10/25, and 5/24/25. On 5/28/25 at 9:59a.m., the administrator and health unit coordinator (HUC) stated both were responsible for and completed the schedule. They attempt to conduct block scheduling when possible and have been struggling with call ins for scheduled shifts. On an average day they aim to have one charge nurse, 2-trained medication administrators (TMA), 2-3 nursing assistants, and on nights 1-2 nurses, and 1-2 aides. The administrator and HUC confirmed they attempt to check and verify they have RN coverage by reviewing the schedule and time cards, however they confirmed sometimes it did not happen. The Administration confirmed they did not have consecutive RN coverage on 5/10/25 and 5/24/25. Furthermore, the administrator stated it was important to have RN coverage in the facility because it was a requirement of skilled nursing. A Staffing policy was requested, and none was provided.	F 727	waiver has been requested for our Minnesota SNF Medicare/Medicaid facility. Franklin Restorative Care Center will continue to have a full time registered nurse who is regularly on duty at the facility 40 hours a week and may be the Director of Nursing. A registered nurse or a physician is available to respond to telephone calls from the facility regarding nursing services for our residents. 2. All residents could be affected. 3. The Administrator will continue to hire qualified RNs for charge nurse positions and also RN managers - so that daily 8 hour consecutive RN hours are maintained. Time and attendance records will be used to reflect that coverage and to be used in collecting the required PBJ data accurately. Agency staff will be contacted for RN coverage candidates as well. Three new RN managers have been hired during May and June. A charge nurse RN had also been hired during November 2024 during the PBJ period referred to in this tag. Facility will continue to offer competitive wages, fill managerial RN nursing positions, advertise open RN positions in indeed and other available employment candidate sites. RNs will be trained by the Administrator on the requirement of 8 or more consecutive hours of RN coverage including exclusion of the 30 minute meal break as required by PBJ. 4. The Administrator or designee HUC manager will complete a random audit of	

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F 727	Continued From page 28	F 727	the RN daily coverage from the data provided by the time and attendance program which is also used for the PBJ data submission weekly for 4 weeks. Audits will be reviewed by the Administrator until such time as consistent substantial compliance has been achieved as determine by the QAPI committee. PIP study will be continued with guidance under the QAPI committee. This plan of correction will be monitored at the monthly Quality Assurance meeting until such time consistent substantial compliance has been met. Date: June 18, 2025 To: Judy Loecken, SupeNisor Minnesota Department of Health Health Regulation Division: Licensing & Certification 4140 Thielman Lane, Suite 101 St. Cloud, MN 56301 judy.loecken@state.mn.us From: Judith Sandmann, LNHA-LALD, Administrator of Franklin Restorative Care Center Re: Request a RN Waiver in a Minnesota SNF Medicare/Medicaid Provider CCN#245400 State Vendor or	

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F 727	Continued From page 29	F 727	Medicaid #1080422300 Franklin Restorative Ca re Center, located at 900 3rd Street, Franklin, MN 55333, hereby requests a one-yearwaiverto 483.35(b)-theSNFrequirementto have a registered nurse for at least 8 consecutive hours a day, 7 days a week atthefacility. The facility understands it will need to request a renewal of the waiver after one year if adequate RN coverage remains an issue. This waiver request is consistent with the waiver requirement detailed at 483.35(f)(1). To support the granting of a waiver, the facility provides the following information: 1. Franklin Restorative Care Center is located in a rural area in southern Minnesota. The supply of skilled nursing facility seNices in the area is not sufficient to meet the needs of the individuals residing in the area. 2. Franklin Restorative Care Center has made, and will continue to make, the following diligent efforts to hire Registered Nurses: A. Offering wages at the community prevailing rate for nursing facilities (and above) B. Advertising open positions in the following manner to include posting on social Media platforms to include Indeed, Facebook, Salary.com, Glassdoor, CareCrew, Rapid interviews, etc. Other opportunities could include advertising in local newspapers, job	

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F 727	Continued From page 30	F 727	fairs, mailings. 3. Franklin Restorative Care Center will continue to have one full time registered nurse who is regularly on duty atthefacility40 hours a week (this nurse may or may not be the DON, and may perform some DON and some clinical duties if the facility so desires); and the facility either-- A. Has only patients who physicians have indicated (through physician orders or admission notes) that they do not require the services of a registered nurse or a physician for a 48 hour period or, B. Has made arrangements for a registered nurse or a physician to spend time at the facility, as determined necessary by the physician, to provide necessary skilled nursing services on days when the regular full time registered nurse is not on duty; 4. Franklin Restorative Care Center believes a waiver of the requirement will not endanger the health or safety of individuals staying in the facility (Medical Director agrees to this statement and waiver request, Statement attached) 5. Franklin Restorative Care Center agrees to having a registered nurse or a physician respond immediately to telephone calls from the facility; 6. If a waiver is granted the facility agrees to provide a notice of the waiver to the Office of Ombudsman tor Long Term Care, MDH Office of Health Facility Complaints, and the Office of Ombudsman tor Mental Health and Developmental Disabilities; 7. If a waiver is granted the facility agrees	

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F 727	Continued From page 31	F 727	to provide a notice of the waiver to residents of the facility (or, where appropriate, the guardians or legal representatives of such residents) and resident representatives. Jun 26, 2025 V. Simon Mittal, M.D	
F 732 SS=F	Posted Nurse Staffing Information CFR(s): 483.35(i)(1)-(4) §483.35(i) Nurse Staffing Information. §483.35(i)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census.	F 732		7/11/25

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F 732	Continued From page 32 §483.35(i)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (i)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents, staff, and visitors. §483.35(i)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(i)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, the facility failed to ensure all required data were included on the nurse staffing information posted daily. This had the potential to affect all 35 residents residing in the facility and their visitors who may wish to view the information. Findings include: The Facility's PBJ Staffing report 1705D dated quarter 1 2025 October 1st-December 31st, indicated the facility had triggered the following staffing concerns: 1. One star staffing rating. 2. Excessively low weekend staffing. 3. No RN hours. The staff schedule and posting documentation	F 732	F732 Posted Nurse Staffing Information Based on record review and interviews, the facility failed to ensure all required data were included on the nurse staffing information posted daily. This had the potential to affect all 35 residents residing in the facility and their visitors who may wish to view the information. 1.Immediate action taken for all residents of Franklin Restorative Care Center to ensure all required data were included on the nurse staffing information posted daily included a revision of the staff posting form. It does include Facility name, current date, facility census, total number of staff and actual hours worked by licensed staff as well as their designation	

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F 732	Continued From page 33 dated from October 2024 through May 2025, was reviewed and the following dates failed to include any or all of the following requirements for the daily staff posting: 1. Facility name. 2. Current date. 3. Facility Census. 4. Total number and actual hours worked by licensed staff. 5. Total number of licensed staff, and their designation or title. October 2024: 10/5/24, 10/12/24,10/13/24, 10/15/24,10/19/24, 10/20/24, 10/24/24, 10/28/24 December 2024: 12/19/24, 12/31/24 February 2025: 2/6/25, 2/17/25, 2/23/25, 2/24/25 March 2025: 3/2/25, 3/3/25, 3/9/25, 3/1025, 3/16/25, 3/17/25, 3/23/25, 3/24/25, 3/3025, 3/31/25 April 2025: 4/6/25, 4/7/25, 4/13/25, 4/14/25, 4/16/25 through 4/30/25. May 2025: 5/1/25 through 5/16/25, and 5/18/25 through 5/28/25. On 5/28/25 at 9:59 a.m., the administrator and the health unit coordinator (HUC) stated the HUC prepared the staff posting and the night nurses were responsible for listing any staff changes, and posting it in the morning. The administrator and the HUC stated they believed the posting was required to have the name of the facility, census, name of staff, the shift they worked, and the hours they worked. The administrator and the HUC confirmed the above listed staff postings	F 732	as to RN or LPN. 2. All resident are potentially impacted by the deficiant practice. 3. The Nurse Staffing Posting Information Policy was reviewed. A new posting form was developed to include the areas required. Licensed nursing staff are designated to post the Nurse Staff Information on the night shift for that 24 hour day. Licensed staff are to make changes as staff changes are known. Licensed staff will be retrained on their responsibilities related to posting of nurse staff information June 25, 26 & 30, 2025. 4. The Administrator or designee HUC manager will complete a random audit of staff completing the new form for posting and the licensed staff for updating with known changes weekly for one (1) month. The time and attendance logs will be used to further update the data on the posted daily form to capture the change in shifts by the nursing staff. Nursing schedules are reviewed by BOM Manager and HUC Manager for addition of changes in worked hours prior to completion of submission of time and attendance sheets send to payroll and used in PBJ data compilation. Audits will be reviewed by the Administrator until such time consistent with substantial compliance has been achieved as determined by the QAPI committee. This plan of correction will be monitored at the monthly Quality Assurance meeting until such time	

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F 732	Continued From page 34 were missing some or all of the required information. The administrator stated the importance of posting all of the correct information, so the facility and residents were aware of how many staff were working. A staff posting policy was requested and none was provided.	F 732	consistent substantial compliance has been met.	
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(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. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and	F 755		7/11/25

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F 755	Continued From page 35 §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement a system to monitor stored narcotics to prevent diversion. This had the potential to affect all 16 residents prescribed Schedule II-V medications. Findings include: On 5/21/25 at approximately 11:00 a.m., assistant director of nursing/infection preventionist (ADON/IP) confirmed the following: 1. The facility's "West" Individual Narcotic Record's Index page indicated the last narcotic entered on the Index page was Lyrica entered on page 55. However, the narcotic book had medications documented through page 127. 2. The facility's "East" Individual Narcotic Record's Index page indicated the last narcotic entered on the Index page was Lyrica entered on page 55. However, the narcotic book had medications documented through page 127. On 5/28/25 at 11:07 a.m., registered nurse (RN)-A and licensed practical nurse (LPN)-C were observed completing a medication cart narcotic count. LPN-C had the narcotic book. RN-A unlocked the narcotic box in the medication cart, pulled out the first card, called out the number noted at the top of the card, LPN-C turned to the corresponding page in the narcotic book, LPN-C stated the number of remaining doses listed in the narcotic book, RN-A held up	F 755	Tag Cited: F755 Pharmacy Services Based on observation, interview and document review, the facility failed to implement a system to monitor stored narcotics to prevent diversion. This had the potential to affect all 16 residents prescribed Schedule II-V medications. 1. Immediate Action(s) taken for the resident(s) found to have been affected include: A policy addendum to the Controlled Substance Admin and Accountability policy has been created to identify specific measures taken, including staff responsibilities regarding safe storage of all narcotics, outlining facility processes and expectations. A check list has been added to the Controlled Substance Admin and Accountability policy to identify staff responsibilities to ensure a safe, accurate medication reconciliation process. 2. Identification of all residents that have the potential to be affected was accomplished by: All residents with controlled medication orders will be reconciled/documented in a manner that will ensure accuracy of the medication reconciliation process and prevent potential diversion. 3. Actions taken/systems put into place to	

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F 755	Continued From page 36 the card and both nurses verified that the number of doses that remained in the medication card matched the number indicated in the narcotic book. The nurses stated they followed the same procedure for each narcotic, and after the procedure was completed, they both signed and dated the task was completed in the back of the narcotic book. On 5/28/25 at 11:12 a.m., RN-A stated a "C" was noted in the resident's medication administration record (MAR) which indicated that medication was a controlled substance and needed to be secured in the locked narcotic drawer and the count maintained in the narcotic book. RN-A stated narcotic counts were completed at every shift change. RN-A stated the facility no longer used the Index pages located at the front of each book to log when a new medication was received and place in the locked narcotic drawer, and they did not use the Index pages to determine which pages to review during each shift change narcotic count. RN-A stated staff knew what medications should be maintained the drawer "from repetition" and "we would just know" if a narcotic card was missing. On 5/28/25 at 3:54 p.m., director of nursing (DON) confirmed the facility did not use the "index" pages at the front of the narcotic books to track and monitor each narcotic, and no other method or list was maintained that indicated what medications should be kept in each locked narcotic drawer. DON stated records needed to be maintained to account for every narcotic that entered the facility. DON stated the facility did not have a clearly refined system in place to monitor stored narcotics to prevent diversion.	F 755	reduce risk of future occurrences: All licensed staff/those that have medication administration responsibilities will be In-serviced regarding the responsibilities regarding the safe, accurate medication reconciliation process outlined in the Controlled Substance Logbook checklist on June 25, 26 & 30, 2025 by the Director of Nursing/designee. 4.How the corrective action(s) will be monitored to ensure the practice will not recur: The DON/designee will complete three (3) random weekly audits for one (1) month and every other week thereafter for 2 additional months, as directed by the QAPI committee to ensure continued compliance. The verification checklists will be reviewed by the NHA. Summary of the audit results will be reported to the QAPI committee until such time consistent substantial compliance has been achieved, as determined by the QAPI committee.	

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F 755	Continued From page 37 The facility's handwritten Controlled Medications document, undated, provided on 5/28/25, indicated 9 controlled medications for 6 residents were in the facility's East medication cart, and 14 controlled medications for 10 residents were in the facility's West medication cart. However, the document failed to indicate the corresponding narcotic book page number for each medication listed. The facility's Controlled Substance Administration and Accountability policy, dated 2024, indicated the facility would have safeguards in place to prevent loss or diversion of controlled substances.	F 755		
F 756 SS=E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a	F 756		7/11/25

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F 756	Continued From page 38 minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure pharmacist consultant recommendations were acted upon for 5 of 5 residents (R8, R15, R22, R24, R27) reviewed for unnecessary medications. Findings include: R8's quarterly minimum data set (MDS) dated 4/19/2025, indicated R8 was admitted 11/3/23, was moderately cognitively impaired, and had the following diagnoses: hypertension (HTN) (high blood pressure), hyperlipidemia (HLD) (high level of fat content in the bloodstream), dementia, and depression. R8's order report summary dated 5/20/25, indicated R8 was currently prescribed the following medications: 1. Mirtazapine (antidepressant) take 2 tablets by	F 756	Tag F756 Drug Regimen Review, Report Irregular, Act On Based on interview and document review, the facility failed to ensure pharmacist consultant recommendations were acted upon for 5 of 5 residents (R8, R15, R22, R24, R27) reviewed for unnecessary medications. 1. Immediate action(s) taken for the resident(s) found to have been affected include: A review of the medication regimen and identified irregularities was conducted by the Director of Nursing Services for resident(s) R8, R15, R22, R24, and R27 on 06/19/25. Irregularities were addressed, and responses were documented. The physician was notified of those irregularities requiring MD	

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F 756	Continued From page 39 mouth daily, and take 1 tablet 7.5 mg by mouth daily 2. Olanzapine (antipsychotic) 2.5 mg by mouth twice daily (BID) R8's monthly pharmacy reconciliations were reviewed for the last 6 months. Of those, the corresponding months had the following recommendations: 1. April 2025-Pharmacist requested laboratory work up for Olanzapine, as none had been completed since 2024. 2. May 2025- Pharmacist requested order clarification for Mirtazapine, order stated dosage as two tabs, but order also listed one tab, and no change has been made to the order. R8's medical record lacked any evidence the facility ever responded to or updated the physician regarding the pharmacist recommendations. R15's admission MDS dated 2/10/25, indicated R15 was admitted on 2/4/2025, was moderately cognitively impaired, and had the following diagnoses: anemia (low iron count in the bloodstream), heart failure (failure of the heart to pump blood efficiently), renal insufficiency (kidneys inability to filter blood efficiently), diabetes, HLD, and anxiety. R15's order summary report dated 5/20/25, indicated R15 was currently prescribed the following medications: 1. Alprazolam (benzodiazepine) 0.5 mg (milligrams)-give two tablets by mouth every 6 hours PRN 2. Sertraline (Antidepressant) 50 mg by mouth once daily.	F 756	notification. All June pharmacy consultations were sent to the provider on 6/19/25. R27 Haloperidol PRN was discontinued on 5/27/25, A rationale/diagnosis was requested by the hospice nurse to the hospice provider (ordering provider), and a GDR/pharmacy recommendations concerning Lexapro was also requested from the hospice (ordering) provider on 6/19/25. The June pharmacy consultation sheet will be given to the provider on 6/19/25 to address. R22 NP to address June pharmacy recommendations, Nystatin cream, follow up lipid panel and atorvastatin use on 6/19/25. R24 NP to address June pharmacy consultation recommendations, Calcipotriene cream, insulin use, and hydrocodone frequency to be addressed by provider on 6/19/25. R15 NP to address June pharmacy consultation requests PRN Alprazolam and clinical rationale for sertraline use will be addressed with provider on 6/19/25. R8 NP to address June pharmacy consultation requests on 6/19/25. Hospice nurse sent ordering provider/hospice physician a message to address labs that were recommended for olanzapine use, and rounding provider will address the mirtazapine order. 2. Identification of other residents having the potential to be affected was accomplished by: All residents of the facility have the potential to be affected by this practice. Review of pharmacy	

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F 756	Continued From page 40 R15's monthly pharmacy reconciliations were reviewed for the last 6 months. Of those, the corresponding months had the following recommendations: 1. March 2025- Pharmacist requested clinical rational for Alprazolam, it was overdue for 14-day review. 2. April 2025- Pharmacist requested a second request for rationale for Alprazolam, and Sertraline, both were over the 14-day review mark. 3. May 2025- Pharmacist requested a third request for rationale for Alprazolam, and a second request for Sertraline R15's medical record lacked any evidence the facility ever responded to or updated the physician regarding the pharmacist recommendations. R22's significant change MDS, dated 2/21/25, indicated R22 was admitted on 4/17/23, was cognitively intact, and diagnoses included diabetes, PVD, and pancreatic insufficiency. R22's order summary report, dated 5/20/25, indicated R22 was currently prescribed the following medications: 1. Nystatin cream (used to treat fungal or yeast infections) 100000 unit/gm topically BID 2. Atorvastatin (used to lower cholesterol levels) 40 mg by mouth daily R22's monthly pharmacy reconciliations were reviewed for the last 6 months. Of those, the corresponding months had the following recommendations: 1. March 2025-pharmacist recommended	F 756	recommendations was completed on 6/19/25 3. Actions taken/systems put into place to reduce the risk of future occurrence include: The Director of Nursing Services reviewed the guidelines with the staff nurses and nurse managers on 6/30/25. The pharmacist consultant will notify the DON when the monthly pharmacy consult review is completed. The DON (or delegated staff member) will print these, review, and have send to the appropriate provider for review and advisement within three (3) business days of pharmacy notification to DON. 4. How the corrective action(s) will be monitored to ensure the practice will not reoccur: Nurse Managers will audit 20 random charts each month X3 months to ensure that pharmacy recommendations have been addressed. Results of audits will be reported to the facilitys Quality Assurance and Performance Improvement (QAPI) Committee monthly and action taken as needed.	

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F 756	Continued From page 41 Nystatin cream be changed from scheduled BID to PRN. 2. May 2025-pharmacist noted R22's last lipid panel in 2024 was within normal limits (WNL), recommended another lipid panel and discontinue (d/c) atorvastatin if the lipid panel results were still WNL "to reduce interactions and effects of polypharmacy". R22's record lacked evidence the facility updated the physician regarding the 3/13/25 and 5/7/25 pharmacist recommendations. R24's quarterly MDS, dated 3/19/25, indicated R24 was admitted on 2/8/24, was cognitively intact, and diagnoses included diabetes, heart failure, and chronic obstructive pulmonary disease (COPD). R24's order summary report, dated 5/20/25, indicated R24 was currently prescribed the following medications: 1. Calcipotriene cream (used to treat psoriasis) 0.005% topically BID 2. Lantus (long-acting insulin) 100 unit/mL - inject 18 unit subcutaneously daily 3. Humalog (rapid-acting insulin) 100 unit/mL - inject 5 units subcutaneously with meals 4. Humalog (rapid-acting insulin) 100 unit/mL - inject as per sliding scale subcutaneously before meals 5. Hydrocodone-Acetaminophen (used to treat moderate to severe pain) 5-325 mg by mouth three times R24's monthly pharmacy reconciliations dated 4/11/25, indicated the following: 1. Pharmacist recommended the 2/11/25 order for calcipotriene cream be changed from	F 756		

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F 756	Continued From page 42 scheduled BID to PRN. 2. Pharmacist noted R24 was receiving long-acting Lanus and had a continuous glucose monitor. Beer's criteria high risk drug: sliding scale insulin produces high rates of hypoglycemia without adequate control of blood sugars or outcome benefit. Pharmacist recommended an increased dose of basal insulin and d/c sliding scale to establish control and outcome benefit. 3. Pharmacist recommended reducing Hydrocodone frequency or changing to PRN. R24's record lacked evidence the facility updated the physician regarding the 4/11/25 pharmacist recommendations. R27's significant change MDS dated 2/20/25, indicated R27 was admitted on 5/3/23, was severely cognitively impaired, and has the following diagnoses: peripheral vascular disease (PVD) (inability of the blood vessels and capillaries in the extremities to constrict enough to send the blood back to the heart), arthritis, Alzheimer's, and anxiety. R27's order summary report date 5/20/25, indicated R27 was currently prescribed the following medications: 1. Haloperidol (antipsychotic) inject 0.25 ml intramuscularly (IM) every 24 hours PRN, with a start date 3/21/25. 2. Lexapro (antidepressant) give 10 mg my mouth daily with a start date of 8/6/24. 3. Olanzapine (antipsychotic) give 10 mg three times daily (TID) and every 4 hours PRN with a start date of 3/21/25. R27's monthly pharmacy reconciliations were reviewed for the last 6 months. Of those, the	F 756		

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F 756	Continued From page 43 corresponding months had the following recommendations: 1. January 2025- pharmacist requested the clinical rational for Haloperidol surpassing the 14 days, for a second time. 2. April 2025- Pharmacist was requesting the clinical rationale for Olanzapine, a third request for the rationale for Haloperidol, and requested a gradual dose reduction (GDR) for Lexapro. 3. May 2025- Pharmacist had send a fourth request for haloperidol clinical rationale, and a second request for Olanzapine clinical rational. R27's medical record lacked any evidence the facility ever responded to or updated the physician regarding the pharmacist recommendations. On 5/28/25 at 1:56 p.m., the consulting pharmacist (PharmD) stated the facility was expected to resolve monthly medication review recommendations prior to the next monthly pharmacist visit. PharmD stated the facility was responsible for ensuring the recommendations were reviewed by the providers. On 5/28/25 at 3:54 p.m., the director of nursing (DON) stated the regional director of nursing had to contact the consulting pharmacist to obtain the pharmacist recommendations that were missing, and confirmed that R8, R15, R22, R24, and R27's pharmacist recommendations had not been acted upon by the facility. DON stated staff were expected to manage pharmacist recommendation prior to the next consulting pharmacist visit (one month), and it was important to ensure resident medication safety. The facility's Medication Regimen Review, dated	F 756		

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F 756	Continued From page 44 2024, indicated the drug regimen of each resident was reviewed at least once a month by a licensed pharmacist with the goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with medications, and facility staff would act upon all recommendation according to procedures for addressing medication regimen review irregularities.	F 756		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(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. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(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. §483.45(h)(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	F 761		7/11/25

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F 761	Continued From page 45 by: Based on observation and interview, the facility failed to maintain separately locked and permanently affixed compartments for storage of controlled medications in the medication room refrigerator reviewed for medication storage. Findings include: On 5/20/25 at 10:00 a.m., a vial of Lorazepam Oral Concentrate USP 2 mg/ml (2 milligrams of medication/per milliliter of liquid) a schedule IV (four) controlled Substance was observed in the door of the refrigerator outside of the double lock box. The lock box was not permanently secured to the refrigerator and had a key in the lock. Licensed practical nurse (LPN)-B stated they were agency staff and confirmed the unaffixed lock box, with key, had been there since they had started working in the facility. LPN-B confirmed the key was always left in the box. LPN-B confirmed the Ativan should have been stored and locked in the lock box. Next, writer and LPN-B went to confirm the Ativan medication count in the narcotic box, which was correct, and the Director of nursing (DON) passed by. At 10:14 a.m., the DON came into the medication room and confirmed the Ativan was inappropriately stored and not locked in the refrigerator door and confirmed it should have been double locked in the locked box. The DON confirmed the box had the key stored in the lock and stated it should have been locked at all times with the key having been kept with the charge nurse, and not left in the box. On 5/28/25 at 1:56 p.m., the consultant pharmacist (O)-D stated their expectation was Lorazepam Oral Concentrate USP should be	F 761	Tag Cited: F761 Label/Store Drugs and Biologics Based on observation and interview, the facility failed to maintain separately locked and permanently affixed compartments for storage of controlled medications in the medication room refrigerator reviewed for medication storage. 1. Immediate Action(s) taken for the resident(s) found to have been affected include: A locked storage box was obtained and affixed to the med room refrigerator. Refrigerated narcotics are now securely double locked in this compartment. The key is maintained with other controlled substance keys and are reconciled while all controlled substances are reconciled, including those in refrigerator lock box. A policy addendum to the Controlled Substance Admin and Accountability policy has been created to identify specific measures being taken, including staff responsibilities regarding safe storage of all narcotics, including those that require refrigeration, outlining facility processes and expectations. 2. Identification of all residents that have the potential to be affected was accomplished by: All future residents with medication orders for controlled medications requiring refrigeration will be maintained in a separately locked and permanently affixed refrigerated	

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F 761	Continued From page 46 stored double locked in an affixed structure/compartment within a refrigerator. On 5/28/25 at 3:54 p.m., the DON stated their expectation was Lorazepam Oral Concentrate should have been double locked and stored in affixed structure/compartment within the refrigerator. The DON stated the importance of storing narcotics properly to prevent misappropriation and have a process for safe medication storage in place. The facility Medication Policy dated 2024, indicated schedule II (two) drugs and back-up stock of schedule III (three), IV (four), and V(five) medications are stored under double-lock and key. Schedule II controlled medications are to be stored within a separately locked permanently affixed compartment when other medications are stored in the same area, such as in a refrigerator.	F 761	compartment. 3. Actions taken/systems put into place to reduce risk of future occurrences: All licensed staff/those that have medication administration responsibilities will be In-serviced regarding the responsibilities regarding safe storage of all narcotics, including those that require refrigeration and related policy revisions on June 25 & 26 by the Director of Nursing/designee. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The DON/designee will 3 random weekly audits for one (1) month and every other week thereafter for 2 additional months, as directed by the QAPI committee to ensure continued compliance. The verification checklists will be reviewed by the NHA. Summary of the audit results will be reported to the QAPI committee until such time consistent substantial compliance has been achieved, as determined by the QAPI committee.	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State	F 812		7/11/25

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F 812	Continued From page 47 and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure dishwasher temperatures were within the manufactures minimum temperatures to ensure resident dishes were sanitized. In addition, the facility failed to ensure temperatures were monitored in 4 of 4 refrigerators and 2 of 2 freezers reviewed for the kitchen. This had the potential to affect all 35 residents who resided in the facility. Findings include: On 5/18/25 at 1:50 p.m., during the initial walk through of the kitchen the dishwashing machine was being used by a nursing assistant (NA)-A, the machine was labeled a Jackson Temp star Dishwasher with temperature requirements as follows: wash temperature 150 degrees Fahrenheit (F), and rinse temperature of 180 degrees F. The actual temperatures observed were as follows: 1. 2:02 p.m., wash -165 degrees F, rinse -170 degrees F 2. 2:03 p.m., wash -164 degrees F, rinse -168 degrees F 3. 2:04 p.m., wash -165 degrees F, rinse -170	F 812	Tag 812 - Food Procurement, Store/Prepare/Serve-Sanitary Based on observation, interview and document review the facility failed to ensure dishwasher temperatures were within the manufactures minimum temperatures to ensure resident dishes were sanitized. In addition, the facility failed to ensure temperatures were monitored in 4 of 4 refrigerators and 2 of 2 freezers reviewed for the kitchen. This had the potential to affect all 35 residents who resided in the facility. 1. Dishwasher has been temporarily adjusted to run as a low temp dishwasher and temperatures need to be between 120-160 for the wash and rinse cycles. Staff are to document wash and rinse temps once during each meal. 2. The facility has determined that all residents who use dishware and is consuming anything by mouth has the potential to be affected The facility has	

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F 812	Continued From page 48 degrees F 4. 2:05 p.m., wash -154 degrees F, rinse -160 degrees F NA-A confirmed the temperatures for the rinse were not reaching the required 180 degrees F, and stated they were responsible for checking the machines temperatures were within range each mealtime or at least three times a day. NA-A confirmed they had conducted the temperature check when they arrived to work, and it had been working correctly. However, had not noticed the low temperatures until they were pointed out by surveyor. NA-A then notified their supervisor unprompted, and stated they would use paper material until the machine could be repaired. On 5/18/25 at 2:08 p.m. the certified dietary manager (CDM) arrived onsite and confirmed the dishwasher was not reaching the required temperatures and stated maintenance had been updated and confirmed they would be using paper products until the issue had been resolved, which was confirmed by observation at the next meal time. The Jackson Warewashing Systems: Tempstar series installation, operation, and service manual last revised 11/30/15, indicated the facility's machine was a Tempstar S Steam Heated Model with the follow minimum temperature requirements: 1. Wash temperature (minimum): 150 degrees F 2. Rinse temperature (minimum): 180 degrees F On 5/21/25 at 1:12 p.m., the maintenance director (M)-A stated the machine had maintenance conducted on 4/30/25 and had been	F 812	determined that the long-term solution will be to replace the dishwasher. A machine will be rented and serviced by Martin Brothers. 3. All dietary staff have been in-service on the facilitys policies and practice guideline for Dishwashing Machine Use. In-service included sanitizing process and following/documenting proper temperatures and testing for the proper chemical levels with the low temp dishwasher. A competency was completed on each dietary employee to determine if they employee was performing the procedure correctly. Finds were reviewed with each employee. Corrective action was provided as well. 4. The Dietary Manager or designee will complete training on taking all temps on dishasher, chemical level testing, and complete random audits of dietary staff performing procedures to ensure staff performance is in accordance with facility policy. Audit will be reviewed by the Registered Dietitian until such time consistent substantial compliance has been achieved as determined by the committee. This plan of correction will be monitored at the monthly Quality Assurance meeting until such time consistent substantial compliance has been met.	

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F 812	Continued From page 49 in working order since then. The refrigerator and freezer temperature logs were reviewed from March through May for the 2 freezers, and 4 refrigerators in the kitchen. The logs information showed the following: 1. Small Freezer: a. March: 15/62 opportunities were documented. b. April: 40/60 opportunities were documented. c. May: 21/44 opportunities were documented. 2. Big Freezer a. March: 14/62 opportunities were documented. b. April: 36/60 opportunities were documented. c. May: 20/44 opportunities were documented. 3. Refrigerator Number 2: a. March: 12/62 opportunities were documented. b. April: 38/60 opportunities were documented. c. May: 23/44 opportunities were documented. 4. Refrigerator Number 3: a. March: 13/62 opportunities were documented. b. April: 41/60 opportunities were documented. c. May: 21/44 opportunities were documented. 5. Refrigerator Number 4: a. March: a March log was requested for refrigerator number 4; however, none was provided. b. April: 41/60 opportunities were documented. c. May: 21/44 opportunities were documented. 6. Refrigerator Number 5: a. March: 13/62 opportunities were documented. b. April: 42/60 opportunities were documented. c. May: 23/44 opportunities were documented. On 5/22/25 at 10:03 a.m., the CDM stated their	F 812		

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F 812	Continued From page 50 expectation was for the dishwasher wash cycle to meet 150 degrees F and the rinse cycle to meet 180 degrees F, and it was important to ensure the dishwasher was functioning properly, so all of the items were sanitized properly. Furthermore, the CDM confirmed the four refrigerator logs, and two freezer logs were missing information. The CDM stated the cooks were typically responsible for completing them, and they were expected to be done in the morning and the evening, and it was important to store food appropriately and keep the food safe. On 5/22/25 at 10:05 a.m., the administrator stated they expected the dishwasher to be meeting manufacturers temperature requirements, and it was important to ensure the safety of the residents and proper sanitation of the dishes. Furthermore, they expected the refrigerator and freezer temperature logs to be completed daily, and it was important to ensure the safety of the food they are giving the residents. The facility Dishwashing Machine Use policy revised march of 2010, indicated dishwashing machines that use hot water to sanitize must maintain the following wash solution temperatures: 150 degrees F and dishwashing machines that use hot water sanitation rinse may not be more than 194 degrees F or less than 180 degrees F. The facility Refrigerators and Freezers policy last revised 2014, indicated food service supervisors or designated employee will check and record refrigerator and freezer temperatures daily with first opening and at closing in the evening.	F 812		
F 867 SS=F	QAPI/QAA Improvement Activities	F 867		7/11/25

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F 867	Continued From page 51 CFR(s): 483.75(c)(1)-(4)d)(1)(2)(e)(1)-(3)(g)(2)(ii)(iii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.71 and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the	F 867		

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F 867	Continued From page 52 facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and	F 867		

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F 867	Continued From page 53 implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.71. Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the Quality Assurance and Performance Improvement (QAPI) program	F 867	Tag 0867 - QAPI/QAA Improvement Activities Based on interview and document review,	

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F 867	Continued From page 54 effectively sustained ongoing compliance related to repeat citations from past surveys regarding immunizations. This had the potential to affect all 35 residents residing in the facility. Findings include: Review of the facility CASPER Report dated 4/16/25, indicated the facility was cited F883 for influenza and pneumococcal immunizations on the survey exited 3/28/24. See F883: Based on interview and document review, the facility failed to ensure 3 of 5 residents (R10, R27, R31) reviewed for immunizations were offered and/or provided the pneumococcal vaccine series as recommended by the Centers for Disease Control (CDC) to help reduce the risk of associated infection(s). The facility's Quality Assessment and Assurance (QAA) committee meeting minutes from April 2024 through May 2025 lacked ongoing data related to the above repeat citation. On 5/28/25 at 5:31 p.m., the administrator acknowledged the importance of continued monitoring of prior Performance Improvement Projects (PIPS). The facility's Quality Assurance and Performance Improvement policy, dated 2024, indicated the facility monitors the effectiveness of its performance improvement activities to ensure improvements are achieved and sustained.	F 867	the facility failed to ensure the Quality Assurance and Performance Improvement (QAPI) program effectively sustained ongoing compliance related to repeat citations from past surveys regarding immunizations. This had the potential to affect all 35 residents residing in the facility. 1. It was noted the Facility failed to ensure the Quality Assurance and Performance Improvement (QAPI) program effectively sustained ongoing compliance related to repeat citations from past surveys regarding immunizations. The citation related to immunizations was discussed and added to the QAPI held on 6/16/2025 that was for the month of May 2025. 2. The facility has determined that all 35 residents residing in the facility have the potential to be affected. 3. The Administrator will provide education on the Quality Assurance and Performance Improvement Policy and the QAPI Monitoring Policy to: Director of Nursing, A-DON MDS Coordinator, Nurse Manager, Social Services, Dietary Manager, Environmental Service Director, Activity Director, Pharmacy Consultant, and Therapy Director. All citations and progress will be reviewed during QAPI meetings. A performance improvement plan (PIP) will be added regarding the immunizations. 4.The Administrator or designee will complete a monthly audit for 3 months	

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F 867	Continued From page 55	F 867	and then quarterly for the next two (2) quarters and review that all citations are listed on the monthly QAPI with progress and results and any appropriate PIPs created if needed. Audits will also be reviewed by Risk Management and by the Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee.	
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(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 immunization due to medical contraindications or	F 883		7/11/25

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F 883	Continued From page 56 refusal. §483.80(d)(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 3 of 5 residents (R10, R27, R31) reviewed for immunizations were offered and/or provided the pneumococcal vaccine series as recommended by the Centers for Disease Control (CDC) to help reduce the risk of associated infection(s). Findings include:	F 883	Tag Cited: Influenza and Pneumococcal Immunizations Based on interview and document review, the facility failed to ensure 1 of 5 residents (R26) reviewed for immunizations were offered and/or provided the COVID-19 vaccine to help reduce the risk of associated infection(s). 1. Immediate Actions(s) take for the	

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F 883	Continued From page 57 A CDC Pneumococcal Vaccine Timing for Adults feature, dated 10/24, identified various tables when each (or all) of the pneumococcal vaccinations should be obtained. This identified when an adult over 50 years old had received the complete series (i.e., PPSV23 and PCV13; see below) then the patient and provider may choose to administer Pneumococcal 20-valent Conjugate Vaccine (PCV20) for patients who had received Pneumococcal 13-valent Conjugate Vaccine (PCV13) at any age and Pneumococcal Polysaccharide Vaccine 23 (PPSV23) at or after 50 years old. R10's significant change Minimum Data Set (MDS), dated 4/3/25, indicated R10 was 68 years old and diagnoses included dementia, diabetes, rheumatoid arthritis, epilepsy. R10's immunization report, dated 5/21/25, indicated R10 received PPSV23 on 3/22/10, and PCV13 on 3/2/16. R10's immunization consent form indicated R10's guardian signed consent to receive the pneumococcal vaccine on 4/25/24. However, R10's record lacked evidence R10 received PCV20 or PCV21. R27's significant change MDS, dated 2/20/25, indicated R27 was 72 years old and diagnoses included Alzheimer's disease, anxiety disorder, and peripheral vascular disease (PVD). R27's immunization report, dated 5/21/25, indicated R27 received PCV15 on 8/12/22. R27's immunization consent form indicated R27's guardian signed consent to receive pneumococcal vaccine on 4/24/24. However, R27's record lacked evidence R27 received PPSV23, PCV20 or PCV21.	F 883	resident(s) found to have been affected include: R10 - PCV 20 and 21 offered to resident, consent was obtained. Orders to administer as applicable on 6/27/2025. R27 - PCV 20, 21 or 23 offered to resident, consent obtained, orders to administer as applicable on 6/27/2025. R31 - PCV 15, 20 or 21 offered to resident, consent obtained, orders to administer as applicable on 6/27/2025. 2. Identification of all residents that have the potential to be affected was accomplished by: All residents have the potential to be affected. 3. Actions taken/systems put into place to reduce risk of future occurrences: DON or designee will in-service all licensed nurses/those that have injection administration abilities will be in-serviced regarding consented/requested pneumococcal vaccinations on 6/25 & 6/26 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The DON/designee will complete 3 random weekly audits for one (1) month and every 2 weeks thereafter for two (2) additional months. Summary of the audit results will be reported to the QAPI committee until such time consistent substantial compliance has been achieved, as determined by the QAPI committee.	

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F 883	Continued From page 58 R31's significant change MDS, dated 4/7/25, indicated R31 was 79 years old and diagnoses included adult failure to thrive, depression, and osteoporosis. R31's immunization report, dated 5/21/25, indicated R31 had not received any pneumococcal vaccinations. However, R31's record lacked evidence R31 was offered or received PCV15, PCV20, or PCV21. On 5/28/25 at 3:54 p.m., director of nursing (DON) verified the facility failed to administer R10 and R27 requested/consented pneumococcal vaccinations. Additionally, DON verified R31 had not been offered the pneumococcal vaccine. The DON stated it was important to keep resident immunizations up to date to prevent the spread of infection. The facility's Pneumococcal Vaccine policy, reviewed 5/2024, indicated the facility offered residents immunization against pneumococcal disease in accordance with current CDC guidelines and recommendations.	F 883		
F 887 SS=D	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80 Infection control §483.80(d)(3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized;	F 887		7/11/25

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F 887	Continued From page 59 (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects, associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses. (v) The resident or resident representative, has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; and (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident, or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal. (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine;	F 887		

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F 887	Continued From page 60 (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 5 residents (R26) reviewed for immunizations were offered and/or provided the COVID-19 vaccine to help reduce the risk of associated infection(s). Findings include: R26's annual Minimum Data Set (MDS), indicated R26 diagnoses included mild cognitive impairment, transient ischemic attack (TIA) and cerebral infarction (stroke), and aortic valve stenosis. R26's immunization report, dated 5/21/25, indicated R26 had not received any COVID-19 vaccinations. R26's immunization consent form indicated R26 was offered and signed consent to receive the COVID-19 vaccine on 4/26/24. However, R26's record lacked evidence the facility provided the requested COVID-19 vaccine. On 5/28/25 at 3:54 p.m., director of nursing (DON) verified R26's clinical record lacked evidence the facility provided the COVID-19 vaccine to R26. DON stated the COVID-19 vaccine was important to prevent the spread of infection and staff were expected to review and offer immunizations upon admission and quarterly at care conferences.	F 887	Tag Cited: F887 Covid 19 Immunization Based on interview and document review, the facility failed to ensure 1 of 5 residents (R26) reviewed for immunizations were offered and/or provided the COVID-19 vaccine to help reduce the risk of associated infection(s). 1. Immediate Actions(s) take for the resident(s) found to have been affected include: R26 was offered a COVID 19 vaccine/consent signed on 6/23/25. 2. Identification of all residents that have the potential to be affected was accomplished by: All residents have the potential to be affected. 3. Actions taken/systems put into place to reduce risk of future occurrences: DON or designee will in-service all licensed nurses/those that have injection administration abilities regarding consented/requested pneumococcal vaccinations on _June 25 & 26, 2025. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The DON/designee will complete 3 random weekly audits of COVID-19	

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F 887	Continued From page 61 The facility's COVID-19 Vaccination Policy and Procedure, revised 5/2024, indicated it is the policy of the facility to minimize the risk of acquiring, transmitting or experiencing complications from COVID-19 by educating and offering COVID-19 vaccination to our residents and staff members.	F 887	consents and administration if applicable for one (1) month and every 2 weeks thereafter for two (2) additional months. Summary of the audit results will be reported to the QAPI committee until such time consistent substantial compliance has been achieved, as determined by the QAPI committee.	
F 921 SS=E	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on document review, interview, and observation the facility failed to ensure shared resident refrigerator 1 of 1 was kept in sanitary conditions and 2 of 2 (shared resident refrigerator and medication refrigerator) reviewed for temperature control were monitored. Findings include: On 5/19/25 at 11:03 a.m. a shared resident refrigerator was observed to contain multiple open, and undated bottles, and a container of milk. Two bottles of "pepsi", a bottle of flavored water, and a container of chocolate milk. All opened and undated in the refrigerator. In the freezer, there was a large box of orange popsicles with had melted. There was a large amount of sticky orange substance on the floor of the freezer which encompassed a Tupperware container containing an unknown item. The container was affixed to the floor of the	F 921	Tag F921 - Safe/Functional/Sanitary/Comfortable Environment Based on document review, interview, and observation the facility failed to ensure shared resident refrigerator 1 of 1 was kept in sanitary conditions and 2 of 2 (shared resident refrigerator and medication refrigerator) reviewed for temperature control were monitored. 1. The Housekeeping Department immediately sanitized resident fridge. All food in the fridge was reviewed and disposed of properly that was passed the 3 day threshold. 2. The facility has determined that all residents who use the communal resident fridge have the potential to be affected.	7/11/25

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F 921	Continued From page 62 refrigerator by the orange substance. The certified dietary manager (CDM) confirmed the residents used this refrigerator and freezer. Both were unsanitary and unappealing. The CDM was unsure of the last time the refrigerator had been cleaned. The temperature logs of the shared refrigerator were reviewed and the CDM confirmed the temperature log for May of 2025 was missing significant amounts of information, and they were unsure who was responsible for checking and maintaining the temperatures. The temperature log for the shared resident refrigerator dated May 2025, indicated there was no temperature information noted for 9/20 days listed. The monthly deep cleans log dated January 2025, indicated the shared resident refrigerator cleaning schedule, there was no date listed to indicate the last time the refrigerator was cleaned. On 5/20/25 at 1:17 p.m., the administrator provided the above listed temp logs and cleaning schedule, and confirmed they had no evidence of the last time the refrigerator was cleaned. On 5/20/25 at 10:00 a.m., the medication refrigerator in the medication room had five small see-through containers on a shelf, each held insulin pens. The insulin pens were inside of a plastic bag, and then placed in the see through container, each of the 5 containers and bags had water inside the bags and within the containers. The freezer compartment of the refrigerator was covered in a hard block of white ice and was leaking down into the insulin bags and containers. Additionally, the temp log on the refrigerator was reviewed, and was found to be missing significant	F 921	3. All Housekeeping Staff have been in-serviced on the facility polices and practice guideline for Use and Storage of Food Brought in by Family or Visitors on June 27, 2025. In-Service training included reviewing cleaning schedule, Temp Log, and proper way to sanitize fridge. Policy will be discussed with residents at Resident Council and review the process. 4. The Environmental service Director or designee will complete a random audit of staff performing procedures weekly for one (1) month to ensure it is being done according to facility policy. Audits will be reviewed by Administrator until such time consistent substantial compliance has been achieved as determined by the committee. This plan of correction will be monitored at the monthly Quality Assurance meeting until such time consistent substantial compliance has been met.	

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F 921	Continued From page 63 amounts of information. The Medication/Insulin temperature logs were reviewed for March, April and May of 2025, and the following information was noted: March 2025-26/62 shifts had no temperature noted. April 2025-16/60 shifts had no temperature noted. May 2025-44/62 shifts had no temperature noted. On 5/20/25 at 10:00 a.m., Licensed practical nurse (LPN)-B confirmed there was water within the bags, and containers and confirmed no water should be in them. LPN-B stated the nurse on duty was responsible for reviewing the temperature logs, and they are expected to complete the logs daily. On 5/20/25 at 10:14 a.m., the Director of nursing (DON) confirmed there should be no water within the bags or containers which store medications, and the refrigerator needed to be defrosted. On 5/28/25 at 1:36 p.m.., the consultant Pharmacist stated their expectation was insulin should be stored and temperature controlled between 36 degrees Fahrenheit(F) to 46 degrees F, and the condition listed above was unsanitary and there should be no water within their storage compartments for medications, and temperatures logs should be completed per facility policy. The pharmacist stated it was important to store medications in appropriate conditions and temperatures to ensure effectiveness, and to ensure the product does not breakdown. On 5/28/25 at 3:54 p.m., the DON their expectation was for insulin pens to be stored in sanitary conditions, and temperature logs were to	F 921		

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F 921	Continued From page 64 be completed every 24 hours. The DON stated the importance of storing medications in sanitary conditions and completing temperature logs to have safe storage process in place and prevent spoiling of contents of the refrigerator. On 5/22/25 at 10:05 a.m., the administrator stated housekeeping was responsible for weekly cleaning and temperature tracking of the shared resident refrigerator, and confirmed it had not been cleaned since January 2025. It was important to keep the refrigerator clean and the temperature logs maintained to safely store the resident's food. The facility policy Refrigerators and Freezers last revised 2014, indicated food service supervisors or designated employee will check and record refrigerator and freezer temperatures daily with first opening and at closing in the evening. The facility policy Medication storage dated 2024, indicated temperatures are maintained within 36-46 degrees F. Charts are kept ton each refrigerator and temperature levels are recorded daily by the charge nurse or other designee.	F 921		

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	245273	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/20/2025**

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K 000	INITIAL COMMENTS Fire Safety An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 05/20/2025. At the time of this survey, Franklin Restorative Care Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

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

Electronically Signed | 06/19/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See 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.

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Franklin Rehabilitation & Healthcare Center was constructed as follows: The original building was constructed in 1962, is one-story, has a partial basement, is fully fire sprinkler protected, and was determined to be of Type II(111) construction; The 1st Addition was constructed in 1972, is one-story, has a partial basement, is fully fire sprinkler protected, and was determined to be of Type II(111) construction; The 2nd Addition was constructed in 1994, is	K 000		

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K 000	Continued From page 2 one-story, has no basement, is fully fire sprinkler protected, and was determined to be of Type II(111) construction. The building has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridors, which is monitored for automatic fire department notification. The facility has a capacity of 40 beds and had a census of 36 at the time of the survey.	K 000		
K 226 SS=D	The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: Horizontal Exits CFR(s): NFPA 101 Horizontal Exits Horizontal exits, if used, are in accordance with 7.2.4 and the provisions of 18.2.2.5.1 through 18.2.2.5.7, or 19.2.2.5.1 through 19.2.2.5.4. 18.2.2.5, 19.2.2.5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain fire barriers per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.2.5, and 7.2.4.3.1. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 05/20/2025 between 9:15 and 11:15 AM, it	K 226	This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain fire barriers per NFPA101 (2012 edition), Life Safety Code, sections19.2.2.5, and 7.2.4.3.1. This deficient finding could have an isolated impact on the residents within the facility. 1. Corrective Action for Affected Area:	6/23/25

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K 226	Continued From page 3 was revealed by observation that the fire doors by the Physical Therapy area did not latch when released from the self-closing device. An interview with the Enviornmental Services Director verified this deficient finding at the time of discovery.	K 226	The identified fire barrier was immediately assessed and fire doors were adjusted to they automatically latch when released from self-closing device. 2. Identification of Other Areas: All other horizontal exits were inspected. No additional issues were found. 3. Systemic Changes: Maintenance staff were educated on NFPA 101 (2012) standards. Monthly safety checks include all horizontal fire barriers. 4. Monitoring: Maintenance Director will audit monthly for 2 months. Results will be reviewed in QAPI until sustained compliance is confirmed.	
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided	K 363		6/23/25

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K 363	Continued From page 4 with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.6.3.1, and 19.3.6.3.5. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 05/20/2025 between 9:15 and 11:15 AM, it was revealed by observation that the door for resident room 125 did not latch when it was closed due to the latching hardware missing from the door. An interview with the Environmental Services Director verified this deficient finding at the time	K 363	K363(D) - Corridor Doors This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.6.3.1, and 19.3.6.3.5. This deficient finding could have an isolated impact on the residents within the facility. 1. Corrective Action for Affected Area: The identified corridor door was repaired immediately to ensure it closes and latches properly. 2. Identification of Other Areas: All resident room corridor doors were	

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K 363	Continued From page 5 of discovery.	K 363	inspected. No additional issues were found. 3. Systemic Changes: Maintenance staff received re-education on NFPA 101 (2012) standards for corridor doors. Weekly door checks were implemented. 4. Monitoring: The Maintenance Director will audit all corridor doors weekly for 3 months, then monthly. Findings will be reviewed by QAPI until compliance is sustained.	
K 918 SS=D	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to	K 918		5/21/25

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K 918	Continued From page 6 manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain the emergency generator per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, sections 8.3.4, and 8.4.9. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 05/20/2025 between 9:15 and 11:15 AM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide documentation showing a four (4) hour load bank test has been completed within the last 36 months for the generator. An interview with the Environmental Services Director verified this deficient finding at the time of discovery.	K 918	K918(D) - Electrical Systems Essential Electric System This STANDARD is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain the emergency generator per NFPA 99 (2012edition), Health Care Facilities Code, section6.4.4.1.1.3, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, sections 8.3.4, and 8.4.9. This deficient finding could have a widespread impact on the residents within the facility. R (4) hour load bank test was completed on 5/21/2025 by Interstate Power Systems. 1. Corrective Action for Affected Area: A 4-hour load bank test was completed on 5/21/2025 by Interstate Power Systems to meet NFPA requirements. 2. Identification of Other Areas: Generator documentation and testing logs were reviewed for the previous 12 months. No other deficiencies were identified. 3. Systemic Changes: The facility updated	

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K 918	Continued From page 7	K 918	its generator testing schedule to ensure timely compliance with NFPA 99 (2012) and NFPA 110 (2010). Maintenance staff were re-educated on emergency power system requirements. 4. Monitoring: The Administrator or designee will audit generator test documentation monthly for 6 months. Results will be reviewed during QAPI to ensure ongoing compliance.	

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 23, 2025

Administrator

Franklin Restorative Care Center

900 3RD STREET SOUTH

FRANKLIN, MN 55333

RE: CCN: 245273

Cycle Start Date: May 1, 2025

Dear Administrator:

On June 13, 2025, we notified you a remedy was imposed.

On July 29, 2025, the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of July 11, 2025.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective August 1, 2025, did not go into effect. (42 CFR 488.417 (b))

In our letter of June 13, 2025, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from August 1, 2025, due to denial of payment for new admissions. Since your facility attained substantial compliance on July 11, 2025, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Your request for a 24-hour RN waiver has been approved based on the submitted documentation.

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
PO Box 64975 | 625 Robert Street North
St. Paul, MN 55164-0975
Office: 651-201-4384
Email: holly.zahler@state.mn.us